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 27 November 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 24 September 2024	Decision	Chair	Paper
5.	09:40	Action log and matters arising	Assurance / decision	Chair	Paper
6.	09:45	Patient and Staff Story – learning disabilities	Assurance	Service Line Manager	Presentation
ITEMS FOR DECISION					
7.	10:00	Calendar of Board meetings 2025/26	Decision	Company Secretary	Paper
8.	10:10	Salary Sacrifice Schemes	Decision	Group Director of Finance & Digital	Paper
9.	10:20	Proposed Constitutional Amendment Re: Constituencies	Decision	Chair	Paper
ITEMS FOR ASSURANCE					
10.	10:30	Chair's Report	Assurance	Chair	Paper
11.	10:40	Chief Executive's Report	Assurance	Chief Executive	Paper
12.	10:50	Governance Reports:			
		i) Board Assurance Framework	Assurance	Company Secretary	Paper
		ii) Organisational Risk Register	Assurance	Chief Nurse	Paper
13.	11:05	Assurance from Board Committees:			
		i) Finance and Performance Committee – October and November 2024	Assurance	Chair of the Committee	Paper
		ii) Quality Governance Committee – October 2024	Assurance	Chair of the Committee	Paper
		iii) People and Organisational Development Committee – November 2024	Assurance	Chair of the Committee	Paper
		iv) Digital Committee – October 2024	Assurance	Chair of the Committee	Paper
		v) Group Remuneration Committee	Assurance	Chair of the Committee	Paper
14.	11:25	Finance Report	Assurance	Group Director of Finance and Digital	Paper
15.	11:35	Strategic Objectives and Constitutional Standards Report	Assurance	Group Director of Finance and Digital	Paper
16.	11:45	Learning From Deaths 6 monthly report	Assurance	Group Medical Director	Paper

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No	Start time	Item	Purpose	Lead	Paper / Verbal
17.	11:55	Maternity Integrated Oversight Report	Assurance	Head of Midwifery	Paper
18.	12:05	Nurse Staffing Exception Report	Assurance	Chief Nurse	Paper
ITEMS FOR INFORMATION / MEETING GOVERNANCE					
19.	12:15	Cycle of Business	Information	Company Secretary	Paper
20.	12:20	Questions from Governors in Attendance	Discussion	Chair	Verbal
21.	12:30	Any Other Business	Discussion	Chair	Verbal
22.	12:35	Date and Time of Next Meeting – 9:30am on Wednesday 29 January 2025	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 Tuesday 24th September 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 Strategic Relations
Mrs Joanne Halliwell	Group Chief Operating Officer
Mr Martin Hedley	Non-Executive Director / Senior Independent Director
Dr Carmen Howey	Group Medical Director
Mrs Kris Mackenzie	Group Director of Finance and Digital
Mr Andrew Moffat	Non-Executive Director
Mrs Hilary Parker	Non-Executive Director
Mrs Maggie Pavlou	Deputy Chair / Non-Executive Director
Mr Mike Robson	Non-Executive Director
Mrs Anna Stabler	Non-Executive Director
Mrs Amanda Venner	Group Director of People & Organisational Development
Attendees present	
Mrs Jennifer Boyle	Company Secretary
Ms Alyson Duncan	Service Line Manager (24/09/06)
Ms Debbie Heslop	Matron (24/09/06)
Ms Catherine Lilley	Endoscopy Sister (24/09/06)
Ms Tracy Healy	Freedom to Speak Up Guardian (24/09/20)
Dr J Singh	Endoscopy Clinical Lead (24/09/06)
Ms Diane Waites	Corporate Services Assistant
Governors and Observers	
Ms Helen Adams	Staff Governor
Mr Les Brown	Public Governor – Western Gateshead
Apologies	

Agenda Item No		Action Owner
24/09/01	**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 and highlighted that this will be Mrs Anna Stabler's last meeting as one of the Trust's Non-Executive Directors. She thanked Mrs Stabler for her hard work and contributions to the Board and wished her well in her new role.	

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Agenda Item No		Action Owner
	Mrs Marshall highlighted that there were a number of items on the agenda for this meeting and asked presenters to take reports as read.	
24/09/02	**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. Mrs H Parker, Non-Executive Director and Mrs M Pavlou, Deputy Chair, declared an interest in relation to Agenda Item 11, QE Facilities Chair and Non-Executive Director appointments.	
24/09/03	**Apologies for Absence:** There were no apologies noted.	
24/09/04	**Minutes of the Previous Meeting:** The minutes of the meeting of the Board of Directors held on Wednesday 31st July 2024 were approved as a correct record.	
24/09/05	**Matters Arising from the Minutes:** The Board reviewed the action tracker as below: • Action 24/06/14 relating to the bi-annual inpatient safer nursing care staffing report and the need for discussions to take place to agree outputs and further work around the calculations relating to the emergency department. It was highlighted that a new model has been agreed with the Emergency Department which releases some funding and a business case is now being developed. Action was agreed for closure. • Action 24/07/09 relating to the clinical leadership elements from the organisational restructure. Further work is required and a survey to members of the clinical strategy group has been circulated. This will be discussed further on today's agenda therefore it was agreed to close this action and include any new actions following discussion. • Action 24/07/11 relating to future Board Development session to discuss potential impact of change in government direction and expectations around efficiency and recovery work. It was agreed that this action will remain open until a date is identified and will also include any work from the Lord Darzi report.	

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	• Action 24/07/12 relating to the Great North Health Care Alliance work plan and developing connections between Non-Executive Directors across the Alliance. The work plan will be discussed in Part 2 of today's meeting and a meeting with Alliance partners is planned to take place in December 2024 therefore it was agreed to close these actions. • Action 24/07/17 relating to the development of a process around the assurance report template for referrals to other Committees. The template has been amended to enable cross-referral to Executive leads rather than directly to Board committees therefore action agreed for closure. • Action 24/07/21 relating to the inclusion of any decreases and increases against previous month figures within future Nurse Staffing Exception reports. Trend analysis is now included within the report therefore action agreed for closure • Action 24/07/25 relating to assessment of the impact of the Health Service Journal article on very senior manager recruitment and a request to brief the Board on key implications. Mrs A Venner, Group Director of People and Organisational Development, highlighted that this had been a national review and there was little impact on this region however a succession planning template is being developed and will be reviewed in more detail by the Executive Management Team. It was therefore agreed to close this action. 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.	
24/09/06	**Staff Story – Endoscopy** The Board welcomed Ms Alyson Duncan, Service Line Manager, Ms Debbie Heslop, Matron, Ms Catherine Lilley, Endoscopy Sister, and Dr J Singh, Endoscopy Clinical Lead who provided a presentation on the achievements and how challenges were addressed within the department leading to the Joint Advisory Group (JAG) on Gastrointestinal Endoscopy accreditation of quality assurance standards. The team highlighted the improvements made in relation to waiting lists and performance standards including cancer targets following additional support and activity. Dr Singh highlighted some of the improvements made within the department following capital investment via the Regional Endoscopy Network including new equipment and estates upgrade. This also included a seminar room to support training with the Northern Endoscopy Training Academy.	

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	Ms Heslop provided an update on the work undertaken in relation to workforce which focussed on the health and wellbeing of staff as well as providing further development opportunities. The team are now fully established with a reduction in sickness absence and Ms Heslop drew attention to some of the positive feedback given by staff. Mrs T Davies, Group Chief Executive, thanked the team for their hard work and effort in obtaining the accreditation which demonstrated strong leadership and shared purpose within the team. Mrs J Halliwell, Group Chief Operating Officer, felt that this provided learning opportunities across the organisation particularly around approaches to sickness reduction and Ms Heslop explained that it was important to engage with the workforce and provide supportive networks. Mrs K Mackenzie, Group Director of Finance and Digital, felt that it was important to commend how the team had also focussed on financial sustainability. Mrs Davies highlighted that further work will be considered around how other services and teams can be supported using tools and methodologies from learnings across the organisation. Mr N Halford, Medical Director of Strategic Relations, felt that it was important for the Board to be sighted on work taking place within departments to manage changing environments and Ms Duncan highlighted that further work is taking place around succession planning and training to enable additional capacity within the department. The Board thanked those involved and the staff for their work and dedication and acknowledged the significant achievements within the department. Ms Duncan, Ms Heslop, Ms Lilley, and Dr Singh left the meeting.	
24/09/07	**Winter Plan 2024/25:** Mrs J Halliwell, Group Chief Operating Officer, presented the draft Winter Plan 2024/25 Strategic Overview Assurance Report and highlighted that a supporting Operational Trust Winter Plan will be produced to provide specific guidance, information and instructions for teams to operationally respond during the winter period. Mrs Halliwell drew attention to the proposed priorities within the report which demonstrates strong alignment to the continuous work already being undertaken within the Emergency Preparedness, Resilience and Response (EPRR) team and highlighted the system governance structure which incorporates strategic oversight and operational management/response at system and Trust level which has been agreed and implemented.	

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	Following a query from Mrs Marshall in relation to system support, Mrs Halliwell explained that regional and internal discussions are taking place in relation to lessons learned and the System Group meeting is taking place later this month. Mr A Crampsie, Non-Executive Director, felt that it would be beneficial for discussions to feed into the Alliance work. Mrs Halliwell noted there may be an opportunities to bring the winter plans together to form a collective Alliance position. Mr Crampsie also felt that it would be beneficial for the plan to provide some links to staff welfare including sickness absence rates and Mr M Robson, Non-Executive Director, commented that further details around the financial plan may be required due to the current financial environment. Discussion took place around the level of detail provided to the Board and it was felt that further discussions should take place within the Board Tier 1 Committees. It was suggested that the document presented to the local winter group and regional group could be shared. Following a query from Mrs A Stabler, Non-Executive Director, in relation to the organisational locally managed risks, Mrs Halliwell explained that the current risk on the Organisational Risk Register is being reviewed to reflect risks for the winter period. After consideration, it was: **RESOLVED:** to endorse the approach within the Winter Plan 2024/25 Strategic Overview Assurance Report and support the work noting the risks identified.	JH
24/09/08	**Terms of Reference:** Mrs J Boyle, Company Secretary, presented the revised terms of reference for Group Audit Committee and Gateshead Health Leadership Group for ratification. Mrs Boyle highlighted that the Group Audit Committee Terms of Reference have been reviewed by the Committee and some minor amendments have been made in accordance with the new governance structure. Some changes were also proposed to bring the terms of reference in line with good practice outlined in the latest Healthcare Financial Management Association (HFMA) Audit Committee Handbook. Mr M Robson, Non-Executive Director, also highlighted that an amendment was made in relation to the quoracy of the Committee which provides the Committee with the right to pragmatically invite other Non-Executive Directors to attend for a single meeting in order to achieve quoracy if the lack of quoracy is short term / short notice and this is recommended to be adopted by other Committees.	JB

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	Mrs Boyle also drew attention to the Terms of Reference for the Gateshead Health Leadership Group, which is an important new addition to the governance structure and connects the Tier 2 Groups to the Tier 1 Committees and is accountable to the Board. Mr Robson noted that the Terms of Reference make reference to the Trust's Standing Orders and Scheme of Delegation therefore felt that it was important to update those accordingly which was agreed by the Board. After consideration, it was: **RESOLVED:** to ratify the Group Audit Committee and Gateshead Health Leadership Group terms of reference on the recommendation of the Committee and Group.	JB
24/09/09	**National Pay Award:** Mrs K Mackenzie, Group Director of Finance and Digital, presented the report relating to the implementation of the nationally mandated pay award. Mrs Mackenzie explained that the Government have committed to accepting the NHS Pay Review Body (PRB) recommendations on pay for 2024/25 which relate to uplifting all pay points for Agenda for Change (AfC) staff by 5.5% on a consolidated basis, with effect from 1 April 2024. It also includes adding intermediate pay points at bands 8a and above and working with the NHS Staff Council to take forward the PRB's recommendations on AfC pay structures. At present it is not possible to quantify the cost to the organisation and there is no clarity on the formula being applied to determine levels of funding being allocated. Therefore, it is not possible to assess or quantify the overall financial consequences, although noted is the statement that the intention is for the pay award to be cost neutral. Discussion took place around approval mechanisms in relation to mandated pay awards and whether this should be included within the Trust's Standing Financial Instructions (SFIs) and Scheme of Delegation as an item requiring approval, or treated as an exception (given that it is nationally mandated). It was agreed that the award should be approved by the Board for completeness and good governance, however the wording within the SFIs and Scheme of Delegation will be reviewed. Mrs Mackenzie highlighted that once the once the financial impact is quantified a paper will be brought back to Board. Following further discussion, it was:	KMac

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	RESOLVED: to support the acceptance and implementation of the nationally mandated pay award.	
24/09/10	**QE Facilities Pay Award:** Mr G Evans, QE Facilities Managing Director, presented the report relating to the 2024/25 QE Facilities Staff Pay Award. Mr Evans reminded the Board that QE Facilities employs staff under Agenda for Change and QE Facilities' terms and conditions as well as having a commitment to the Real Living Wage. Details are provided in the paper and options have been considered by the QE Facilities Board. It is therefore recommended to implement the national Agenda for Change pay award of 5.5% for all staff groups regardless of terms and conditions with the exception of those on the National Living Wage and implement a pay award of 7.7% for those staff on QE Facilities terms and conditions currently on the national living wage to ensure an hourly pay rate of £12. All proposals will be backdated to 1st April 2024. Discussion took place in relation to the different pay structures in place in QE Facilities and future workforce strategies. Mrs K Mackenzie, Group Director of Finance and Digital, reminded the Board that the financial impact in relation to pay award was currently unknown as the funding formula had not been confirmed nationally. After consideration, it was: **RESOLVED:** to support the recommendations of the QE Facilities Board in relation to the implementation of the pay awards.	
24/09/11	**QE Facilities Chair and Non-Executive Director Appointment:** Mrs H Parker, Non-Executive Director and Mrs M Pavlou, Deputy Chair, left the meeting for this agenda item following declarations of interest noted. Mrs A Marshall, Chair, presented the report which proposes the extension of the terms of the current QE Facilities Chair and Non-Executive Director for a further 12 months. Mrs Marshall reminded the Board that following the subsidiary governance review in summer 2023, the Group Board of Directors considered the composition of the QE Facilities Board of Directors at an extraordinary meeting on 4 September 2023. The Deloitte report recommended that QE Facilities transitioned to a new Board structure over time, recognising the volume of work being undertaken to reset and strengthen the governance and strategy for the Group.	

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	The proposals have been considered by the Group Remuneration Committee and therefore it recommends the extension of the terms of Maggie Pavlou as QE Facilities Chair and Hilary Parker as QE Facilities Non-Executive Director, for a further 12 months. Mrs Marshall explained that retaining the current postholders mitigates risks of destabilising the Board and organisation and provides continuity at a time when changes and improvements are embedding. There are also no additional finance implications. Following consideration, it was: **RESOLVED:** i) to retain an internally-appointed Chair and NED for a further 12 months; ii) to extend the term of Maggie Pavlou in the role of QEF Chair for a period of 12 months commencing on 1 October 2024 with remuneration for the Chair role of £10k and a time commitment of 3-4 days per month, in line with the existing job description; and iii) to extend the term of Hilary Parker in the role of QEF NED for a period of 12 months commencing on 1 October 2024 with remuneration for the NED role of £5k and a time commitment of 2-3 days per month, in line with the existing job description Mrs Parker and Mrs Pavlou returned to the meeting.	
24/09/12	**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. She began her report with the sad news of the loss of a valued colleague. Lisa Robson sadly passed away on 30 July after a courageous fight. Lisa worked with us for over 38 years across catering, paediatrics and Special Care Baby Unit (SCBU) and her absence is profoundly felt by her team and wider colleagues. She is very much missed and on behalf of the Board, Mrs Marshall expressed our deepest condolences to Lisa's family, friends and colleagues, particularly her sister who also works at the Trust. Mrs Marshall again thanked Mrs A Stabler for her commitment and valued contribution to the Board in her role as Non-Executive Director, and wished her success in her new role as a substantive Non-Executive Director role on the Board of Directors at Newcastle Hospitals. The Governor Remuneration Committee is leading the recruitment process for a clinical Non-Executive Director replacement and also a Non-Executive Director with significant NHS finance experience who will replace Mr Mike Robson when he leaves the Board next year.	

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	The Jubilee courtyard garden, which has been named the Garden of Hope, was officially opened by the Lord Lieutenant of Tyne and Wear, Ms Lucy Winskell OBE (King Charles' representative in our region). The Garden of Hope was made possible by kind donations to the Gateshead Health Charity and sincere thanks were recorded to all those who contributed to the project. Mrs Marshall drew attention to the Star of the Month nominations for July and August 2024 and congratulated the winners. Following discussion, it was: **RESOLVED:** to receive the report for assurance.	
24/09/13	**Chief Executive's Report:** Mrs T Davies, Chief Executive, gave an update to the Board on current issues which have aligned to the Trust's Strategic Aims. She drew attention to the following updates in relation to Strategic Aim 1: *We will continuously improve the quality and safety of our services for our patients* – The Trust has been named as a finalist for Trust of the Year at the Health Service Journal (HSJ) Awards 2024 and is one of nine trusts to be shortlisted. This is a fantastic achievement and is a testament to the dedication and hard work of all of our colleagues and volunteers. The Trust is also monitoring the emerging situation in relation to the GP collective action and business continuity plans are in place however the potential impact is currently unclear therefore has been added as one of the top three organisational risks. In relation to Strategic Aim 2: *we will be a great organisation with a highly engaged workforce* – Mrs Davies wished to record her thanks to Dr Issac Evbuomwan for his hard work and dedication in chairing both the Medical Staffing Committee (MSC) and Local Negotiating Committee (LNC) and the team are looking forward to working with Dr Andrew Lowes as the incoming Chair of the MSC and Ian McClintock, incoming Chair of the LNC. In relation to Strategic Aim 3: *we will enhance our productivity and efficiency to make the best use of resources* – Mrs Davies highlighted that there is a significant focus on improving our financial position and making the best use of the resources available to us as well as preparing for winter. It is recognised that connectivity between our teams and timely, accurate and compassionate communication will be key therefore opportunities will be available via the Chief Executive roadshows. Mrs Davies highlighted that a formal incident management approach was implemented in relation to technical issues experienced with the Trust's	

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	PACS radiology image viewing solution and Mrs J Halliwell, Group Chief Operating Officer, reported that a further overnight fix will take place and work is ongoing to monitor this going forward and ways to evolve the system. The Executive Team will be reviewing learning and ensuring that staff feedback and concerns are escalated accordingly. In relation to Strategic Aim 4: we *will be an effective partner and be ambitious in our commitment to improving health outcomes* – Mrs Davies highlighted that she recently attended a national provider Chief Executive meeting where the 10 year plan for the NHS was discussed which will be informed by the key themes emerging from the Lord Darzi report. Some key findings are also attached at the end of the report. In relation to Strategic Aim 5: *we will develop and expand our services within and beyond Gateshead* – Mrs Davies highlighted that the opening of the Community Diagnostics Centre (CDC) at the Metrocentre in partnership with Newcastle Hospitals is fast approaching and will feature as a showcase presentation at our Annual General Meeting and Annual Members' Meeting on 25 September 2024. After further discussion, it was: **RESOLVED:** to receive the report for assurance.	
24/09/14	**Organisational Structure – Clinical Leadership:** Dr C Howey, Group Medical Director, provided a verbal update on the work being undertaken around the clinical leadership elements of the organisational structure work. She reported that detailed discussion took place at the Clinical Strategy Group away day and a survey has been circulated. Once the results are analysed, they will be used to inform future developments with clinical leadership and work continues to review roles. Following a query from Mrs A Stabler, Non-Executive Director, in relation to investment and potential financial implications, Dr Howey explained that remodelling work is taking place however some investment may be required. Dr T Davies, Group Chief Executive, highlighted that good discussions have taken place and there has been high clinical engagement however structure work is required and is being developed via the current leadership programme. A progress report is planned to be presented back to the Board in January 2025. Following further discussion, it was:	Cycle of business

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	RESOLVED: to receive the report for assurance and to note progress being made.	
24/09/15	**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 Trust, including a full register, and provides details of reviewed compliance and risk movements. This report covers the period 19th July 2024 to 19th September 2024. Dr Findley highlighted that there are currently 21 risks on the ORR which includes three new risks, no escalated risks, no reduced risks and no closed risks during August and September 2024. One risk has been moved to managed. The new risks relate to the risk of service disruption due to GP collective action, the non-achievement of the financial plan and large-scale change in relation to the business continuity plans in the event of an evacuation. The top three organisational risks relate to the GP collective action, non-achievement of the financial plan and medical staffing spend. Dr Findley also highlighted that a full review of the Risk Management Policy has been undertaken, including consultation with the Group Audit Committee. Mrs J Halliwell, Group Chief Operating Officer, highlighted that the risk relating to delay in transfer to community patients which has been moved to managed may need to be reviewed alongside discussions taking place around winter risks. Mrs K Mackenzie, Group Director of Finance and Digital, explained that the risk around the non-achievement of the financial plan is not a new risk but has been rewritten for this financial year. Mr A Crampsie, Non-Executive Director, drew attention to the summary slide relating to current risk ratings and queried whether risks were being monitored accordingly as scores had remained static for some time. Dr Findley explained that a number of controls and risk mitigations are in place around the risks and therefore the scores do not reflect the level of work being undertaken. Mrs Marshall reminded the Board that the Tier One Committees will focus discussions around the top three organisational risk and ensure these are considered when reviewing reports. After consideration, it was: **RESOLVED:** to receive the report for assurance.	
24/09/16	**Assurance from Board Committees:**	

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	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 August 2024 meeting and drew attention to the most recent meeting which took place on 23rd September 2024. Mr Robson highlighted that there was one issue identified as requiring alert to the Board which relates to the financial risk as previously discussed. This risk is currently scored as 20 however concerns were raised by the Committee that actions being taken to address the financial position may have a negative impact on the staff survey results. There are some areas subject to ongoing monitoring which includes: • the financial risks relating to the national pay award and impact of the PACS issue. • Concerns raised in relation to the Trust's cash position as this will decrease as the year progresses therefore further work will be taking place around forecasting and overall risk approach. Positive assurance was provided to the Committee in relation to the following areas: • Consistency in key performance indicators including improvements within the Emergency Department were noted however it was hoped that the Trust would be in a stronger position ahead of the winter months. • A positive report was received in relation to the changes implemented around the Paediatric Audism Pathway however there are still challenges and work continues. • It was agreed that the Committee will receive reports in relation to the Great North Healthcare Alliance at meetings which take place in alternative months to the Board. • A positive update was provided on the Community Diagnostic Centre and the Terms of Reference for the Tier 2 Group were reviewed. **Quality Governance Committee:** Mrs A Stabler, Committee Chair, provided a brief verbal overview to accompany the narrative report following the August meeting. She reported that there were two issues identified as requiring escalation to the Board for further action which relates to shared care arrangements and the Committee raised concerns that the work around health inequalities was not yet clearly articulated. A clear workplan and	

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	timescales has therefore been requested and an update will be given at the next Committee meeting. Dr C Howey, Group Medical Director, is picking up some of the work around this and a meeting is taking place to discuss organisational priorities and where this work will formally report to in line with the new governance arrangements. Feedback will therefore be provided via the Quality Governance Committee. There are some areas subject to ongoing monitoring which includes the Fuller Inquiry and a verbal update on staffing will be provided at the next meeting. Mrs Stabler reported that there were no changes on the risk register however a risk score on the Board Assurance Framework around the Quality Improvement Plan has been reduced. **People and Organisational Development Committee:** Mrs M Pavlou, Committee Chair, provided a brief verbal overview to accompany the narrative report following the July 2024 meeting. She reported that there were no issues requiring escalation to the Board however there are some areas subject to ongoing monitoring which includes: • Sickness absence and turnover and a deep dive report has been requested for assurance. Mrs A Venner, Group Director of People and Organisational Development, highlighted that this work will be completed via the Tier 2 Group meeting. • Whole Time Equivalent Headcount has been identified as an area of focus and a report is also expected at the next meeting. Following a query from Mr A Moffat, Non-Executive Director, Mrs Venner explained that this was due to delays in planned targets therefore the Committee will review this in further detail. • The Committee noted the disappointing Pulse survey responses and following a query from Mr Moffat, Mrs Venner explained that this is a mandated survey however the People and Organisational Development Team are developing engagement plans to increase response rates. The Committee received good assurance in relation to the equality, diversity and inclusion key milestones, vision, and dashboard and the Workforce Disability and Race Equality Standards action plan was approved for publication. Mrs Pavlou confirmed that there were no changes to current risks. **Group Audit Committee:** Mr A Moffat, Audit Committee Chair, provided a brief verbal overview to accompany the narrative report following the September 2024 meeting. He reported that there were two issues requiring escalation to the Board and highlighted that the Integrated Care Board are proposing to	

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	undertake an independent review to review financial governance and cost controls across the system. This will be undertaken by Audit One and may influence System Oversight Framework (SOF) ratings dependent on the findings. Mr Moffat also wished to highlight the current capacity issues within the Finance Team and the Committee felt that this needed to be managed. Following a query, Mrs K Mackenzie, Group Director of Finance and Digital reported that a good discussion took place at the meeting and Audit One have provided some self-assessment checks and the return has been adjusted accordingly. Mr Moffat reported that there were some areas subject to ongoing monitoring which includes a recommendation raised by the External Auditors as part of the value for money review and relates to the challenges in achieving cost reduction plans. It was noted that the Finance and Performance Committee seeks assurances over these risks on behalf of the Board. The Committee received good assurance in relation to processes and controls for Freedom to Speak Up and positive effectiveness reviews were received for the Committee, internal audit, external audit and counter fraud. Mr Moffat will inform the Council of Governors of the outcome of the external audit effectiveness review at the next Council meeting. There are no changes to current risks. **Group Remuneration Committee** Mr M Hedley, Committee Chair, provided a brief verbal overview to accompany the narrative report following the August 2024 meeting. He reported that there were no issues requiring escalation to the Board however there are some areas subject to ongoing monitoring which included the extension of the roles of the QE Facilities Non-Executive Director and Chair and the paper has been presented to the Board earlier in the meeting recommending approval for the roles to be extended for a further year. The Committee also received a paper on the appointment of the QE Facilities Commercial Director and it was noted that they will be a non-voting member of the QE Facilities Board. There were no risks identified during the meeting. Mrs Marshall thanked the Committee Chairs for their reports. After consideration, it was: **RESOLVED**: to receive the reports for assurance	
24/09/17	**Board Walkabout Feedback:**	

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	Dr G Findley, Deputy Chief Executive and Chief Nurse, presented the report which provides an overview of observations and reflections from Board walkabouts, supporting triangulation with other sources of information and assurance. The report covers three visits to the Emergency Department, Maternity and Special Care Baby Unit. Dr Findley highlighted that all visits were positive however issues were raised in relation to staffing with assurances provided that recruitment is underway. The Board will be aware of challenges in relation to the maternity estate and it was noted that the teams are working incredibly hard in a challenging environment however exhibited great team working and pride in patient outcomes. Following discussion, it was: **RESOLVED**: to receive the report for assurance	
24/09/18	**Finance Report:** Mrs K Mackenzie, Group Director of Finance and Digital, provided the Board with a summary of financial performance for April to August 2024 (Month 5) for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds). Mrs Mackenzie highlighted some of the key points and reported that the Trust has reported an actual deficit of £9.437m however this is favourable variance to forecasted plans. Current risks to the Trust's revenue position include pay and medical workforce costs. The Trust is forecasting to achieve its approved Capital Programme and this will be monitored via the Capital Delivery and Capital Steering Group. After consideration, it was: **RESOLVED:** to receive Month 5 financial position and note partial assurance for the achievement of the forecast 2024/25 planned deficit as a direct consequence of the reported year to date position and financial risks.	
24/09/19	**Leading Indicators 2024/25 Report:** Mrs K Mackenzie, Group Director of Finance and Digital, presented the progress, risks and assurance in relation to the Trust's Strategic Objectives for Month 5 2024/25. Mrs Mackenzie drew attention to the executive summary and following key areas:	

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	Strategic Aim 1: *We will continuously improve the quality and safety of our services for our patients* – there has been a reduction in the rate of falls rates per bed day for the second month in a row and this continues to be reviewed by the Trust wide Falls Group. A comprehensive plan to understand and prevent falls across the Trust is in place. Strategic Aim 2: *We will be a great organisation with a highly engaged workforce* – vacancy rates have slightly improved in month however vacancy pressures continue in key service delivery areas and workforce realignment is underway whereby over recruited areas are supporting workforce critical gaps. Mrs A Venner, Group Director of People and Organisational Development, explained that enhanced controls have been put in place in relation to current financial constraints and target measures are being monitored via the People and Organisational Development Committee. Strategic Aim 3: *we will enhance our productivity and efficiency to make the best use of our resources* – there has been an increase in length of stay rates however this relates to a change in data collection. Mrs J Halliwell, Group Chief Operating Officer, highlighted that there had been some ambulance handover delays identified however this was due to capacity within the emergency department and patient safety requirements. A weekly clinically led Task and Finish delivery meeting is in place to review the sustainability of trajectories and a workshop is taking place to firm up the areas of targeted improvement and review additional findings from the deep dive. Following a query from Mrs M Pavlou, Deputy Chair, in relation to winter planning, Mrs Halliwell reported that proactive discharge planning is taking place and discussions with the Local Authority continue to support this however challenges across the system remains. Strategic Aim 4: *we will be an effective partner and be ambitious in our commitment to improving health outcomes* – one of the biggest challenges continues to relate to maintaining gynaecology waiting times however this is currently being affected by the recent reduction in consultant capacity. Following consideration, it was: **RESOLVED:** to receive the report for assurance and note the key areas of improvement and challenge.	
24/09/20	**Freedom to Speak Up Guardian Report:** Mrs T Healy, Freedom to Speak Up (FTSU) Guardian, provided an update of FTSU activity for the year to date. She drew attention to some of the key points and highlighted that there has been 71.4% increase this year in concerns raised and is indicative	

Agenda Item No		Action Owner
	of the promotional work carried out across the organisation as well as the work with the People and Organisational Development Team and Equality, Diversity, Inclusion (EDI) and Engagement Manager around projects to support Zero Tolerance, Show Racism the Red Card, and development of Bystander Training. Further projects are also now underway alongside zero tolerance including the "it's not ok" champaign which includes sexual safety in the workplace. The report also highlights key findings and shows that the current data demonstrates that 80% of concerns raised relate to culture, bullying and harassment, treatment at work, etc and the other 20% of concerns raised are directly about patient safety. Ms Healy explained that data also shows that staff with protected characteristics are the group of staff who are less likely to raise concerns however further work is planned with staff forums with support from EDI. Future developments include further resources being available to staff and managers to access and a Microsoft Teams site is being developed for education and training for FTSU champions as well as a discussion forum for the Guardian and Champions. Monthly meetings take place with the FTSU Guardian and Non-Executive Director Lead. Dr G Findley, Deputy Chief Executive and Chief Nurse, thanked Ms Healy for the report and congratulated the team on the work being carried out. Following a query from Mrs M Pavlou, Deputy Chair, in relation to the acknowledgement that concerns being raised were being dealt with, Dr Findley explained that meetings will take place in confidence with staff and feedback is gathered via a questionnaire. Mrs A Venner, Group Director of People and Organisational Development, also highlighted that concerns raised in relation to staffing issues are supported by the People and Organisational Development Team. After further discussion, it was: **RESOLVED:** to receive the report for assurance on FTSU concerns and broader activity. Ms Healy left the meeting.	
24/09/21	**Workforce Race and Disability Equality Standard (WRES / WDES) Update Report:** Mrs A Venner, Group Director of People and Organisational Development, presented the report which shares with Board the Group WRES and WDES metrics taken from the staff survey and the actions that are needed to address areas which need to improve. The report will also be published on the Trust's website in line with statutory obligations. Mrs Venner reported that the report demonstrates that there is lots of work taking place however there are some areas of concern highlighted	

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	from the staff survey which are being addressed. She drew attention to the key metrics dashboard and high level action plans which will support focussed improvement work and highlighted that progress is being made. The People and Organisational Development Committee will continue to receive regular updates on the dashboard to provide assurance on progress and ensure that any issues are escalated appropriately. Mrs Marshall highlighted that each Non-Executive Director has been provided with an EDI objective and will be circulated to the Board for assurance. Mrs T Davies, Group Chief Executive, felt that it would be beneficial to discuss further at a Board Development Day with the support of networks and Mrs Venner highlighted that discussions around collective work are taking place at the HR Director Network. Discussion took place around the level of information provided within the report and Mrs Venner explained that this related to statutory responsibilities however this would support leadership approaches. After consideration, it was: **RESOLVED:** to receive the report for assurance and agree the associated actions and publication.	AM AV / JB
24/09/22	**Maternity Integrated Oversight Report:** Dr G Findley, Deputy Chief Executive and Chief Nurse, presented a summary of the maternity indicators for the Trust for August 2024. She drew attention to the key performance indicators within the Maternity Dashboard and highlighted that there has been a sustained increase in the number of births and work is being undertaken to review re-admission cases to identify learning. The report demonstrates the difficulties around compliance with the Maternity Incentive Scheme and Birth Rate Plus position due to staffing and this will continue to be monitored. Following discussion, it was: **RESOLVED:** to receive the report for assurance.	
24/09/23	**Nurse Staffing Exception Report:** Dr G Findley, Chief Nurse and Deputy Chief Executive, presented the report for August 2024 which provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls.	

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	Dr Findley highlighted that following the report from the National Quality Board, greater fill rates are being introduced therefore the staff escalation protocol has been adjusted which will be approved by the Executive Team to focus on efficiencies and the effective use of staff. Following a query in relation to the staffing levels reported to the Board, Dr Findley explained that the report shows the Board if the planned staffing in any area drops below 75%. Mrs M Pavlou, Deputy Chair, felt that it may be beneficial to demonstrate whether this relates to sickness absence and Dr Findley explained that recovery plans are in place for the areas identified within the report. Mr M Robson, Non-Executive Director, raised a query in relation to the red flags and Dr Findley reported that there was an escalation process in place however discussions would be encouraged around rostering practices. Following discussion, it was: **RESOLVED:** to receive the report for information and assurance.	
24/09/24	**Provider Collaborative Managing Director's Report:** Mrs T Davies, Group Chief Executive, shared the Provider Collaborative update with the Board for information and assurance. She explained that the report was presented at the Provider Collaborative Leadership Board to provide an update against the four key work areas for the Collaborative including the Elective programme, Clinical strategy, Corporate programme, and Aseptics programme After consideration, it was: **RESOLVED:** to receive the report for information and assurance.	
24/09/25	**Register of Official Seal:** Mrs J Boyle, Company Secretary, provided the Board with details of the use of the Trust's official seal between 1 September 2023 and 31 August 2024. She explained that this report is presented to the Board each September in accordance with the cycle of business and formally documents the use of the official seal in accordance with Standing Order paragraph 25.5. The seal has been used on one occasion in relation to the Bowel Cancer Screening Services Ethical Wall Agreement in March 2024. Following consideration, it was:	

Agenda Item No		Action Owner
	RESOLVED: to formally note the use of the official seal during this current year (September 2023-2024).	
24/09/26	**Care Quality Commission Statement of Purpose:** Dr G Findley, Deputy Chief Executive and Chief Nurse, provided an updated Statement of Purpose document to the Board. Dr Findley explained that a previous version of the Statement of Purpose shared with the Board earlier this year included an addition of the Community Diagnostic Hub (CDC) as a location to our registration however after discussion with the CQC, the Trust is no longer required to include the CDC as a separate location but as a satellite site. Dr Carmen Howey has also been added as the new Group Medical Director. Following discussion, it was: **RESOLVED:** to receive the report for information and assurance.	
24/09/27	**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 the cycle of business for the forthcoming financial year 2024/25.	
24/09/28	**Questions from Governors in Attendance:** No questions were raised from Governors in attendance.	
24/09/29	**Any Other Business:** Mrs Marshall ended the meeting by recognising the hard work and contributions to the Board from Mrs Stabler and the Board wished her well in her new role.	
24/09/30	**Date and Time of Next Meeting:**	

Gateshead Health
NHS Foundation Trust

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	The next meeting of the Board of Directors will be held at 9.30am on Wednesday 27th November 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
24/07/11	31/07/2024	Chief Executive's Report	To discuss potential impact of change in government direction and expectations around efficiency and recovery work. To work through plans at future Board Development Session	25/09/2024	TD / AM/JB	Sept 24 - It was agreed that this action will remain open until date identified and will also include any work from the Lord Darzi report.	
24/09/07	24/09/2024	Winter Plan 2024/25	To share the document presented to the local winter group and regional group.	27/11/2024	JH		
24/09/08	24/09/2024	Terms of Reference	To amend all Committee Terms of reference in relation to Non-Executive Director attendance to achieve quoracy	29/01/2025	JB	Nov 24 – to be amended as part of the review of all terms of reference through embedding the new governance structure	
			To ensure that the Standing Orders and Scheme of Delegation are updated to reflect changes to Terms of Reference	29/01/2025	JB	Nov 24 – to be scheduled for January's Board meeting	
24/09/09	24/09/2024	National Pay Award	To review and update the wording in the SFIs and Scheme of Delegation relating to Board approval of national pay awards. Paper to come back to Board once financial impact is quantified	27/11/2024	Kmac		

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
24/09/21	24/09/2024	WRES and WDES Report	To circulate Non-Executive Director EDI objective for reference	27/11/2024	AM		
			To consider Board Development Session with network support to agree collective work	27/11/2024	AV /JB	Sept 24 – the December Board development day facilitated by Deloitte LLP will include a focus on EDI.	

Closed Actions from last meeting

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
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 be repeated and reported back via the Quality Governance Committee and its assurance report to Board	~~31/07/2024~~ 25/09/2024	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 paper "operating in times of pressure" to be discussed on the July Board agenda). To remain open due to further discussions required. **Sept 24** - Several meetings have now been held to discuss staffing. New model agreed from EAU, which releases some funding. Business case for ED now being developed. Action agreed for closure.	
24/07/09	31/07/2024	Organisational Structure Consultation Outcome	A further update on the clinical leadership elements would be provided at the next Board meeting in September 2024	25/09/2024	GF / CH	**Sept 24** - Survey to members of the clinical strategy group has been circulated. Results are pending. This will inform future developments with clinical leadership. This will be discussed further on today's agenda therefore it was agreed to close this action and include any new actions following discussion.	
24/07/12	31/07/2024	Great North Healthcare Alliance Progress Report	To bring the Alliance work plan to the next Board meeting To follow up on the progress made in developing connections between Non-Executive Directors across the Alliance	25/09/2024	AM / TD	Sept 24 - The work plan will be discussed in Part 2 of today's meeting and a meeting with Alliance Board is planned to take place in December 2024 therefore it was agreed to close these actions.	
24/07/17	31/07/2024	Board Committee Assurance	To develop process around assurance report template for referrals to other Committees	25/09/2024	JB	12/08 – template has been amended to enable cross-referral to Executive leads rather than directly to Board committees. Action agreed for closure.	

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
24/07/21	31/07/2024	Nurse Staffing Exception Report	To consider highlighting any decreases and increases against previous month figures for future reports	25/09/2024	GF	Sept 24 - Trend analysis is now included within the report – Action agreed for closure	
24/07/25	31/07/2024	Any Other Business	National Pay Award – to assess the impact of a the HSJ article on very senior manager recruitment and brief the Board on key implications	25/09/2024	AV	This had been a national review and there was little impact on this region however a succession planning template is being developed and will be reviewed in more detail by the Executive Management Team. It was therefore agreed to close this action.	

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 7

Report Title:	**Calendar of Board Meetings 2025/26**			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	27 November 2024			
Author:	Diane Waites, Corporate Services Assistant			
Executive Sponsor:	Alison Marshall, Chair			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☒
	To inform the Board of the planned Board meeting dates for 2025/26.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☒
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	-			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• Proposed dates follow a similar pattern to previous years and are scheduled to enable timely review of the previous month's finance and performance data.			
Recommended actions for this meeting:	The Board is asked to approve and receive the dates of the Board of Directors' meetings to be held in 2025/26.			

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

Board of Directors' Meetings 2025/26

During 2025/26 the Board of Directors will hold 9 public meetings including the Annual General Meeting. The Board are also asked to note the Board Development dates.

Date	Time	Venue
29 January 2025	9.30am	Room 3, Education Centre
5 March 2025 Board Development Day	9.00am	Room 3, Education Centre
26 March 2025	9.30am	Room 3, Education Centre
23 April 2025 Board Development Day	9.00am	Room 3, Education Centre
21 May 2025	9.30am	Room 3, Education Centre
25 June 2025 Board Development Day	9.00am	Room 3, Education Centre
30 July 2025	9.30am	Room 3, Education Centre
20 August 2025 Board Development Day	9.00am	Room 3, Education Centre
23 September 2025 (Tuesday)	9.30am	Room 3, Education Centre
24 September 2025 Annual General Meeting	9.30am	Lecture Theatre, Education Centre
22 October 2025 Board Development Day	9.00am	Room 3, Education Centre
26 November 2025	9.30am	Room 3, Education Centre
10 December 2025 Board Development Day	9.00am	Room 3, Education Centre
28 January 2026	9.30am	Room 3, Education Centre
4 March 2026 Board Development Day	9.00am	Room 3, Education Centre
25 March 2026	9.30am	Room 3, Education Centre

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Report Cover Sheet Agenda Item: 8

Report Title:	**National Minimum Wage - Lease Car & White Goods Scheme Reintroduction Proposal**			
Name of Meeting:	Trust Board			
Date of Meeting:	27th November 2024			
Author:	Mr Michael Smith Assistant Director of Finance – Governance & Control			
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:** ☐
	This report sets out a proposed approach for the re-introduction of salary sacrifice schemes following a hold being in place since May 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*	*Financial Planning, Performance and Assurance Group, November 2024;* *JCC November 2024* *Financial Performance Committee November 24*			
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*	Since the significant increase in the National Minimum Wage (NMW) in May 2024 the Group was required to provide top up payments to those employees that breached its limit. The Group also suspended the Leased Car and White Goods Schemes for new applications to mitigate the risk of more employees breaching NMW. This paper seeks to re-introduce both schemes by introducing improved controls incorporating a £13.50 per hour 'buffer' from December 2024, whilst also seeking to recover the top up payments provided to employees, from January 2025 following a financial appraisal based upon individual circumstances.			

<table>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">The recommendation is to re-introduce the lease car scheme as follows:

To reintroduce the Lease Car and White Goods Schemes within the Group including the following:

• Allow new applications and renewals for both net deduction and salary sacrifice schemes from December 2024.

• Introduce a new control environment including an individual financial appraisal to ensure applicants do not fall below the new eligibility buffer of a minimum of £13.50 per hour.

• Commence recovery of NMW top-ups made to employees from January 2025.

• Re-appraise those schemes on pause, with payments restarted from December 2024 if viable after full appraisal of NMW implications.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☐</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="6">Achieving financial sustainability</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☐</td><td>Responsive
☐</td><td>Well-led
☒</td><td>Effective
☐</td><td colspan="2">Safe
☐</td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="6">Overall risk of not meeting financial plan, with contributing risks relating to achievement of income, cost reduction and other mitigation targets alongside overspend against delegated budgets.</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td colspan="2">Not applicable
☒</td></tr>
</table>

1. Introduction and Purpose

1.1 The leased car and white goods schemes are managed for the Trust by CNTW via an SLA. This report sets out a proposed approach for the re-introduction of the lease car scheme following a hold being in place since May 2024.

1.2 The scheme was placed on hold along with other employee benefit offers due to the significant increase in national minimum wage in April 2024. From the 1 April 2024 the (NMW) National Minimum Wage increased from £10.42 to £11.44 (an increase of 10%) this was far greater than any previous increase.

1.3 The number of staff in scope of falling below the NMW increased massively across the country due to this large increase which was unforeseen or predicted by the OBR (Office of Budget Responsibility), this coincided with the HMRC appearing to apply more robustly current guidelines. The public sector was severely impacted as they have the greatest volume of salary sacrifice schemes, and it was these deductions against the higher NMW that lead to the breaches and the subsequent need for top up payments required to make good any breaches.

1.4 This paper is to inform and reassure the Trust the scheme can be implemented in a way that offers staff a benefit, returns the Trust significant savings and offers reassurance the risk and exposure to national minimum wage breaches is fully managed.

2 Scheme Legal Position

2.1 Like most Trusts impacted by the NMW increase in April, we sort legal advice in a number of areas, to understand the impact of:

- Breaching the NMW and making good by top-up payments,
- What schemes were in scope of reducing salary below the NMW
- What could be done to amend contracts that were causing the breach to avoid continued top-up payments

2.2 We are comfortable the advice given, is very much in line with advice provided by other solicitors to colleagues in other Trusts.

2.3 Our assessment is such:

- Any salary sacrifice scheme operated by the Group would be in scope for NMW considerations.
- Any deduction scheme whereby the deduction was for goods or services directly related to the employment of the individual would be in scope. This included any schemes whereby the employer retained the deductions for their own use or were perceived to be directly benefitting from the arrangement.
- Out of scope would be any deduction scheme operated by a third party and to which the group simply collected the money from the employee and passed this on to the third party.

- Top-up payments can be made, if they were paid as we have been (within the following pay period and for the full amount due).

2.4 So as far as the lease car scheme is concerned, salary sacrifice arrangements would be in scope, but the salary deduction scheme would not be.

3 Current Trust Position

3.1 Lease Cars

3.1.1 19 employees were taken below the NMW threshold in April 2024 that included lease car salary sacrifice deductions. This amounted to £1,981.05 in top up payments.

3.1.2 All 19 contracts were re-scheduled, and no top up payments have been required for lease cars. Since the 1st April 2024, 34 cars have been delivered that were previously on order and under a salary sacrifice arrangement and none of these have breached or are forecast to breach the NMW during their contract periods.

3.1.3 The Trust currently achieves an annual saving of circa £400k per annum for the salary sacrifice lease car fleet.

3.2 White Goods

3.2.1 50 employees were taken below the NMW threshold in April for this scheme. This amounted to £1,572.86 in top up payments. These payments were placed on hold and with effect from the December pay run, deductions will be rescheduled to allow the payment of these to re-commence. Deductions may be reduced, and the period extended to allow payment not to impact NMW, but the monies will be recovered as quickly as possible without risking a further breach.

3.2.2 The scheme generates an average of £120k per annum in payroll savings for the Trust and approximately 160 employees per annum have enjoyed the benefit.

4 Current Implications

4.1 The current implications are twofold, the negative impact this has had on existing and potential staff members not having access to the scheme together with the financial loss of Group employer savings.

4.2 Since the scheme has been placed on hold the lease car team has received 25 requests from employees for access to the scheme for the first time, this includes requests from people looking to take new roles within the Group.

4.3 Based on the last 34 cars delivered, the current average saving the Trust achieves through a lease car salary sacrifice arrangement is £2,005 per annum. If these had been converted those 25 staff to deliveries this would have achieved an additional £50k per annum saving for the Trust, recurring for three years achieving £150k.

5 Risk Mitigation

5.1 Gateshead currently has its scheme on hold, but we can mitigate the risk against NMW through the use of an hourly rate ‘buffer’. The hourly rate ‘buffer’ is effectively a

threshold rate above the NMW, but it is the minimum level we would allow an employee to reduce their salary down to, after a scheme deduction. This means that when the NMW increases again in the future, salaries after schemes have been deducted should still be higher than the NMW increase due to the buffer threshold used.

5.2 All new applications must not reduce an employee's salary below a buffer of £13.50 per hour, the current NMW rate is £11.44, increasing to £12.21 from April 2025.

5.3 Each applicant would also be reviewed for existing schemes, both inside and currently out of scope, to ensure all relevant information was captured and factored into the authorisation process.

5.4 A report for all applicants with a complete breakdown of the financial assessment will be prepared by CNTW and will be counter checked by Gateshead's finance section as well as the lease car team before approval. An example of the financial assessment is provided in Appendix 1.

5.5 The rate of £13.50 per hour will be reviewed every quarter in line with government changes and predictions. The rate of £13.50 is predicted to significantly exceed the NMW rate for 2028, allowing for new contracts to complete without breach at any time.

5.6 Monthly NMW breach reports will continue to be received from Payroll, should any employee with a lease car salary sacrifice appeared on the report, a top up payment will be made in the next pay period to mitigate the breach, with the contract either rescheduled or cancelled before the next pay period to remove any further exposure and recover any amount due including any top-up made.

6. Recovery of Top-Up Payments

6.1 Top-ups paid to date (including those made in Octobers pay) total a net £29,514.32 to 611 Group employees. Repayment terms will be agreed with each employee and be implemented from January 2025.

6.2 Following the payment of the annual pay award only three employees are currently in breach of the NMW, and these are all in respect of car parking charges.

6.3 The repayment terms will be calculated to both ensure the amounts due are repaid as quickly possible, whilst also mitigating against any further breaches in NMW.

7. Schemes on Pause

7.1 Some deductions were paused (mainly the white goods scheme) to stop the breaches from occurring and top-ups becoming necessary. These deductions will be reviewed against the new pay staff have received from October and again deductions will be restarted from December 2024.

7.2 The scheme allows for the rescheduling of payments and where necessary amounts will be reduced and terms extended to allow repayment to happen without breaching NMW. Repayment will be actioned as quickly as possible and extended terms will only be used where necessary to avoid further NMW breaches.

8 Recommendations

8.1 To reintroduce the Lease Car and White Goods Schemes within the Group incorporating the following:

8.1.1 Allow new applications and renewals for both net deduction and salary sacrifice schemes.

8.1.2 Agree a new eligibility buffer of a minimum of £13.50 per hour, reviewed quarterly or whenever government predictions prejudice the current rate.

8.1.3 Limit the spend on the white goods scheme to 3 items at any one time for any individual.

8.1.4 Provide a full finance appraisal of all applications, including all existing arrangements both sacrifice and deduction, clearly demonstrating compliance with the £13.50 per hour buffer.

8.1.5 Nominate a senior finance colleague within the Group to counter approve all applications before authorisation, having been provided with all relevant finance information.

8.1.6 All applications that fail to meet the compliance requirements, will not be provided to the Group via CNTW for approval, but will be included within reports for the quarterly review.

8.1.7 Monitor the payroll reports monthly and take immediate top-up and rescheduling/termination action. With a report provided to finance monthly from CNTW of any remedial actions.

8.1.8 Should any NMW breach occur continue to provide a top-up payment in the next pay period and take the most effective course of action to mitigate the risk and recover all monies including any top-up as quickly as possible.

8.1.9 Note full visibility in reporting which will provide an audit trail of all actions and remedies taken, together with complete assurance of the effective management of the process

8.1.10 Review this position quarterly with a summary paper prepared for appraisal and continued support.

8.2 Commence recovery of NMW top-ups from January 2025 in accordance with section 6 above.

8.3 Re-appraise those schemes on pause, with payments restarted from December 2024 if viable after full appraisal of NMW implications.

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Report Cover Sheet Agenda Item: 9

Report Title:	**Proposed Constitutional Amendments**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 November 2024			
Author:	Jennifer Boyle, Company Secretary			
Sponsor:	Alison Marshall, Chair			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To seek Board approval for a proposed constitutional amendment to merge the Central and Eastern Gateshead public constituencies and an amendment to the composition of the appointed Governors.			
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*	Council of Governors – 20 November 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 proposed merger of Central and Eastern Gateshead constituencies should result in:
	  • Increased public Governor representation and ability to deliver the 'holding to account' element of the role
	  • Increased ability to achieve quorum at the Council of Governors
	
	• A by-election will result in additional financial cost, but at present the Council cannot operate effectively with the number of vacancies remaining from the current election.
	
	• The inclusion of Gateshead Healthwatch as an appointed Governor will support in ensuring that the patient voice and the views of those from hard to reach communities in the area are represented at the Council.			

<table>
<tr><td></td><td colspan="5"></td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">It is recommended that the Board approves a constitutional amendment to merge the Central and Eastern constituencies. The exact changes to the Constitution are set out in Appendix 1.

It is recommended that the Board approves the change to the composition of the appointed Governors from Gateshead Diversity Forum to Gateshead Healthwatch as outlined in Appendix 2.</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 strategic objectives that the report relates to:</td><td colspan="5">All indirectly</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="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">Risk 4577 - Achievement of 2024/25 revenue financial plan (20)</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>

Proposed Constitutional Amendment – Public Constituencies

1. Executive Summary

1.1. The Trust currently has four public constituencies. Of the Gateshead constituencies Eastern is the smallest constituency in respect of numbers of members and in recent years there has been a lack of interest in members self-nominating for Governor positions.

1.2. Despite a focus on engaging with the public and members in the Eastern area, the current elections have again resulted in no Governor representation in the East.

1.3. Historically there has been a strong level of interest in the Central constituency resulting in contested elections. Given the close geographical proximity of parts of the Central constituency and the Eastern constituency and the wider role of Governors to consider the interests of the public at large it is proposed to merge the two constituencies together.

1.4. This would help to improve public representation at the Council of Governors and maintain the important public accountability of the Foundation Trust to Gateshead residents.

1.5. With regards to the second proposed constitutional amendment the inclusion of Gateshead Healthwatch as an appointed Governor will support in ensuring that the patient voice and the views of those from hard to reach communities in the area are represented at the Council.

1.6. The Council of Governors approved both constitutional amendments at its meeting on 20 November 2024.

2. Background to the constituency change proposal

2.1. The Trust currently has four public constituencies – Western Gateshead, Central Gateshead, Eastern Gateshead and the Out-of-Area constituency.

2.2. In recent years Governor representation in Eastern Gateshead has proved particularly challenging. This is shown in the below table:

	Western	Central	Eastern	Out of Area
January 2025 start date				
Seats available	3	2	3	N/a
Nominations received	1	4	0	N/a
Vacant seats	2	0	3	N/a
January 2024 start date				
Seats available	2	2	2	1
Nominations received	3	2	0	2
Vacant seats	0 but increased to 1 during the year	0	2 but increased to 3 during the year	0
January 2023 start date				
Seats available	3	4	3	N/a

Nominations received	3	6	1	N/a
Vacant seats	0	0	2	N/a

2.3. The table shows that over the last 3 years there has only been 1 member who self-nominated for the Eastern constituency. Sadly, this Governor passed away and since this time there has been no Governor representation in Eastern Gateshead. This will continue through into the 2025/26 financial year as there have been no nominations in the current elections.

2.4. The table also shows that Western Gateshead will not be as well represented given that there was only one nomination for the current elections. The historic data does not indicate that this is longstanding issue and therefore the current situation is not comparable to Eastern Gateshead.

2.5. This paper proposes a constitutional change to mitigate the risks presented by the lack of Eastern representation.

2.6. Constitutional changes require approval by both the Council of Governors and the Board of Directors. Any changes impacting upon the power or duties of Governors must also be presented retrospectively to the Annual Members' Meeting for voting (and the changes reversed should members not support them).

3. Constituency change proposal

3.1. The lack of representation in Eastern Gateshead has a number of implications.

3.2. As Foundation Trusts are accountable to the public and members via the public Governors, and public Governors also represent the interests of members and the public, this risks weakening the ability to deliver the accountability and representation role.

3.3. It reduces the number of current public Governors on the Council. In order to be quorate one third of the Governors in office (i.e not counting vacant posts) must be present, with the majority of those in attendance being public Governors. From January 2025 the composition of the Council will be 12 public Governors, 6 staff Governors and 6 appointed Governors. As 50% of the Council is made up of staff and appointed Governors, many of which are good attenders, it means that achieving quorum is challenging. This has been evidenced through recent meetings.

3.4. A number of steps have been taken to encourage both membership and interest in Governor positions in Eastern Gateshead. Current Governors have supported with this by reaching out to members of the public and contacts. This included attending a community event in the Eastern constituency in August 2024. Whilst this generated 10 new members, only 2 lived in the Eastern constituency area and none translated into nominations for the Governor positions.

3.5. On reflection all membership engagement and recruitment events in recent years have actually been held in or on the border of the Eastern constituency - namely the two Trust Open Days, a talk at Felling Methodist Church and the stall at Embells Community Market.

3.6. The challenge of filling the Eastern seats has been discussed with the Membership, Governance and Development Committee. The discussions at the Committee have resulted in the proposal to merge the Central and Eastern constituencies together to create one constituency.

3.7. The Central Gateshead constituency typically attracts more interest in Governor nominations. Over the last 3 years all seats have been filled and on 2 occasions there has been a contested election, meaning some keen members lose out on the opportunity to become Governors. This will be the case in the current election, where there are 4 candidates for 2 seats. Meanwhile 3 Eastern Gateshead seats across a notional border remain vacant.

3.8. Through discussions with the Committee it was noted that when Governors engage with members / the public and represent their interests they don't restrict themselves to their constituency areas. Additionally, as NHS England's *Addendum to your Statutory Duties* document (2022) clarified Governors are also expected to represent the interests of the Trust as a whole and the public. The document states that Governors are required to seek and form a view of the interests of the 'public at large'.

3.9. Merging the two constituencies together should in time increase the number of public Governors who are able to represent the interests of the public and strengthen the chain of representation and accountability which is key to Foundation Trust governance. It will also support the Council in being able to achieve the important principle of public Governors accounting for the majority of Governors attending Council meetings, enabling quorum to be reached for decision-making.

3.10. As shown in Appendix 1 merging the constituencies together would result in a combined minimum membership of 10,000 members represented by 10 Governors.

3.11. The Committee discussed whether the Western constituency should be included in the merger, creating a single Gateshead constituency. Whilst this could be a future option, the Committee recommends proceeding with a merger of the Central and Eastern constituencies first and assessing the impact of this before taking any further steps to adjust constituencies.

3.12. This was further discussed at the Council of Governors on 20 November, along with a broader review of the membership database. Following discussion it was agreed to proceed with the Central and Eastern merger only at this stage, with a future intention to merge Western Gateshead should the Central and Eastern merger have a positive impact (recognising that the principles of representing the wider public apply equally to Western Gateshead Governors). It was also agreed that steps would be undertaken to assess the pros and cons of undertaking a full cleansing process of the membership list to ensure that all current members wish to remain members of the Trust. The intended outcome would be achieve a active and engagement membership. The Company Secretary will work with the Membership, Governance and Development Committee to develop a proposal around this for consideration prior to the commencement of the next full election process in Summer 2025.

3.13. Should the recommendation to merge the Central and Eastern constituencies be supported by the Board, it is proposed that a by-election is held to fill the vacant seats. Whilst this will incur an additional cost from the election company, it is

critical to support the ability of the Council to be quorate over the next year. The by-election would be held in Q4 2024/25.

4. Additional Constitutional amendment re: appointed Governors

4.1. At the Council of Governors meeting in February 2024 the Council formally considered a number of proposed changes to update the appointed Governor composition as outlined in the Constitution.

4.2. One of the proposals was to replace the Gateshead Diversity Forum seat (which no longer exists) with Gateshead Healthwatch. As Healthwatch represents the interests of all members of the community in having a voice and input into health and social care services, it was agreed that this would be good alternative to a dedicated diversity group.

4.3. The Company Secretary had met with Healthwatch to ensure that should the constitutional change be approved they would be able and willing to put forward a representative. At the time of the meeting Healthwatch were still carefully considering whether taking up the Governor position would be compatible with their role and whether any potential conflicts of interest could be mitigated. The constitutional amendment was therefore paused pending confirmation from Gateshead Healthwatch on whether they would be able to take up a Governor position. The Chair of Gateshead Healthwatch observed the May 2024 Council meeting to help inform the decision.

4.4. The Chair of Gateshead Healthwatch contacted the Company Secretary on 15 November to inform that their Board has now agreed that Gateshead Healthwatch can take up a place on the Council.

4.5. As such the original proposed change to the Constitution is now recommended to the Council for approval. Please see Appendix 2 for the proposed changes.

5. Solutions / recommendations

5.1. It is recommended that the Board approves a constitutional amendment to merge the Central and Eastern constituencies. The exact changes to the Constitution are set out in Appendix 1. This amendment was approved by the Council of Governors on 20 November 2024.

5.2. It is recommended that the Board approves the change to the composition of the appointed Governors from Gateshead Diversity Forum to Gateshead Healthwatch as outlined in Appendix 2. This amendment was approved by the Council of Governors on 20 November 2024.

5.3. Should the Board approve these amendments they will be presented to the next Annual Members' Meeting in September 2025 (although they can be enacted before this time, the change must be unwound if members do not provide approval).

APPENDIX 1 – Proposed Constitutional Amendments – Constituencies

5.2 The Trust is to have four~~five~~ Membership Constituencies, namely:

(a) Three~~Four~~ "Public Constituencies" (including the "Out of Area Constituency), and

(b) One "Staff Constituency"

5.3 Public Constituencies (other than "Out of Area"):

5.3.1 An individual who lives in an area specified in Annex 1(a) or ~~,~~ (b) ~~or (c)~~ as an area for a public constituency may become or continue as a member of the Foundation Trust.

5.4 Out of Area Constituency:

5.4.1 Members of the Trust who are Members of the Out of Area Constituency are to be:

(a) Individuals who live in the area of the Trust listed in Annex 1 (c~~d~~) or

(b) Individuals who live outside the area of the Trust listed in Annex 1 (a)~~,~~ (b) or~~,~~ (c) ~~or (d)~~ and who have used any of the Trust's services within the 7 years immediately preceding the date of their application for membership and had domestic responsibility for the care of the patient once they have received their treatment from the Trust (other than an individual providing care in pursuance of a contract (including a contract of employment) or as a volunteer for a voluntary organisation.

Annex 1

Public Constituencies Of The Trust

Name of Constituency	Area	Minimum number of Members	Number of Governors
(a) Western Gateshead	The Western area will consist of Prudhoe, Crawcrook & Greenside, Chopwell & Rowlands Gill, Winlaton & High Spen, Blaydon, Ryton, Crookhill & Stella, Whickham North, Whickham South & Sunniside, Dunston & Teams, Dunston Hill & Whickham East.	600	6
(b) Central and Eastern Gateshead	The Central and Eastern area will consist of Lamesley, Birtley, Lobley Hill & Bensham, Bridges, Saltwell, Deckham, Low Fell, Chowdene, High Fell Chester-Le-Street, Ouston and Pelton, Washington, Felling, Windy Nook & Whitehills, Pelaw & Heworth, Wardley and Leam Lane and parts of Jarrow & Hebburn.	1,000~~700~~	10~~7~~
~~(c) Eastern Gateshead~~	~~The Eastern area will consist of Felling, Windy Nook & Whitehills, Pelaw & Heworth, Wardley and Leam Lane and parts of Jarrow & Hebburn.~~	~~300~~	~~3~~
(c~~d~~) Out of Area	The geographical area covered by the North East and North Cumbria Integrated Care System other than any areas noted above and users of Trust services living outwith the areas (a) (b) (c) and (d)	100	1

APPENDIX 2 – Proposed Constitutional Amendments – Appointed Governors

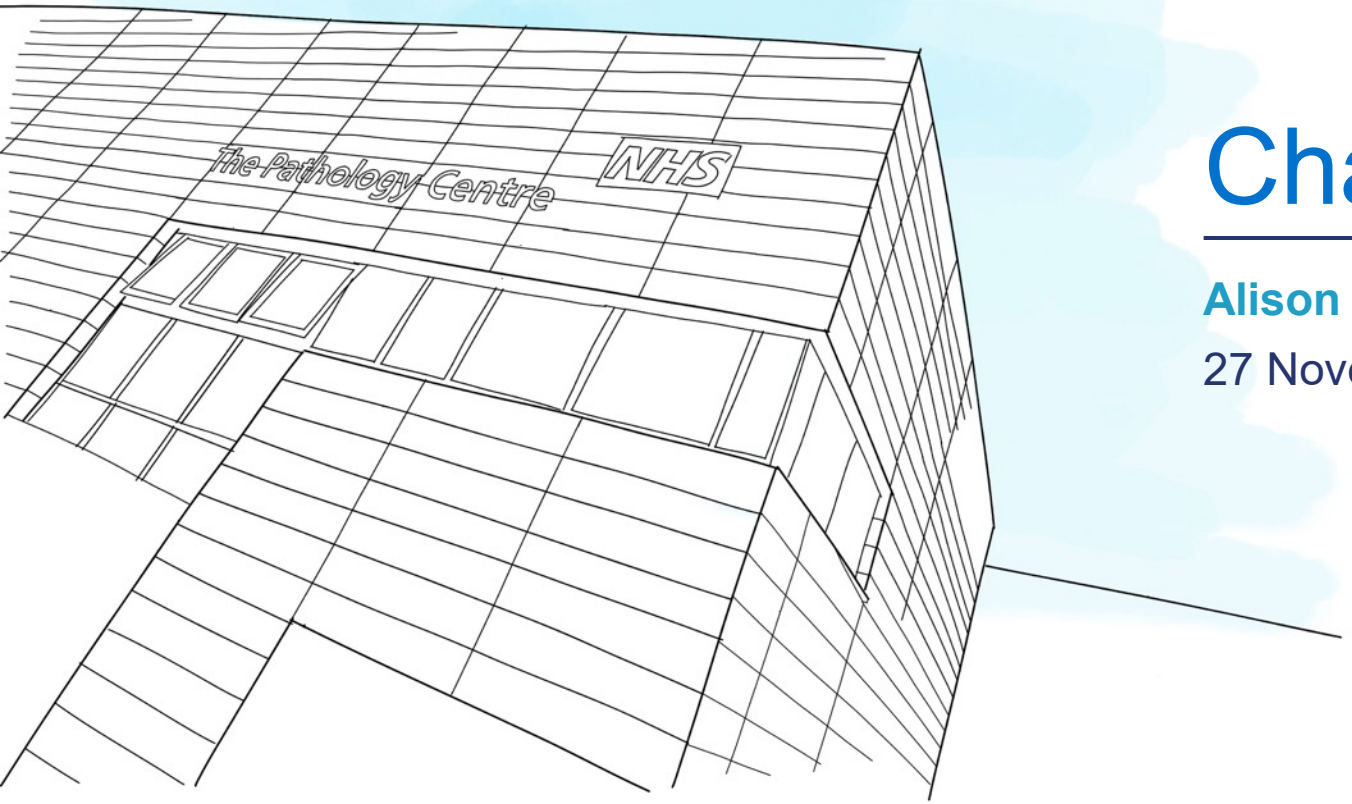
6.3 The specified partnership organisations below may appoint one Member of the Council of Governors:

(a) Newcastle University
(b) Northumbria University
(c) Gateshead College
(e) Gateshead Jewish Community Council
(f) Gateshead ~~Diversity Forum~~Healthwatch
(g) Gateshead Youth Assembly

6.7 **Other Partnership Governors:**

6.7.1 Newcastle University, Northumbria University, Gateshead College and Gateshead Voluntary Organisation Council, Gateshead Jewish Community Council, Gateshead ~~Diversity Council~~Healthwatch, and Gateshead Youth Assembly are authorised to appoint one Governor each pursuant to a process agreed by those organisations and the Trust. Where a Partnership Governor post falls vacant, the relevant organisation will appoint another Governor within three months of the Trust Secretary having received notification that the post is vacant.

Gateshead Health
NHS Foundation Trust



Chair's Report

Alison Marshall, Chair of the Board of Directors

27 November 2024

Board updates and Partnership working

Gateshead Health NHS Foundation Trust

Board of Directors

- The Governor Remuneration Committee led the process for the appointment of a new Clinical Non-Executive Director on behalf of the Council of Governors.
- On 31 October 2024 the Council of Governors ratified the appointment of Dr Gerry Morrow following a competitive recruitment process.
- Dr Gerry Morrow will commence in post on 1 December 2024 for a three year term, following the completion of the pre-employment checks process.
- Dr Gerry Morrow is a GP by background with experience of operating as a Non-Executive Director for 7 years on the Board of North East Ambulance Service NHS Foundation Trust. He is a medical director and editor at a private sector healthcare technology company, and Dr Morrow is also responsible for editing Clinical Knowledge Summaries for the National Institute for Health and Care Excellence (NICE).
- He will be a member of the Quality Governance Committee and Group Audit Committee, as well as being the Board's Maternity Safety Champion.
- The Financial Non-Executive Director recruitment process did not progress past the shortlisting stage and discussions with the Governor Remuneration Committee are ongoing regarding next steps (noting that Mike Robson's term does not end until 30 June 2025 and therefore this does not present an immediate risk).

Governor and Member Updates

Gateshead Health NHS Foundation Trust

- Our Governor elections process for the terms commencing on 5 January 2025 has now been completed and the results are as follows:

Constituency	Available Seats	Outcome
Staff	2	2 nominations received and 2 candidates are therefore elected unopposed: • Dr Andy Lowes – re-elected to second term of office (5 Jan 2025 – 4 Jan 2028) • Janet Thompson – elected to first term of office (5 Jan 2025 – 4 Jan 2028)
Central Gateshead	2	4 nominated received and therefore a contested election was held. The following candidates received the most votes and are therefore elected: • Mark Learmouth – elected to first term of office (5 Jan 2025 – 4 Jan 2028) • Carol Hindhaugh – elected to first term of office (5 Jan 2025 – 4 Jan 2028)
Western Gateshead	3	1 nomination received and therefore 1 candidate elected unopposed, with 2 vacancies remaining: • Gordon Main – re-elected to second term of office (5 Jan 2025 – 4 Jan 2028)
Eastern Gateshead	3	0 nominations received – 3 vacant seats remain

- Congratulations to all new and returning Governors!
- We would like to record our sincere thanks and gratitude to those Governors who will be leaving the Council on 4th January 2024:
  - John Bedlington, Public Governor for Central Gateshead, who has served as a Governor since January 2019;
  - Brenda Webb, Public Governor for Central Gateshead, who has served as a Governor since January 2022;
  - Ged Quinn, Public Governor for Western Gateshead, who has served as a Governor since January 2022; and
  - Richard Morrell, Staff Governor, who has served as a Governor since January 2022.
- A proposal has been developed to amend the Constitution to merge the Central and Eastern Gateshead constituencies – see separate agenda item.

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
- North ICP Meeting
- Non-Executive Director interviews
- Consultant interviews
- Star Awards
- Opening of the Community Diagnostic Centre (CDC)

We were delighted to be able to invite our Governors, colleagues and valued stakeholders for a preview of the CDC at the Metrocentre in the days before we welcomed our first patient in October 2024. The facility, in partnership with Newcastle Hospitals, provides services such as MRI, CT, ultrasound, echocardiogram scans, blood tests and heart and lung function tests.

Star of the Month Nominations

September

- Vicky Handy - **Rachel Sloan**
- Ryan Charlton - Angie Simm
- Leanne Slasor - Devon Stephenson
- Marie Lisle - Naomi Barwick
- Adonna Brown - Hannah Wood
- Helen Bradley

October

- Rachel McCrate - Virginia Stanton
- Lynsey Jarvis - Vicky Moody
- Mark Richardson - Stephanie Gray
- Angela Proctor - Abby Corkindale
- Michael Storey - Jenna Charlton
- James Rankin - Lucy Burton

You're a Star Winner

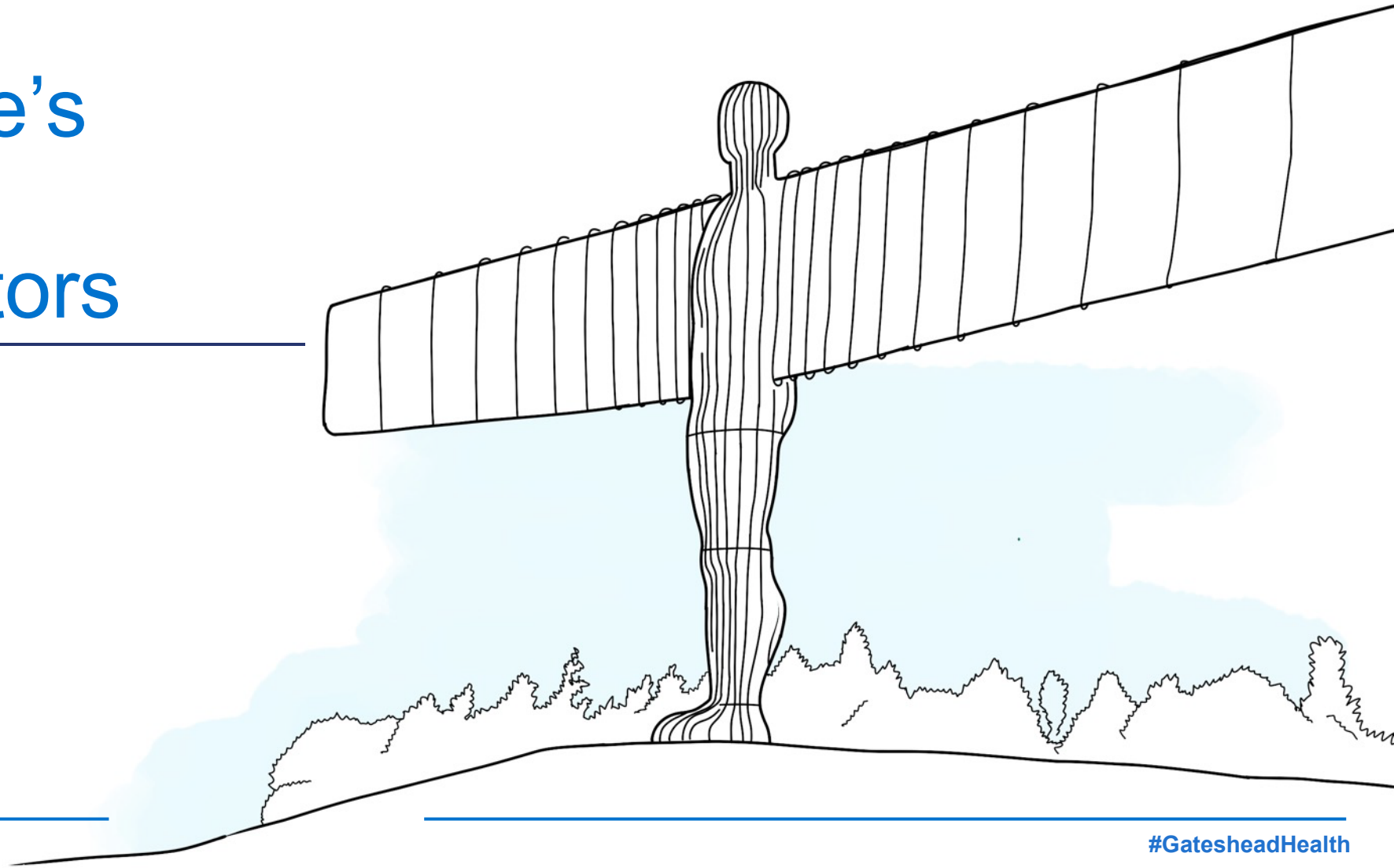
Rachel Sloan

NHS
Gateshead Health
NHS Foundation Trust

Chief Executive's Update to the Board of Directors

Trudie Davies, Chief Executive

27 November 2024



National statistics and context

Gateshead Health NHS Foundation Trust

National policy, context and operating models

Department of Health & Social Care and NHS England to work closer together

Change NHS consultation, development of the 10 year plan and focus on the 3 shifts – community, prevention and technology

NHS productivity plan due shortly (Autumn)

More group and shared leadership arrangements emerging

New CQC Chief Executive announced – Sir Julian Hartley

Budget announcements:

- £22.6billion increase in day-to-day health budget this year and next
- £3.1billion increase in capital budget this year and next
- £1billion to tackle RAAC and repairs backlog
- £1.5billion of funding for new surgical hubs and diagnostic scanners

National pay awards of 5-6% for Agenda for Change staff, doctors and Very Senior Managers

Pay disputes resolved for junior doctors and consultants

National performance headlines

Gateshead Health NHS Foundation Trust

National performance

In general September's figures show that trusts are increasing activity and improving performance against national targets.

76.3% of patients seen within 4 hours in A&E (August 24). For type 1 A&E performance this was 62.5%.

Busiest summer on record for urgent and emergency care.

Decreased number of emergency admissions compared to 5 years ago.

8.6% of patients at A&E departments (type 1 and 2) waited more than 12 hours from arrival.

Maintenance backlog in the NHS has tripled in size since 2010/11 – £11.6bn

Delayed discharges remain a national challenge. As an example on Saturday 31 August, there were 20,600 patients who no longer met the criteria to reside in hospital. Of these, 60% remained in hospital that day.

The 28 day faster diagnosis target was met, but the 31 day and 62 day pathway standards were not (July 24). The numbers of treatments waiting over 52 weeks dropped to the lowest since December 2020.

High demand for elective care – record number of urgent cancer referrals in July.

Significant financial challenges in the NHS – 31 out of 42 ICSs have deficit plans

National context

Change NHS

- A national consultation has been launched to help build a health service fit for the future. *Change NHS: help build a health service fit for the future* is described as a national conversation to develop the 10-Year Health Plan.
- This follows on from the Lord Darzi report which identified some of the challenges facing the NHS. A summary of the key findings was shared at the last Council of Governors meeting.
- Amongst other things the consultation seeks views on the proposed 3 ‘shifts’:
    - Shift 1: moving more care from hospitals to communities
    - Shift 2: making better use of technology in health and care
    - Shift 3: focussing on preventing sickness, not just treating it
- *Change NHS* was launched by the Health and Social Care Secretary Wes Streeting and invites the public, patients, carers and NHS workers to share experiences and suggestions for change.
- Responses can also be submitted collectively on behalf of organisations (closing date 2 December).
- Further information can be found on the dedicated website: Change NHS
- Trust and Great North Healthcare Alliance responses are being prepared, with all colleagues invited to complete a survey to inform the submissions.

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

Gateshead Health NHS Foundation Trust

- We received excellent results in the **CQC's 2024 Urgent and Emergency Care Survey**. Over 270 patients rated their experience highly and we achieved an overall score of 8.5, up from 7.4 in 2023. We performed better than the majority of trusts in three essential areas: the cleanliness of the A&E department, support with communication needs during hospital visits, and ensuring patients knew whom to contact for advice post-discharge.
- Our **Secondary Prevention Service (lipid management pharmacy service)** has been shortlisted in the Outstanding NHS Industry Collaboration category at the Bright Ideas in Health Awards 2024. In addition the initiative to **reduce CO2 emissions in the emergency department** has also been shortlisted for the Towards Net Zero Award.
- Our **Breast Care Nursing** team were commended at the recent Northern Cancer Alliance (NCA) annual awards. The team created a six week programme to help patients with breast cancer feel supported and learn more about their illness. The programme created a place where patients could meet other people going through the same thing, share advice and learn new things to help them feel less anxious and more knowledgeable about their condition.
- We held our annual **Patient Safety Conference** – a great opportunity to share experiences and collectively learn more about patient safety and creating the right kind of learning culture.
- A new **mental health room for young people** in crisis has been created within our Paediatrics Emergency Care Department. This offers a quiet, safe space for young people experiencing a mental health crisis. Local young artists from the Baltic Arts Centre.
- The **North East and North Cumbria Learning Disabilities Network** visited the Trust in November. This was a helpful visit which provided an opportunity to highlight strengths, discuss any challenges we are facing and identify opportunities for learning. We await a formal written outcome from the visit.

Engagement, involvement and visits:

- CDC opening
- Cragside and Sunniside
- Theatres
- Patient Safety Conference

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

Gateshead Health NHS Foundation Trust

- We hosted our annual **Star Awards** on 1 November, recognising the fantastic achievements of our colleagues across the Trust and QE Facilities. Congratulations to all of our winners and nominees. A special congratulations to our Lead Governor, Steve Connolly, who won the award for Volunteer of the Year!
- We celebrated **Black History Month** in October with the theme of 'reclaiming narratives'. We shared profiles of colleagues of black heritage who help to make Gateshead Health a great place to work. This is important to reinforce the Trust as an inclusive organisation which celebrates and fosters diversity.
- We took part in national **Speaking Up Month**, promoting the importance of Freedom to Speak Up (FTSU) as a way for colleagues to raise concerns. The theme for this year was #ListenUp and a number of our FTSU Champions and leaders shared their pledges. This is particularly important given historic challenges with colleagues feeling heard as outlined in recent reviews.
- On World Mental Health Day a **memorial garden** was opened in partnership with Gateshead Health Charity and national charity Doctors in Distress. Dr Andreas Hinsche planted a plant as part of the Doctors in Distress national tree planting campaign and those in attendance took time to remember colleagues we have lost. The garden creates a quiet and peaceful garden space for colleagues.
- The **Employment Rights Bill** was introduced to Parliament in October 2024. A briefing paper is appended to this report to outline our approach to ensuring that we remaining compliment with the legislation.

Engagement, involvement and visits:

- Star Awards
- Memorial garden opening ceremony
- CEO roadshows
- Consultant interviews
- Non-Executive Director interviews

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

- Due to a significant increase in demand for our **maternity services**, we have had to take some difficult decisions to manage demand and ensure that our birthing numbers are in line with our capacity to provide safe, quality care. We are actively reviewing and monitoring the number of bookings over the forthcoming months and working closely with our regional partners to facilitate this.
- We have been undertaking work to **prepare us for winter**, working closely with our system partners. As part of this we are focussing on patient flow to ensure we are caring for our patients in the place that is most appropriate for their needs. We are also encouraging colleagues to take up the opportunity to be vaccinated against flu to protect themselves, their families and our patients.
- At the end of month 7 we are reporting a **financial deficit of £5.998m**, representing a £0.026m negative variance from revised planned deficit levels of £5.942m. The Trust is required to deliver a revised forecast outturn deficit position of £7.088m, aided by an additional £5m non-recurrent deficit support funding which has been allocated to the North East and North Cumbria Integrated Care System (ICS).
- The **Cost Reduction Plan** (CRP) is behind plan with a negative variance of £1.2m with £8.5m transacted as at month 7 against a plan of £9.7m. Risks remain in the proportion of non-recurrent savings (one-off) made to date and the CRP plan being heavily weighted towards Q3 and Q4.
- There remains a significant focus on improving our **financial position** and making the best use of the resources available to us. We are working with our clinical and non-clinical teams to look at how we can ensure efficiency, effectiveness and quality in the delivery of our services. This links to our planning for winter and future strategy development.
- Further information on performance against Strategic Aim 3 is included in the Finance Report and the Strategic Objectives and Constitutional Standards Report.

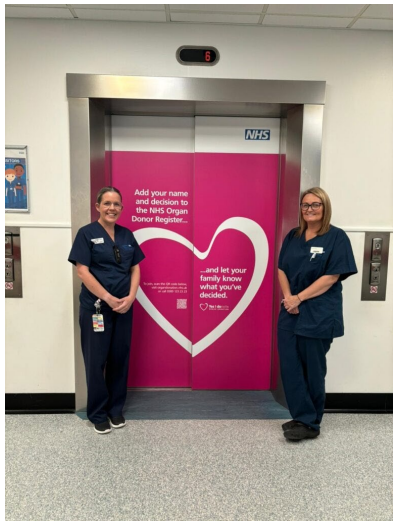
Strategic Aim 4: We will be an effective partner and be ambitious in our commitment to improving health outcomes

Gateshead Health NHS Foundation Trust

- Colleagues from Critical Care and the Organ Donation Committee hiked up Scafell Pike in partnership with other trusts to 'turn the peaks pink' and promote **Organ Donation Week**. Over the past year, 9 people in Gateshead have had their lives saved or transformed thanks to deceased organ donors from across the UK. However, sadly 3 people a day will still die while in need of a transplant due to the shortage of people willing to donate organs.
- As a member of the region's Imaging Network a **new artificial intelligence (AI) tool** will be added to our X-ray kit to help catch lung cancer quicker. The AI technology acts like a second pair of eyes for clinicians, with the ability to prioritise cases where the X-ray has found something suspicious which may indicate possible lung cancer. It has been shown to improve diagnostic accuracy by 45% and increase diagnostic efficiency by 12%.
- We have made a number of **new consultant appointments**, including in acute medicine and psychiatry. The quality and number of applications is a positive sign that consultants really want to work at Gateshead and share our commitment to improving health outcomes.

Engagement, involvement and visits:

- Provider Collaborative workforce meetings
- Great North Healthcare Alliance meetings ICS Chair and CEO workshop
- Place-based meetings



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

- The **Community Diagnostic Centre (CDC)** opened at the Metrocentre in October 2024 and welcomed its first patients. The CDC is a partnership between Gateshead Health and Newcastle Hospitals, providing a variety of diagnostic services such as imaging, respiratory and cardiac investigations. It takes healthcare into the community and aims to relieve pressures on local hospitals. We were delighted that a number of Governors could join us on a tour of the facility during the opening week.

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Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 11

Report Title:	**Employment Rights Act update**			
Name of Meeting:	Trust Board			
Date of Meeting:	27 November 2024			
Author:	Amanda Venner, Executive Director of People and OD			
Executive Sponsor:	Amanda Venner, Executive Director of People and OD			
Report presented by:	Amanda Venner, Executive Director of People and OD			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
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*	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 Employment Rights Bill was introduced to Parliament in October 2024. The government have committed to consult on many of the changes that are included from early 2025 meaning that the majority of the reforms will take effect no earlier than 2026. The key headlines are proposed changes to the following areas: • Unfair Dismissal • Rights for bank workers • Flexible Working requests • New rights for Unions • Third Party harassment • Paternity, parental and bereavement leave • Pregnant workers • Fire and rehire • Gender and Ethnicity Pay gaps • Menopause There are some fundamental changes proposed so there will be work to do to ensure our policies and procedures			

	are updated as appropriate and staff briefed appropriately.				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	Accept update for information and take assurance that the People and OD team will ensure the Group remain compliant with all relevant legislation.				
Trust Strategic Aims that the report relates to:	**Aim 1** ☐	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust strategic objectives that the report relates to:					
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):					
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 12i

Report Title:	**Board Assurance Framework (BAF) 2024-25**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 November 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 – July 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 latest updates agreed at each committee meeting are shown in red text in enable the changes to the BAF to be tracked. • The updates to the BAF demonstrate that there has been active review and update of the controls and assurances for each strategic risk area. • No risks have achieved the target score set by the Board in June 2024, although movement in current risk scores can be seen for a number of the strategic risk areas (such as in relation to maternity, the quality improvement plan and growing and developing our people). • There is correlation between the strategic risk scores shown on the BAF and the top 3 organisational risks outlined on the Organisational Risk Register report on the Board's agenda, with two of the highest scoring risks being in relation to finance and medical staffing. This correlates with the strategic BAF risk on finance (scored at 20 on			

<table>
<tr><td></td><td colspan="6">the BAF) and the strategic risk relating to growing and developing our people (also scored at 20).
• 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 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>
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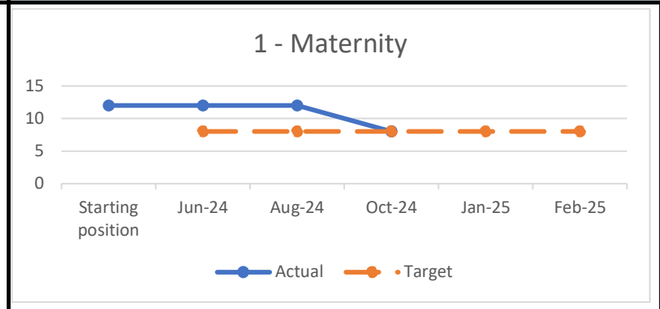
<tr><td>Aim 5
☒</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust strategic objectives that the report relates to:</td><td colspan="6">As outlined on the BAF itself</td></tr>
<tr><td>Links to CQC Key Lines of Enquiry (KLOE):</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td 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 – new risks, or those already recognised on our risk management system with risk reference number):</td><td colspan="6">Risks identified on the BAF</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>

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:	Oct-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
2 (was 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

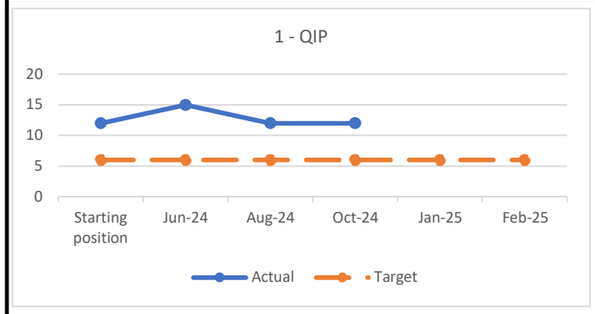
2438 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures – 8

2341 - There is a risk to ongoing business continuity of service provision due to ageing Trust estate – 16

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	Oct 24 - work being undertaken with other local trusts and the ICB re: managing demand from out of area patients.	
Six monthly reviews of maternity staffing conducted	Estates strategy currently being refreshed – next report to Board due in ~~July 2024~~ April 2025.	QEF Managing Director	~~July 2024~~ April 2025	Sept - update provided to Board in July. Oct 24 - The refresh of the Estates Strategy has been set as one of the Objectives for QEF in 2024/25 and is expected back at board in April 2025. The tender process to identify a specialist contract to support this has now been completed however a review of the proposal is required to account for the potential impact of the Great North Healthcare Alliance and the “Big Build”	

Maternity Safety Champion role in place and active	[redacted]	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. Sept 24 - All outstanding actions have now been completed with no further reports of pest activity, as such **action recommended for closure.**	
Neonatal Badger system in place						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Performance is monitored within the department at governance meetings						
Divisional Safecare meetings in place						
Twice daily safety huddles in place in maternity						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Maternity staffing report presented to Board and Quality Governance Committee biannually						
Maternity IOR presented to every QG Committee and Board meeting						
Assurance (Level 3 – external)						
MIS audit from AuditOne provided reasonable assurance – actions taken to enhance compliance and achieve MIS						
Full compliance with MIS Year 5 confirmed by NHS Resolution						
Maternity services rated ‘good’ by CQC in 2023						
CQC patient survey ranked GH maternity as 5th best in the country						
Maternity Assurance Visit						

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:	Oct-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
		4	**3**	**12**	**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 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~~ (risk closed - no further balloting taken place0 ~~2545 - Risk of delayed transfers of care and increased hospital lengths of stay - 8~~ (risk closed - was a local risk raised by Medicine - superseded by a locally managed risk in relation to focussed financial planning to support mitigation of this risk - linked to social care assessment and complex discharge requirements)						

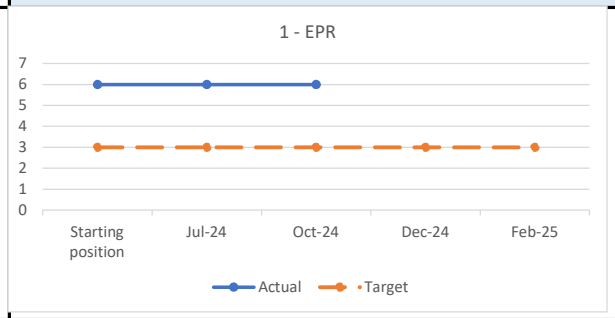
Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
CQC compliance manager in place	New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24	Sept - tier 2 meetings now in place alongside GHLG. Effectiveness to be assessed within 6 months. **Action to be considered for closure**	
Clinical audit programme in place	Quality Improvement Plan not yet reviewed by the Committee	Chief Nurse	Aug-24	Aug - this has now been reviewed by the Committee and gap agreed as closed.	
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					
Quality Improvement Plan in place					
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	Aug 24 - information provided and Committee agreed gap has been closed.	
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	Aug 24 - information provided and Committee agreed gap has been closed.	
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 deep dives reports into complaints and falls reviewed by QGC						
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.						
External accreditations						
7 external assurance visits to CSS including NHSE Paediatric Audiology, UKAS Assessment HSE visit, SQAS Bowel Cancer Screening, Regional Endoscopy training review, HTA inspection, aseptic unit accreditation						
ICB inpatient review visit and RcPsych Psychiatric Liaison Accreditation Review for Older Persons Mental Health Services						
CQC Mental Health Act Monitoring Visits to Cragside and Sunniside						
ADQM assessment						
Annual CBRN audit						
Cancer Patient Experience Report provides good assurance						

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:	Oct-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.



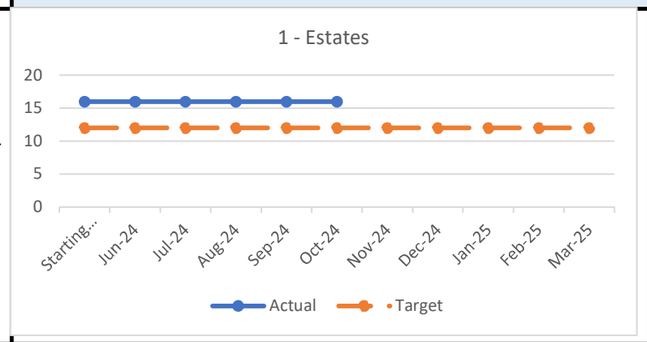
CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
2	3	6	1	3	3

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 4554 - risk of cyber threats and vulnerabilities - 15

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	Mar-25	Oct 24 - business case to be presented at Board in January 25	
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	Oct 24 - job description has been shared with colleagues in the Alliance	
Digital strategy in place	New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24	Sept - tier 2 meetings now in place alongside GHLG. Effectiveness to be assessed within 6 months. Action to be considered for closure Oct 24 - Committee agreed to keep action open and consider for closure at the next meeting	
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:	Oct-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

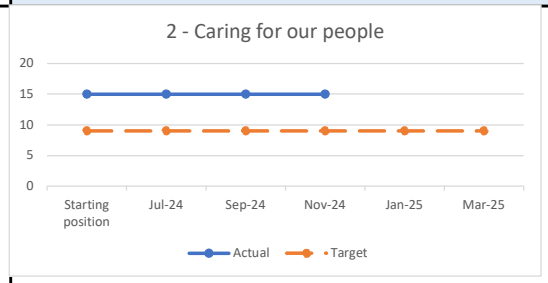
Links to risks on the ORR:	2341 - There is a risk to ongoing business continuity of service provision due to ageing Trust estate – (16)

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 Organisation's priorities - A revised strategy is to be submitted to the Group Board.	QEF Managing Director	Mar-25	Oct 24 - work paused on individual estates strategy pending discussions on an Alliance estates strategy	
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	~~August 24~~ Nov 24	Oct 24 - The existing CAT D & E Capital Works request processes are still in place however as presented at CSG on the 9th October work is ongoing with the Trust Corporate Services Team to define a revised process that we hope to submit back to the CSG at the November meeting.	
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	Sept - tier 2 meetings now in place alongside GHLG. Effectiveness to be assessed within 6 months. **Action to be considered for closure**	
Capital plan for 2024/25 in place following Board approval					

Collaborative work across the Alliance and ICB to review estates related issues across the patch with a view to developing collaborative strategic approaches					
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	Oct 24 - A Monthly Capital Update Report has now been produced with the first draft submitted to the Gateshead Leadership Group at the 26th Sept 24 meeting. **Action recommended for closure**	
	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~~ Nov 24	Oct 24 - The reporting route is currently in discussion with a proposal submitted to the Group Finance Director and Chief Operating Officer.	
	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~~ Nov 24	Oct 24 - To be decided dependent on the outcome of the conversation detailed above.	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Regular reports to Trust Board on estates prioritisation and strategy development					
Estates option paper for Bensham site discussed and agreed at Trust Board					
Assurance (Level 3 – external)					
External Assessment of the Estate against the 6 facets identified in Estatecode including, Estate condition.					

Strategic Aim 3: 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:	Nov-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:

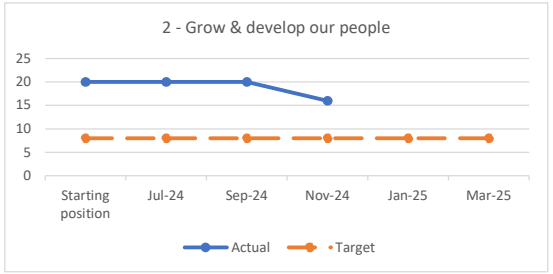
2425 - Activity is not delivered in line with planned trajectories, leading to reduction in income - 16

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	Sept - tier 2 meetings now in place alongside GHLG. Effectiveness to be assessed within 6 months. **Action to be considered for closure**	
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	Dec-24		
Zero tolerance campaign in place	Low uptake of exit interviews - target to achieve a 25% uptake.	Executive Director of POD	Dec-24	Currently at 12% uptake. Further work being carried out by People Promise Exemplar programme.	
Show Racism the Red Card training provided with further sessions planned	Lack of adherence to Managing Attendance policy	Executive Director of POD	Jan-25	Sickness absence training being rolled out to managers.	
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	Nov-24		
New governance structure provides a greater focus on workforce and culture through the POD Tier 2 and Tier 3 groups	Turnover not reducing from 11.7% - need a detailed overview on retention data	Executive Director of POD	Nov-24	Nov 24 - Committee noted turnover rate increase and requested more assurance over controls	

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						
Occupational health pilot in place						
Good visibility on sickness						
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 commenced July 2024 with monthly meetings now in place.	
POD Steering Group now in place		Absence levels remain higher than plan - POD Committee to receive a deep dive report in July 24	Executive Director of POD	Jul-24	Deep dive report received July 2024, further updated paper to follow September 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	Jan-25		
		Further work required to triangulate themes and trends in relation to sickness absence and turnover in order to gain greater improvements and impact and target work in the right areas	Executive Director of POD	Jan-25		
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						
Robust discussions on sickness absence at the Oct 24 POD Committee - recognise issues and remaining gaps						
Deep dive report on sickness absence received at October POD meeting						
Deep dive report on turnover received at October POD meeting						
Absence deep dive report received at July POD Committee for assurance						
Assurance (Level 3 – external)						
Engagement score on NHS staff survey is above average						

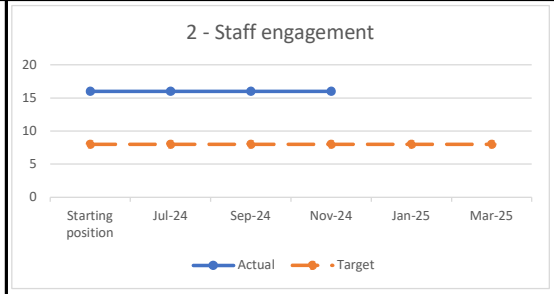
Strategic Aim 2: we will be a great organisation with a highly engaged workforce								
Strategic objective:	Growing and developing our people in order to improve patient outcomes, reduce reliance on temporary staff and deliver the 24-25 workforce plan							
Executive Owner:	Group Executive Director of People and OD							
Board Committee Oversight:	People and OD Committee							
Date of Last Review:	Nov-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
		Was 5 now 4	**4**	**16**	**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 4525 - Risk of lack of a strategic workforce planning - 12 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 - (was 20 now 16)							

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	Jan-25	6 step methodology agreed, workforce planning group meeting weekly to align workforce planning with business planning. 2 Trustwide planning sessions taking place in September to embed in the divisions Sept 24 - POD Committee agreed to amend the timescale to Jan 25	
Agency spend authorisation process in place	Medical staffing function and processes under review, including establishment, budget and control environment	Executive Director of POD	Dec-24	New MD in post and discussions ongoing re transition of the team.	
Planning group in place to respond to industrial action	Workforce alignment to strategic intent not yet completed.	Executive Director of POD	Jan-25		
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	Jan-25	Sept - tier 2 meetings now in place alongside GHLG. Effectiveness to be assessed within 6 months. Action to be considered for closure Nov 24 - action agreed for closure as new structures now in place	

GAiN apprenticeship programme in place		Long term workforce plan implications and associated funding not confirmed	Executive Director of POD	Jan-25	Elections have delayed the confirmation of funding and timescales. Sept 24 - POD Committee agreed the timescale to be adjusted to Jan 25	
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	Jan-25		
Reduction in reliance on temporary staffing evidencing that there is a stronger control environment in place		Training space limited and not always fit for purpose	Executive Director of POD	Jan-25	Discussions ongoing re the Estates strategic plan Sept 24 - POD Committee agreed the timescale to be adjusted to Jan 25	
New governance structure supporting greater controls and the flow of assurance through to POD Committee						
Professional Nurse Advocacy programme in place to support reflection and learning						
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	POD Steering group commenced July 2024 with monthly meetings now in place.	
Dashboards showing workforce information shared via numerous professional forums and wider						
POD team meetings						
POD Steering Group now in place						
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:	Nov-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

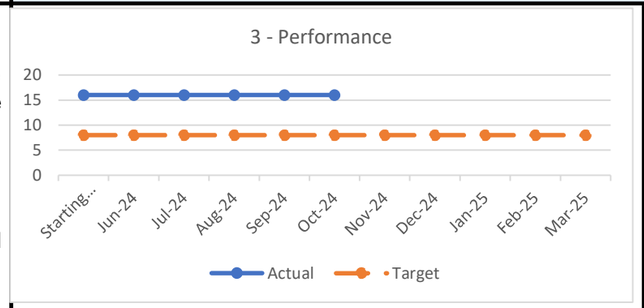
Links to risks on the ORR:

4417 - Increase in incivility and disrespectful behaviours being reported - 12

3132 - Exposure to incidents of violence and aggression in ECC - 15

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	Jan-25	Sept - tier 2 meetings now in place alongside GHLG. Effectiveness to be assessed within 6 months. Action to be considered for closure	
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. Further support required to re-define the networks and what/how the network groups feed into the Board and EMT	Executive Director of POD	Dec-24		
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	Jan-25		
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	Jan-25	Actions underway to include in all Board members appraisals for 24/25	
Pulse surveys held during the year	Strategic direction and timescales for EDI work requires further development	Executive Director of POD	Jan-25	Time out session held with HREDI group to focus priorities for 24/25	
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	Dec-24		
EDI dashboard in progress	Lack of internal oversight on WTE growth and bank positions being filed. Need to understand where the growth is and plans to address	Executive Director of POD	Dec-24		
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 commenced July 2024 with monthly meetings now in place.	
POD Steering Group now in place		Culture programme group not yet reformed	Executive Director of POD	Nov-24	Initial meeting with AV/TD/LF took place in August to review focus of culture programme. Sept 24 - POD Committee agreed the timescale to be adjusted to Nov 24	
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						
ADQM report received at POD Committee						
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 enhance our productivity and efficiency to make the best use of our resources						
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:	Oct-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~~ (risk closed - was a local risk raised by Medicine - superseded by a locally managed risk in relation to focussed financial planning to support mitigation of this risk - linked to social care assessment and complex discharge requirements) ~~2432 - Risk of Significant, unprecedented service disruption due to industrial action – 16~~ (risk closed - no further balloting taken place0 ~~2582 - Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI - 12~~ (risk deescalated from ORR as there is no organisational risk to statutory reporting requirements) 4591 - Risk of significant service disruption due to GP collective actions including reduction in shared care service provision (was 20 now 16)						

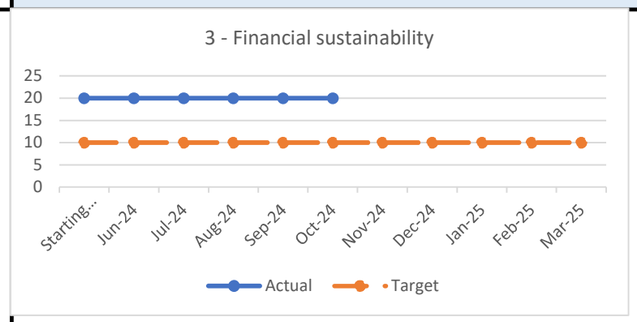
Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Annual plan developed and in place	New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24	Sept - tier 2 meetings now in place alongside GHLG. Effectiveness to be assessed within 6 months. **Action to be considered for closure**	
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	Oct 24 - Surgery now providing a divisional update. A one page summary process document to be developed to outline the controls which have been put in place	
New business intelligence post in place	Revision of information and reporting required	Chief Operating Officer / Director of Finance	Jul-24	Oct 24 - key projects underway to streamline reporting. A number of examples of new and revised reports added under the 'assurance' section. **Action recommended for closure**	
Membership and participation in the UEC strategic board	Patient Access Policy to be reviewed and updated	Chief Operating Officer	Sep-24	Oct 24 - work ongoing to streamline the Patient Access Policy with other organisations	

Membership and participation in the Strategic Elective Care Board					
Leadership of the Theatres and Perioperative Medicine regional workstream					
Weekly performance meetings in place					
Key projects underway to streamline reports and enhance the business intelligence offer					
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	July- now launched.	
Weekly Access and Performance Meetings	Tier 3 groups specifically focussed on activity monitoring / operational capital programme delivery being implemented	Chief Operating Officer	Aug-24		
Operations Oversight Group meeting is in place	Deep dive reports needed to understand actions re: 4 hour and 12 hr performance	Chief Operating Officer	Aug-24	Sept - deep dive reports were presented at the August meeting, giving some assurance. Action to remain open until impact of the work can be seen. **Revised timescale to be agreed.**	
New reports in place to support operational management - e.g. planned care report, CDC reporting, wait for first outpatient reporting, enhanced discharge reporting, sit-rep reports for pharmacy and winter					
Open referral stratification reporting in place, supporting operational waiting list management of follow-up patients					
Enhanced elective care activity plan reporting to weekly planning group and Tier 3 groups reporting into Operational Oversight Group					
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Finance and Performance Committee receive the Leading Indicators and Elective Recovery report					
Board receives the Leading Indicators report at every meeting					
Mutual aid report presented to the Finance and Performance Committee					
Performance reported and discussed at the regional ICB Performance Improvement and Oversight meeting monthly					
Assurance (Level 3 – external)					
Regional benchmarking report provides assurance over the Trust's relative performance					

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

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:	Oct-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~~ (risk deescalated from ORR as there is no organisational risk to statutory reporting requirements)

2424 - Risk that efficiency requirements are not met - 16

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 (16)

2341 - There is a risk to ongoing business continuity of service provision due to ageing trust estate - 16

4577 - Achievement of 24/25 revenue financial plan - 20

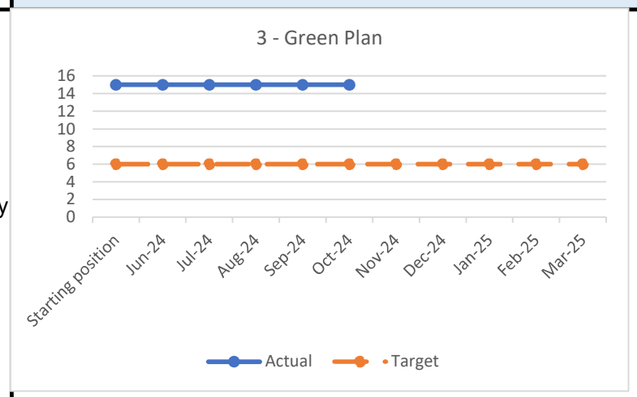
Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Annual plan developed and in place	Efficiency plans not yet fully developed within each division and corporate area	Group Director of Finance & Digital	**TBC**	July 24 - fully articulated plan not yet in place	
Agreed 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	Sept - tier 2 meetings now in place alongside GHLG. Effectiveness to be assessed within 6 months. **Action to be considered for closure**	
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	Gaps in controls identified in relation to medical staffing	Medical Director	**TBC**	Strategic workstream identified with Medical Director as the Exec lead Oct 24 - new Associate Director post now in place. Senior Medical Staffing Manager also in post with new procedures developed and increased team capacity. Risk reduced from 20 to 16. **Consider whether action can be closed**	

More detailed information now available to support forecasting	Appointment of service manager for medical staffing not yet in place	Chief Operating Officer	Sep-24	August - the COO to verify if this appointment has taken place and report back in September Oct 24 - Associate Director for Medical Staffing now in place. Action therefore recommended for closure	
Financial sustainability framework in place					
Medical staffing team increased with new Associate Director post and Senior Medical Staffing Manager in place. New SOPs developed					
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	To include forecasting information in more detail in the finance report for the next meeting	Group Director of Finance and Digital	Sep-24		
Financial sustainability framework being utilised for Medicine division	Midwifery and ED staffing papers deferred from the agenda - to be provided in October	Group Director of Finance and Digital	Oct-24	Nov 24 - paper on midwifery staffing received in October's meeting. ED staffing schedule for November	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Leading Indicators and finance report presented to F&P Committee					
QEF financial performance reported to F&P Committee					
CRP options paper developed and presented at F&P to identify alternative options for delivery given financial position					
Assurance (Level 3 – external)					

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

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:	Oct-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.

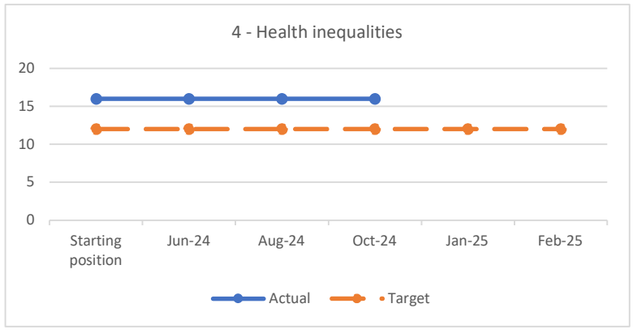


CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
5	**3**	**15**	**2**	**3**	**6**

Links to risks on the ORR:	4577 - Achievement of 24/25 revenue financial plan - 20

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	~~Sept 24~~ Jan 25	Oct 24 - A meeting has been held with the Sustainability Teams for Northumbria and Newcastle to discuss the potential for a peer review to provide recommendations to support best practice. With the QEF Sustainability Manager now back in post this review is expected to be completed by the 31st December 2024.	
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~~ Jan 25	Oct 24 - This will form part of the review as detailed above.	
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	Oct 24 - Following a successful recruitment process the new Head of SHEQ is expected to be in post on the 2nd December 2024. **On this basis action recommended for closure**	
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	~~Sept 24~~ Jan 25	25/06 - Committee discussed gap in assurance. KM to discuss further with GE to determine if quarterly updates to come via F&P Oct 24 - See update on the delivery of a peer review by Northumbria and Newcastle Sustainability Teams.	
		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	~~Sept 24~~ Jan 25	Oct 24 - See update on the delivery of a peer review by Northumbria and Newcastle Sustainability Teams.	
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:	Oct-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:	4402 - Inability to support legislation and best practice associated with records management - 16 ~~2582 - Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI - 12~~ (risk deescalated from ORR as there is no organisational risk to statutory reporting requirements)							

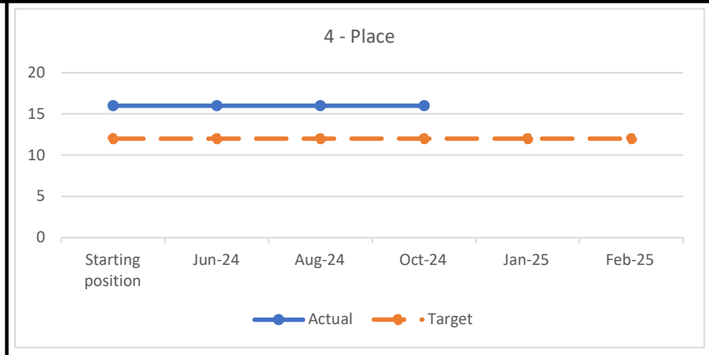
Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Health inequalities strategy approved by Quality Governance Committee	New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24	Sept - tier 2 meetings now in place alongside GHLG. Effectiveness to be assessed within 6 months. Action to be considered for closure	
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	Reporting of health inequalities not clear under the new governance structure. Medical Director to work with Chief Nurse and Company Secretary to ensure reporting route is clarified.	Medical Director	Nov-24	Nov 24 - update report to QGC outlined proposed new reporting from Health Inequalities Group to the GH Leadership Group	
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	Nov 24 - paper to QGC proposed inclusion of consideration into the terms of reference of each Board committee plus an annual health inequalities Board report	
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	Nov 24 - proposals outlined to develop a Data Oversight Group to support divisional understanding of health inequalities within performance reporting	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
~~Health Inequalities Board reports to Quality Governance Committee quarterly~~						
Health Inequalities Assurance report received at QGC						
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:	Oct-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.



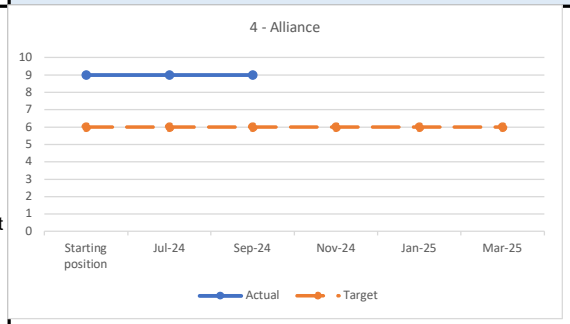
CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
4	**4**	**16**	**3**	**4**	**12**

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

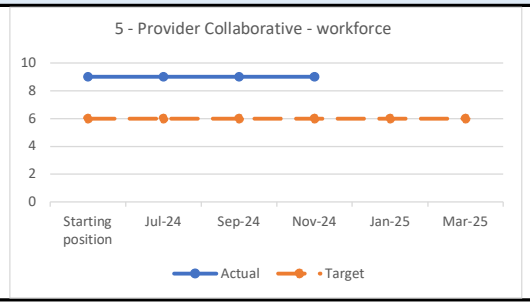
Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Senior engagement in Gateshead Cares meetings	Review and monitor external meeting membership and attendance to ensure appropriate engagement	Medical Director	Sep-24	Nov 24 - controls updated to reflect meeting representation. Consider whether action can be closed	
Appropriate director level attendance at Gateshead Overview and Scrutiny and Health and Wellbeing Boards					
Gateshead Health CEO chairing Gateshead Cares Board					
Direct engagement with GPs and PCNs through PCN meetings and GP weekly meetings					
Regular LMC liaison with local GPs					
Representation on SEND Strategic Board via Director of Ops for Medicine, Community and OPMH					
Representation at the Better Care Fund Working Group					
Partner on the Integrated Commissioning Group meeting					

Work underway to review the community contract at place level					
Representation on the Children's Strategic Board via Director of Ops for Medicine, Community and OPMH					
Systems approach taken to winter planning					
Place presentation planned for October to be delivered by CEO, Place Director and the CEO of the local authority on the benefits of collaborative working at place - evidence of good place relationships					
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					
Approach to winter planning at place level shared formally with the Board in Sept 24					
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:	Sep-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 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								

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]					
Alliance workplan shared with the Board	[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:	Nov-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 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 4525 - Risk of lack of a strategic workforce planning - 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	~~Dec 24~~ Jan 25	Nov 24 - agreed to revise due date to Jan 25 to reflect capacity	
POD Director meeting with Alliance HRDs to discuss opportunities	Challenge of provider collaborative, ICB and Alliance groups, discussions and programmes of work. Corrective Action - to understand the priorities and 'must-do's'	Executive Director of POD	~~Dec 24~~ Jan 25	Nov 24 - agreed to revise due date to Jan 25 to reflect capacity	
Gateshead CEO as regional Workforce Lead					
Workforce Sharing Agreement in Place					
Close working with ICB People team - members of HRD network and meet weekly					
CDC is contributing to the regional workforce programme					
The Chief Operating Officer is leading the medicine workforce for the Provider Collaborative					
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)					

	[redacted]					
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:	Oct-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									

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~~ Nov 24	Oct 24 - The Business Development Strategy was discussed at a Board Strategy Workshop on the 15th August 24 with the completed Strategy document to be presented to the QEF Board on the 17th October 24.	
A Board Agreed QEF Business Development Strategy.		The existing Business Development Strategy has not been ratified by Board.	QEF Managing Director	~~Sept 24~~ Nov 24	Oct 24 - This strategy will be presented to the Board on ratification by the QEF Board at the Strategy Development Workshop on the 17th October 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~~ Nov 24	Oct 24 - Following the development of the Business Development Strategy we are agreeing the Business Development Process with a focus of developing detailed Business Plans for 25/26.	
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	~~July 24~~ Nov 24	Oct 24 - Interviews for the role of Commercial Director are to be held on the 15th October 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	~~Sept 24~~ Nov 24	Oct 24 - The draft Terms of Reference for an “Occupied Healthcare Facility Contract Review Group” have been provided to the Trust and it is hoped that the first meeting will take place in November 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	Mar-25	Oct 24 - The reporting of the targeted commercial pipeline will form part of the detailed business plans expected to be in place by 31st March 25.	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Assurance (Level 3 – external)						

Gateshead Health NHS Foundation Trust

Agenda Item: 12ii

Report Title:	**Organisational Risk Register (ORR)**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27th November 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 into the Gateshead Health Leadership Group (GHLG) Meeting, 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 meeting in October and the following updates and movements agreed. Note: Novembers meeting was stood down due to quoracy. The accompanying Report shows the following changes and is detailed within this report.			

<table>
<tr><td>

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

</td><td colspan="5">-There were 0 risks added, 0 escalations, 4 reductions, 3 risks removed, 2 closed.
-Compliance with reviews has improved since last reporting period and sits at 94% for risks and 82% for associated actions.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The Board are asked to:

• Review the risks and actions on the attached report and discuss and seek further information relating to risks as appropriate.
• Take assurance that risks are reviewed in line with risk management arrangements.
• Be sighted on the top 3 risks for the organisation.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="4">We will look to utilise our skills and expertise beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">Each risk is linked to a corporate objective, see report.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Safe
☒</td><td>Effective
☒</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and InPhase reference)</td><td colspan="5">Included in report</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

Organisational Risk Register

Executive Summary

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

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

Good governance processes have been demonstrated throughout the period, with reviews of the ORR at ERMG, as well as relevant Tier 1 and Tier 2 committees as per Risk Management Framework.

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

This report covers the period 19th September-19th November 2024 (extraction date for this report).

Organisational Risk Register

Movements:

Following ERMG meeting in October 2024, 0 risks have been added to the ORR. There have been 0 escalations, 4 reductions, 3 risks removed from the ORR and 2 closures.

There are currently 18 risks on the ORR, agreed by the group as per enclosed report.

New Risks:

There have been 0 new risks added in period:

Risks increased:

0 No risks have escalated in score**.**

Risks reduced

4 risks have reduced**:**

- **(4559) Medical Director**–There is a risk that appropriate support is not available to our medical staff to enable 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. There is a secondary financial risk that this contributes to significant overspend on our medical workforce. (16)
    - -Reduced from 20 to 16
    - **-**Recruitment of a band 4 post into medical staffing to increase capacity.
    - -Standard operating procedures and FAQ's developed.

  - -Medical staffing team transitioned into the MD portfolio for better clinical oversight.
  - -senior medical staffing manager in post October 2024.

- **(4591) CEO**- Risk of significant disruption to services due to GP collective action to "work to contract" including withdrawal from shared care agreements. The impact of this is currently unknown, however, may result in suboptimal quality of care, reduced performance against targets, realignment of clinical resources and reputational harm. (16)

  - The risk has not manifested as significantly as initial predictions. whilst pockets of the organisation have experienced significant issues, organisationally, the risk has not collectively impacted services.
  - Resulted in reduction from 20 to 16

- **4575 (Digital)** The trust performance against the mandatory 20-day turnaround (as per the Freedom of Information Act) for Freedom of Information requests is below tolerance of 90%. Increasing the likelihood of complaints/reports to the ICO from requestors. (12)
  - Reduced from 16 to 12
  - Improvement in compliance noted, therefore likelihood reduced.

- **4541 (NMQ)** 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. (12)

  - Reduced from 16 to 12
  - Functionality of committees and escalation reports has been positive with no significant concerns of note.

Risk removed from ORR

1 risk has been agreed to be managed locally by Planning and Performance.

- **2582 (P+P)**- Risk of ineffective and inefficient management of services due to availability of and access to appropriate and timely BI. (12)

  - No change to score, however there is no organisational risk to statutory reporting requirements.

Risks closed:

2 Risks have been closed

- **2432 (POD)-** 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.
    - No further balloting has taken place.

- **2545 (Medicine)** Risk of delayed transfers of care and increased hospital lengths of stay.

Risk has been superseded by the locally managed risk for medicine, in relation to financial constraints and the ability to effectively and timely discharge patients. These groups of patients are awaiting social care assessment or have complex discharge requirements resulting in considerable strain on financial spend. There is significant emphasis on focused financial planning to support mitigation.

4653 (Medicine) Risk of being unable to deliver services within current budget as a result of using escalation beds. This is due to patients who no longer meet the criteria to reside remaining within our bed base. This is leading to unplanned spend. (20)

Top 3 Organisational Risks:

1- **Finance risks-** CRP – lack of a delivery plan, which impacts on performance, finance workforce and quality.
2- **NMQ governance risk-** Implementation of the new governance structure, including ensuring appropriate quality impact assessment.
3- **MD workforce risk- (Medical staffing)-** infrastructure and support/oversight to operational divisions. Medical staffing is not delivering the expectations of the organisation due to various reasons (capacity, competency and system) impacting on finances, performance and potentially quality of care.

- **4577** (**Finance)** Risk that the trust does not achieve its 2024/25 planned deficit totalling £12.6 M and does not deliver its CRP, resulting in significant impact on financial sustainability. (20)

- **4541** (**NMQ)** Risk of failure of governance arrangements as we transition to a new governance structure, resulting in critical information potentially being lost or missed and Executives being unaware of risks within the organisation. (12)

- **4559** (**MD)** Risk that the appropriate support is not available to our medical staff to enable 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. There is a secondary financial risk that this contributes to significant overspend on our medical workforce. (16)

Current compliance with Risk reviews:

Risk review compliance is currently at 94%. Action review compliance is 82%. This is an improvement since September's report.

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 as per risk governance framework.

Organisational Risk Report - Board

Total Risks (Current/Managed)

18

People

5

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Resources	Medical Director's Office	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	16
	Chief Operating Officer	4574	A risk of being unable to relocate in the event of an evacuation due to capability and capacity issues within the estate that may potentially result in patient safety issues	12
	People & OD	4525	Risk of Lack of a strategic workforce planning	12
Staff Safety	People & OD	3132	Exposure to incidents of violence and aggression	15
Wellbeing	People & OD	4417	Increase in incivility and disrespectful behaviours being reported	12

Quality

4

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Effectiveness	Chief Executive Office	4591	Risk of significant service disruption due to GP collective actions including reduction in shared care service provision	15
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

Finance

4

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Finance	Finance	4577	Achievement of 2024/25 revenue financial plan	20
Finance	Finance	2425	Activity is not deliverved in line with planned trajectories, leading to reduction in income	16
Finance	Finance	2424	Risk that efficiency requirements are not met.	16
Business Continuity	QE Facilities	2341	There is a risk to ongoing business continuity of service provision due to ageing trust estate	16

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	4576	Non compliance with SARs response turnaround time could result in ICO imposed penalties.	15
Compliance	Digital	4575	Non compliance with FoI response turnaround time could result in ICO imposed penalties.	12
Compliance	Nursing, Midwifery & Quality	4541	Risk of governance failure as we transition to new governance arrangements	12

This report does not contain any data

Reputation

Organisational Risk Register (Current/Managed)

18

Stage: 2 selected | Organisational Risk: Organisational | Rating: 0 to 25

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
4577	Finance & Performance Committee BU Dir. Governance Meeting Organisational Risk	Risk that the trust does not achieve its 2024/25 planned deficit totalling £12.6 M and does not deliver its CRP, resulting in significant impact on financial sustainability.	Kris Mackenzie	Finance	Finance	-Financials & Sustainability workstream. -Vacancy control, non-pay discretionary spend, temporary staff reduction group, medical & nursing staff workstreams, roster management, updated -SFI's and scheme of delegation, additional spending controls	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.	25	20	10	22 Jul 2024	23 Nov 2024	Current Risk	
2341	BU Dir. Governance Meeting Organisational Risk Finance & Performance Committee Health and Safety Committee BAF Operations Oversight Group PPAI	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.	Anthony Pratt	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	23 Nov 2024	Current Risk	
2424	BU Dir. Governance Meeting Finance & Performance Committee Organisational Risk BAF	Risk that 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. Finance and performance assurance group to over see CRP performance on a monthly 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 4.1 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 SA 4.2 Work collaboratively as part of the Gateshead system to improve health and care outcomes to the Gateshead population 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	27 Nov 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
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 elective recovery funding.	Kris MacKenzie	Finance	Finance	2024-25 activity plans informed 24-25 planned income targets. Monthly reporting against planned income targets, including performance analysis by speciality, point of delivery and HRG. Attendance at system elective recovery meetings Weekly access and performance clinics to monitor performance and agree actions plans Coding & counting workstream to support the capture of activity data	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. SA 4.1 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	20	16	4	22 Nov 2022	17 Nov 2024	Current Risk	
4559	BU Dir. Governance Meeting Organisational Risk People and OD Committee Quality Governance Committee Finance & Performance Committee	There is a risk that appropriate support is not available to our medical staff to enable 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. There is a secondary financial risk that this contributes to significant overspend on our medical workforce.	Ross Peddie	Medical Director's Office	Medical Directorate	-Recruitment of a band 4 post into medical staffing to increase capacity. -Standard operating procedures and FAQ's developed. -Medical staffing team to be transitioned into the MD portfolio for better clinical oversight. -senior medical staffing post holder started 1st October (Associate Director). -recruitment of a band 6 to support.	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. 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	8	11 Jun 2024	15 Dec 2024	Current Risk	
4402	BU Dir. Governance Meeting Digital Committee Organisational Risk BAF PPAI	Risk of breaching legislative requirements due to lack of long term strategic approach to the management and storage of health records [both digital and paper]. This could lead to regulatory and reputational harm.	Catherine Bright	Digital	Digital Transformatic and Assuranc	-Action to scope and procure an EPR to support robust record management requirements [Record Lifecycle - creation to destruction]	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	22 Nov 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
4405	BAF BU Dir. Governance Meeting Digital Committee Organisational Risk	Risk of data mismanagement, leading to inappropriate access, misuse or inappropriate disclosures. Due to failure to incorporate best practices in the management of information across the organisation. Resulting in patient harm and/or failure to comply with UK law, national standards and contractual requirements.	Dianne Ridsdale	Digital	Digital Transformatic and Assuranc	Trust Policies, procedures, guides, materials and tools. Staff training, awareness and communication programmes Internal and external auditing and IG spot check programme	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	15 Dec 2024	Current Risk	
4576	BU Dir. Governance Meeting Digital Committee Organisational Risk	There is a risk that as the trust is failing to meet the mandated turnaround time of a calendar month for Subject Access Requests (below 95% tolerance), complaints to the ICO from requestors could increase. 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 Transformatic and Assuranc	-Trust policy and procedure in place	SA 1.3 Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.	20	15	5	16 Jul 2024	24 Nov 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	-Various controls in place and monitored via CiSG.	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	24 Nov 2024	Current Risk	
4591	BU Dir. Governance Meeting Finance & Performance Committee Organisational Risk Quality Governance Committee Winter Planning	Risk of significant disruption to services due to GP collective action to "work to contract" including withdrawal from shared care agreements. The impact of this is currently unknown, however, may result in suboptimal quality of care, reduced performance against targets, realignment of clinical resources and reputational harm.	Neil Halford	Chief Executive Office	Chief Executive Office	-monitoring via central database -task and finish group- impact assessment - collated list of drugs which will continue to be provided -Central EPRR mailbox monitored for issues to be reported into -Internal multi-disciplinary group established led by the Group Medical Director to coordinate the response and quantify the impact of withdrawals and action -Twice-weekly reporting (by exception) of issues to the System Coordination Centre at the NENC ICB - Communications circulated to primary care colleagues	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 3.1 Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025. SA 4.1 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	25	15	10	16 Aug 2024	29 Nov 2024	Current Risk	
3132	BU Dir. Governance Meeting Organisational Risk Quality Governance Committee People and OD Committee Health and Safety Committee BAF	Risk of harm to staff (psychological and physical) due to exposure to violence and aggression from patients and visitors who exhibit challenging behaviours. This could result in injury, increased absence from work, staff morale and confidence and potentially effect recruitment and retention.	Laura Farrington	People & OD	Workforce Development	Sexual Safety and Bullying & Harassment Policies revised and in place to support staff Civility and Respect / Active Bystander training available Reporting pathways open to staff with increased work in this area planned for 2024-25. Forums for debrief/discussion and support available Zero-Tolerance Programme Group established and moving into year 2. Now reporting through to the Culture Programme Group and POD Steering Group. "It's not OK" campaign launched. Violence Reduction group re-established	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	23 Nov 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
3107	BAF BU Dir. Governance Meeting Organisational Risk Quality Governance Committee Operations Oversight Group PPAI	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 -draft contingency BCPs has been developed and required further discussion with clinical team and execs.	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 Dec 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	12	4	13 May 2024	05 Dec 2024	Current Risk	
4574	Business Resilience Group BU Dir. Governance Meeting Organisational Risk Quality Governance Committee	A risk of being unable to relocate in the event of an evacuation due to capability and capacity issues within the estate that may potentially result in patient safety issues and impact quality.	David Patterson	Chief Operating Officer	EPRR	Ongoing work to review the current trust evacuation and shelter plan Pre-determined areas being scoped in review of business continuity plans	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.	16	12	8	16 Jul 2024	23 Nov 2024	Current Risk	
4575	BU Dir. Governance Meeting Digital Committee Organisational Risk	Risk that the trusts failure to meet the mandatory 20 day turnaround (as per the Freedom of Information Act) for Freedom of Information requests could increase 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 Transformatic 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	12	8	16 Jul 2024	24 Nov 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
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 SA 5.2 Evidenced business growth by March 2025 with a specific focus on Diagnostics, Women's health and commercial opportunities	16	12	8	26 Mar 2024	27 Nov 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	-Established the zero tolerance campaign and have introduced the "it's not ok providing training and support for colleagues in identifying and responding to bullying, harassment and discrimination from colleagues, patients or service users. -Established 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. -Increased the number of FTSU champions form 8 to now 30 covering a wide range of professions, areas / sites. -Undertaken increased promotion of services on multiple media platforms.	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	07 Dec 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. SA 4.2 Work collaboratively as part of the Gateshead system to improve health and care outcomes to the Gateshead population	15	8	4	16 Aug 2022	22 Jan 2025	Current Risk	

Risks Removed from ORR in Period (all levels) 3

Stage: 4 selected

Date Removed from ORR: 2024-09-19 to 2024-11-19

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 Removed from ORR	Next review Date	Stage	Open Form
2582	BU Dir. Governance Meeting BAF	Risk of ineffective and inefficient management of services due to availability of and access to appropriate and timely BI. Current capacity, capability and configuration of teams and systems supporting the provision of BI is not timely in meeting business needs. There is limited capacity within existing teams to produce an overarching BI strategy in support of a data driven organisation	Ian Vause	Planning & Performance	Planning & Performance	Associate Director of BI appointed Apr 24 to compliment existing senior management team across 'informatics'. Baseline assessment conducted and programme of work outlined to deliver steps to resilience. Existing reporting mechanisms include; - 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. Real-time cancer performance dashboards developed in line with revised cancer standards for FDS, 31 Day, and 62 Day Treatments - SitRep Reporting: Outputs from SitReps 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 P&P Team - Leading Indicators: Manual compilation from existing excel outputs (from various sources) and co-ordination by P&P Team - Health Inequalities Data: Information team produce HIE view of RTT and Cancer PTLs 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	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 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.	16	12	4	08 Oct 2024	26 Oct 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 Removed from ORR	Next review Date	Stage	Open Form
2545	BAF BU Dir. Governance Meeting 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	08 Oct 2024	08 Oct 2025	Closed Risk	
2432	BAF BU Dir. Governance Meeting 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	8	8	08 Oct 2024	06 Jan 2025	Closed Risk	

Changes in CRR

Owner

All 12 selected

Risk ID	Risk Stage	Open	Risk Title	Owner	Business Unit	Service	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024
4577	Current Risk		Achievement of 2024/25 revenue financial plan	Kris Mackenzie	Finance	Finance		20	20	20	20	20
2341	Current Risk		There is a risk to ongoing business continuity of service provision due to ageing trust estate	Anthony Pratt	QE Facilities	Estates	16	16	16	16	16	16
2424	Current Risk		Risk that efficiency requirements are not met.	Kris Mackenzie	Finance	Finance	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	16
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	Ross Peddie	People & OD	Medical Directorate	20	20	20	20	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
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
4576	Current Risk		Non compliance with SARs response turnaround time could result in ICO imposed penalties.	Kris Mackenzie	Digital	Digital Transformation and Assurance		15	15	15	15	15
4554	Current Risk		Cyber Threats and Vulnerabilities	Kris Mackenzie	Digital	IT	15	15	15	15	15	15
4591	Current Risk		Risk of significant service disruption due to GP collective actions including reduction in shared care service provision	Neil Halford	Chief Executive Office	Chief Executive Office			20	20	15	15
3132	Current Risk		Exposure to incidents of violence and aggression	Laura Farrington	People & OD	Workforce Development	15	15	15	15	15	15
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
4541	Current Risk		Risk of governance failure as we transition to new governance arrangements	Gill Findley	Nursing, Midwifery & Quality	Corporate Nursing	16	16	16	16	12	12
4574	Current Risk		A risk of being unable to relocate in the event of an evacuation due to capability and capacity issues within the estate that may potentially result in patient safety issues	David Patterson	Chief Operating Officer	EPRR		12	12	12	12	12

Risk ID	Risk Stage	Open	Risk Title	Owner	Business Unit	Service	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024
4575	Current Risk		Non compliance with FoI response turnaround time could result in ICO imposed penalties.	Kris Mackenzie	Digital	Digital Transformation and Assurance		16	16	12	12	12
4525	Current Risk		Risk of Lack of a strategic workforce planning	Sophia Grainger	People & OD	Human Resources	12	12	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	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	8	8	8	8	8	8

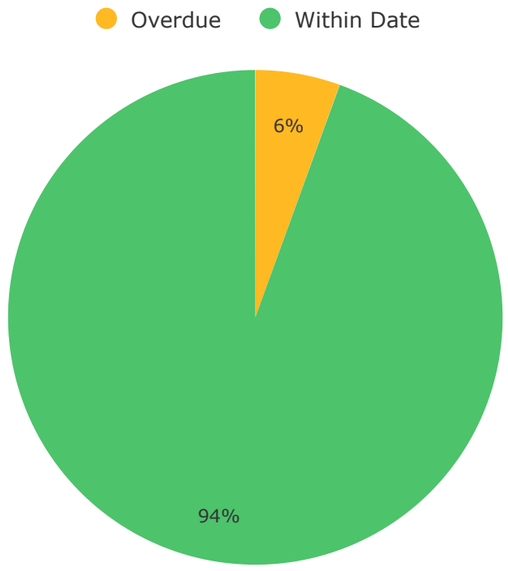
No slicers

Open Risk Actions

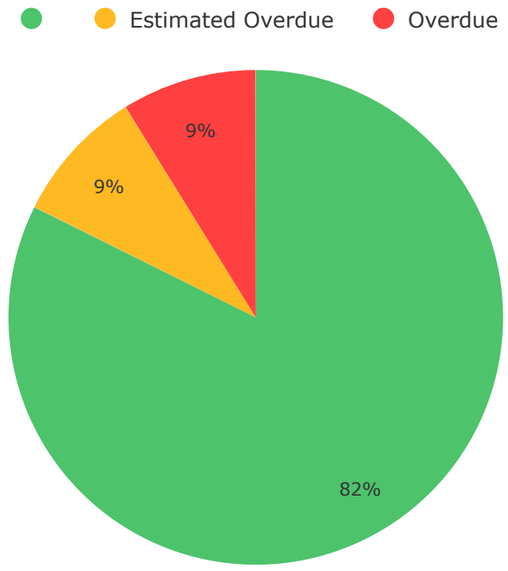
Risk ID	Risk Description	Priority	Total Actions	Action Description	Action Stage	Details	Owner	Owner Dept	Overdue	% Complete	Start Date	Due Date
Risk 00002341	There is a risk to maintaining business continuity of services and recovery plans due to the estate infrastructure, age and backlog maintenance 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		30%	31/03/2023	31/12/2024
Risk 00002424	Risk that Efficiency requirements are not achieved.	Normal	2	Create CRP Working Group	Not Started		Jane Fay	Finance		0%	28/10/2024	30/11/2024
				Development of CRP governance documentation and framework to underpin the delivery of CRP	In Progress		Jane Fay	Finance		0%	28/10/2024	13/12/2024
Risk 00002425	Activity is not delivered in line with planned trajectories, resulting in the Trust having reduced access to elective recovery funding.	Normal	2	Counting and Coding Review	In Progress		Kris Mackenzie	Finance		60%	31/05/2023	31/12/2024
				Timely and detailed reporting information	In Progress		Jane Fay	Finance		30%	17/03/2023	31/12/2024
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	2	looking into estate options	In Progress		Kate Hewitson	surg 2		10%	29/04/2021	31/03/2025
				Work with EPRR lead to develop improved & strong BCP	In Progress		Karen Parker	surg 2		20%	23/08/2024	31/12/2024
Risk 00003132	Risk of harm to staff (psychological and physical) due to exposure to violence and aggression from patients and visitors who exhibit challenging behaviours. This could result in injury, increased absence from work, staff morale and confidence and potentially effect recruitment and retention.	Normal	1	communications campaign	In Progress		Kerry Gowland	People and OD		20%	07/11/2024	31/12/2024
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	4	Develop OBC for integrated EPR	In Progress		Catherine Bright	Digital		80%	01/02/2025	01/02/2026
				Develop Records Management Strategy	Not Started		Catherine Bright	Digital		0%	28/10/2024	31/07/2025
				Develop trust wide records management strategy	Not Started		Catherine Bright	Digital		0%	01/01/2025	30/06/2025
				Establish the scope and procurement options for an EPR	In Progress		Catherine Bright	Digital		80%	05/06/2023	31/12/2024
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	1	Embed FTSU Champions within the Organisation	In Progress		Tracy Healy	People and OD		60%	31/10/2023	01/01/2025
Risk 00004525	There is a risk that the lack of a strategic workforce plan that delivers our specific future priorities (women's health, diagnostics, etc) leads to a lack of appropriate skilled staff and negative impacts on service delivery, patient safety and staff engagement and an increase in costs for temporary staffing.	Normal	7	1. Workforce planning	In Progress		Sophia Grainger	People and OD	Estimated Overdue	35%	22/05/2024	30/12/2024
				Develop and ensure good rostering practice across the organisation	Not Started		Laura Edgar	People and OD	Overdue	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	Estimated Overdue	25%	26/03/2024	01/12/2024
				Education, learning and Workforce development group to continue work on the implications of the LTWF	In Progress		Sarah Neilson	People and OD	Overdue	50%	26/03/2024	30/10/2024
				Focus on absence management	In Progress		Carol O'Flaherty	People and OD		30%	26/03/2024	31/03/2025
				Reduce turnover in line with the leading indicator target of 9.7% with a focus on retention	In Progress		Sophia Grainger	People and OD		25%	22/04/2024	12/03/2025
				robust management of leading indicators for WTE	In Progress		Amanda Venner	People and OD		25%	26/03/2024	31/03/2025

Risk ID	Risk Description	Priority	Total Actions	Action Description	Action Stage	Details	Owner	Owner Dept	Overdue	% Complete	Start Date	Due Date
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		90%	01/06/2024	30/11/2024
Risk 00004554	▪ 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).	Normal	2	Monitor delivery of IRM programme - gap in assurance around cyber	Not Started		Kingsley Okojie	Finance		0%	28/10/2024	31/01/2025
				Proposal and costing for a centralised asset inventory encompassing all aspects of asset management	Not Started		Kingsley Okojie	Finance		0%	20/08/2024	29/11/2024
Risk 00004559	There is a risk that appropriate support is not available to our medical staff to enable 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. There is a secondary financial risk that this contributes to significant overspend on our medical workforce.	Normal	3	In-person options for medical staff to get support	In Progress		Ross Peddie	Medical Director		50%	26/07/2024	01/01/2025
				Monitor compliance against newly created SOP's	In Progress		Carol O'Flaherty	Medical Director		0%	26/07/2024	01/12/2024
				Ongoing monitoring and quality checking of medical staffing team following training	In Progress		Carol O'Flaherty	Medical Director	Estimated Overdue	0%	26/07/2024	29/07/2024
Risk 00004574	A risk of being unable to relocate in the event of an evacuation due to capability and capacity issues within the estate that may potentially result in patient safety issues and impact quality.	Normal	3	No notice table top exercising with ward areas	In Progress		David Patterson	COO		50%	17/06/2024	30/11/2024
				Review of trust evacuation and shelter plan	In Progress		David Patterson	COO		25%	14/07/2024	30/11/2024
				scope out the use of PIU and outpatients for use in an evacuation situation	In Progress		David Patterson	COO		20%	24/09/2024	30/11/2024
Risk 00004576	▪ There is a risk that as the trust is failing to meet the mandated turnaround time of a calendar month for Subject Access Requests (below 95% tolerance), complaints to the ICO from requestors could increase. ▪ 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	Further development of Disclosures management tool	In Progress		Catherine Bright	Finance		10%	25/10/2024	31/01/2025
				Task and Finish Group to be established to review processes	In Progress		Mark Smith	Finance		75%	16/07/2024	30/11/2024
Risk 00004577	Risk that the trust does not achieve its 2024/25 planned deficit totalling £12.6 M and does not deliver its CRP, resulting in significant impact on financial sustainability.	Normal	2	F.A.P framework	In Progress		Kris Mackenzie	Finance		0%	17/09/2024	31/12/2024
				sustainability group	In Progress		Kris Mackenzie	Finance		0%	17/09/2024	31/12/2024

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:	29 October 2024
Chair of Board Committee:	Mr M Robson

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

- Financial Position - the Committee wished to alert the Board to concerns about the forecast outturn and cash position. The Committee will be provided with additional information to the next meeting in November for assurance, setting out in detail all actions and timescales for each of the CRP actions identified.

- Community Services Contract – The Committee was advised that an initial financial assessment of the community services provision had identified a deterioration in the financial position. The Committee was advised of next steps to address this and the CEO will be overseeing this and will provide an action plan to the next meeting of the Committee in November.

- Strategic Objectives – There is concern that the 4 hour standard is below target and planned improvement levels, the 12 hour wait time is high and 12hr waits and non-elective stay are also below target.

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)

- Sustainability – the Committee has received information on the PWC Investigation and Intervention process and the establishment of the CRP response team which are both helpful, but improvements will need to be seen.

- Strategic Objectives – over 52 week waits and waiting lists are increasing – these will be tracked for observation.

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

- The Committee was assured that the tier 2 groups are working effectively having received the AAA reports from the Financial Planning, Performance and Assurance Group and the Operation Oversight Group.

• The Committee was provided with an update on the Community Diagnostic Centre and congratulated the project team on their achievements. It was noted some further assurance will be provided in relation to governance and qualified numbers.
Risks (any new risks / proposed changes to risk scores)
• There were no changes to risks.
Cross-referrals to Executive Directors
• To refer to POD Committee to review sickness and turnover rates as the figures seem to be intractable – is POD content that they have the assurance they need that actions are being taken to bring these rates down?

Gateshead Health
NHS Foundation Trust

Committee Escalation and Assurance Report

Name of Board Committee	Quality Governance Committee
Date of Board Committee:	29 October 2024
Chair of Board Committee:	Mr A Crampsie

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

- Children in Care – due to increased demand there are capacity issues in providing the service needed for children in care and the Committee wished to alert the Board to this situation. This has been escalated to the ICB for some time and the ICB are imminently due to consider additional funding allocations and it is hoped that this will mean the issue can be de-escalated. The Committee are due to be provided with an update at the next meeting.

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

The Committee identified the following advisory issues:

- Maternity – a restriction has been placed on the number of births due to the increase in numbers seen in recent months and this will prioritise women from Gateshead. However the Committee noted a deterioration in a number of performance metrics and some concern about staff wellbeing and the Committee will monitor this.

- Coroners – An issue was raised about training/briefings for coroners on the new system. The Committee was advised that the ICB are not aware of this being a wider issue. This issue had been raised as an escalation by Safecare due to coroners requesting information from alternative meetings which do not have the same context and this was identified as an organisational risk. There was also some awareness that this issue had been raised nationally. It was agreed that the CEO and Chief Nurse would raise this directly with the ICB.

- Falls – the Trust's approach to falls is being reviewed and this issue is also being discussed on a regional basis.

- PSII delays – this has been identified as an issue due to a gap in oversight in the patient safety team but incidents are now being allocated for investigation more quickly.

- Pharmacy Medicines Assurance Report – The Committee suggested that a version of the Pharmacy Medicines Assurance Report should be reported to the Clinical Strategy Group.

- Pharmacy – building work has started on the new pharmacy robot and it is anticipated that this will have an impact on service delivery between October and December but extra staff are being put in place to mitigate the impact.

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

Positive assurances were agreed in relation to:

- Health Inequalities – a comprehensive report was received and this was referred to the Gateshead Health Leadership Group for the recommended actions to be considered.

- Safeguarding – the report confirmed that safeguarding is in line with requirements.

- External visits – the Committee noted that 15 external visits have taken place since January.

- ICB Feedback – positive feedback was received from the ICB in relation to the operation of the Committee and the open and transparent approach to the ICB attending and contributing to meetings. The ICB also noted an improvement in reports and the assurance being provided.

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

- There were no changes to risks on the ORR

Cross-referrals to Executive Directors

- There were no cross referrals.

Gateshead Health
NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	People and OD Committee
Date of Committee / Group:	Tuesday 12 November 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)

- Designated Body and Responsible Officer Annual Board Report and Statement of Compliance – the Committee considered and accepted for assurance the report of the Medical Director regarding compliance of the organisation with the Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) for the relevant time period. This is a statutory return to NHSE and the Board is being asked to approve the submission at the November Board meeting.

- Sickness absence – to advise the Board that the sickness absence rate has seen an increase to 6.3% in October and this is early in the winter period to see an increase. The Committee received a further deep dive report on sickness absence and the actions being taken and the POD Steering Group is looking at it in detail.

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)

The Committee identified the following advisory issues:

- Employees aged 20-30– the Committee received a number of deep dive reports and identified a trend across a number of themes relating to employees in this age bracket, including higher incidences of sickness absence due to stress related issues, turnover rates and flight risk. This also linked in with issues being raised by resident doctors. The Committee noted there may be a need for some additional work to look at this in more detail.

- GMC Survey – the report shows that the Trust is in the top third of all Trusts in the UK and is the top acute trust in the North East region. This is positive but there are areas where the position has deteriorated, and in some clinical areas there were insufficient respondents to enable reporting meaning there is limited assurance re the quality of training in those areas. The committee recognised ongoing risks to GMC survey results for the Trust as a whole, although it was noted that the establishment of the Medical Education Group (MEG) will give prominence and visibility to the needs of resident doctors in training within the organisation.

- Workforce Growth – the trajectory is not on course to meet the target set out in the plan but there are plans to address this.

Assure
(key assurances received and any highlights of note)

Positive assurances were agreed in relation to:

- Triple A reports from the POD Steering Group – these reports were received and the Committee is comfortable with the assurance being provided under the new governance arrangements.

- ADQM Report – a positive report has been received with no areas of concern raised, demonstrating again a high quality education provision is provided by the Trust in both medical and non-medical areas.

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

Escalation and Assurance Report

Name of Committee / Group:	Digital Committee
Date of Committee / Group:	2 October 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)

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)

- The Committee was advised about an issue raised in relation to a recent procurement exercise in the light of the recent PACS issues. This procurement process had followed a compliant route, but going forward there is a need to consider how the process can incorporate the business case and due diligence in product choice to ensure user wants and requirements are fully considered.
- The Digital Committee recognised that the PACS outage has had an impact across a range of performance indicators and will have an impact on a range of costs. An assessment is ongoing to identify the full cost and performance impact.
- The Digital Committee noted the PACs outage issue has links to cultural issues in the organisation in relation to tolerating poor performance of systems and this led to a delay in recognising the issues with PACS. This culture needs to be addressed.
- EPR – The Committee was advised that the EPR project is on track to meet the strategic objective and to progress the Outline Business Case in line with timescales. However there are risks around the financing/funding for the EPR.

Assure
(key assurances received and any highlights of note)

- The Committee received partial assurance in relation to SARs, with some improvement to response times and new systems introduced to speed up responses.

• The Committee noted that the terms of reference and cycle of business for the Committee will be revised to include Data and this will provide assurance that this area is being reported through to a tier 1 committee. • The Committee was pleased to note the decommissioning of WinDip has been completed.
Risks (any new risks / proposed changes to risk scores)
• There is a risk due to the potential income recovery and performance costs linked to the PACS outage. This has also been reported via the Finance and Performance Committee. • The Committee highlighted a risk around uncertainty in relation to funding/financing for the EPR. • The Committee identified a new risk in relation to the lack of strategy around patient administration and the need for this to be fully incorporated into digital prioritisation. An action has been identified for the Chief Operating Officer to address this as part of the refresh of the Organisational Strategy in 2025.
Cross-referrals to Tier 1 Board Committees
• None

Gateshead Health
NHS Foundation Trust

Committee Escalation and Assurance Report

Name of Board Committee	Group Remuneration Committee
Date of Board Committee:	2 October 2024
Chair of Board Committee:	Mr M Hedley

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 matters of concern to alert 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)

To advise the Board that:

- The Committee considered the appraisal and remuneration recommendations provided for each executive director, QEF Directors, and the CEO and approved the recommendations set out in the report.
- The Committee considered a report on succession planning and noted opportunities for further sub-executive development. This has been included as an objective for the CEO for 2024/25.
- The Committee agreed to increase the membership of the Committee from 5 NEDs to all 7 NEDs. This will be reflected in amended Terms of Reference.

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

- The Committee was assured that due process has been followed in relation to the appraisal process for the CEO, Executive Directors, and QEF Directors.
- The Committee was assured by the outcome of the Committee effectiveness review, noting the positive responses to the survey and the high level of compliance with the terms of reference.

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

- No new risks had been identified during the meeting.

Cross-referrals to Executive Directors

- None

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 14

Report Title:	**Consolidated Finance Report – Part 1**			
Name of Meeting:	Trust Board			
Date of Meeting:	27th November 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 had an original approved 2024-25 planned deficit of **£12.650m** before adjustments for donated asset depreciation, and **£12.405m** after. Following the allocation of non-recurring deficit support funding to North East and North Cumbria Integrated Care System to deliver breakeven across the System, the Trust has been allocated **£5.317m** non-recurring funding and a revised planned deficit of **£7.333m** before adjustments for donated asset depreciation, and **£7.088m** after. Reporting since September is against the revised planned deficit. As of October 2024, the Trust has reported an actual deficit of **£5.998m** after adjustments for donated asset depreciation. This is an adverse variance of **£0.026m** from the year-to-date target for reasons detailed in the body of this report.			

	The Trusts approved 2024-25 capital plan totals **£17.211m,** including £7.271m PDC supported. As of October 24, the Trust has reported net capital spend totalling **£9.160m**, which is **£2.382m** less than planned. As of October 24 the Trusts is forecasting achievement of its revised planned deficit supported by a best-case scenario forecast. The Trust also continues to forecast achievement of its capital plan.				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper.*	The recommendation to Board is to receive the report, discuss the potential implications and record partial assurance for the achievement of the 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 October 2024 (Month 7) 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 October 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 **£7.088m** 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	Oct-24 Plan	Oct-24 Actual	Oct-24 Variance	RAG	Apr-24 to Oct-24 Plan	Apr-24 to Oct-24 Actual	Apr-24 to Oct-24 Variance	RAG
I&E (Surplus) / Deficit (adjusted perf.) £m	0.2	0.3	0.1		6.0	6.0	0.0	
Income £m	(42.4)	(40.7)	1.7		(238.3)	(238.5)	(0.1)	
Pay Expenditure £m	27.4	28.1	0.8		158.3	161.0	2.7	
Non Pay Expenditure £m	14.9	12.5	(2.4)		83.5	81.0	(2.6)	
Non Operating Income £m	(0.1)	(0.1)	(0.0)		(1.0)	(1.1)	(0.1)	
Non Operating Expenditure £m	0.5	0.6	0.0		3.7	3.9	0.1	
Agency Expenditure £m	0.4	0.2	(0.3)		2.8	1.2	(1.5)	
CRP Delivery £m	(2.5)	(2.0)	0.5		(9.7)	(8.5)	1.2	
Capital Expenditure £m	0.6	0.2	(0.4)		11.5	9.2	(2.4)	
Cash position £m	(0.9)	10.8	11.7		13.3	34.2	20.9	
Liquidity (days)	(13.6)	(6.5)	7.2		(13.6)	(6.5)	7.2	
Better Payment Practice Code (BPPC)								
NHS	95.0%	95.8%	0.8%		95.0%	96.2%	1.2%	
Non NHS	95.0%	100.0%	5.0%		95.0%	93.5%	-1.5%	
Aged Debt								
Receivables over 90 days NHS	10.0%	55.0%	45.0%		10.0%	55.0%	45.0%	
Receivables over 90 days non NHS	10.0%	37.5%	27.5%		10.0%	37.5%	27.5%	

Table 1: Finance KPIs

2.2 For the period of October 24 only the Trust has reported a deficit of **£0.298m** after the adjustment for donated asset depreciation which is a **£0.024m** adverse variance against plan.

2.3 Year-to-date the Trust has reported a deficit of **£5.998m** which is an adverse variance of **£0.026m** against plan.

2.2.3 The key drivers of this adverse variance are use of escalation beds, including overnight boarders in SDEC, in response to increased admissions, 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 **£2.581m** and surgical business units **£1.035m** driven by staffing approved junior medical rota's, premium rate payments on bank, agency and WLI; with additional pressures on clinical supplies.

2.2.4 Variable income performance (£2.937m), pathology testing income and interest receivable mitigate the cost pressures.

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

	NHSE APRIL - MARCH 25 FINAL PLAN							
	Annual Plan	Plan In Month	Actual In Month	Plan to Date	Actual to Date	Variance (Actual - Plan)	Previous Month Variance	Movement in Month
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Operating								
Operating Income from Patient Care activities								
Income From NHS Care Contracts	(349,952)	(36,908)	(36,457)	(213,867)	(214,719)	(852)	439	(1,291)
Income From Local Authority Care Contracts	(90)	(41)	(19)	(203)	(217)	(14)	(36)	22
Private Patient Revenue	(684)	(57)	(67)	(400)	(500)	(101)	(91)	(10)
Injury Cost Recovery	(504)	(42)	1	(292)	(140)	152	109	43
Other non-NHS clinical revenue	(1,700)	(19)	(15)	(130)	(135)	(4)	(8)	3
Total Operating Income From Patient Care activities	**(352,930)**	**(37,067)**	**(36,557)**	**(214,891)**	**(215,711)**	**(820)**	**413**	**(1,233)**
Other Operating Income								
Education and Training Income	(11,257)	(1,974)	(1,502)	(7,702)	(6,776)	926	454	**472**
R&D Income	(564)	(100)	(107)	(693)	(691)	2	9	**(7)**
Other Income	(21,790)	(3,276)	(2,574)	(14,993)	(15,301)	(308)	(1,010)	**702**
Donations & Grants Received	0	(8)	0	(58)	0	58	50	**8**
Total Other Operating Income	**(33,611)**	**(5,359)**	**(4,184)**	**(23,446)**	**(22,768)**	**678**	**(497)**	**1,175**
Total Operating Income	**(386,541)**	**(42,426)**	**(40,741)**	**(238,338)**	**(238,480)**	**(142)**	**(84)**	**(58)**
Operating Expenses								
Employee Expenses - Substantive	242,176	26,207	27,130	149,860	153,040	3,180	2,258	**922**
Employee Expenses - Bank	7,502	643	711	4,975	5,893	918	850	**69**
Employee Expenses - Agency	3,993	444	169	2,761	1,218	(1,543)	(1,268)	**(275)**
Employee Expenses - Other	1,104	91	135	673	808	135	91	**44**
Total Employee Expenses	**254,775**	**27,386**	**28,145**	**158,269**	**160,959**	**2,690**	**1,931**	**759**
Purchase of Healthcare - NHS bodies	8,172	670	906	4,692	4,870	178	(58)	**236**
Purchase of Healthcare - Non NHS bodies	3,300	264	399	1,905	2,468	563	427	**135**
NED's	192	16	15	109	106	(3)	(3)	**(1)**
Supplies & Services - Clinical	37,782	3,716	3,454	23,903	25,447	1,544	1,806	**(262)**
Supplies & Services - General	2,943	238	284	1,728	1,778	50	4	**46**
Drugs	24,772	2,031	2,327	14,783	14,438	(345)	(642)	**296**
Research & Development expenses	0	0	0	0	6	6	6	**0**
Education & Training expenses	1,488	205	197	1,026	993	(33)	(25)	**(8)**
Consultancy costs	276	22	63	185	440	255	213	**42**
Establishment expenses	4,344	363	335	2,558	2,445	(113)	(85)	**(28)**
Premises	19,123	1,891	1,022	11,753	10,872	(881)	(13)	**(868)**
Transport	1,545	114	129	1,019	766	(253)	(268)	**14**
Clinical Negligence	9,120	752	759	5,310	5,003	(307)	(314)	**7**
Operating Leases	1,212	(19)	838	597	1,031	434	(423)	**857**
Other Operating expenses	5,513	3,416	781	5,707	3,998	(1,709)	(813)	**(896)**
Reserves	0	0	0	0	0	0	0	-
Operating Expenses included in EBITDA	**119,782**	**13,679**	**11,509**	**75,277**	**74,660**	**(617)**	**(186)**	**328**
Depreciation & Amortisation - Purchased / Constructed	10,287	864	630	5,971	4,432	(1,538)	(1,296)	**(243)**
Depreciation & Amortisation - Donated / Granted	245	19	24	136	167	30	18	**13**
Depreciation & Amortisation - Finance Leases	3,540	295	260	2,065	1,844	(221)	(194)	**(27)**
Impairment & Revaluation	96	8	57	58	(150)	(208)	(257)	**49**
Operating Expenses excluded from EBITDA	**14,168**	**1,187**	**971**	**8,230**	**6,293**	**(1,937)**	**(1,729)**	**(208)**
Total Operating Expenses	**388,725**	**42,252**	**40,626**	**241,776**	**241,912**	**137**	**16**	**121**
(Profit)/Loss from Operations	**2,184**	**(174)**	**(116)**	**3,438**	**3,433**	**(5)**	**(68)**	**63**
Non Operating								
Non-Operating Income								
Finance Income	(1,220)	(102)	(128)	(1,035)	(1,132)	(97)	(72)	**(26)**
Total Non-Operating Income	**(1,220)**	**(102)**	**(128)**	**(1,035)**	**(1,132)**	**(97)**	**(72)**	**(26)**
Non-Operating Expenses								
Finance Costs	824	69	66	480	396	(84)	(82)	**(2)**
Gains / (Losses) on Disposal of Assets	0	0	0	0	0	0	0	**0**
PDC dividend expense	4,420	368	368	2,579	2,578	(0)	(0)	**(0)**
Total Finance Costs (for non-financial activities)	**5,244**	**437**	**435**	**3,059**	**2,975**	**(84)**	**(82)**	**(2)**
Other Non-Operating Expenses								
Misc. Other Non-Operating expenses	0	0	0	0	0	0	0	
Total Non-Operating Expenses	**5,244**	**437**	**435**	**3,059**	**2,975**	**(84)**	**(82)**	**(2)**
(Surplus) / Deficit Before Tax	**6,208**	**161**	**191**	**5,462**	**5,275**	**(187)**	**(222)**	**35**
Corporation Tax	1,125	94	131	656	890	233	196	**37**
(Surplus) / Deficit After Tax	**7,333**	**254**	**322**	**6,117**	**6,165**	**48**	**(24)**	**72**
(Surplus) / Deficit After Tax from Continuing Operations	**7,333**	**254**	**322**	**6,117**	**6,165**	**48**	**(24)**	**72**
Remove capital donations / grants I&E impact	(245)	(24)	(24)	(145)	(167)	(22)	(18)	(4)
Adjusted Financial Performance (Surplus) / Deficit	**7,088**	**230**	**298**	**5,972**	**5,998**	**26**	**(42)**	**69**

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 August £12.627m is forecast to be achieved which is a shortfall of £10.173m

	2024-25 FINANCIAL YEAR				
Business Unit	2024-25 Annual Target £000	2024-25 Annual Achieved £000	2024-25 Original Planned Schemes £000	2024-25 Updated Forecast Schemes £000	2024-25 Shortfall £000
Chief Executive	138	0	64	30	(108)
Chief Operating Officer	138	195	0	195	56
Clinical Support & Screening Services	4,307	1,782	2,559	3,539	(767)
Community Services	1,475	787	448	1,241	(234)
Estates & Facilities	233	0	400	400	167
Finance and Digital	800	463	460	463	(337)
Medical Director	58	59	26	59	1
Medicine & Elderly	3,861	142	678	208	(3,653)
Nursing & Midwifery	239	146	185	171	(68)
People & Organisational Development	251	127	337	241	(10)
Surgical Services	4,231	1,450	2,633	1,582	(2,650)
Trust Financing	4,069	428	4,655	1,498	(2,571)
Sub-total Trust Performance	19,800	5,578	12,445	9,627	(10,173)
QEF	3,000	1,931	3,000	3,000	0
Sub-total QEF Performance	3,000	1,931	3,000	3,000	0
Total Group Performance	**22,800**	**7,509**	**15,445**	**12,627**	**(10,173)**

Table 3: Cost Reduction Target Performance

4 Capital

4.1 The Trusts 2024-25 approved capital programme totals £16.553m comprising of £9.810 CDEL limit and £6.737m of PDC awards relating to the Community Diagnostic Centre.

4.2 Variations to the approved programme at October 2024 include an additional PDC award totalling £0.534m relating to Digital Diagnostics and charitable funded schemes totalling £0.130m, resulting in available capital funding of £17.211m as summarised below.

Capital Funding	£'000s	£'000s
Net Depeciation*		9,324
Cash		486
PDC Funded Schemes		
- CDC	6,737	
- Digital Diagnostics	534	7,271
Charitable Funds		130
Total		17,211

* After principal loan repayments

Table 4: Capital

5 Cash and Liquidity

5.1.1 Group cash as of 31st October totalled £34.194m, an increase of £10.842m from September (£23.352m). The cash balance is equivalent to an estimated 32.10 days operating costs (September 21.92 days).

5.1.2 The liquidity metric for October was (6.45) days; 7.16 days better than plan of (13.61).

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

Statement of Position - October 2024

	2024/2025 September 2024 Group	2024/2025 October 2024 Group	Movement from Prior Month	2024/2025 October 2024 QEF	2024/2025 October 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	167,430	166,972	(458)	1,116	165,856
Right of Use Assets	7,177	6,916	(260)	3,573	3,343
Trade and Other Receivables, Net	2,139	2,073	(66)	726	1,347
Finance Lease - Intragroup				40,579	0
Trade and Other Receivables - Intragroup Loan	0	0	0		2,988
Total Non Current Assets	176,826	176,041	(785)	46,074	190,359
Current Assets					
Inventories	5,175	5,291	116	2,975	2,316
Trade and Other Receivables - NHS	3,567	2,078	(1,489)	296	1,782
Trade and Other Receivables - Non NHS	8,979	7,001	(1,978)	2,912	4,089
Trade and Other Receivables - Intragroup				9,264	225
Trade and Other Receivables - Other	0	0	0	0	0
Prepayments	6,136	6,662	526	781	5,881
Cash and Cash Equivalents	23,352	34,194	10,841	7,785	26,408
Other Financial Assets - PDC Dividend	0	0	0	0	0
Accrued Income - NHS	9,623	7,761	(1,862)	220	7,540
Accrued Income - Other	1,891	1,565	(327)	881	683
Finance Lease - Intragroup				314	0
Trade and Other Receivables - Intragroup Loan					1,858
Total Current Assets	58,724	64,552	5,828	25,429	50,784
Liabilities					
Current Liabilites					
Deferred Income	8,758	11,238	2,480	52	11,186
Provisions	4,248	4,226	(22)	632	3,593
Current Tax Payables	4,845	7,406	2,562	672	6,734
Trade and Other Payables - NHS	1,046	1,667	621	0	1,667
Trade and Other Payables -Intragroup				225	9,264
Trade and Other Payables - Other	11,214	11,849	635	3,304	8,545
Lease Liabilities	2,050	1,792	(258)	353	1,439
Trade and Other Payables - Capital	1,908	1,598	(310)	0	1,598
Other Financial Liabilities - NHS Accruals	6,090	5,870	(220)	56	5,814
Other Financial Liabilities - Accruals	22,132	21,641	(491)	9,946	11,695
Other Financial Liabilities - Borrowings FTFF	499	499	0	0	499
Other Financial Liabilities - PDC Dividend	0	368	368	0	368
Other Financial Liabilities - Intragroup Borrowings	0	0		1,858	0
Finance Lease - Intragroup	0	0		0	314
Total Current Liabilities	62,789	68,155	5,366	17,099	62,716
NET CURRENT ASSETS (LIABILITIES)	(4,065)	(3,602)	462	8,330	(11,932)
Non-Current Liabilities					
Deferred Income	2,010	2,010	(0)	1,719	291
Provisions	2,487	2,487	0	0	2,487
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	20,908	20,907	(0)	7,845	56,630
TOTAL ASSETS EMPLOYED	151,854	151,531	(323)	46,559	121,796
Tax Payers' and Others' Equity					
PDC	170,535	170,535	0	0	170,535
Taxpayers Equity	0	0	0	0	0
Share Capital	0	0	0	16,824	0
Retained Earnings (Accumulated Losses)	(31,960)	(32,283)	(323)	29,735	(62,018)
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	151,854	151,531	(323)	46,559	121,796
TOTAL ASSETS EMPLOYED	151,854	151,531	(323)	46,559	121,796

Table 5: Statement of Financial Position

6 Conclusion

6.1 The Trust has a 2024-25 planned annual deficit totalling £7.088m.

6.2 Year-to-date the Trust has reported an adjusted deficit of **£5.998m** which is an adverse variance of **£0.026m** from its year to date target.

6.3 The cost reduction programme planned to achieve £9.668m, including £2.835m vacancy factor, at 31st October 24; and whilst not fully transacted in the Trust ledger has delivered £8.511m, reporting an overachievement of £1.157m. The Trust is forecasting to achieve £10.173m against its £22.800m target.

6.4 The Trust is forecasting to achieve its planned deficit target of £7.088m by the achievement of mitigations to reduce spend, maximise income and 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
November 2024

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 15

Report Title:	Strategic Objectives & Constitutional Standards			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 November 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 M6 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 improved to 95%. Maternity Incentive Scheme (MIS) remains static at 89%. Delivery of the **Quality Improvement Plan** is at 72% of actions on track for delivery. **PSIRP**: The volume of falls has reduced in month, although falls harm rates have increased. **QA**: The Trust has reported one case of C. difficile in M7 and a total of 24 year to date against our annual threshold is 37. In month rates per 100k bed days have therefore decreased to 6.2. However, recent outbreaks of norovirus have impacted on patient flow, bed base available and staffing. **QA**: Performance against learning disability and autism training remains below target levels of 85%, although improving in month			

• *Equality, diversity and inclusion*	from 50.7% to 55.4%, challenges remain in the Trust and across the ICB in finding suitable training locations, we await the publication of the national code of practice for the Oliver McGowan training. Mental Health Act Policy training improved to 55.4% in month and remains below target levels of 90%. Medicines management indicators are still under review to support high impact SMART and measurable KPI's. Programme work remains delayed circa 1 month re: the **agreed strategic approach to EPR.** The delay is attributed to additional consideration and preparation of the Outline Business Case (OBC) linked to Alliance discussions. A target date of Jan-25 had been agreed for the OBC to go to Board. Work is continuing to align plans with a shared Digital Alliance Strategy and establish core digital standards. **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. There are currently 22 estate risks with a combined risk score of 280. • At the end of M7, the Trust is now in line with the target reduction of safety incidents reported linked to estate issues. There were 2 estates safety incidents reported in October there are no consistent themes in incidents reported to date. • Multi-disciplinary PLACE audits have taken place in three areas across the Trust in October. Scoring remains outstanding as the Team continue to implement PLACE Lite. • A reduction in the value of backlog maintenance score will be heavily influenced by the work ongoing to rationalise aging estate. **We will be a great organisation with a highly engaged workforce.** • Vacancy rates have deteriorated in month from 2.7% to 4.6%, above the target of 2.5% this is primarily attributed to recruitment in the Community Diagnostic Centre. Vacancy pressures continue in key service delivery 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. • Turnover rates are demonstrating a downward trajectory, in month position of 11.2% is however higher than our target of <9.7%.

	• Sickness absence rates remain at 5.6% and continue to be above target levels of 4.9%. • Temporary staffing spend has increased slightly and is now at 0.6% of total pay bill and remains below the planning target of 2.3%. **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 in month to 7.24 days in October, 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. Other factors influencing this indicator include: the discharge profile and the patients who remain in hospital who no meet the criteria to reside - the daily average was 45 in October. The ED 4-hr standard deteriorated to 67.8% in October, below national target level of 78% and planned improvement levels – both admitted and non-admitted are also below their differential standards. There were 3 reportable 12-hr delays for admission in October and an increase of waits for admission with 3.7% of patients admitted to a bed within an hour requiring a bed. Higher levels of norovirus in the hospital impact on the ability to create flow and the ability to discharge patients earlier in the day is impacting on our patients spending longer time in ED and waiting longer for bed. A weekly clinically led Task and Finish delivery meeting is now in place to: (i) Review drivers of variation in performance, (ii) Establish quick PDSA improvement cycles (iii) identify supporting planned improvement trajectories (iv) Deploy more sophisticated predictor tools. The group are also reviewing alternative options to SDEC overnight surge capacity, in support of maximising the full SDEC footprint to achieve the 4-hr target. Winter pressures are impacting on the ability to free up SDEC capacity. Although green shoots of improvement are evident in early November with clinical teams avoiding SDEC in times of surge correlating with an early improvement in the 4-hr standard. The revised stretch target of achieving zero > 52 weeks by Q2 was not achieved and over 52 week waiters and pressures remain with 106 patients waiting over 52 weeks at the end of October. This upward trend is also mirrored in the total RTT waiting list with waits increasing over the summer period (although now improving in October)

	Lower than planned activity levels in some key specialty areas, additional unplanned workforce pressures and pre-assessment challenges have all contributed to longer waits. Overall 52 week recovery trajectories are off-track Speciality level pressures continue in Gynaecology and T&O. Whilst significant improvements have been made in urology via mutual aid and the specialty is on track to achieve zero > 52 weeks at the end of Q3. In T&O demand and capacity is in balance overall to support delivery of zero 52 weeks by year end, however current capacity delivery challenges are being reviewed via weekly Access & performance meetings. Current improvement projections and capacity plans are under review and will be re-forecast. An established group is in place to review and improve counting & coding and productivity in outpatients. 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.** **Plan:** At the end of month 7 we are reporting a deficit position of £5.998m against revised planned levels of £5.942m representing a negative variance of £26k. Risks remain around achieving the year end plan due to overspending against delegated budgets largely in medical and nursing workforce and non-delivery against recurrent CRP targets. **Cost Reduction Plan** (CRP) is behind plan with a negative variance of £1.2m with £8.5m transacted at M7 against a plan of £9.7m. Risks remain in the proportion of non-recurrent savings made to date & the CRP plan heavily weighted towards Q3 and Q4. Focus remains in recurrent savings to support financial sustainability. The Trust is planning to deliver a revised forecast outturn deficit position of £7,088m, aided by an additional £5.3m non-recurrent deficit support funding, and we are also 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 inequalities will be driven by the Health Inequalities Strategy and plan – further work is ongoing in the group to revise the delivery plan.

<table>
<tr><td></td><td colspan="6">Digital teams will continue to support efforts to reduce digital exclusion by repurposing hardware in 2024/25 and have achieved the target to date. Gynaecology transformation plans are supporting waiting times reduction although the recent reduction in consultant capacity has impacted on current waits at 38 weeks. Improvement work supporting paediatric autism assessments and diagnosis have not yet delivered waiting time reductions as per the plans, waiting times remain static at 82 weeks.

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

Plans to increase QEF externally generated income by 0.5% are ahead of schedule with Month 7 delivery at 3%.</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 audit scores not yet generated from PLACE Lite
• SMART Medication metrics: Planned update next month

No movement in key areas:
• Staff engagement score: Annual staff survey underway
• Fragile & vulnerable service review: Planned review in for end of December to align with strategy discussions.
• Health Inequalities: Review of strategy, plan and realignment of key determinants of health to start Oct, supported by Public Health.</td></tr>
</table>

	Areas requiring attention: **Quality & Safety:** • Increase in risk scores linked to Estates to understand drivers. **Workforce:** Staff engagement, turnover vacancy rates, sickness absence **Productivity & Efficiency:** Increased risk of achieving zero 52 week waiters Outpatients with procedures below target percentage of 33% Discharge and flow issues impacting on Urgent and Emergency Care metrics and 4hr A&E target Risk in achieving financial plan: Reducing expenditure and achieving CRP. Waiting times reductions in gynaecology and ASD pathway improvements		
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

NHS
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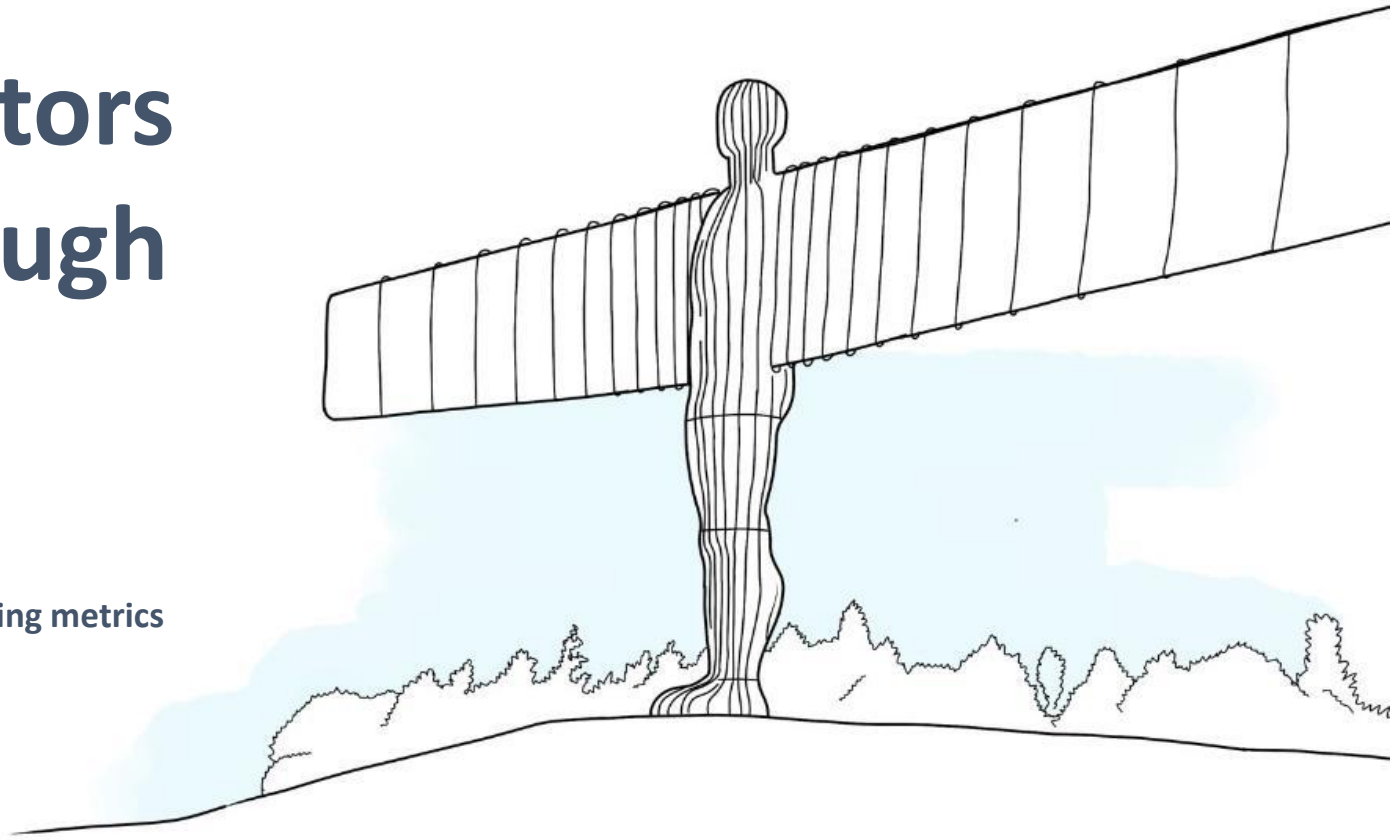
NHS Foundation Trust

Strategic Objectives 2024/25

Leading Indicators and Breakthrough Objectives



Including Constitutional standards monitoring metrics

Reporting Period: October 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

NHS Gateshead Health NHS Foundation Trust

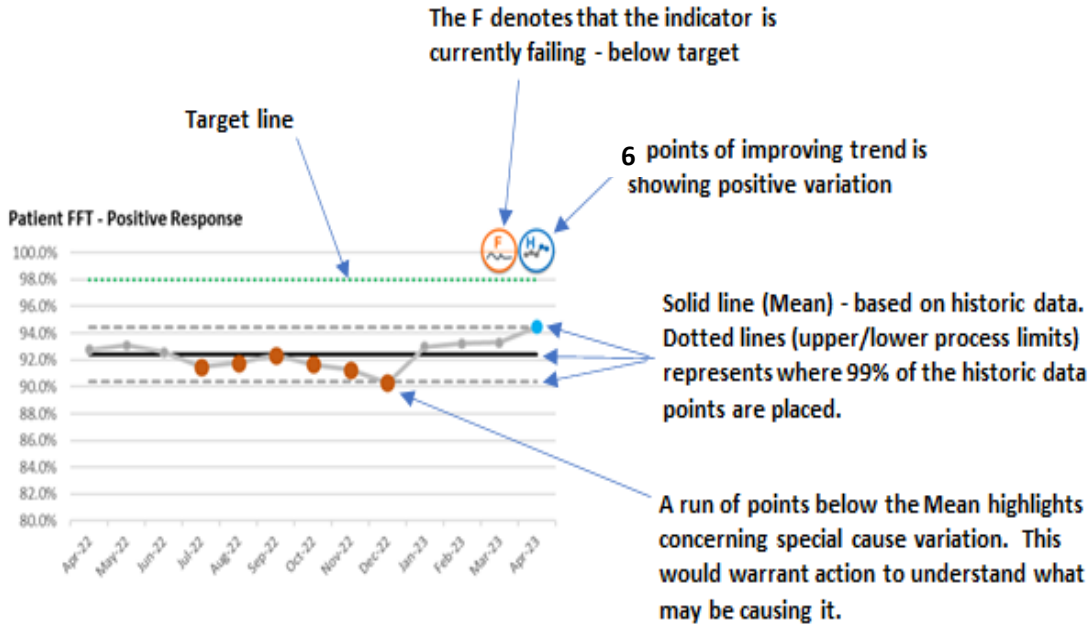
Improved	No Change	Needs further attention
We will continuously improve the quality and safety of our services for our patients		
Compliance with Level 1 training plans for learning Disability & Autism training improved to 55.41%	Scoring in domains in areas of PLACE inspection not available	Strategic approach to development of EPR is behind schedule by a month
Mental Health Act Training requires a training package for all registered staff increased to 84.2%		Severity of risk scores linked to estates to 280 remains high
Reduction in patient safety incidents linked to estate issues: reduced to 2		Quality Improvement Plans reduced to 72% compliance
Maternity Incentive Schemes Compliance improved to 89%		
Ockenden recommendations compliance improved to 90%		
Harm rate from falls improved to 3.95		
C.Difficile rate has reduced to 6.7.		
We will be a great organisation with a highly engaged workforce		
	Improve the staff engagement score to 7.3 (currently at 6.63)	Achievement of the internal turnover standard of 9.7% (currently at 11.7%)
	Reduction in temporary staffing spend evidenced early month reduction to 0.4% of pay bill.	Internal sickness absence standard at 5.6%
		Maintain the vacancy rate at <=2.5%, currently at 2.7%
We will enhance our productivity and efficiency to make the best use of our resources		
	Review and revise 2022/25 Green Plans: Align governance to group structure - Meetings underway	Average non-elective length of Stay < 4 Days
		Achievement of Zero 52 weeks.
		Reduce the number of patients with no Criteria to Reside (October - 45)
		Achievement of 4-hr A&E target (Below planned trajectory and target)
		Achievement of the trajectory to achieve 60% RTA to Bed within 1 hour
		Risk in achievement of financial plans including CRP
		Reduce >12 hour total time in Emergency Department
		Increase in New & Follow up value added activity to 33% (increased slightly to 29.7% in October)
We will be an effective partner and be ambitious in our commitment to improving health outcomes		
Increase in the number of digital devices repurposed to the local community	Evidence a reduction in the number of 'fragile' and 'vulnerable' services as a direct outcome of Alliance working	Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients by March 2025
	Evidence in an improvement in health inequalities in the key focus areas linked to the determinants of Health for Gateshead	Reduction in the wait for gynaecology outpatients to no more than 26 weeks by March 2025.
		Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 weeks by March 2025
We will develop and expand our services within and beyond Gateshead		
Increase in QEF externally generated turnover to 2.2%		

Strategic Objectives 2024/25 | **How to interpret the SPC icons and charts** | Gateshead Health NHS Foundation Trust

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

				
Improving			Achievement of the internal turnover standard of 9.7% Achievement of the 52 week RTT standard	
Neither improving or deteriorating		Harm falls rate per 1000 bed days Achievement of the % to reduce >12 hour total time in Emergency Department C.Diff Healthcare associated rate per 100,000 occupied bed days 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 Achievement of the internal sickness absence standard of 4.9% Achievement of the 4 hours trajectory Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 by March 2025	
Deteriorating		Maintain the vacancy rate at <=2.5%	Average Length of Stay Non-Elective <4 days Achievement of the trajectory to achieve RTA to Bed within 1 hour	
	Consistency in PASSING the target	**Inconsistency in HITTING, PASSING and FALLING SHORT of the target**	**Consistency in FAILING the target**	

Strategic Objectives 2024/25	We will continuously improve the quality and safety of our services for our patients

NHS 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	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Ass/Var	Trend
LEADING INDICATORS																	
Ockenden Recommendations % compliance with Total Recommendations	100%	55.5%	88.8%	88.8%	88.8%	77.7%	77.7%	77.7%	78.0%	78.0%	74.0%	74.0%	89.0%	90.0%	95.2%		
Maternity Incentive Schemes % compliance with Total Recommendations	100%								62.9%	70.8%	76.4%	77.5%	83.0%	89.0%	89.0%		
Reduction in patient safety incidents linked to estate issues	<=4	2	2	1	9	1	4	4	3	4	6	4	7	3	2		
Compliance with the quality improvement plan indicated by the % of actions on track	100%	76%	76%	84%	80%	84%	88%	88%	88%	88%	76%	84%	88%	84%	72%		
BREAKTHROUGH OBJECTIVES																	
Scoring in domains in areas of PLACE inspection composite score > 95%	> 95%																
Reduction in severity of risk score linked to estates	TBA								252	252	252	267	279	284	280		
Harm falls rate per 1000 bed days	12	1.27	2.54	2.37	4.48	4.16	3.96	2.58	3.60	3.17	4.21	3.57	3.50	4.13	3.95		
Cdiff Healthcare associated rate per 100,000 occupied bed days	<=3.20	36.2	41.2	7.0	33.5	20.1	36.5	21.0	21.1	20.9	22.1	28.4	27.8	42.0	6.7		
90% of staff to complete Mental Health Act training.	90%					92.2%	92.2%	89.7%	89.7%	87.9%	87.9%	78.9%	77.6%	81.8%	84.2%		
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%	41.53%	46.93%	50.76%	55.41%		

Strategic Objectives 2024/25

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

Gateshead Healt
NHS Foundation Tru

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

	Measure	Summary
1	Ockenden recommendations % compliance with total recommendations	The Trust is reporting compliance at 95%. Areas non-compliant are: Managing complex pregnancy, Informed Consent, RA throughout pregnancy, and monitoring guidelines. Progress made includes MNVP website review completed, LMNS assurance visit report received. Q2 LMNS review completed – review of feedback ongoing, Q2 documentation (risk assessment) audit results in progress and need to complete PCP audit of 5%.
	Maternity incentive schemes % compliance with total recommendations	The Trust is reporting compliance at 89%. Areas non-compliant are: Safety Action 6 (SBL Care Bundle) Safety Action 7 (MVP) and Safety action 9 (Trust Board Oversight). BR+ establishment approved by EMT, annual LMNS assurance visit completed.Demand & capacity challenges. Update of maternity governance structure in line with Trust, recruitment to midwifery vacancies.
2	Compliance with the quality improvement plan indicated by the % of actions on track.	Latest reported data relates to October 2024 with 72% of the Improvement Plan actions on track to deliver. Octobers performance shows progress is not where would plan to be at this stage in the year. Plans are in place with the relevant action owners for actions that are reporting risk of non achievement. Challenges continue for resus checks daily checks taking place and COSHH files being up to date. The Chief Matrons are working with the matrons and Health and Safety Team to improve the continuous low compliance against both of these. Low compliance with trustwide appraisal rates, local induction rates and staff retention rates are being monitored via Tier, 1,2 and 3 POD meetings. Current Flu vaccine rates are 22% against a target of 75% of all staff by April 2025, work continues to drive the flu campaign however to note there is a risk of non-achievement against this indicator. Anomalies noted are likely to be due to the audit tool. A new process for collecting and reporting is being rolled out from September/October which should see a marked improvement in compliance. This is currently at risk of non-achievement. Embed the action plan from the newly developed MH strategy has been downgraded from on track to amber, the MH Group has now been established however engagement work around the strategy needs to be completed. This work is underway.
	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.	Compliance in October is 55.41% which is an increase of over 6% since last month. Ongoing discussion regarding next steps with regards to LD and Autism awareness training, with scoping on going as to delivery models when national guidance produced. Challenge remains regarding regional hub where e-learning is hosted which at times is impacting completion being noted in the system, discussions ongoing regarding a fix for this
	Improve Mental Health Act Policy Training Compliance to 90% for all *registered* staff via training and audit.	There has been an increase in performance to 84.2% this is due to additional training being added for community staff. Percentage of staff trained has been negatively affected by rotational OT's coming into post who require training. However, additional training sessions have been offered in October to support compliance. General nursing staff training mapping has been completed, due to the volumes (426) this will be a challenge for the limited numbers of training staff (to date 35 staff 8% have received training) but additional sessions for 2025 have been put in place. CPN team, Younger persons memory Service and Memory Hub staff are 100% compliant with training. Competencies can only be added annually so the training for General nursing staff cannot yet be added to ESR as a mandatory training module.
	Improve our IPC C.Difficile infection rates per 100 000 occupied bed days.	The Trust's C-diff threshold for 24/25 is 37, year to date we are repprting 24 cases. Rates per 100 000 bed days have decreased to 6.7. A 10 point c-diff reduction plan is in place, with a drive to 'back to basics' for clinical areas particularly around hand hygiene, AMP and learning. A review into antimicrobial prescribing is ongoing. Community prevalence continues to be higher than normal levels, reflecting national and local elevated levels of C.Diff.
	Harm related falls will reduce by 5% by March 2025.	The number of reported falls has decreased this month, whereas the number of falls with harm has increased very slightly. Pilot work is ongoing on the COTE wards offering decaffinated drinks, as a falls prevention initiative. It has been shown in other areas to reduce falls but it is too early for us to identy improvement The wards also continue to explore different pyjama cuffs, which are known to be a trip hazard for some patients, with a view to trialling them with patients. The trust Falls Steering group did not meet last month due to leave, and work is being done to identify a suitable regular day/time for maximum attendance. There is a plan to review and update the falls prevention policy as an MDT approach, to include intelligence gathered from incident review and action plan analysis.
3	Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.	Work delayed by an estimated calendar month - this was to allow for the full review of an additional option for consideration within the business case linked to alliance discussions. Commercials have been obtained from suppliers to support with costing the options; initial costing has been developed, these are being reviewed by finance. A full list of anticipated benefits has been developed and a core set of benefits are currently being profiled which will remain as a driver throughout the programme. Progression with alliance discussions, while positive, have impacted the delivery date of the OBC. The target date to get to Trust Board is now Jan 25. Initial discussions have taken place with the cabinet officer and EPR Investment Board to establish process for approvals/controls. Current drivers are due to the contractual limitations of the existing provision decision regarding strategic route will be required in January to allow sufficient time for procurement of a solution, including due diligence. At this stage, the re-development of the business case has been split into workstreams with leads identified for each. A timeline for supporting governance is under development. There are also discussions at an alliance level, to explore potential options for collaboration. Current digital contracts directly associated with the delivery scope of the core EPR are currently being reviewed; the constraints against these are being used to inform the schedule of work required for the procurement options that have been identified. Required activity for the identified options commences in Q4 24/25 and completes before Dec 2027. Alliance meeting to discuss shared digital strategy has taken place, further work is being undertaken to establish the core 'digital standards' of the alliance, detailed scheduling of implementation of the main options is being developed. Full plan will be developed as part of the FBC and subsequent implementation programme
4	Reduction in risks and severity of scores linked to estate issues	22 Risks with combined critical infrastructure risk score of 280. Current High scoring risks include: Theatre ventilation UPS (20), Maternity (20) Bensham Retraction (16) Audiology ventilation (16) Audiology clinical diagnosis (16) Endoscopy washers (12) Records management (16) Laparoscopic theatre (12). A full review of these risks is planned. No further risks have been added or removed however risk 2507 has decreased from 16 to 12.
	Reduction in patient safety incidents linked to estate issues	There are 2 estates related incidents reported in October. There are no consistent themes with the current incidents.
	Scoring in domains in areas of PLACE inspection composite score > 95%	PLACE lite implementation is still awaited to produce percentage scores. In October ward 12, SDEC, Breast and WNOD have been reviewed. Minor dust/dirt concerns were addressed at time of SDEC visit for bed frames and nursing trolleys. Work ongoing with the PLACE app, over the next 12 months a more robust plan for PLACE visits to be created.
	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 capital programme has been confirmed and an update will be available when capital projects are completed.

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	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Ass/Var	Trend
LEADING INDICATORS																	
Maintain the vacancy rate at <=2.5%	<=2.5%	2.3%	1.8%	2.5%	2.5%	2.3%	2.2%	2.4%	1.7%	1.7%	1.6%	3.2%	3.1%	2.7%	4.6%		
Improve the staff engagement score to 7.3	>=7.3		7.00			6.60			6.60			6.63			*Awaiting results of NHS Staff Survey		
BREAKTHROUGH OBJECTIVES																	
Achievement of the internal turnover standard of 9.7%	<=9.7%	13.0%	13.1%	13.2%	13.2%	12.8%	12.9%	12.5%	12.0%	11.8%	12.1%	11.7%	11.7%	11.7%	11.2%		
Achievement of the internal sickness absence standard of 4.9%	4.90%	6.0%	6.2%	5.9%	6.0%	6.3%	5.6%	5.2%	5.5%	5.7%	5.8%	5.8%	5.7%	5.6%	5.6%		
Reduction in temporary staffing spend of pay bill evidenced month on month	<=2.3%								1.4%	1.0%	0.9%	0.4%	0.5%	0.4%	0.6%		

Measures requiring focus this month

Measure	Summary
Maintain the vacancy rate at <=2.5%	Current vacancy rate is at 4.6% a 1.9% increase compared to September 24. This is primarily due to a budgeted establishment increase of 90 WTE for Community Diagnostic Centre. The overall % of vacancies can mask certain critical vacancies that are causing operational pressure and additional pay spend. A review of the VCF process is in place to ensure there is tighter scrutiny in place for all vacancies. Vacancies add pressure to the group and our ability to provide a safe and high-quality service
Improve the staff engagement score to 7.3	*The National Quartley Peoples Pulse survey is replaced by the annual NHS staff survey in Q3 - results expeced December 2024 to January 2025. A number of actions in place to address staff engagement such as L&D, FTSU, improved comms, revised appraisal process.
Achievement of the internal turnover standard of 9.7%	Turnover has remained at 11.7%. Staff are leaving the NHS across all providers given the significant work pressures and burnout. Turnover adds pressure to the group and our ability to provide a safe and high-quality service. Recruitment costs of backfilling as well as additional temporary staffing on an interim basis add to the costs. Conversely our significant WTE growth is positively impacted (reduced) with turnover, however the challenge lies in where this turnover occurs in the Group. The people promise exemplar programme is now underway, and as part of this work there are working groups in place for induction, stay conversations, flexible working and self-rostering. This work is being monitored via the ICB - good feedback received from ICB on the robust and clear project plan.
Achievement of the internal sickness absence standard of 4.9%	Sickness remained at 5.6% for a rolling 12 months in October across the Group, which is 0.7% above the target. The trust continues a monthly case management approach of all long-term sickness absences. Ongoing training, development and support against our new absence management policy. Absence adds pressure to the group and our ability to provide a safe and high-quality service. Not managing sickness absence results in staff being off work for longer periods of time.
Reduction in temporary staffing spend evidenced month on month reduction and no higher than 2.3 % of pay bill.	Temporary staffing spend remains under target at 0.4%. Challenges in that temporary staffing spend is continuing, further controls to be put in place for the Bank and Agency reduction monitoring group.

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

Metric	Target	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Ass/Var	Trend
LEADING INDICATORS																	
Average Length of Stay Non-Elective <4 days *Revised to align with operational guidance definitions*	<=4	5.23	5.74	5.23	5.31	5.38	5.26	4.46	5.19	7.62	6.87	7.17	7.73	7.96	7.24		
Achievement of the 4 hours trajectory	≥78% (Local ≥80%)	71.4%	70.6%	70.5%	66.1%	68.6%	69.0%	72.2%	71.8%	72.0%	76.3%	71.0%	72.2%	71.4%	67.8%		
Achievement of the 52 week RTT standard	Apr 24 - 58 May 24 - 42 Jun 24 - 18 Jul 24 - 0	293	273	263	143	113	112	76	72	109	88	81	108	123	106		
Achievement of 2024/25 financial Plan - Variance (£k)	Figure in brackets favourable								2,312	2,609	0.009	(0.004)	(0.073)	(0.042)	0.026		
Finance - Forecast Out-turn Deficit (Plan)	12,650 (R)7,088								12,650	12,650	12,650	12,650	12,650	7,088	7,088		
BREAKTHROUGH OBJECTIVES																	
Achievement of the trajectory to reduce >12 hour total time in Emergency Department	0	614	562	453	750	692	458	362	358	413	225	531	391	395	749		
	2.0%	6.5%	5.7%	4.9%	7.4%	7.0%	4.9%	3.6%	3.8%	4.1%	2.3%	5.4%	4.4%	4.4%	7.6%		
Reduce the number of patients with no Criteria to Reside	<10	40	40	42	41	39	44	36	35	35	55	48	46	38	45		
Achievement of the trajectory to achieve RTA to Bed within 1 hour	60.0%	9.5%	9.1%	12.3%	10.0%	10.6%	8.8%	13.6%	9.7%	5.5%	6.1%	5.2%	5.6%	6.3%	3.7%		
Increase % of Outpatient % with procedures	>=33%	27.6%	29.0%	28.9%	28.5%	27.9%	28.4%	27.9%	31.4%	32.0%	31.6%	30.5%	28.9%	28.7%	29.6%		
2024-25 CRP Delivery Variance	Figure in brackets favourable								0	0	98	0	(570)	680	1,157		
No less than £5m cash as per forecast at March 2025	>=£5m								£5m	£5m	£5m	£5m	£5m	£5m	£5m		

Strategic Objectives 2024/25	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 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

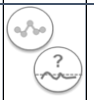
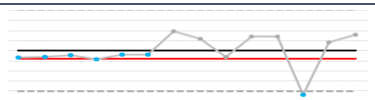
Measure		Summary
1	**Average Length of Stay Non-Elective <4 days**	Length of stay has reduced slightly in October following ongoing detailed work to ensure the patients who do not need to be in a hospital bed are promptly discharge. A working group on Criteria to Reside has now had two meetings and individual responsibility for discharge allocated to team members which should evidence an improvement.
	Achievement of the 4 hours trajectory	Performance against the 4-hr target remains below planned performance levels and dipped further during October. This was partly due to the lack of timely availability of beds on the base medical wards as the result of a Norovirus outbreak. A detailed piece of work to examine why this is the case has taken place and an ongoing plan to avoid bedding SDEC to support flow is in place. Availability of RAT in evenings, staffing overnight matched to demand and admission profile, availability of hot clinics for referral, inappropriate conveyances, appropriate allocation of work between SDEC, UTC and ED, appropriate use of Emergency Health Care Plans to avoid admission. Challenges with Flow including use of SDEC at times of surge. The team are working with the UEC guidance and Metrics as part of an improvement project to deliver the 78% target.
	Achievement of the trajectory to reduce >12 hour total time in Emergency Department	Performance at 7.6% showed a deterioration from what had been an improving position. Availability of beds on EAU and back of house is key to achieving this objective. Focus on ensuring flow earlier in the day, use of the discharge lounge, estimated date of discharge and actual date of discharge enable this to be reviewed. Patient discharge early in the day, achieving this would enable us to ensure that patients did not remain within ED. Also reviewing non admitted waits to understand times of day and improvements required. The discharge improvement project is focusing on measurably improving discharges. Changes to the Dashboards implemented at the end of August and review at all patient flow meetings is now in place.
	Achievement of the trajectory to achieve 60% RTA to Bed within 1 hour	Performance of 3.7%. This is driven by late bed availability in the day, specifically EAU. Appropriate streaming to SDEC. Discharge profile is later in day, address planning for tomorrow's discharges today. Discharge work and review of mechanism to alert Patient Flow team to timeframe.
	Reduce the number of patients with no Criteria to Reside	Average number of patients per day who do not meet the criteria to reside was 45. 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. Challenge in improving the process and outcomes for patients who do not need a hospital bed but do need support in the Community. Daily review with Social Care, review by Discharge Co-ordinators, service improvement plan developed.
	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 October was not achieved; delivery challenges remain in T&O, Gynaecology and Urology due to capacity and demand imbalances and challenged shared pathways in key service areas, this is being managed through access and performance meeting and weekly service meetings. Review of waiting lists by consultant, exploring pooling and alternative ways of releasing capacity. Additional theatre lists where possible and ongoing validation of pathways.
	Increase in New Outpatient activity	Current performance is at 29.7%, below the 33% target. Improvements noted across several specialties and plans to achieve 33% target by end of year. Continuous review of clinical pathways in conjunction with clinical teams to realise any further opportunities. Review of coding to assure activity is recorded appropriately.
2	**Evidence achievement of the 24-25 financial plan**	The Trust has a planned deficit at M7 of £5.972m and actual performance of £5.700m deficit which is a negative variance of £0.026m. In month 6 the Trust received notification it will receive £5.317m non-recurrent deficit support funding resulting in a revised outturn of £7.088m We forecast to achieve the planned deficit outturn position although risks remain around overspending against delegated budgets and identification and delivery of CRP targets. The Trust has a planned CRP target at M7 of £9.668m and actual performance of £8.511m which is a negative variance of £1.157m. There is £1.221m delivered recurrently which is £3.606m less than planned. As the plan is more heavily loaded and weighted towards year end delivery focus remains on identifying recurrent savings schemes to support future financial sustainability. As the trust is forecasting to achieve its planned deficit cash is also forecast to deliver as planned and be no less than £5m at the financial year end. Owing to the additional non-recurrent deficit support of £5.317m cash outturn is expected to be circa £10m provided the £7.088m deficit is not exceeded.
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 was held 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	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Ass/Var	Trend
BREAKTHROUGH OBJECTIVES																	
Increase in the number of digital devices repurposed to the local community	>300								100	100	50	58	0	0	10		
Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients by March 2025	>=98%	90.2%	90.6%	92.6%	88.7%	92.2%	93.4%	91.1%	92.1%	91.6%	92.5%	90.5%	88.8%	91.6%	89.7%		
Reduction in the wait for gynaecology outpatients to no more than 26 weeks	<=26	26.7	26.8	27.9	25.9	28.1	28.0	39.7	35.9	27.0	37.0	37.0	8.0	34.0	38.0		
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 by March 2025	<=30	71	73	75	75	77	76	78	80	81	83	85	82	78	78		

Measures requiring focus this month

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. To date in 24/25 318 devices have reached end of life 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 89.7% against this measure.
Reduction in the wait for gynaecology outpatients to no more than 26 weeks by March 2025.	The median wait is currently 38 weeks impacted by loss of 2 consultants over the Summer (one now back to work) and reduced consultant capacity in Gynae due to pressures in Obstetrics. Working with the clinical team to review OP pathways to maximise opportunity for additional new appointments. Managing current risk with unexpected loss of consultant capacity. Recruitment process underway with additional capacity online from Mar 25. Capacity and Demand imbalance for New OP. Workshop undertaken with Gynae team in October to look at additional opportunities to manage demand.
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 weeks by March 2025	Current waits are at 78 weeks for autism assessment pathways, which is a slight reduction since new model of delivery online in October 24 offering additional New patient capacity. To monitor trajectory on monthly basis. Increase in referrals over recent years for Paeds ASD service which has led to a Capacity and Demand challenge and significant backlog.

Strategic Objectives 2024/25

We will develop and expand our services within and beyond Gateshead

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	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Ass/Var	Trend
LEADING INDICATORS																	
0.5% increase in QEF externally generated turnover	>=0.5%								0.2%	0.2%	0.2%	0.8%	1.8%	2.2%	3.0%		

Measures requiring focus this month

Measure	Summary
0.5% increase in QEF externally generated turnover	Current cumulative performance is 3% which is ahead of target plan. Performing well at engagement, VAT consultancy and target more than exceeded. Work ongoing across other areas to increase performance. Additional income received YTD re: VAT consultancy and new NUTH Transportation contract. Work ongoing around additional VAT consultancy and a bid for NUTH transportation services was successful. Discussions ongoing on current contracts to agree extensions where appropriate.

NHS
Gateshead Health
NHS Foundation Trust

Constitutional Standards 2024/25

Reporting Period: October 2024

Constitutional standards 2024/25	Constitutional Standards metrics Assurance Heatmap	NHS Gateshead Health NHS Foundation Trust

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

Constitutional Standards

Metrics

NHS Gateshead Health NHS Foundation Trust

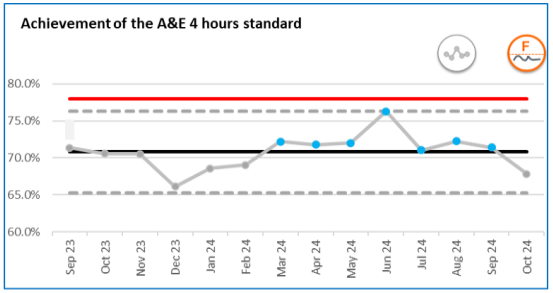
Metric	Target	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Ass/Var
Achievement of the A&E 4 hours standard	>78%	71.4%	70.6%	70.5%	66.1%	68.6%	69.0%	72.2%	71.8%	72.0%	76.3%	71.0%	72.2%	71.4%	67.8%	
12 hour trolley waits (DTA to left department)	0	50	24	0	7	1	0	0	1	4	0	3	0	0	3	
% of ED attendances > 12 hours in department	<2%	6.5%	5.7%	4.9%	7.4%	7.0%	4.9%	3.6%	3.8%	4.1%	2.3%	5.4%	4.4%	4.4%	7.6%	
Ambulance handover delays 30-60 minutes	0	123	99	80	110	25	1	0	0	2	1	10	4	3	3	
Ambulance handover delays 60 minutes +	0	122	100	51	50	2	0	0	0	0	0	13	0	0	0	
Achievement of the RTT 18 week standard	>92%	67.0%	66.9%	67.7%	67.2%	68.3%	67.8%	67.9%	68.9%	70.6%	70.6%	70.3%	69.2%	68.6%	68.5%	
Achievement of the 52 week RTT standard	Apr 24 - 58 May 24 - 42 Jun 24 - 18 Jul 24 - 0	293	273	263	143	113	112	76	72	109	88	81	108	123	106	
Achievement of the 6 week diagnostic standard	>95%	88.6%	92.4%	94.1%	91.4%	90.0%	92.1%	91.2%	88.8%	86.0%	83.8%	84.7%	84.3%	87.9%	88.4%	
Achievement of the Cancer 28 day standard	>77%	76.0%	76.8%	78.5%	80.4%	75.9%	83.0%	81.1%	79.7%	82.1%	80.7%	80.6%	79.7%	77.7%	82.5%	
Achievement of the Cancer 31 day standard	>96%	99.5%	100.0%	99.4%	99.4%	99.6%	100.0%	97.9%	99.1%	99.6%	100.0%	98.9%	99.8%	100.0%		
Achievement of the Cancer 62 day standard	>70%	70.4%	68.6%	70.0%	64.6%	72.4%	71.2%	73.9%	75.3%	68.1%	70.9%	70.7%	74.2%	66.4%		

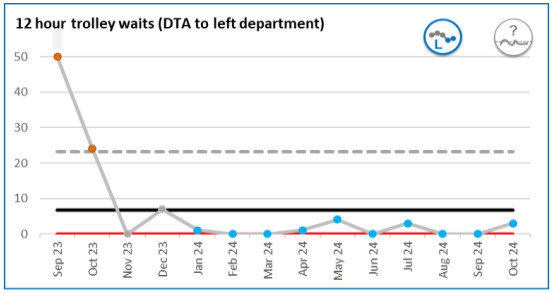
Validated data unavailable at time of report

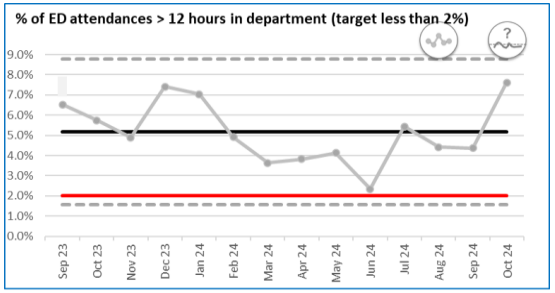
Constitutional Standards

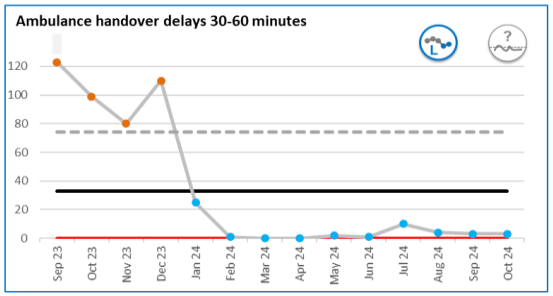
Metrics (SPC)

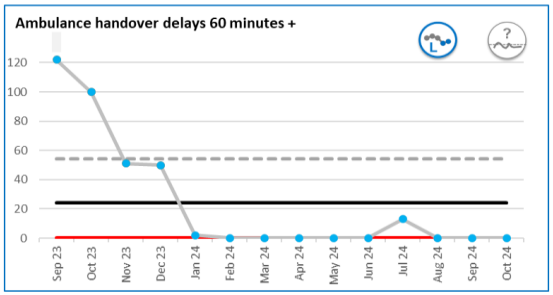
NHS Gateshead Health NHS Foundation Trust

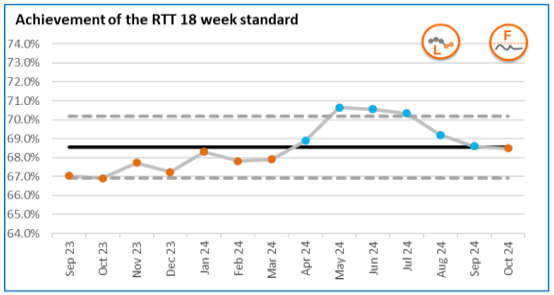


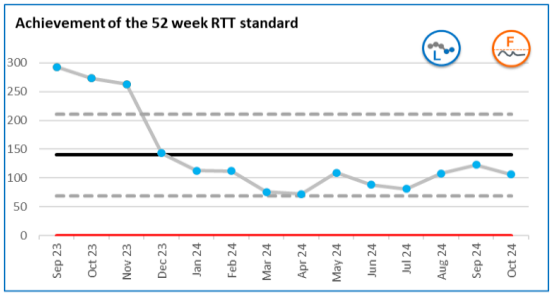


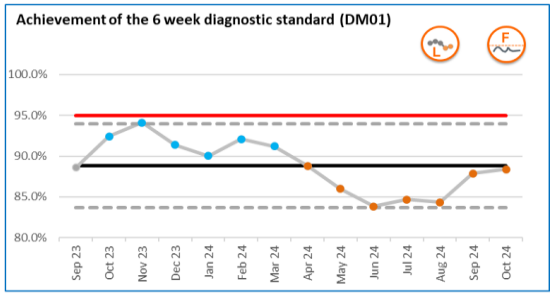


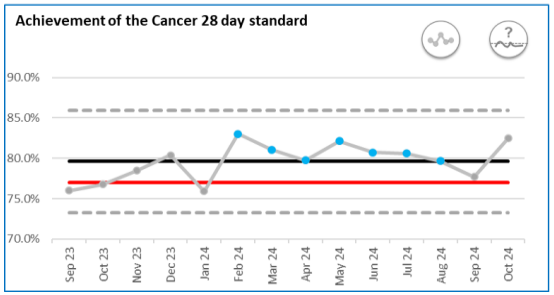


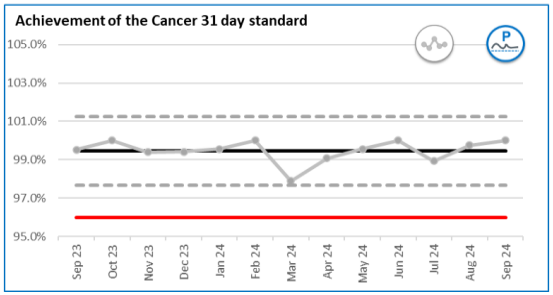


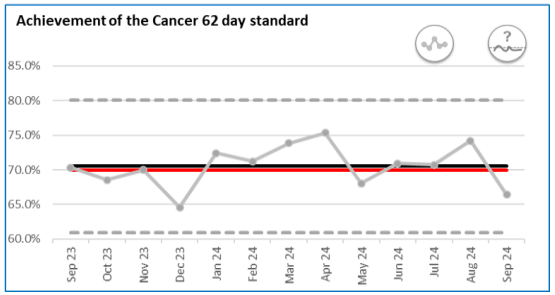












Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 16

Report Title:	Mortality Report – six monthly update			
Name of Meeting:	Trust Board			
Date of Meeting:	27th November 2024			
Author:	Andy Ward – Senior Information Analyst – Quality & Patient Safety Wendy McFadden – Strategic Lead Clinical Effectiveness			
Executive Sponsor:	Dr Carmen Howey – Group Medical Director			
Report presented by:	Dr Carmen Howey – Group Medical Director			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To provide an update on Mortality and Learning from deaths over the last six months.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	NA			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• The Trust's latest publication of the national mortality indicator places the Trust with a banding of 'As expected' for the SHMI • 25 deaths were reviewed by the Medical Examiner, 3 of these have been reviewed subsequently either by the Mortality Council or at ward level. • 99.1% of cases reviewed are identified as being definitely not preventable; 97.0% of cases reviewed were identified as good practice; No potentially preventable deaths were identified during the period. • 90 cases still require a Mortality Council review. • 46 cases still require a ward level review. • Backlog of Learning Disability and SMI death reviews – plans in place to work through these. • Identified changes to the future reporting with the intention of giving greater assurance regarding our organisational learning from deaths and actions which have taken place.			

<table>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">To receive the paper for assurance and agree the new reporting format.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☐</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
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☐</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
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☐</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">List corporate objective reference and headline – e.g., 1.4 Maximise the use of Nervecentre to improve patient care</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☐</td><td>Responsive
☐</td><td>Well-led
☐</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">NA</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

Mortality Report

Executive Summary

The latest SHMI was published on 10th October 2024 covering the period from June 2023 to May 2024. The Trust has a SHMI Banding of 'As Expected' with a score of 1.01.

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

99.1% of cases are identified as being definitely not preventable.
97.0% of cases reviewed were identified as good practice.
One potentially preventable death identified during the period. (Hogan score >=4)

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

1. Introduction:

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

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

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

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

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

Now include changes to SHMI Methodology

A number of changes were introduced to the SHMI methodology from the May 2024 publication onwards as detailed below.

- COVID-19 activity will be included if the discharge date is on or after 1 September 2021
- Hospice sites within non-specialist acute trusts will be excluded (St Benedict's Hospice -South Tyneside and Sunderland)

- In the site level breakdown of the data, a SHMI value will only be calculated for a subset of sites
- The methodology for identifying the primary and secondary diagnoses for spells consisting of multiple episodes will be updated.
- Activity with an invalid primary diagnosis will be moved to a separate diagnosis group.

In addition to the above changes. From May onwards the Trust moved from recording Same Day Emergency Care (SDEC) activity from its Admitted Patient Care dataset (APC) to the Emergency Care Data Set (ECDS) as Type 5 A&E activity. It was mandated that all NHS Trusts record SDEC information as Type 5 activity within the ECDS by July 2024

Some trusts who have moved their SDEC data from the inpatient data set to ECDS have seen an increase in their SHMI value. This is caused by two factors.

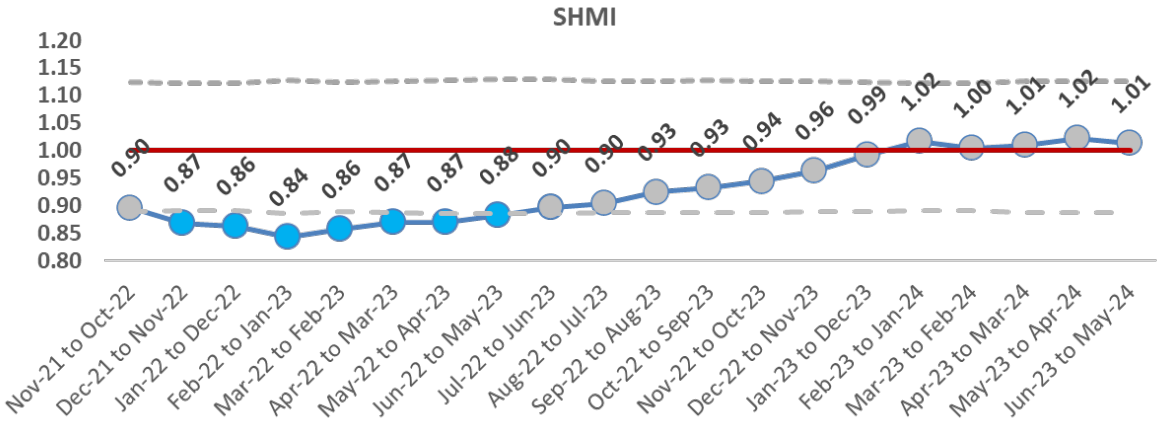
Firstly, the observed number of deaths remains approximately the same as the mortality rate for this cohort is very low, because they are well enough to be managed in SDEC i.e. in a non-admitted pathway.

Secondly, the expected number of deaths decreases because a large number of spells are removed from the SHMI, all of which would have had a small, non-zero risk of mortality contributing to the expected number of deaths.

SHMI Trust Position June 2023 to May 2024

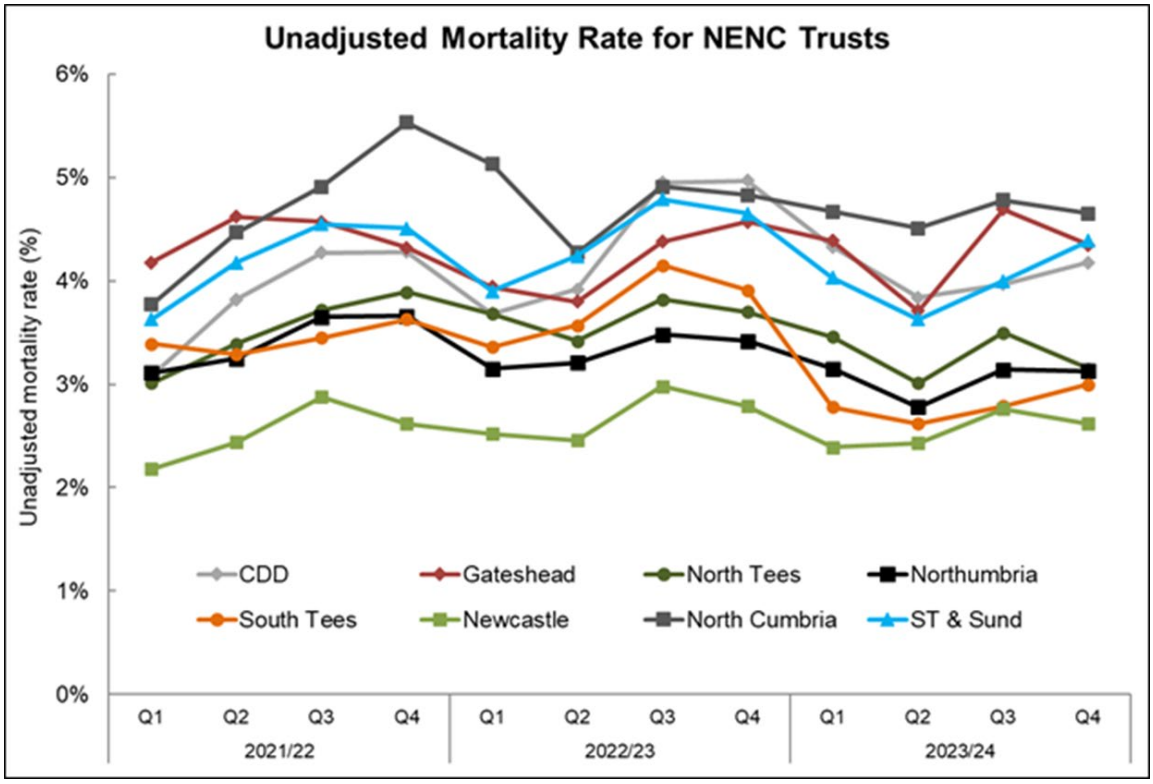
The latest SHMI published for Gateshead Trust on 10th October 2024 covering the period from June 2023 to May 2024. The Trust has a SHMI Banding of 'As expected' with a score of 1.01. Following an increasing trend in the SHMI the indicator appears to be stabilising however will be monitored closely following removal of SDEC activity.

The latest figures only include one month of SDEC removal, any effect of this change may not be observed until further publications.



Trends in mortality rate

The unadjusted mortality rate varies between trusts and quarters from 2.2% to 5.5% across the period April 2021 to March 2024 with a range of 2.6% to 4.7% in the latest period. The SHMI and the unadjusted rate include all deaths in hospital plus deaths within 30 days of discharge; the rates are not strictly comparable between trusts.



3. Trust based data analysis:

Mortality Alerts from HED (Healthcare Evaluation Data)

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

	Alert	CCS Diagnostic Group	Period	Observed Deaths	Expected Deaths	Obs -Exp	HSMR SHMI / CUSUM Score	% Reviewed (where death within Trust)	% Definitely not preventable	% NCEPOD Good Practice
	SHMI	Cancer of the prostate, testis, other male genital organs	Jun 23 to May 24	15 (11 in hospital)	5.4	9.6	275.7	90.9%	100%	100%
	SHMI	Cancer of the colon	Jun-23 to May-23	34 (27 in hospital)	19.2	14.8	177.2	92.6%	100%	100%
	SHMI	Cancer of bronchus; lung	Jun-23 to May-23	79 (59 in hospital)	57.3	21.7	137.8	96.6%	100%	100%

There were three SHMI alerts for the period June 2023 to May 2024.
The trust routinely triggers for cancer alerts in the SHMI.

Analysis of internal review and scrutiny shows that the majority of cases have received scrutiny by the medical examiners office and were deemed to be 'Definitely not preventable and Good Practice.

Patients with a cancer diagnosis receive curative treatments at neighbouring Trusts. In addition, the SHMI does not risk adjust for palliative coding which may account for Gateshead having higher observed figures compared to expected.

Cancer of the prostate
10/11 cases reviewed be the Medical Examiner. All 10 cases scored as Definitely not preventable and Good Practice. 1 patient released by the Lead Medical Examiners Officer and therefore not scored.

Cancer of the Colon
25/27 cases reviewed and scored as by the Medical Examiner as definitely not preventable and good practice. 1 patient released by the Lead Medical Examiners Officer. The remaining case is awaiting scoring at Mortality Council as the patient had a severe mental illness diagnosis and requires specialist input for the review, however initial scoring by the Medical Examiner is Definitely not preventable and good practice.

Cancer of Bronchus; lung
57/59 deaths reviewed and scored as by the Medical Examiner as definitely not preventable and good practice. 1 elective case awaiting mortality council scoring, the Medical Examiner scoring was Definitely not preventable' and 'Good practice'.

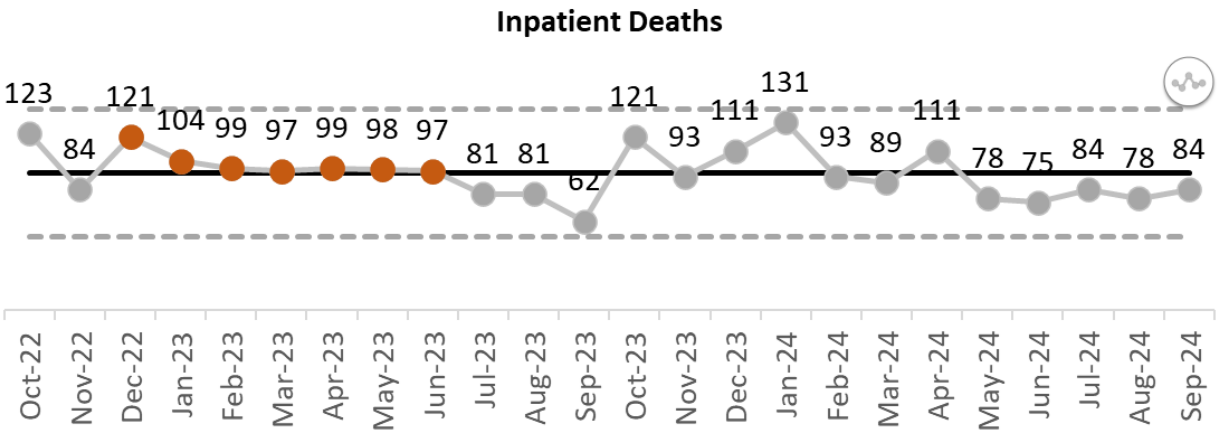
In the remaining case The Medical Examiner identified room for improvement with a delayed biopsy and a delay to discharge via hospice at home. These issues were also picked up via internal governance systems (Safety Triangulation Group and liaison with palliative care) This record has been referred to the ward team and is awaiting final scoring.

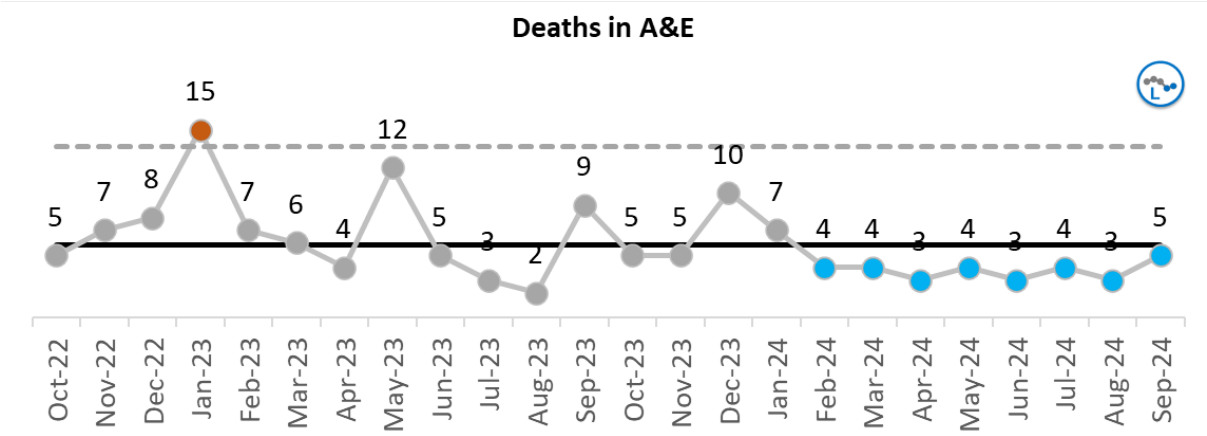
Inpatient mortality and deaths in A&E

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

Inpatient mortality was variable over the winter months remaining relatively stable and below the 24-month average in recent months varied in recent months with common cause variation observed over the last 15 months.

Deaths in the A&E department have remained low, below the 24-month average for the last 8 months triggering special cause variation (low).





4. Learning from Deaths and Mortality Review

Mortality Review Reporting

Mortality Review Data Extracted 15/10/2024
Deaths 01/10/2023 to 30/09/2024

Period Figures	Deaths in period	Deaths Scrutinised by Medical Examiner	Learning Disability Deaths reviewed at Mortality Council	Severe Mental Illness deaths reviewed at Mortality Council	Number awaiting scoring Mortality Council review	Number awaiting Ward level review	Number awaiting Ward Level review following referral by ME	There has been one death of a patient sectioned under the Mental Health Act. This was reported to the CQC appropriately
	1205	* 1180	2	1	90	46	31	
	Denominators	1205	16	14		67		
		97.9%	12.5%	7.1%		68.7%		
		Total oustanding to date	16	18			78	

The scores below relate to reviews undertaken by either the Medical Examiner Scrutiny, Mortality Council, or the Ward based team.
Mortality Council review score supercedes the Ward Based Team review score, which in turn supercedes the ME scrutiny.
The figures below represent the outcomes of 1087 cases fully reviewed and scored.

Period Figures	Hogan 1 - Definitely Not Preventable	Hogan 2 - Slight Evidence of Preventabiliy	Hogan 3 - Possibly Preventable (Less than 50:50)	Hogan 4 - Probably preventable (more than 50:50)	Hogan 5 - Strong Evidence Preventable	Hogan 6 - Definitely Preventable	Potentially avoidable deaths (Hogan 4 and above)	Ward Team Reviews	
	99.1%	0.6%	0.2%	0.1%	0.0%	0.0%	0.1%	159	13.2%

Period Figures	NCEPOD Score 1 Good Practice	NCEPOD Score 2 Room for improvement - Clinical Care	NCEPOD Score 3 Room for Improvement - Organisational Care	NCEPOD Score 4 Room for Improvement Clinical and Organisational Care	NCEPOD Score 5 Less Than Satisfactory	NCEPOD score 6 Insufficient data	No Score Allocated
	97.0%	0.6%	1.2%	1.1%	0.0%	0.2%	0.0%

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

25 deaths were reviewed by the Medical Examiner, 3 of these have been reviewed subsequently either by the Mortality Council or at ward level.

12.5% (2/16) of learning disasblity deaths and 7.1% (1/14) of deaths from patients with severe mental ilnness (SMI) have been reviewed.

The Learning Disability service comprises of one member of staff, who has unfortunately was absent for a considerable period. The Lead Nurse for learning disabilities has returned to work and reviews are recommencing to work through the backlog of cases. An additional learning disability nurse has been recruited to the team and will commence in November

2024 for a 12 month period. Learning Disability death reviews are specialised and are not able to be completed by any other staff members.

In terms of the back of SMI cases, there have been considerable pressures within the Older Person's Mental Health team, a plan has been agreed to work through the backlog by completing two cases per month.

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

- 99.1% of cases are identified as being definitely not preventable.
- 97.0% of cases reviewed were identified as good practice.
- 2.8% of cases identified room for improvement.
- 1 death identified as potentially avoidable (Hogan score >=4)

Hogan 4:
Patient with bipolar on long term lithium treatment. Attended ED after a fall/decreased mobility and was discharged back to their residential home. They re-attended a few hours later and were admitted for social sort. Transferred from EAU to ward 24 at 3am without being seen on the post take ward – ward 24 was being used for acute admission at this time (day before easter bank holiday). Lithium level not checked on admission. Potential delay in recognising/treating lithium toxicity. Discussions took place around holding the lithium, however not with the on call psychiatrist. Patient seen over weekend by consultant, clinical picture was improving, was up and about on the ward. Discussed with diabetic consultant symptoms not consistent with diabetes insipidus. Had cardiac arrest on 1st April and died on 6th April

COD: 1a Bronchopneumonia
1b Nephrogenic diabetes insipidus and hypernatremia
1c Lithium toxicity

Learning:
- IVT management, wasn't given enough fluid, U&Es not done daily, no robust way to capture/prescribe/monitor fluid
- No bloods taken over the bank holiday weekend
- Lithium levels not checked on admission
- Rising lithium level not discussed with on call psychiatrist
- Inappropriate transfer to ward 24 without consultant review

There are 90 cases that require a further review by the Mortality Council and 46 that require a review by the ward based team.

In an attempt to decrease the backlog of cases requiring review by the Mortality Council, additional Councils have been held and some have increased in length. Unfortunately, Councils were stood down due to the impact of industrial action. An advert to promote attendance by medical staff at the Mortality Council featured in the staff newsletter and also the MD bulletin, with an aim to decrease the occasions when the meeting cannot go ahead due to lack of representation. Clinicians are also now invited to the Mortality Council to present their cases if they so wish.

Learning from Mortality Council

For the period April 2024 to September 2024, 68 cases were reviewed by the Mortality Council. The scores of the review are detailed in the table below:

Hogan 1 – Definitely not preventable	54
Hogan 2 – Slight evidence of prevention	10
Hogan 3 – Possibly preventable less than 50:50	2
Hogan 4 – Probably preventable – more than 50:50	1
Initial review undertaken not yet scored	1

NCEPOD 1 – Good practice	35
NCEPOD 2 – Room for improvement clinical care	3
NCEPOD 3 – Room to improve organisation of care	16
NCEPOD 4 – Room to improve clinical and organisational	13
Initial review undertaken not yet scored	1

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

Learning

Documentation

- Documentation in multiple areas – not everyone using the same system – i.e. some only using NerveCentre, some only using notes, some using both – no consistency across the Trust – being raised with Digital Team.
- DNACPR form filed in previous volume, forms should be filed within the most recent volume of the patient's notes.
- Consent form – must always be a copy filed within the patient's notes.
- Consent – it is difficult to record the full discussion with the patient on the current paper form. Electronic consent will assist with this.

Fluid Balance

- Recording of fluid balance and management of hypernatremia is common theme within the Mortality Council. Fluid balance is not recorded electronically and is not possible with the IT system in place at present.
- IVT management – not given enough fluids, U&Es not done daily, no robust way to capture/prescribe/monitor fluid
- No fluid balance sheet – SOP not being followed.

Task & Finish group instigated to look at improving fluid balance management across the organisation.

Ward moves/transfers

- Multiple and inappropriate ward moves contributed to the deterioration of patients.
- Issues regarding transfer/treatment of acutely unwell patients within the wards on site outside of the main hospital building.
- Pathways are needed regarding sending patients to Freeman and receiving them back and how to capture the communication
- Inappropriate transfer to Ward 24 without consultant review
- Transfer of sick patients for interventional radiology – felt patient was too unwell for transfer to Freeman but interventional radiologist wouldn't come to trust – despite being usual practice

Task and finish group now in place to review and develop standard operating procedures for ward transfers and boarders.

Test results

- Blood results following a patient, paperbased system causes problems. There is an electronic solution available, however, this will come at a cost.
- Lack of ownership of test results for patients who transfer from ED to other specialities
- Variation in what is being red alerted and what is not
- Robust system required for managing red flagged CT scan results, especially with the outsourced work
- Everlight incorrectly reported scan – missed opportunity to transfer for thrombolysis – has been discussed with Everlight

Task and finish group established for review results management – work to date to be shared and consulted on with Clinical Strategy Group in November meeting and time out session in December.

Clinical pathways

- Discussion to take place to with AAA screening team to understand the process for follow up/escalation when patients do not attend for regular screening appointments.
- Urgent endoscopy needing GA – look at how they are prioritised and use of emergency theatre– SOP under development
- SOP-pathway to be developed for urgent endoscopies required under GA – input some surgeons, endoscopy and anaesthetics – SOP under development
- Obtaining an ERCP under general anaesthetic is challenging, a formal process for this is necessary – SOP under development
- Communication of anaesthetic decision making to be clear re: suitability for surgery– SOP under development
- Formal written clinical guideline required for fibroid management – Clinica guideline drafted
- CT scans should be carried out as early as possible when a bowel leak is suspected

- Advanced Life Support prompts have been devised for patient who present with hypothermic cardiac arrest

Medication

- Missed opportunity to provide broad-spectrum antibiotics – IV drug users at high risk of contamination in a high clot area
- Lithium levels not checked on admission / Rising lithium level not discussed with on call psychiatrist - Lithium clinical guideline being reviewed by Pharmacy team.
- CIWA undertaken in A&E and stat dose of pabrinex now given if appropriate to patients who are in the waiting area

Miscellaneous

- Following use of contrast during investigations, patients should be given information and advice for any side effects to look out for and what action to take.

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

5. Medical Examiner

It is proposed from November 2024, the Lead Medical Examiner will separately present to the Trust Board on a quarterly basis learning and areas of concerns highlighted through their scrutiny. See Future reporting.

6. Triangulation of mortality data

There are a number of ways in which mortality data is triangulated with other areas within the organisation:

- Any potential patient safety incidents identified during the course of the medical examiner scrutiny are highlighted either to the treating team to report an incident via Inphase or in some cases this is completed by the Medical Examiner. Any Inphase incidents with a level of harm classified as 'fatal' are listed for discussion at the weekly Executive Safety Panel.
- Deaths referred to the coroner which have the potential to progress to an inquest are shared with the Legal Team.
- For deaths reviewed by the Mortality Council, information is obtained in advance of the meeting in relation complaints/PALs, patient safety, legal and safeguarding, to ensure that the full picture is available for the discussion.
- Complaints from relatives/carers of the deceased are shared by the complaints team for discussion at the Mortality Council.
- Outcomes and learning from Inquests for individual patients is presented to the Mortality Council.

7. Future reporting

Following presentation of this report to the Quality Governance Committee last month, we have identified some improvements to our reporting of mortality review and governance arrangements. Therefore, it is proposed that the reporting going forward will change to three separate reports and the frequency will be quarterly rather than the current six monthly:

Report 1: Mortality Data report to include eg SHMI data and any Mortality alerts
Report 2: Medical Examiner report to include outcomes from scrutiny of deaths.
Report 3: A Learning from Deaths report

a. addresses any outlier status from the data report.
b. describes where we are in terms of review of deaths, what percentage require ward review/mortality council discussion and if the learning is in relation to preventability of death of something else.
c. addresses any individual cases where there is learning with an action plan if relevant eg for a Patient Safety Incident Investigation (PSII)
d. addresses thematic learning with the action plans which are embedded in the work of the Patient Safety team through PSIRF

These changes are intended to provide further assurance and more detailed information on the learning and actions which have taken place as a result of mortality reviews. These reports can be considered to address the “What?” the factual data in relation to deaths, the “So What” the scrutiny from the ME and the “What Now?” as we learn from deaths in the organisation.

8. Recommendation

The Board is asked to receive this paper for information and assurance and agree the new reporting format.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 17

Report Title:	**Maternity Integrated Oversight Report – October 2024**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 November 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 October 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 19/11/2024 SBU Ops Board 27/11/2024 Safecare Steering Group 19/11/2024 Trust Board 27/11/2024			
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 October 2024, there were 163 births, 1 MNSI case and 1 perinatal loss. • Exceptions reported – positive reports for CO monitoring & breastfeeding, high SPC for induction of labour, caesarean sections, low maintained for PPH • Moderate harm incidents – 5 incidents reported & 1 MNSI final report received **Q2 SBLCB:** 67% compliant with passes for 5/6 elements **Q1&Q2 Legal:** 1 claim closed			
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 October 2024

Maternity IOR contents

- Maternity Dashboard 2024/25:
  - October 2024 data

- Exception reports:

- Items for information:
  - Strategic Objectives Perinatal Quality Surveillance minimum dataset
  - Incidents
    - 1 MNSI cases reported in October 2024 (birth in August 2024)
  - Perinatal Mortality and Morbidity
    - 1 perinatal loss in October 2024
  - Q2 Saving Babies Lives report
  - Q1 & Q2 legal

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Births	Oct 24	164	-			163	116	210
Spontaneous vaginal deliveries	Oct 24	62	-			77	52	102
Assited births	Oct 24	102	-			86	57	115
Induction of Labour	Oct 24	48	-			63	36	90
Maternity Readmissions	Oct 24	1	-			3	-3	10
Neonatal Readmissions	Oct 24	4	-			5	-2	12
Smoking at time of booking	Oct 24	4.95%	15.00%		P	8.71%	2.49%	14.94%
Smoking at time of delivery	Oct 24	4.94%	6.00%		?	6.78%	0.07%	13.49%
In area CO at booking	Oct 24	93.96%	90.00%	H	?	90.14%	79.23%	101.05%
In area CO at 36 weeks	Oct 24	85.47%	80.00%		?	82.89%	72.15%	93.62%
Admitted directly to NNU (SCBU) (>37 weeks)	Oct 24	1	4		?	8	-2	17
Percentage Admitted directly to NNU (SCBU) (>37 weeks)	Oct 24	0.66%	6.00%		?	5.04%	-0.83%	10.92%
Preterm birth rate <=36+6 weeks at birth	Oct 24	0.00%	6.00%		?	5.33%	-1.07%	11.73%
Continuity of Carer: Percentage placed on pathway (29 w	Oct 24	10.32%	-			16.66%	7.33%	25.98%
Continuity of Carer: Percentage from BAME backgrounds	Oct 24	12.00%	-			28.11%	-1.14%	57.35%
Spontaneous Vaginal Births (%)	Oct 24	38.04%	-			47.41%	35.69%	59.12%
Induction Rate	Oct 24	29.63%	-			38.97%	27.17%	50.77%
Instrumental Delivery Rate	Oct 24	12.35%	-			13.44%	4.90%	21.98%
Elective C Section Rate	Oct 24	18.40%	-			18.15%	7.90%	28.41%
Emergency C Section Rate	Oct 24	31.29%	-			21.20%	9.75%	32.64%
C Section Rate	Oct 24	49.69%	-			39.35%	25.55%	53.15%
3rd or 4th degree tear (Total) Precentage	Oct 24	2.47%	3.00%		?	1.17%	-1.31%	3.65%
Massive PPH >=1.5L (All births)	Oct 24	7	2	L	?	9	0	18
Breastfeeding: Percentage of Initiated Breasfeeding	Oct 24	81.37%	66.20%		?	75.83%	65.03%	86.63%
Breastfeeding: Breasfeeding at Discharge (Transfer to Co	Oct 24	61.94%	56.20%	H	?	57.53%	42.52%	72.53%

Safe

Responsive

Maternity

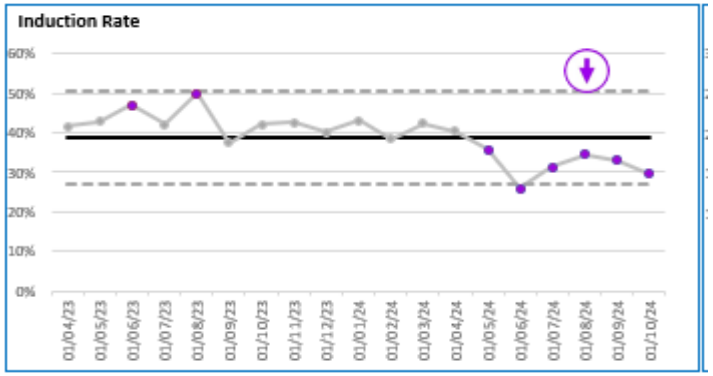
NHS Gateshead Health NHS Foundation Trust

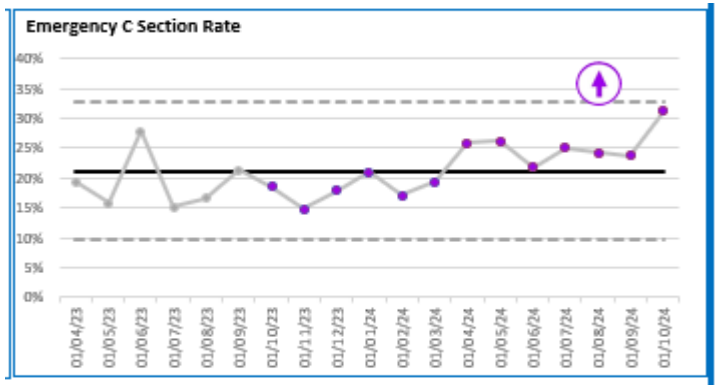
Maternity Dashboard 2024/25

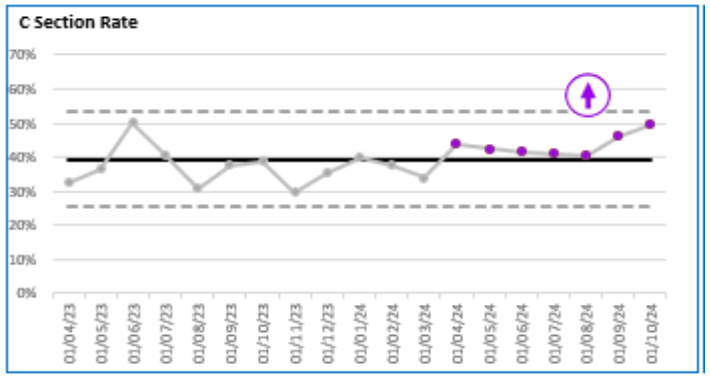
Maternity Dashboard 2024/25

Maternity

NHS Gateshead Health NHS Foundation Trust







- **Background**
  - Reduction in induction of labour
  - Increased emergency & overall caesarean section rate
- **Assessment**
  - Impact of increase in number of births & acuity continues to place significant pressure on the maternity service
  - Increased use of theatre time is creating significant pressure on wider SBU activity & workforce
- **Actions**
  - Maternity services pressure workplan
  - Ongoing monitoring of metrics linked to workplan
- **Recommendations**
  - Additional SBU discussions re theatre activity

Maternity Dashboard 2024/25

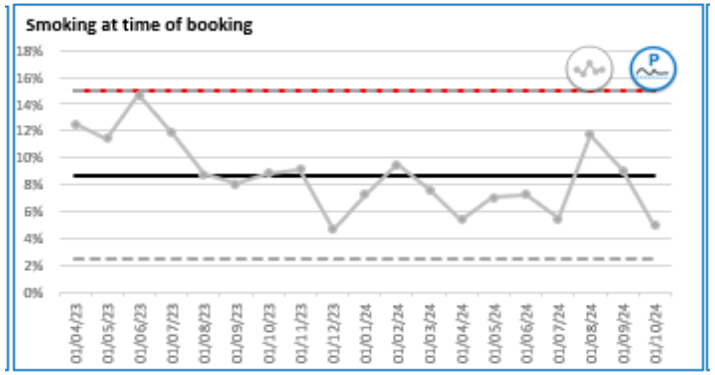
Maternity

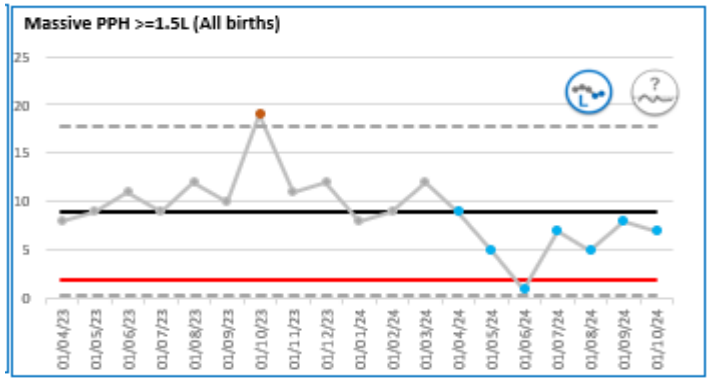
Gateshead Health NHS Foundation Trust

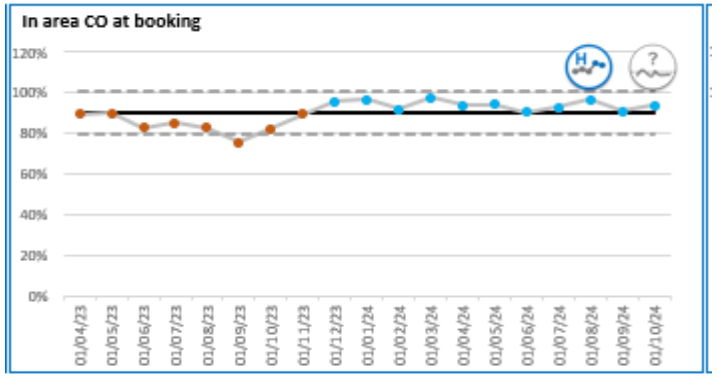
Responsive

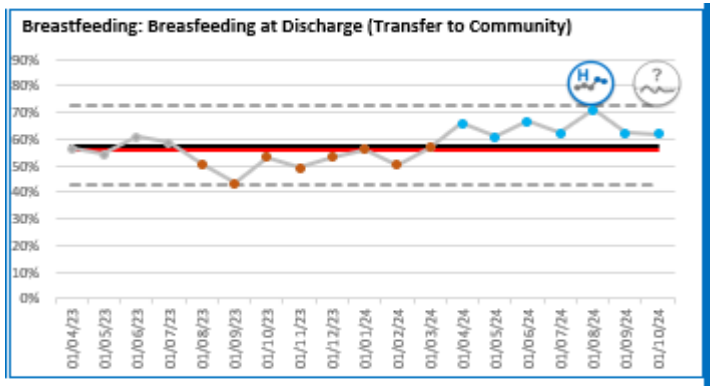
Safe

- **Background**
  - Sustained lower PPH rates
  - Sustained lower SATOD rates
  - Sustained higher CO monitoring rates
  - Sustained breastfeeding rates
- **Assessment**
  - Four positive outliers on SPC
- **Actions**
  - No areas of concern identified
- **Recommendations**
  - Share learning via Safecare









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	9	9	9	9					
Areas Not Applicable												
No. Compliant	7	7	5	5	3	4	4					
No. Non Compliant	2	2	4	4	6	5	5					
Percentage Compliance	78%	78%	74.0%	74%	89%	90%	95%					

Areas compliant: (List domains compliant)
1. Enhanced Safety, 2. Listening to families 3. Staff training & MDT working, workforce

Areas Non compliant: (List domains non-compliant)
4.Managing Complex Pregnancy, 7. Informed Consent, 5. RA throughout pregnancy 6. Monitoring Guidelines.

How are we performing or Progress Made?
MNVP website review completed
LMNS assurance visit report received

What is driving performance or what are the challenges

What actions is being taken or future risks & planned developments
Q2 LMNS review completed – review of feedback ongoing, LMNS assurance visit
Q2 documentation (risk assessment) audit results in progress
Need to complete PCP audit of 5%

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	89	89	89	89	89	89	89					
Areas not Applicable	6	6	6	6	6	6	6					
No. Compliant	56	63	68	69	74	79	79					
No. Non Compliant / Unassessed	35	26	15	14	15	4	4					
Percentage Compliance	63.0%	71.0%	76.0%	78%	83%	89%	89%					

Areas compliant: (List domains compliant)
Safety Action 1 (PMRT) Safety Action 2 (MSMDS) Safety Action 3 (ATAIN), Safety Action 4 (Clinical Workforce Planning), Safety Action 8 (Core Competency Framework) Safety Action 10 (HSIB & ENS), Safety Action 5 (Midwifery Workforce)

Areas Non compliant/Not Assessed: (List domains compliant)
Safety Action 6 (SBL Care Bundle) Safety Action 7 (MVP) Safety action 9 (Trust Board Oversight)

How are we performing or Progress Made?
BR+ establishment approved by EMT, annual LMNS assurance visit completed

What is driving performance or what are the challenges
Demand & capacity

What actions is being taken or future risks & planned developments
Update of maternity governance structure in line with Trust, recruitment to midwifery vacancies

Maternity

NHS
Gateshead Health
NHS Foundation Trust

Safe

Well Led

2024/25		April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Number of perinatal losses		0	0*	1	0	0	0	1					
Number of HSIB cases		1	0*	0	0	0	0	1 (August birth)					
Number of incidents logged as moderate harm or above		1	0	0	0	0	2						
Minimum obstetric safe staffing on labour ward		100%	100%	100%	100%	100%	100%	100%					
Minimum midwifery safe staffing including labour ward (average fill rates)	Day shift	107.7	110.0%	98.4%		100%	97.8%						
	Night shift	105.2	109.7%	102.8%		103.1%	105.6%						
	CHP PD*	18.3	18.7	18.4		12.2	10.1						
Service user feedback	FFT “Overall how was your experience of our service” – total score for *very good* and *good* responses	100%	90%	100%									
	Complaints	2	1	1	3	0	3	1					
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust		0	0	0	0	0	0	0					
Coroner Reg 28 made directly to Trust		0	0	0	0	0	0	0					

*CHPPD overall care hours per patient per day

Exception report

Maternity

Gateshead Health NHS Foundation Trust

Final MNSI report received MI-037182 (InPhase #4611)

Summary:

- Concealed pregnancy, attended A&E with back pain.
- Transferred to Maternity – scan performed = approximately 40 weeks gestation
- CTG – suspicious – caesarean section performed – thick meconium present
- Extensive resuscitation & transfer to tertiary unit for therapeutic cooling
- MRI at Day 10 – possible brain injury

Safety recommendations and safety prompts

This report contains no safety recommendations. The findings and safety prompts identified provide organisations with the opportunity to identify areas of learning.

Safety prompts

MNSI safety prompts.

The investigation learned that equipment for emergency neonatal care was not immediately at hand in the operating theatre.

- How does the Trust standardise and streamline neonatal equipment for easy access in an emergency?

The investigation learned that equipment required to optimise ongoing care of the Baby was available on the special care unit.

- Are there barriers in the process of transferring a baby following initial resuscitation to the special care unit to access additional equipment to support and optimise ongoing care of a baby?

Exception report

InPhase report #7923

MNSI case reported MI-038680

Summary:

- Primip, low risk pregnancy, BMI 34 (normal GTT)
- SROM at 37+3 – immediate augmentation with prostin
- Bradycardia at 7cm – class 1 caesarean section (GA)
- Normal cord gases
- Postnatal collapse of baby on ward
- Required resuscitation & transfer to tertiary unit
- Seizure activity
- MRI
- Attended following discharge from tertiary unit with seizures
- Neonatal stroke diagnosed

Learning

- **CTG interpretation & escalation (*perinatal stroke is extremely difficult to determine cause, most occur antenatally, however intrapartum or early postnatal causes also a possibility)**
- **Delays for risk review due to capacity within specialist & obstetric teams**
- **3 organisations involved in care – no parental concerns for Gateshead**
- **Eligible for MNSI & ENS reporting – both done**
- **MNISA referral for support**

Maternity

NHS
Gateshead Health
NHS Foundation Trust

Exception report

InPhase report #8477

Summary:

Severe PET at 28+5.
Admitted to AN ward
Pathological CTG, decision for Category 2 EMCS, transferred to LW.
Eclamptic seizure, patient stabilised,
CS upgraded to Category 1 in theatre. Baby transferred to RVI.

Learning

- Missed history of migraines at booking and ANC at 14+5
- 28+4 Referred to PAU for BP profile triaged at 1 hour at PAU
- Understanding of antihypertensive actions & regime
- Pet protocol not followed – BP, CTG, fluid balance
- Delays to review
- CTG paused to allow toilet despite being abnormal

Maternity

NHS
Gateshead Health
NHS Foundation Trust

Exception report

InPhase report #8607

Summary:

5 pulls with forceps, 3rd degree and cervial tear, PPH, high block, arterial line

Learning

- Risk assessment at booking
- Growth scan missed at term
- CTG interpretation in labour
- 5 pulls with forceps.
- Use of FSE to minimise LOC
- Holistic review of appropriate method of delivery including review of contractions and progression.
- Appropriate Consultant attendance for delivery & 2nd for PPH

Maternity

NHS
Gateshead Health
NHS Foundation Trust

Exception report

InPhase report #7856
Complaint #IP24784

<u>Summary:</u>

Term admission – transferred out – ?meconium aspiration/infection
Low risk pregnancy, IOL for reduced fetal movements at 39+1
CTG suspicious – pathological – class 2 LSCS – meconium present
Apgar 7, sats 92/93%, PEEP for 4 min
Postnatal ward – sats 90% - to SCBU

<u>Learning</u>

CTG reviews – systematic, ward round
Liquor B/S at ARM – no further mention until birth
No cord gases taken
Delay to Registrar review on ward

Exception report

InPhase report #7724

Maternity

NHS

Gateshead Health

NHS Foundation Trust

Summary:

- Absence of the cavum septum pellucidum at anomaly scan at 20+6 – not detected
- Ventriculomegaly at 32+1 week scan not detected
- Scan at 36+1 identified ventriculomegaly measuring 18.5mm. Fetal medicine referral made.
- MRI at RVI identified agenesis of the corpus collosum. Patient opted for fetocide at 38+0 weeks and delivered on 23/8/24 (RIP)

Learning

- At the anomaly scan, the cavum septum pellucidum could have been noted as missing. This would have triggered a fetal medicine referral where the condition the fetus had would have been detected at 20 weeks instead of 36 weeks.
- At the growth scan at 32 weeks – the ventriculomegaly should have been detected, measured and immediately referred to the fetal medicine unit. This would have meant the anomaly could have been detected at 32 weeks instead of 36 weeks.

Gateshead Health NHS Foundation Trust

Q2 Saving Babies Lives report

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially implemented	60%	Partially implemented	70%	CNST Met
Element 2	Fetal growth restriction	Partially implemented	60%	Partially implemented	60%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Partially implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	60%	Partially implemented	40%	CNST Not Met
Element 5	Preterm birth	Partially implemented	74%	Partially implemented	70%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	70%	Partially implemented	67%	CNST Not Met

- LMNS Q2 review meeting held 12/11/24
- Additional pieces of evidence for Element 4 to be submitted to achieve full compliance

Legal summary: Q1 & Q2

Responsive

Gateshead Health NHS Foundation Trust

Incident Date	Closed Date	Summary	Amount Settled
24 July 2020	2 May 2024	Failure to recognise injury during C section leading to a ureteric stent retrograde procedure	£5000

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 18

Report Title:	**Nursing Staffing Exception Report**			
Name of Meeting:	Board of Directors Meeting			
Date of Meeting:	27th November 2024			
Author:	Helen Larkin, Clinical Lead E-rostering			
Executive Sponsor:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Drew Rayner, 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 October 2024. October has demonstrated some areas with staffing challenges relating to sickness absence and enhanced care requirements. During October, 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 retention of staff and managing staff attendance. Wards where staffing fell below 75% of the funded establishment are shown within the paper. Detailed context and actions taken to mitigate risk are documented. A staffing escalation protocol is now in operation across all areas within the organisation and			

<table>
<tr><td></td><td colspan="6">assurance of this operating as expected, is provided by the number of staffing incident reports raised through the incident reporting system.</td></tr>
<tr><td>Recommended actions for this meeting:</td><td colspan="6">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="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"></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><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 and DATIX reference)</td><td colspan="6">There was 18 nurse-staffing incidents raised via InPhase during the month of October, of which there was three low physical harm. Four incidents highlighted low psychological harm. St Bedes raised eight incidents relating to HCA staff redeployment from the unit to other areas. Peapod raised four incidents due to insufficient nurses.</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>

Gateshead Health NHS Foundation trust
Nursing and Midwifery Staffing Exception Report
October 2024

1. Introduction

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

Table 1: Whole Trust wards staffing October 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 (%)**
93.4%	**108.2%**	**95.5%**	**100.7%**

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 usually 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 completed in August.

Contextual information and actions taken

Through the month of October Critical Care showed a shortfall in Registered Nursing staff during day shift at 74.8%, they should run with 10 RN on days but there has been less rostered due to increased vacancies, five nurses on maternity, one paternity leave and long term sickness, redeployments of staff should be in post from November.

Sunniside Registered Mental Health Nurse days were 67.6% during October; this was due to RMN vacancy and one nurse working non-clinically. Staffing gaps were mitigated with support from Cragside following real time risk assessment however this redeployment was not captured using the safe care live system, with HCA staff supporting some of the shortfall. Safecare live training is ongoing with the senior nurses, to ensure this is captured correctly.

SCBU Healthcare support worker days report 50.9% fill rates during October. This has been due to significant sickness within the small team, a number of bank shifts were filled to mitigate the risk associated with this.

Ward 28 Healthcare Support Worker nights reported fill rates 64.8%. Ward 28 rostered a number of nights without healthcare support due to the reduced elective activity on selected days of the week, utilising staff efficiently during busier periods. Additionally, when Healthcare staff are rostered they are redeployed to other areas to support shortfall and enhanced care.

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 October are as below:

September 2024	
Registered Nurse Days	**%**
Critical Care Dept.	74.8%
Sunniside Unit	67.6%
Registered Nurse Nights	**%**
N/A	N/A
Healthcare Support Worker Days	**%**
SCBU	50.9%
Healthcare Support Worker Nights	**%**
Ward 28	64.8%

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

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

3. Care Hours Per Patient Day (CHPPD)

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

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

Ward level CHPPD is outlined in Appendix 1. For the month of October, the Trust total CHPPD was 7.8. This compares fairly 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. For example, short notice sickness, staff moves or inability to fill the rota.

There were 18 nurse-staffing incidents raised via the incident reporting system. Four were in relation to Paediatric Emergency Assessment highlighting insufficient staffing, one of which identified as causing Low Physical Harm. Eight incidents were reported by St Bedes. One with low physical harm and three with low psychological harm. One incident was reported by AAA Screening NE, due to sickness nineteen appointments needed to be rescheduled. One was raised by ward 27 due to insufficient nurses for the acuity and dependency of the patients on the ward. One incident was raised by Anaesthetics and Recovery due to insufficient staffing, resulting in delayed breaks. One was raised by ward 9 due to insufficient nurses to provide necessary patient supervision. One incident in SCBU due to insufficient nurses. One incident by Rapid Response due to insufficient nurses. One incident on JASRU was raised due to redeployed staff leaving department with insufficient nurses to manage complex patient acuity and dependency.

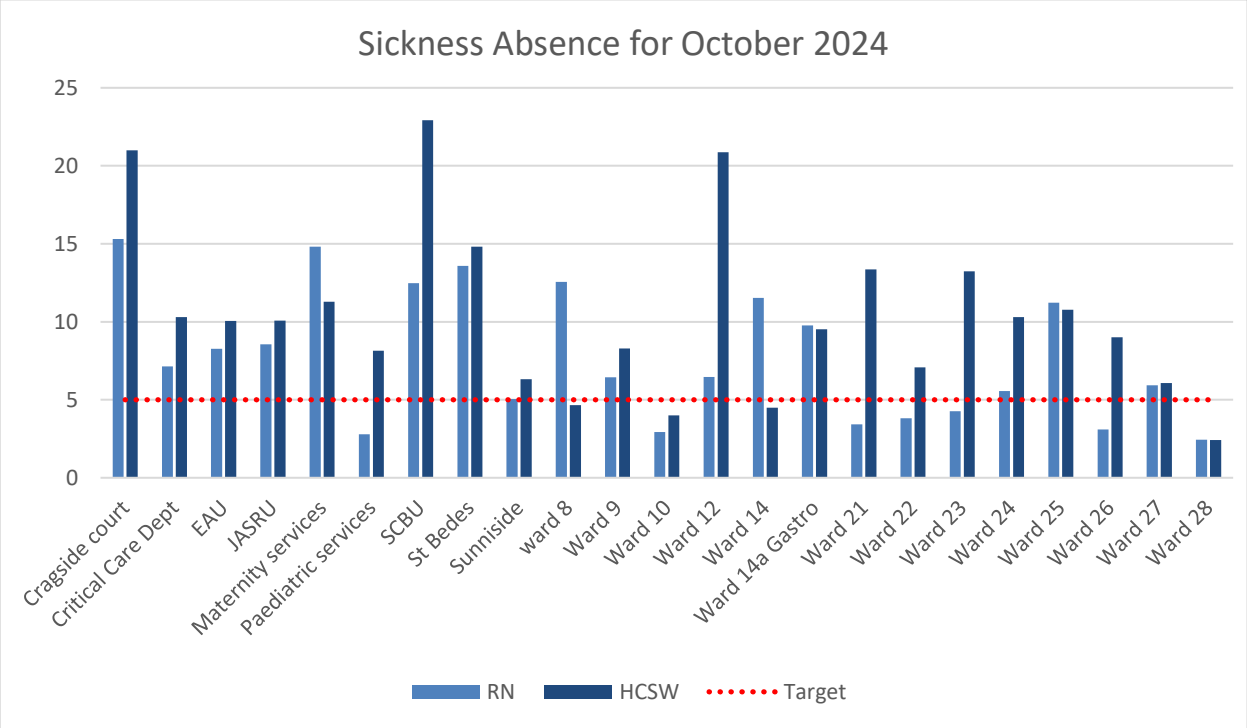
Nursing Red Flags

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 because of rostering practice/shortfall in staffing or by the nurse in charge if they identify a shortfall in staffing requirements resulting in

basic patient care not able to be delivered. Throughout the month of October there were 84 nursing red flags reported. This compares to 61 red flags reported in September. Of those red flags raised Twenty five were in SDEC as patients were cared for in the department overnight, some days saw multiple flags raised due to staff shortages and delays to provision of care. Twelve were on ward 25, nine were in paediatrics, nine were in JASRU, seven on ward 14, five on ward 14a, four were on St Bedes, three on ward 8, three on ward 9, two on ward 12 and one red flag was raised by wards, 21, 22, 23, 24 and the Emergency Department.
There were, however no red flags raised by any of the areas with recorded fill rates below 75%

5. Attendance of Nursing workforce

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



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

8. Recommendations

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

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

Appendix 1- Table 3: Ward by Ward staffing October 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	96.1%	101.2%	85.9%	154.9%	331	6.1	7.3	13.4
Critical Care Dept	74.8%	130.7%	94.3%	100.2%	272	27.2	6.2	33.4
Emergency Care Centre - EAU	77.3%	117.5%	76.9%	122.7%	1416	5.6	4.3	10.0
JASRU	91.0%	90.5%	114.2%	86.6%	613	3.6	4.1	7.7
Maternity Unit	94.6%	107.4%	99.9%	88.7%	664	12.2	4.3	16.5
Special Care Baby Unit	85.8%	50.9%	113.1%	84.0%	205	8.9	2.1	11.0
St. Bedes	85.7%	99.8%	102.2%	75.6%	297	5.1	3.9	9.1
Sunniside Unit	67.6%	147.3%	104.0%	102.0%	307	4.5	4.6	9.1
Ward 08	107.2%	128.8%	93.6%	104.2%	630	3.7	3.7	7.3
Ward 09	107.1%	91.8%	120.9%	93.5%	882	2.9	2.0	4.9
Ward 10	91.0%	126.6%	100.2%	109.4%	770	2.8	3.0	5.8

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Ward 12	78.2%	85.3%	102.4%	107.1%	807	2.4	2.5	4.9
Ward 14 Medicine	114.8%	107.4%	93.2%	97.0%	778	3.1	2.7	5.8
Ward 14a Gastro	106.7%	138.2%	91.7%	146.2%	800	2.9	3.9	6.7
Ward 21 T&O	150.7%	116.5%	108.4%	99.5%	902	3.5	3.0	6.5
Ward 22	102.3%	97.1%	93.0%	77.7%	940	2.6	2.8	5.4
Ward 23	98.7%	96.6%	126.3%	79.7%	731	3.0	3.1	6.1
Ward 24	122.6%	85.5%	83.0%	81.0%	949	2.8	2.6	5.4
Ward 25	102.5%	112.0%	98.7%	86.8%	906	2.8	3.3	6.1
Ward 26	102.8%	109.8%	104.6%	112.1%	889	3.0	3.1	6.1
Ward 27	106.8%	120.5%	97.0%	112.2%	915	2.9	3.2	6.1
Ward 28	93.8%	104.2%	101.9%	64.8%	172	9.3	6.8	16.2
QUEEN ELIZABETH HOSPITAL - RR7EN	**93.4%** ↓	**108.2 %** ↑	**98.5%** ↑	**100.7%** ↓	15176	4.3	3.4	**7.8** ↓

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

	Lead	Type of item	Public/Private	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	Deferred	√	
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	Deferred	√	
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	Deferred		√
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			
Organisational Structure - Clinical Leadership	Group Medical Director	Item for Assurance	Part 1		√	