Board of Directors (Part 1 – Public)

A meeting of the Board of Directors (Part 1 – Public) will be held at 09:30am on 29th January 2025, 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 27 November 2024	Decision	Chair	Paper
5.	09:40	Action log and matters arising	Assurance / decision	Chair	Paper
6.	09:45	Patient and Staff Story – patient experience of women's health clinic	Assurance	Carol Ducker	Presentation
ITEMS FOR DECISION					
7.	10.00	Board Committee Terms of Reference	Decision	Company Secretary	Paper
ITEMS FOR ASSURANCE					
8.	10:10	Chair's Report	Assurance	Chair	Paper
9.	10:20	Chief Executive's Report	Assurance	Chief Executive	Paper
		i) Update on physician and anaesthesia associates letter	Assurance	Group Director of People and Organisational Development	Paper
10.	10:35	Organisational Structure – Clinical Leadership	Assurance	Group Medical Director	Paper
11.	10:50	Governance Reports:			
		i) Board Assurance Framework	Assurance	Company Secretary	Paper
		ii) Organisational Risk Register	Assurance	Chief Nurse	Paper
12.	11:05	Assurance from Board Committees:			
		i) Finance and Performance Committee – December 2024 and January 2025	Assurance	Chair of the Committee	Paper
		ii) Quality Governance Committee – January 2025	Assurance	Chair of the Committee	Paper
		iii) People and Organisational Development Committee – January 2025	Assurance	Chair of the Committee	Paper
		iv) Digital Committee – December 2024	Assurance	Chair of the Committee	Paper
		v) Audit Committee – December 2024	Assurance	Chair of the Committee	Paper
13.	11:25	Board Walkabout Feedback	Assurance	Chief Nurse	Paper
14.	11:30	Finance Report	Assurance	Group Director of Finance and Digital	Paper

No	Start time	Item	Purpose	Lead	Paper / Verbal
15.	11:40	Strategic Objectives and Constitutional Standards Report	Assurance	Group Director of Finance and Digital	Paper
16.	11:50	EPRR Core Standards Self-Assessment Report	Assurance	Group Chief Operating Officer	Paper
17.	12:00	Maternity Integrated Oversight Report	Assurance	Head of Midwifery	Paper
18.	12:10	CNST Maternity Compliance Report	Assurance	Head of Midwifery	Paper
19.	12:20	Nurse Staffing Exception Report	Assurance	Chief Nurse	Paper
20.	12:25	Bi-annual Inpatient Safer Nursing Care Staffing Report	Assurance	Chief Nurse	Paper
ITEMS FOR INFORMATION / MEETING GOVERNANCE					
21.	12:35	Cycle of Business	Information	Company Secretary	Paper
22.	12:40	Questions from Governors in Attendance	Discussion	Chair	Verbal
23.	12:50	Any Other Business	Discussion	Chair	Verbal
24.	12:55	Date and Time of Next Meeting – 9:30am on Wednesday 26 March 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					

Board of Directors (Part 1 – Public)

Minutes of a meeting of the Board of Directors (Part 1) held at 9.30am on Wednesday 27th November 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
Mrs Kris Mackenzie	Group Director of Finance and Digital
Mr Andrew Moffat	Non-Executive Director
Mrs Maggie Pavlou	Deputy Chair / Non-Executive Director
Mr Mike Robson	Non-Executive Director
Mrs Amanda Venner	Group Director of People & Organisational Development
Attendees present	
Mrs Jennifer Boyle	Company Secretary
Mrs Amy Mitchell	Lead Nurse for learning disabilities (24/11/06)
Ms Helen Burn	Specialist Nurse for learning disabilities (24/11/06)
Ms Diane Waites	Corporate Services Assistant
Governors and Observers	
Ms Maxine Duffy	Named Nurse Safeguarding Children
Mrs Helen Fox	Head of Communications and Engagement
Mr Gordon Main	Public Governor – Western Gateshead
Apologies	
Dr Carmen Howey	Group Medical Director
Mrs Hilary Parker	Non-Executive Director

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24/11/01	**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 Governors and observers. Mrs Marshall highlighted that there were a number of items on the agenda for this meeting and asked presenters to take reports as read.	
24/11/02	**Declarations of Interest:**	

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	Mrs Marshall requested that Board members present report any revisions to their declared interests or any additional declaration of interest in any of the items on the agenda.	
24/11/03	**Apologies for Absence:** There were apologies received from Dr C Howey and Mrs H Parker.	
24/11/04	**Minutes of the Previous Meeting:** The minutes of the meeting of the Board of Directors held on Tuesday 24th September 2024 were approved as a correct record.	
24/11/05	**Matters Arising from the Minutes:** The Board reviewed the action tracker as below: • 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 at the last meeting that this would also include any work from the Lord Darzi report. It was agreed that this would be included in the engagement work on the development of the 5 year strategy, rather than through a Board development session. It was therefore agreed to close this action. • Action 24/09/07 relating to sharing the document presented to the local winter group and regional group. This is available to Board members via the Board Reading Room therefore it was agreed to close this action. • Action 24/09/08 relating to amending all Committee Terms of reference in relation to Non-Executive Director attendance to achieve quoracy. The Board were advised that these will be amended as part of the review of all terms of reference through embedding the new governance structure. It was therefore agreed to close this action. • Action 24/09/08 relating to ensuring that the Standing Orders and Scheme of Delegation are updated to reflect changes to Terms of Reference as above. This is scheduled for the January 2025 Board meeting therefore action agreed for closure. • Action 24/09/09 relating to reviewing and updating the wording in the Standard Financial Instructions and Scheme of Delegation around Board approval of national pay awards. This links to action 24/09/08 therefore action agreed for closure as above. • Action 24/09/09 relating to a paper coming back to Board once financial impact of the national pay award is quantified. This is	

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	scheduled for the January 2025 Board meeting therefore action agreed for closure. • Action 24/09/21 relating to circulating the Non-Executive Director Equality, Diversity and Inclusion objective for reference. This has been completed therefore action agreed for closure. • Action 24/09/21 relating to consideration for a Board Development session with network support to agree collective work around Equality, Diversity and Inclusion (EDI). The Board were advised that the December 2024 Board Development session will include a focus on EDI. It was therefore agreed that this action will be closed. 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.	
24/11/06	**John's story:** The Board welcomed Mrs Amy Mitchell, Lead Nurse for learning disabilities, and Ms Helen Burn, Specialist Nurse for learning disabilities, who shared John's patient journey as a 48 year old severely learning disabled gentleman with autism and also presented with obsessive compulsive behaviours. They highlighted some of the difficulties and delays experienced and adjustments required to support the complex needs for John during his patient journey. It was recommended that a home visit would be most appropriate however following the outcome of a multi-disciplinary team meeting, a hospital appointment was recommended which caused further delays. As a result, an In-Phase incident was recorded to highlight the length of time and lack of planning for adjustments to enable John to be seen by the most appropriate team outside of the "standard" pathway. John was eventually seen at home 49 days after his initial referral. Mrs Mitchell and Ms Burn felt that there was further work required to explore alternatives outside of "standard" pathways and the need for increased collaborative working and understanding to ensure further planning around adjustments takes place. Dr G Findley, Chief Nurse and Deputy Chief Executive, thanked Mrs Mitchell and Ms Burn for highlighting the difficulties around adjustments required for patients with learning disabilities and it was accepted that further learning and specialist support was required around complex transitional services. Mr N Halford, Medical Director of Strategic Relations highlighted that emergency healthcare plans are in place however further work is	

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	required around other pathways and ensuring that the relevant multi-disciplinary teams are involved. Mrs J Halliwell, Group Chief Operating Officer, felt that further work was required to ensure that adaptations and reasonable adjustments to standard care models were available and Mrs Mitchell highlighted that the Oliver McGowan mandatory training on learning disability and autism is available however would be beneficial for recommendations to be put in place. Mrs A Venner, Group Director of People and Organisational Development, highlighted that some cultural work was being undertaken with Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, therefore there is an opportunity to work with colleagues across the system to provide support and guidance. There are also plans in place to expand the Learning and Disability team by introducing "champions" across the Trust to support the work. Mrs Marshall thanked Mrs Mitchell and Ms Burn for bringing these issues to the attention of the Board and this will be taken forward. It was agreed that this is a powerful case study to share more widely with colleagues across the Trust to highlight the importance of culture, empowerment and individualisation in appropriately supporting individual needs. Mrs Mitchell and Ms Burn left the meeting.	
24/11/07	**Calendar of Board Meetings 2025/26:** Mrs J Boyle, Company Secretary, provided the Board with the planned Board meeting and Board Development dates for 2025/26. She highlighted that the 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. After consideration, it was: **RESOLVED:** to approve and receive the dates of the Board of Directors' meetings and Board Development sessions to be held in 2025/26.	
24/11/08	**Salary Sacrifice Schemes:** Mrs K Mackenzie, Group Director of Finance and Digital, presented the report which sets out a proposed approach for the re-introduction of salary sacrifice schemes following a hold being in place since May 2024.	

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	Mrs Mackenzie reminded the Board that it was previously agreed to put the leased car and white goods schemes on hold, along with other employee benefit offers, due to the significant increase in National Minimum Wage (NMW) in April 2024. Since the increase, 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. It is now being recommended 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. Mrs Mackenzie highlighted that the Group are working with Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (the scheme provider), to ensure that proactive measures are in place and are already being reported to the Finance and Performance Committee who approved the recommendations at its meeting yesterday. Following a query from Mr A Crampsie, Non-Executive Director, relating to flexibility in the application of the buffer, Mrs Mackenzie explained that the buffer is used as an indicator but each case triggering the buffer would be reviewed on a case by case basis before making any decisions. After consideration, it was: **RESOLVED:** to approve the reintroduction of the Lease Car and White Goods Schemes within the Group in line with the recommendations highlighted within the report.	
24/11/09	**Proposed Constitutional Amendment:** Mrs J Boyle, Company Secretary, presented the report which seeks 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. The proposed amendments were presented to the Council of Governors on 20th November 2024 and approved. Mrs Boyle explained that the Trust has continued to struggle to achieve sufficient public Governor representation within the Eastern constituency compared to over-subscription within the Central Gateshead constituency which has resulted in the loss of two longstanding Governors. The proposed merger should therefore result in increased representation and enable the delivery of the 'holding to account' element of the role as well as increasing the ability to achieve quorum at the Council of Governors. Mrs Boyle highlighted that the approval of the recommendation will result in a by-election within this area and involve an additional financial cost, however at present, the Council cannot	

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	operate effectively with the number of vacancies remaining from the current election. The second amendment proposes the inclusion of Gateshead Healthwatch as an appointed Governor and this 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. This will replace the current vacancy for the Gateshead Diversity Forum which no longer exists. Following discussion, it was: **RESOLVED:** i) to approve a constitutional amendment to merge the Central and Eastern constituencies set out in Appendix 1 of the report. ii) to approve the change to the composition of the appointed Governors from Gateshead Diversity Forum to Gateshead Healthwatch as outlined in Appendix 2 of the report.	
24/11/10	**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 by informing the Board that Dr Gerry Morrow has been appointed as the Trust's new Clinical Non-Executive Director and will commence in post on 1 December 2024 for a three year term. He will be a member of the Quality Governance Committee and Group Audit Committee, as well as being the Board's Maternity Safety Champion. Unfortunately, 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. The report highlights the results of the recent Governor elections and Mrs Marshall congratulated Mr Gordon Main and Dr Andy Lowes on being re-elected for a further term and welcomed our new Governors, Janet Thompson, Mark Learmouth and Carol Hindhaugh. She wished to record the Board's thanks and gratitude to those Governors who will be leaving the Council on 4th January 2024 which includes John Bedlington, Brenda Webb, Ged Quinn and Richard Morrell. Mrs Marshall drew attention to the Star of the Month nominations for September and October 2024 and congratulated the winners. She also congratulated Mr Adam Crampsie, Non-Executive Director, on being named in the Top 100 Influential People list. Following discussion, it was:	

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	RESOLVED: to receive the report for assurance.	
24/11/11	**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 highlighted the areas relating to national policy, context and operating models in particular the Change NHS consultation which is looking at the development of the 10 year plan and will be focussing on the 3 shifts – community, prevention and technology. There will be a Regional launch around this and will inform the work around Place provisions and align to the work plan around the Great North Healthcare Alliance to provide patient centred care. Responses are being collated and are due to be submitted collectively on behalf of organisations by 2nd December 2024. A copy of the response will be circulated to the Board however Mrs Davies explained that further discussions took place at the Finance and Performance Committee in relation to the principles around the transition from hospital to community care and this will be built in to the transformation objective from the Alliance work. In relation to national performance headlines, Mrs Davies drew attention to the maintenance backlog within the NHS and highlighted that this is being looked at locally by Mr G Evans, QE Facilities Managing Director, via the Estates strategy work. Waiting times continue to be a key challenge across the system. Mrs Davies provided the following updates in relation to Strategic Aim 1: *We will continuously improve the quality and safety of our services for our patients* – the results for the Care Quality Commission's 2024 Urgent and Emergency Care Survey have remained static at 7.4% not 8.5% as previously reported however the Trust has still performed well. Mrs Davies highlighted that the Trust's Secondary Prevention Service (lipid management pharmacy service) have won this year's Outstanding NHS Industry Collaboration category at the Bright Ideas in Health Awards 2024 and congratulated the team on their fantastic achievement. In relation to Strategic Aim 2: *we will be a great organisation with a highly engaged workforce* – the Trust hosted its annual Star Awards on 1st November 2024 which recognises the fantastic achievements of our colleagues across the Trust and QE Facilities and the Board congratulated all of the winners and nominees. In relation to Strategic Aim 3: *we will enhance our productivity and efficiency to make the best use of resources* – Mrs Davies highlighted that due to a significant increase in demand for maternity services, the Trust had to take some difficult decisions to manage demand and ensure that our birthing numbers are in line with our capacity to provide safe,	TD

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	quality care. This is being closely monitored and the Trust is working closely with NHS England and regional partners to monitor this. In relation to Strategic Aim 4: w*e will be an effective partner and be ambitious in our commitment to improving health outcomes* – Mrs Davies highlighted that a number of new consultant appointments have been made including in acute medicine and psychiatry and demonstrates that Gateshead is a great place to work and they share our commitment to improving health outcomes. In relation to 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 and there are further opportunities to move into Phase 2 of the development. **Employment Rights Act update** Mrs A Venner, Group Director of People and Organisational Development, provided an update on the Employment Rights Bill which was introduced to Parliament in October 2024. She drew attention to some of the key headlines and explained that there are some fundamental changes proposed therefore the People and Organisational Development team are working through the requirements to ensure that the Trust's policies and procedures are updated as appropriate and staff briefed appropriately. This will be monitored via the People and Organisational Development Committee. After further discussion, it was: **RESOLVED:** to receive the report for assurance.	
24/11/12	**Governance Reports:** **Board Assurance Framework:** Mrs J Boyle, Company Secretary, presented the current Board Assurance Framework (BAF) position which shows the latest updates agreed at each committee meeting. She reported that the updates to the BAF demonstrate that there has been active review and update of the controls and assurances for each strategic risk area however 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. Correlation is also demonstrated 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.	

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	Following a query from Mr A Crampsie, Non-Executive Director, in relation to whether further Board discussions were required around the accountability for the lack of movement in current risk scores, Mrs Boyle explained that this should take place within the Committees to ascertain whether further controls were required. Mrs J Halliwell, Group Chief Operating Officer, highlighted that discussions were taking place around levels of assurance and the requirements around how this can be achieved. Mrs Marshall felt that it was important for all the Board Committees to review the BAF in further detail and provide further feedback when the report is presented back to the Board. After consideration, it was: **RESOLVED:** to receive the report for assurance. **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 September 2024 to 19th November 2024. Dr Findley highlighted that there are currently 18 risks on the ORR which includes no new risks, no escalated risks and four reduced risks. One risk has been removed from the ORR and there have been two closed risks relating to industrial action and delayed transfers of care and increased hospital lengths of stay. This reflects the work that has been taking place with community partners. The Top 3 organisation risks relate to finance, medical staffing and governance structure however Dr Findley explained that the last Executive Risk Management Group was stood down therefore it is expected that the risk relating to the governance structure will be reduced due to the work taking place around the establishment of the Tier 2 Committees. After consideration, it was: **RESOLVED:** to receive the report for assurance.	
24/09/16	**Assurance from Board Committees:** The Board reviewed the Committee escalation and assurance reports which provide improved processes to identify areas of concern and ongoing monitoring of assurances. **Finance and Performance Committee:**	

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	Mr M Robson, Committee Chair, provided a brief verbal overview to accompany the narrative reports following the October 2024 meeting and drew attention to the most recent meeting which took place on 26th November 2024. Mr Robson highlighted that there were three issues identified as requiring alert to the Board which relates to the non-delivery of financial targets however the Committee received some assurances around external mitigations which may see a reduction in the risk to delivery. The Cost Reduction Plan (CRP) also remains challenging and some shortfalls have been identified around the overall delivery however the Committee has been assured that a work plan is being developed which includes recurrent schemes to provide more headroom. The other issue relates to the challenges around delivery of key performance targets including 52 week waits, the 4 hour A&E target, diagnostic waiting times and the number of patients with no criteria to reside however there are signs of improvement. There are some areas subject to ongoing monitoring which includes: • national pay award costs however funding has been received although risk remains around the full year effect. • The Committee received a report which set out the findings and recommendations of PWC from the Investigation and Intervention Audit. It was noted that the outcome was a focus on increased resource into the CRP programme and focussing on recurrent CRP delivery. • The Committee received papers for consideration around the national minimum wage, NHS Provider Selection Regime, Emergency Department Nurse Staffing and received an update in relation to the Healthcall contract. Further discussion will take place around these in Part 2 of the Board however the Committee agreed that the recommendations should be approved by Board. The Committee received positive assurance from the QE Facilities reports and challenges are being addressed. It was noted that there were some gaps in controls within the Board Assurance Framework and it was felt that the objective relating to turnover should be reviewed. **Quality Governance Committee:** Mr A Crampsie, Committee Chair, provided a brief verbal overview to accompany the narrative report following the October meeting. He reported that there was one issue identified as requiring escalation to the Board for further action which relates to the increased demand and capacity issues in providing the service needed for children in care however this was followed up by the representative of the Integrated Care Board at the meeting and Dr G Findley, Chief Nurse and Deputy Chief Executive, reported that a business case has been approved in principle however final sign-off is required by the ICB. An update will therefore be provided at the next meeting.	

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	There are some areas subject to ongoing monitoring which includes: • Deterioration in some of the maternity performance metrics however this is being monitored and will be reviewed at the next meeting. • An issue was escalated to the Committee from SafeCare around training/briefings for coroners on the new Patient Safety Incident Response Framework (PSIRF) and this is being raised with the Integrated Care Board. Dr Findley reported that the ICB has subsequently raised this with the Senior Coroner. Mrs T Davies, Group Chief Executive, highlighted that this has also been discussed with the Alliance and Mr N Halford, Medical Director of Strategic Relations, is working on a collective response. The Committee received positive assurance around the work being undertaken in relation to health inequalities and has been referred to the Gateshead Health Leadership Group for the recommended actions to be considered. **People and Organisational Development Committee:** Mrs M Pavlou, Committee Chair, provided a brief verbal overview to accompany the narrative report following the November 2024 meeting. She reported that there were two issues requiring escalation to the Board relating to the Designated Body and Responsible Officer Annual Board Report and Statement of Compliance which the Committee are recommending approval from the Board in Part 2 of the meeting. The other relates to the increase to the sickness absence rate and the actions from the deep dive report are being taken forward by the People and Organisational Development Steering Group. There are some areas subject to ongoing monitoring which includes: • the Committee received a number of deep dive reports which have identified a trend across a number of themes relating to employees within the age bracket of 20-30. This includes higher incidences of sickness absence due to stress related issues, turnover rates and flight risk. This also linked with issues being raised by resident doctors therefore it was noted that some additional work may be needed to look at this in further detail. • The trajectory for workforce growth is not on target therefore plans are in place to address this. The Committee received positive assurance from the 3A reports from the People and Organisational Development Steering Group and Mrs Pavlou reported that there were no changes to the risks. Further discussion took place around the workforce growth trajectory and Mrs A Venner, Group Director of People and Organisational Development, reported that this linked to the planning submission report in relation to the increased whole time equivalent trajectory against plan	

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	and Mrs T Davies, Group Chief Executive, felt that further work was required to ensure this is linked to finance plans however consideration was required around how this should be presented and this will be discussed further with the Executive Management Team. Mr A Crampsie, Non-Executive Director, felt that further work was required around sickness absence rates particularly those relating to stress and Mrs Venner explained that there were opportunities for further discussions across the Alliance to agree a shared objective relating to occupational health. Mrs Davies highlighted that she has been nominated to take the lead on this work for the Alliance and a meeting is being arranged with Cumbria, Northumberland and Tyne and Wear NHS Foundation Trust. **Digital Committee:** Mr A Moffat, Audit Committee Chair, provided a brief verbal overview to accompany the narrative report following the October 2024 meeting. He reported that there were no issues requiring escalation to the Board however there are some areas subject to ongoing monitoring which includes: • The recent Picture Archiving and Communication (PACs) system outage which has impacted on a number of performance indicators and an assessment is being carried out to identify the full cost and performance impact. The Committee also felt that some cultural issues needed addressing particularly around the delay in recognising the issues within the system. • Some concerns were also discussed in relation to key performance indicators relating to local record management, information data flows and asset registers. Mrs Davies highlighted that this had been raised at the Gateshead Health Leadership Group and support was being implemented to ensure standards are set up to manage performance. **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 appraisal and remuneration recommendations for each executive director, QE Facilities Directors, and the Group Chief Executive which were approved by the Committee. The Committee also agreed to increase the membership of the Committee to include all 7 Non-Executive Directors and this will be reflected in the amended Terms of Reference. There were no risks identified during the meeting.	

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	Mrs Marshall thanked the Committee Chairs for their reports. After consideration, it was: **RESOLVED**: to receive the reports for assurance	
24/11/14	**Finance Report:** Mrs K Mackenzie, Group Director of Finance and Digital, provided the Board with a summary of financial performance for April to October 2024 (Month 7) for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds). Mrs Mackenzie highlighted some of the key points and reported that as of October 2024, the Trust has reported an actual deficit of £5.998m however she highlighted that the planned deficit for 2025/25 has reduced to £7m due to the allocation of £5.317m non-recurring deficit support funding from North East and North Cumbria Integrated Care System to deliver breakeven across the System. The finance team are currently undertaking some modelling work however it is expected that the Trust will achieve the planned deficit of £7m with support from the Alliance partners. After consideration, it was: **RESOLVED:** to receive the Month 7 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.	
24/11/15	**Strategic Objectives and Constitutional Standards 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 7 2024/25. Mrs Mackenzie drew attention to the executive summary and following key areas: Strategic Aim 1: *We will continuously improve the quality and safety of our services for our patients* – the Trust has reported one case of C. difficile in Month 7 and a total of 24 year to date against our annual threshold is 37. Strategic Aim 2: *We will be a great organisation with a highly engaged workforce* – Sickness absence rates remain at 5.6% and continue to be above target levels of 4.9%.	

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	Strategic Aim 3: *we will enhance our productivity and efficiency to make the best use of our resources* – there have been some improvements in the average length of stay and ambulance handovers however there has been an increase to the emergency department 4 hour target although this relates to higher levels of norovirus in the hospital which has impacted on the ability to create flow and to discharge patients earlier in the day. Mrs J Halliwell, Group Chief Operating Officer, highlighted that there has been a national increase in urgent and emergency care activity and a new Tier 3 Group has been set up to monitor activity. The Finance and Performance Committee will also continue to closely monitor performance targets. Strategic Aim 4: *we will be an effective partner and be ambitious in our commitment to improving health outcomes* – improvements in health inequalities will be driven by the Health Inequalities Strategy and plan and are being monitored via the Health Inequalities group and the Digital teams continue to support efforts to reduce digital exclusion by repurposing hardware in 2024/25 and have achieved the target to date. Following consideration, it was: **RESOLVED:** to receive the report for assurance and note the key areas of improvement and challenge.	
24/11/16	**Learning from Deaths 6 Monthly Report:** Mr N Halford, Medical Director for Strategic Relations, provided an update on mortality and learning from deaths over the last six months. He reported that the latest Summary Hospital-level Mortality Indicator (SHMI) was published on 10th October 2024 which covers the period from June 2023 to May 2024 and the Trust has been given a SHMI Banding of 'As Expected' with a score of 1.01. It was noted that a number of changes have been introduced to the SHMI methodology with effect from the May 2024 publication onwards. Mr Halford explained that the Trust routinely triggers cancer alerts however analysis of internal review and scrutiny shows that the majority of cases have received scrutiny by the medical examiner's office and were deemed to be "definitely not preventable and good practice". Further work is also taking place around the backlog of learning disability and severe mental illness death reviews and plans are in place to work through these. Following discussion at the last Quality Governance Committee, some improvements to reporting of mortality review and governance arrangements have been identified and it has been proposed that the reporting going forward will change to three separate reports which will be received quarterly rather than the current six monthly. Following a	

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	query from Mrs Marshall around which reports will be presented to the Board, Dr G Findley, Chief Nurse and Deputy Chief Executive, will review this with Mrs J Boyle, Company Secretary, to ensure this is included within the cycle of business. Mr A Crampsie, Non-Executive Director, felt that further work was required in relation to learning disabilities particularly around training as well as learning from deaths and Mrs T Davies, Group Chief Executive, explained that a service line agreement with Cumbria, Northumberland and Tyne and Wear NHS Foundation Trust has been discussed at the Finance and Performance Committee and some review work is also taking place which will also be reported back to the Quality Governance Committee. Mrs Marshall highlighted that the report continues to refer to the Hospital Mortality Standardised Ratio (HSMR) which is no longer used therefore this will be amended for future reports. After further discussion, it was: **RESOLVED:** to receive the report for assurance.	GF/JB
24/11/17	**Maternity Integrated Oversight Report:** Dr G Findley, Deputy Chief Executive and Chief Nurse, presented a summary of the maternity indicators for the Trust for October 2024. She drew attention to the key performance indicators within the Maternity Dashboard and highlighted that the number of births has decreased to 163 due to the cap however Gateshead women continue to be prioritised and the Quality Governance Committee continue to monitor any incidents to consider if any further measures are required to maintain safety. Mrs J Halliwell, Group Chief Operating Officer, provided an update on declined bookings and indicated that the majority of these had been from Sunderland and Durham after being proactively contacted. Mr A Moffat, Non-Executive Director, felt that it would be useful to include this within the report and Mr N Halford, Medical Director for Strategic Relations, highlighted that a regular quality impact assessment is carried out which can also be reviewed by the Board. Following discussion, it was: **RESOLVED:** to receive the report for assurance.	JH/NH
24/11/18	**Nurse Staffing Exception Report:**	

Agenda Item No		Action Owner
	Dr G Findley, Chief Nurse and Deputy Chief Executive, presented the report for October 2024 which provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls. Dr Findley highlighted that through October shortfalls were reported within Critical Care, Sunniside, Special Care Baby Unit and Ward 28. She explained some of the difficulties moving staff to specialist areas which can impact on the number of beds being managed. Mrs T Davies, Group Chief Executive, reported that some areas had been compensated with clinical support workers which provides assurance that action is being taken to manage the gaps. Following discussion, it was: **RESOLVED:** to receive the report for information and assurance.	
24/11/19	**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.	
24/11/20	**Questions from Governors in Attendance:** No questions were raised from Governors in attendance.	
24/11/21	**Any Other Business:** There was no other business discussed.	
24/11/22	**Date and Time of Next Meeting:** The next meeting of the Board of Directors will be held at 9.30am on Wednesday 29th January 2025.	
Exclusion of the Press and Public:		

Agenda Item No		Action Owner
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
24/11/11	27/11/2024	Chief Executive's Report	To circulate the response submitted in relation to the Change NHS consultation	29/01/2025	TD	Jan 25 – added to Board document library for information. **Action recommended for closure.**	
24/11/16	27/11/2024	Learning from Deaths report	To discuss the recommended changes to the reporting process and agree what the Board should receive to add to the cycle of business	29/01/2025	GF/JB	Jan 25 – agreed reporting months of March, June, September and November. Added to cycle of business. **Action recommended for closure.**	
24/11/17	27/11/2024	Maternity IOR	To provide further information in relation to maternity bookings and review of quality impact assessment	29/01/2025	JH/NH	Capacity and performance are being monitored via the Finance and Performance Committee and impact on safety will be considered further in February EQIA panel.	

Closed Actions from last meeting

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. Nov 24 - It was agreed that this would be included in the engagement work on the development of the 5 year strategy, rather than through a Board development session. It was therefore **agreed to close this action.**	
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	Nov 24 - available to Board members via the Board Reading Room. **Action agreed for closure.**	
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 **Action agreed for closure** as incorporated into the cycle of business for January.	
			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. Added to cycle of business therefore **action agreed for closure**	
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	Nov 24 - links to action 24/09/08 **therefore action agreed for closure as above** Nov 24 - scheduled for the January 2025 Board meeting therefore **action agreed for closure.**	
24/09/21	24/09/2024	WRES and WDES Report	To circulate Non-Executive Director EDI objective for reference	27/11/2024	AM	Completed therefore **action agreed for closure**	

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
			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. Nov 24 – **action agreed for closure**	

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 7

Report Title:	**Terms of Reference**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29 January 2025			
Author:	Company Secretary			
Executive Sponsor:	Chair of the Committee / Chair of the Group Executive Leads			
Report presented by:	Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To ratify the revised terms of reference for the Group Remuneration Committee and the insertion of a new standard clause regarding quoracy across all terms of reference			
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*	Group Remuneration Committee – January 2025 Gateshead Health Leadership Group – January 2025			
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*	When the Group Audit Committee terms of reference were presented to Board for ratification in September 2024, the Board discussed the inclusion of a new clause regarding committee quoracy. The clause was recommended in the model terms of reference included in the HFMA Audit Committee Handbook, namely: *The Committee reserves 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.* The Board supported this as a pragmatic way to address late-emerging quoracy issues and suggested this phrase be included in all Tier 1 Board committee terms of reference. This paper seeks formal approval to include this phrase in the terms of reference for: • Quality Governance Committee; • Finance and Performance Committee;			

	• People and OD Committee; and • Digital Committee The **Group Remuneration Committee** recently reviewed its terms of reference. The Committee approved a change to the membership of the Committee – namely to increase membership to all Non-Executive Directors. The Committee had tried a model with a reduced membership but felt the previous approach had been more effective and productive. Since **Gateshead Health Leadership Group** (GHLG) was first launched in August 2024 a number of agreed changes have been made to the way in which the Group operates. It is important that the terms of reference are periodically updated to reflect these changes. This enables the Group to appropriately discharge its responsibilities and ensure effective alignment between the terms of reference and cycle of business. The latest draft includes the following changes: • Updating the frequency from fortnightly to weekly, with the paper deadlines adjusted accordingly. • Inclusion of the review of the top 3 risks as a standing agenda item each week. • Reducing the review of the ORR to monthly to correspond with the monthly reporting from the Executive Risk Management Group. • Removing the review of the BAF from the remit of Gateshead Health Leadership Group. • Inclusion of the Health Inequalities Group as a group within the governance structure that reports into GHLG.	
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is requested to ratify the Group Remuneration Committee terms of reference (Appendix 1), the Gateshead Health Leadership Group terms of reference (Appendix 2) and the inclusion of the new standard wording regarding quoracy within the terms of reference of the • Quality Governance Committee; • Finance and Performance Committee; • People and OD Committee; and • Digital Committee	
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce
	Aim 3	We will enhance our productivity and efficiency to make the best use of resources

	☒	
	Aim 4 ☒	We will be an effective partner and be ambitious in our commitment to improving health outcomes
	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead
Trust corporate objectives that the report relates to:	Ensuring that there robust terms of reference in place for Board committees should support the seeking of assurance over the delivery of the objectives aligned to the aims.	

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

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

Appendix 1

Tier 1 Committee

Terms of Reference

Gateshead Health NHS Foundation Trust

Group Remuneration Committee

Constitution and Purpose – The Group Remuneration Committee is a formal committee of the Board with delegated responsibility for identifying and appointing candidates to fill all the executive director positions on the Trust Board, Board Member positions on the QE Facilities Board and for determining their remuneration and other conditions of service.

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

Date Adopted / Reviewed	January 2025 – Group Remuneration Committee January 2025 – Trust Board
Review Frequency	Annually
Review and approval	Remuneration Committee
Adoption and ratification	Trust Board

Membership	The Committee shall be appointed by the Trust Board and shall consist of: • Senior Independent Director, who shall act as the Chair of the Committee • Trust Chair • All other Non-Executive Directors on the Trust Board of Directors A Deputy Chair shall be nominated for the Committee.
Attendance	The following will be expected to attend the Committee on a routine basis: • Director of People and Organisation Development, who provides professional advice to the Committee (except on matters relating to their own employment) • Chief Executive (except for matters relating to their own employment) • Company Secretary, who shall be the secretary to the

	Committee.
Meeting frequency and quorum	Meetings shall be called as required but should be held at least twice a year. To be quorate there should be at **least 3 Non-Executive Directors** present (which may include the Chair of the meeting and the Trust Chair). Members and regular attendees are expected to achieve **75% attendance** annually.
Meeting organisation	The Committee shall be supported administratively by the Company Secretary. In accordance with the Trust's Standing Orders, **papers will be circulated to members and attendees six days before the meeting** wherever possible, and no later than three clear days before the meeting, save in emergency. Minutes of the Committee's meetings are held by the Company Secretary and are circulated (alongside the agenda for the following meeting), to members and attendees.

Committee duties and responsibilities	
Positions in scope for this Committee	This Committee is responsible for appointing and setting the remuneration and terms of service for the following positions: • Chief Executive • Chief Nurse • Group Director of Finance and Digital • Chief Operating Officer • Executive Director of People and OD • Executive Medical Director This policy also covers the Board members of QE Facilities (QEF), by way of considering and approving recommendations on pay and appointment from the QEF Remuneration Committee.
Appointments	Undertake a regular review of the **structure, size and composition of the Trust Board** (including skills, knowledge, experience and diversity), making recommendations with regards to proposed changes / future appointments. This should reflect national guidance or requirements such the Board-related provisions of the NHS People Plan. Seek assurance that **robust succession plans** are in place for the positions within the Committee's remit which take into account the challenges and opportunities facing the Group and the skills and expertise needed on the Boards in the future. The Committee is **ultimately responsible for the appointment of the Chief Executive, Executive Directors and QE Facilities'**

	Board Members. As part of this role the Committee should: • Approve the **recruitment plan and timetable**; • Approve the **job description and person specification**; • Assure itself that the recruitment process is **fair and equitable**, considering candidates on merit against objective criteria; and • Ensure that the recruitment process assesses candidates against the **fit and proper person** criteria. The Committee can **appoint external advisers** to facilitate the search and selection process. The Committee must **approve the remuneration and terms and conditions** of new appointees in line with its remuneration role and the remuneration policy. The Committee can **delegate** elements of its appointment role to the appointment panel (e.g. approval of the job description and timetable), but the Committee must **ratify all proposed appointments** recommended to it by the panel. The Committee must seek assurance that the following processes have been completed before an appointee commences in post: • **Pre-employment checks** have been completed, including fit and proper checks; and • **Interests** have been appropriately declared. The Committee must **consider any matter relating to the continuation in office of any Board Executive Director or QE Facilities' Board Member** including the suspension or termination of service of an individual as an employee of the Trust, subject to the provisions of the law and their service contract.
Remuneration	The Committee must establish and keep under review a **remuneration policy**. The Committee is responsible for **appointing any independent consultants** in respect of Director remuneration. In respect of its remuneration role the Committee should have **due regard for any guidance or regulations published by NHS England** in respect of Very Senior Manager (VSM) remuneration and related terms. In accordance with all relevant laws, regulations and Trust policies, **decide and keep under review the terms and conditions of office** of the Trust's Executive Directors and QE Facilities' Board Members, including: • Salary, including any performance-related conditions; • Provisions for other benefits including pensions and cars; • Allowances; • Payable expenses; and • Compensation payments.

	In adhering to all relevant laws, regulations and Trust policies, the Committee should: • Establish levels of remuneration which are sufficient to **attract, retain and motivate Directors** of the quality and with the skills and experience required to lead the Trust and its subsidiary successfully (as outlined in a remuneration policy); • Ensure that any **performance-related elements are stretching and positively benefit the Trust**; • Consider all relevant and current directions relating to contractual benefits; and • Be **sensitive to pay and employment conditions elsewhere in the Trust**, especially when determining annual salary increases. Where individual appointments require the Trust to **seek an opinion** on proposed VSM pay from NHS England, the Committee should **review and approve the submission**. The Committee should seek assurance on an annual basis regarding the **performance of the Chief Executive, Executive Directors and QE Facilities' Board Members (for QEF this may be via reporting from its own Remuneration Committee)** and consider this when reviewing potential changes to remuneration levels. This should include seeking assurance that the performance review process has confirmed that Directors remain '**fit and proper'**. The Committee should consider any **cost of living increases for VSM**s as recommended by NHS England and determine whether they should be locally awarded. To approve any **settlement agreements** prepared by the Trust**.**
Regulatory and governance	To receive for information and assurance **Internal Audit reports** pertaining to the remit of the Committee. To receive for information and assurance any **reports from external reviews** pertaining to the remit of the Committee. To review any material **emerging regulatory guidance / requirements** in relation to Very Senior Manager remuneration and appointment matters on behalf of the Board.

Reporting and monitoring	
Reporting	The Committee shall report to the Board of Directors after each meeting of the Committee. In the case of remuneration matters, this report will be restricted to the reporting that decisions have been made by the Committee and that the manner of making them was in accordance with the Committee's terms of reference and delegated

	powers. The Trust's annual report will include sections describing the work of the Committee including its remuneration policies, details of the remuneration paid to Directors and the process it has used in relation to the appointment of Directors.
Reportable Groups	The QE Facilities' Remuneration Committee will make recommendations to the Group Remuneration Committee on any matters relating to the remuneration, appointment, terms and conditions or performance of the Board Members of QE Facilities.
Monitoring	Compliance with the terms of reference will be reviewed via an annual self-assessment. This will inform any proposed revisions to the terms of reference and the cycle of business. The outcome of the effectiveness and terms of reference review is presented to the Board of Directors following considered by the Committee.

Appendix 2

Terms of Reference

Gateshead Health NHS Foundation Trust

Gateshead Health Leadership Group

Constitution and Purpose – The Gateshead Health Leadership Group (GHLG) is an executive level group with responsibility for oversight of the Tier 2 Groups and cross-cutting subject-specific groups within its remit. The GHLG has responsibility for seeking assurance over the work of these groups and providing assurance or escalating issues through to the Tier 1 Board Committees.

The Group is chaired by the Chair Executive and is the body responsible for overseeing the management of an effective system of governance, assurance, strategic delivery, risk management and internal control across the Trust and QE Facilities' activities (both clinical and non-clinical). It is the formal route to support the Chief Executive in effectively discharging their responsibilities and duties as Accounting Officer.

The GHLG is accountable to the Board of Directors.

Decisions of the Group shall be taken by members on a majority basis. All members of the Group have an equal vote, with the Chair of the meeting holding the casting vote in the event of a tie.

Date Adopted / Reviewed	January 2025
Review Frequency	Annually
Review and approval	Gateshead Health Leadership Group – January 2025
Adoption and ratification	Board of Directors – January 2025

Membership	The Group shall consist of: • Group Chief Executive, who shall chair the Group • Group Chief Nurse / Deputy Chief Executive, who shall act as the Deputy Chair • Group Medical Director • Group Director of Finance and Digital • Group Chief Operating Officer • Group Executive Director of People and Organisational Development • Group Director of Communications and Strategy • QE Facilities Managing Director • Medical Director of Strategic Relations • A clinical representative from the leadership team of each division (i.e. the Associate Medical Director or Associate Director of Nursing / Senior Clinician for Clinical Support and Screening). The clinical representative should be

	nominated by the divisional leadership team and agreed with the relevant Executive Director lead. This will rotate on an annual basis. The Chief Executive chairs the GHLG as it is their core forum for seeking assurance and holding to account from their team. The Executive Directors form the core members of GHLD as they chair the Tier 2 group meetings and are ultimately accountable and responsible for clinical and non-clinical divisions and decision-making within the Trust / QE Facilities. The inclusion of a clinical representative from the leadership teams of each of the divisions as a formal voting member of the Group supports the core principle of the organisation being clinically-led and management supported. Deputy Directors are expected to attend when Executive Directors have provided apologies in advance. Votes from clinical representatives are not transferrable in their absence.
Attendance	The following will be expected to attend the Group on a routine basis: • Directors of Operations for each of the 3 clinical divisions • Associate Medical Directors for each of the 3 clinical divisions* • Associate Directors of Nursing for Medicine / Community and Surgery* • Senior Clinician for Clinical Support and Screening (Chief Pharmacist)* • Company Secretary **Noting that one clinical representative from each division is a formal voting member, as outlined in the Membership section.* The divisional leadership teams are formal attendees to support clinically-led decision-making and ensure that the clinical voice / views are represented in all discussions. Note that their status as attendees (rather than voting members) does not detract from the importance of their views at this meeting. The Company Secretary attendees to provide governance-related advice and input, ensuring effective flows of assurance through the governance structure. Attendees are not required to send deputies in their absence, given that other members of the divisional leadership teams will be in attendance. Other members of staff may be invited to attend meetings depending upon the issues under discussion.
Meeting frequency and quorum	Meetings shall be held weekly.

	To be quorate there should be **at least 6 members present**, including: • **At least 3 Executive Directors** - one must be either the Chief Nurse, Medical Director or Chief Operating Officer (i.e. clinical – to ensure the principles of clinically-led are in place). • **At least 1 clinical divisional member** must be present Members and regular attendees are expected to achieve **60% attendance** annually.
Meeting organisation	The Group shall be supported administratively by the Corporate Office, who shall record the minutes and circulate meeting dates, agendas and papers to members and attendees. A decision log will be maintained and used by members and attendees to communicate the key outputs of the meetings to departments and teams. **Papers will be circulated to members and attendees three days before the meeting** wherever possible, and no later than two clear days before the meeting, save in emergency.

Group duties and responsibilities	
Assurance reporting from Tier 2 and cross-cutting groups	To receive 3A (alert, advise, assure) assurance reports from the chairs of the following groups on a monthly basis: • Operations Oversight Group • Clinical Strategy Steering Group • Safecare Steering Group • Digital, Data and Technology Steering Group • Financial Planning, Performance and Assurance Group • People and OD Steering Group • Health and Safety Group • Health Inequalities Group • Sustainability Group • Executive Risk Management Group • Cancer Group • Mental Health and Learning Disability Group • Policy Review Group These assurance reports will be in the 3A RAG-rated format (alert, assure, advise), supported by exception reporting where relevant. This ensures that the GHLG is sighted on key assurances and issues across the whole governance structure, which may then require reporting to Tier 1 Board committees or the Board.
Strategy and planning	The GHLG will support the development of the **Annual Plan** (and associated business plans) and play a key role in developing and **implementing the overall strategy** of the Trust. The GHLG will seek assurance that process for the development of the annual plan is robust

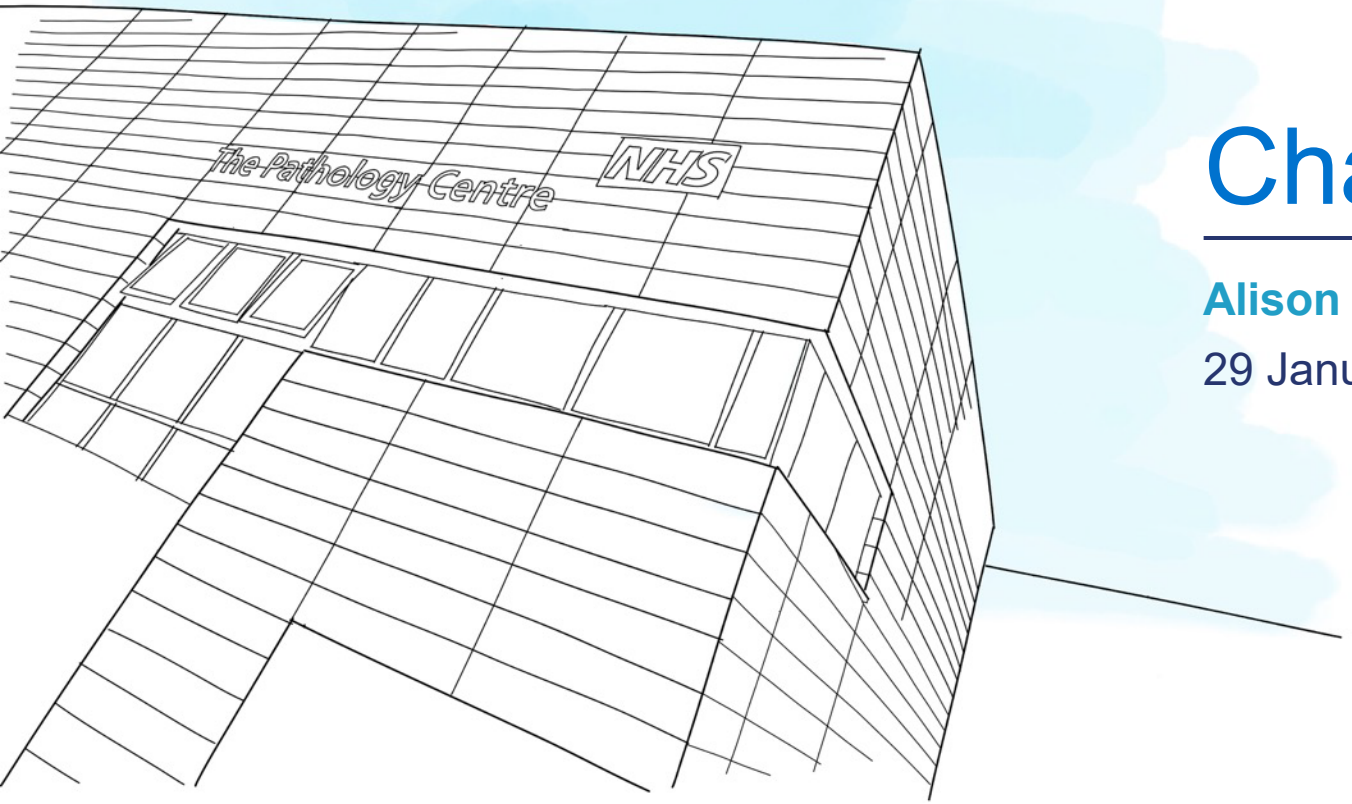
	and that the plan is coherent and consistent across all elements (performance, workforce and finance). In accordance with the Scheme of Delegation GHLG has delegated responsibility for the **approval of in-year changes to the capital spending plan where this equates to less than £1m.** In addition, the GHLG will receive assurance reports showing **in-year monitoring of spend against the approved capital plan**, including the risk of scheme under or over spends (as outlined in the Standing Financial Instructions para 32.4.2). The GHLG will, via the relevant Tier 1 Board Committee make **clear recommendations to the Board on key strategic decisions** which are reserved for the Board under the Scheme of Delegation. The GHLG will review **emerging strategic opportunities, risks and threats** which are brought to its attention by members / attendees or those groups which report directly into it (for example through receiving feedback from attendance at external meetings). As part of this role, the GHLG will seek to ensure that effective arrangements are in place to manage key partnerships and stakeholder engagement. The GHLG will receive for assurance an **exception report detailing agency expenditure above the published price cap** which has been approved in accordance with the Scheme of Delegation. The GHLG will review and approve / reject **business cases** recommended to it by those groups which report directly into it (in accordance with the delegations outlined in the Scheme of Delegation – i.e. revenue and capital business cases less than £1m). The GHLG will **approve / reject all tenders to bid for services** prior to submission (in accordance with the Scheme of Delegation Section 7).
Risk	GHLG will note the **top 3 risks** as agreed at Executive Risk Management Group at the beginning of each meeting. This will help frame discussions on later agenda items, being mindful of the need to seek to manage and mitigate these significant risks. Identification and agreement of **emerging reportable issues** which requiring reporting to the Board (as part of the reportable issues log) or to external regulators. The GHLG will review the **Organisational Risk Register (ORR)** monthly. This will be appended to the 3A report drafted following each Executive Risk Management Group meeting.
Performance	Through bringing together the work of its reportable groups, the GHLG will have a **collective focus and understanding of the performance** of the

	Group and will review the Leading Indicator report in this context. The GHLG will ensure that there is collective and individual responsibility and accountability for delivering operations, required performance and addressing current and emerging risks to maintaining successful delivery. This includes consideration of financial performance at every meeting. The GHLG will receive assurance and have oversight **of Care Quality Commission (CQC) preparedness** and to ensure subsequent actions are effectively embedded.
Policies	The GHLG will receive **policies** recommended to it from the Policy Review Group for ratification. The GHLG will receive a report on **overdue policies** as part of the monthly 3A reporting from the Policy Review Group.
Regulatory and governance	The GHLG will receive all **Internal Audit reports** and ensure that related audit actions are completed in line with agreed timescales and communicated to Internal Audit by reviewing the audit action report on a monthly basis. The GHLG will receive all **External Audit reports** and ensure that related recommendations are implemented in line with agreed timescales, supporting the strengthening of the control environment. To receive for information and assurance any **reports from external reviews** pertaining to the remit of the GHLG. The GHLG will discuss **feedback following each Trust Board, Council of Governors and Tier 1 Board committee** meeting, focussing on items of escalation or where additional risks have been identified. To review any material **emerging regulatory guidance / requirements** in relation to the remit of the GHLG and advise / make recommendations on the actions required to implement / comply.

Reporting and monitoring	
Tier 2 meetings / groups	The following Tier 2 meetings and other cross-cutting groups report into the Group: • Operations Oversight Group • Clinical Strategy Steering Group • Safecare Steering Group • Digital, Data and Technology Steering Group • Financial Planning, Performance and Assurance Group • People and OD Steering Group • Health and Safety Group

	• Sustainability Group • Executive Risk Management Group • Cancer Group • Mental Health and Learning Disability Group • Policy Review Group • Health Inequalities Group The 3As summary of assurances and escalations document are received by the Group as part of the flow of assurance through the Trust's governance structure.
Reporting	The GHLG is accountable to the Trust Board and its Tier 1 Board Committees. Assurances, risks and issues from the GHLG will be presented by the CEO to the Trust Board as part of the Chief Executive's update report (parts 1 and 2, depending upon the content). In addition Executive Directors will present 3A assurance reports to their respective Tier 1 Board committees. The reports will encapsulate the key assurances, risks and issues from the Tier 2 groups, supplemented by any additional relevant points from the GHLG.
Monitoring	Compliance with the terms of reference will be reviewed via an annual self-assessment. This will inform any proposed revisions to the terms of reference and the cycle of business. The outcome of the effectiveness and terms of reference review is presented to the Board of Directors.

Gateshead Health
NHS Foundation Trust



Chair's Report

Alison Marshall, Chair of the Board of Directors

29 January 2025

Board updates and engagement

Board of Directors

- We were delighted to welcome Dr Gerry Morrow, Clinical Non-Executive Director, to the Board of Directors from 1 December 2024, as referenced in the last Chair's report. The Financial Non-Executive Director post will be re-advertised shortly and we will be seeking individuals with significant NHS finance experience.
- Our Board of Directors met with the Boards of Newcastle, Northumbria and North Cumbria Trusts at a Great North Healthcare Alliance (GNHA) leadership event in December 2024. This provided a valuable opportunity to come together to reflect on the GNHA's progress to-date, future opportunities and key workstreams.

Engagement

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

- Visit to Maternity to celebrate the CQC patient survey results
- Chaired Alliance Steering Groups
- Alliance Leadership event
- Alliance meeting with the ICB
- ICB Chair and Foundation Trust Chairs' forum
- Medicine for Members event on Living Well
- Governor workshop
- Light up a Life event with Gateshead Health Charity
- Board development day
- NHS Providers' Chair and Chief Executive network meeting
- Christmas decoration competition across the Trust
- Regional workshop to discuss NHS operating model

Governor and Member Updates

Gateshead Health NHS Foundation Trust

- We were delighted to **welcome our new and returning Governors** on 5 January 2025. Full details of the election outcome were included in the last Chair's report to the Board in November 2024.
- Following Board and Council approval the public constituencies of Central and Eastern Gateshead have now been merged to become **Central and Eastern Gateshead**. An election will commence in early February 2025 to fill the three vacant seats that remain in the newly merged constituency.
- In addition, the election company will be performing a **data cleansing process** to ensure that our membership database is accurate and up-to-date for this new constituency. The benefits of the exercise is that we will have an up-to-date membership database and we can be assured that it accurately reflects those who wish to be current members and want to receive communications and opportunities to engage with the Trust. Other public constituencies will be cleansed during the next round of elections. Postal members in Central and Eastern Gateshead will be contacted to confirm whether they would like to remain as members.
- Our **Governor Remuneration Committee** members have been working with counterparts at Newcastle and Northumbria Foundation Trusts to start the planning process for the recruitment of the Shared Chair across all three Trusts. This will be a Governor appointment, with support from the Senior Independent Directors and Company Secretaries at the three Trusts. Further information on the Shared Chair appointment can be found within the Chief Executive's report.
- We held a **Medicine for Members** event on 9 December with a focus on 'Living Well'. Attendees could choose between small group sessions on physiotherapy and exercise, nutrition and diet, stop smoking and the menopause. We have received positive feedback from attendees and will be looking to hold our next event in early March on the theme of long-term conditions.
- A quarterly **Governor workshop** was held in January 2025. This included an informative presentation on the Integrated Care Board (ICB) and its work at Gateshead place level. This was delivered by Kirsty Sprudd, Deputy Director of Delivery for Newcastle and Gateshead. Governors also received an insightful presentation from Hilary Parker on the role of the Non-Executive Director.

Star of the Month Nominations

November

- Susan Easthaugh
- Tyler Harrison
- Ian McDonald
- Molly Duncan
- Ammar Rabeh
- Matthew Brooksbank

December

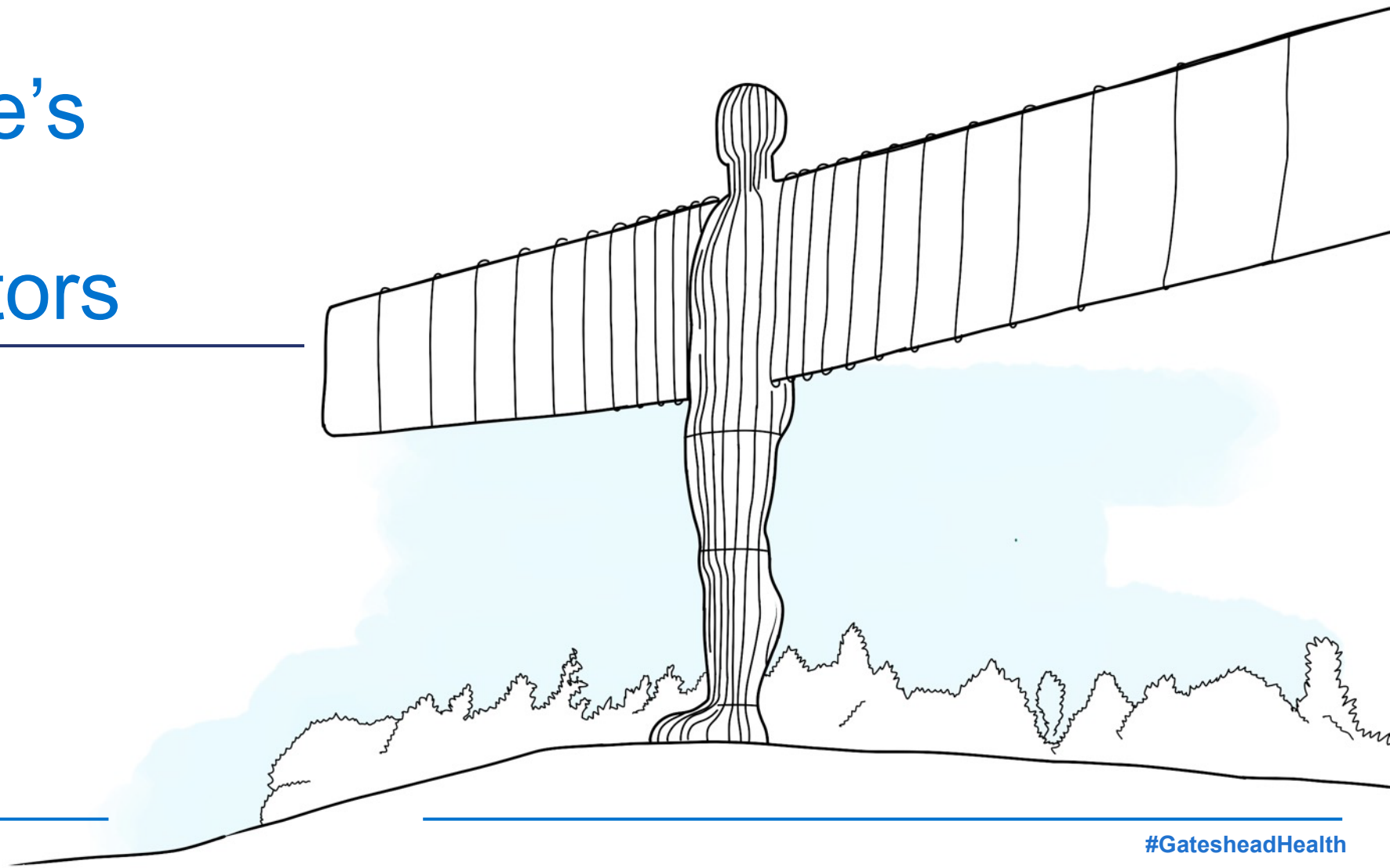
- Steph Livingstone
- Magda Jazeri
- Molly Adamson

You're a Star Winner

Abby Corkindale (October)

NHS
Gateshead Health
NHS Foundation Trust

Chief Executive's Update to the Board of Directors



Trudie Davies, Chief Executive

29 January 2025

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

Gateshead Health NHS Foundation Trust

- At the end of November 2024 we were named as the **top provider of maternity care in England according to the 2024 Care Quality Commission (CQC) patient survey**. This is a significant achievement that reflects the dedication and hard work of our maternity colleagues. In the survey we received outstanding scores in key areas including:
  - Antenatal support – new parents praised the comprehensive information and guidance provided
  - Labour and birth – patients commended the supportive and respectful environment, with positive comments on how well colleagues work together to support patients
  - Postnatal care – praise was received for the commitment to wellbeing, offering support to mothers and their newborns in the early days and weeks.
- We were delighted to receive the **Gold National Joint Registry (NJR) Quality Data Provider Award for 2024**. The scheme recognises providers that excel in promoting patient safety standards through their compliance with the mandatory NJR data submission quality audit. The NJR collects data on hip, knee, ankle, elbow, and shoulder joint replacement surgery and monitors the performance of joint replacement implants.
- We were delighted that Dr Su Ann Tee and the Secondary Prevention Service won the **Outstanding NHS Industry Collaboration award** at the Bright Ideas in Health Awards. The project provided personalised care for patients to help identify and review risk factors contributing to their condition, shortly after an adverse event. The work supports people in achieving cholesterol, diabetes, and blood pressure targets and stopping smoking using approved medical therapies.

Engagement, involvement and visits:

- Visits across the hospital site including SDEC, PeaPod, St Bede's, Maternity and Ward 22.
- Team Brief
- Clinical Strategy Group

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

- We recognise that the current challenging operating environment is very difficult for colleagues. We are continuing to focus on our **health and wellbeing resources**, ensuring that they are accessible to staff. This has included changing our counselling service to be available for members of staff with work-related issues. Referrals for all other reasons will now be signposted to alternative and more specialised services. This should support us to be able to provide staff with more responsive and appropriate access to our counselling service, reducing waiting times.
- With regards to staffing levels, we remain overstaffed on registered nurses. We are currently in the process of recruiting Healthcare Assistants to maintain patient safety. Our sickness absence rates have increased slightly to 5.7% which continues to be above target levels of 4.9%.
- As CEO for Gateshead Health I am the regional and collaborative lead for workforce, both in terms of workforce development and the medium term financial plan. This brings early insight for the Trust and we note the importance of working in collaboration with our partners on the workforce agenda.
- We have continued our focus on **leadership and culture**, committing to create an inclusive, open, honest and transparent culture. A Board development session was held on equality, diversity and inclusion. This included time for our Global Ethnic Majority (GEM) Network members to share how it feels to work here, enabling us to develop a deeper understanding of issues and a meaningful plan on how to address them.
- We were recently awarded the **Better Health at Work: Continuing Excellence Award**. This reflects the ways in which we listen to colleagues through various feedback channels and the range of health and wellbeing resources which are offered. Next year we will be seeking to achieve the next level – Maintaining Excellence Award.
- Gateshead Health's Advanced Clinical Practitioner (ACP) in Emergency Medicine, Andrea Swingler has worked in the Trust for nearly four years and has recently achieved the **RCEM Advanced Clinical Practitioner credential** from the Royal College of Emergency Medicine (RCEM). She is the first qualified RCEM at Gateshead Health and this is a fantastic achievement. As we train more ACPs, they will follow the RCEM process to demonstrate they can look after patients with minor or major injuries, life threatening illness and injuries. This sets a high bar for advanced practice and emergency medicine, ensuring the team is providing high-quality care for our patients.

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

- Colleagues have been working in challenging circumstances over December and January, with **extremely high demand** coupled with **high levels of flu and norovirus**. Patient and staff safety have remained our top priority. A key concern for us all has been long waits in A&E or long waits in unsuitable accommodation. Our clinical leaders also raised these concerns and we took a number of steps to respond quickly to these concerns.
- The processes and systems we have put in place seek to avoid these waits as much as possible. This includes ensuring the longest wait time of patients is fully described in each bed meeting, ensuring that patients waiting in ambulances remains a red line for us and ensuring that our senior leadership team attends and supports extraordinary patient flow meetings during times of pressure.
- On New Year's Eve some new processes were introduced and we were able to discharge 171 patients in 48 hours – an achievement which attracted national attention.
- There have been some excellent examples of our teams working effectively together to prioritise patient safety and patient flow during these challenging times. This has included our pharmacy team who have been working hard to proactively write discharge prescriptions to maintain patient flow and timely discharge. Effective team work enabled us to reduce bed numbers on our winter escalation ward (ward 11) and protect Same Day Emergency Care (SDEC) for its intended use rather than utilising this as a facility to bed patients overnight. Ward 11 has been open during the period of pressure (although our aim is always to keep it closed whenever possible) and we would like to record our thanks to colleagues for covering this.
- The situation remains pressured, although we are seeing improvements for our patients and colleagues and we continue to engage with clinical colleagues to seek feedback and implement actions, such as developing an area outside of the A&E to support people who do not require admission but who cannot return to their place of residence.
- Further information on our performance is included within the Strategic Objectives and Constitutional Standards Oversight report.
- The **annual planning process** is commencing, with the full national guidance expected to be published on 28 January. We know that the financial settlement in particular will be challenging and there will be a significant emphasis on efficiency and productivity. We have already been asked to consider what difficult decisions on service provision may need to be made in order to achieve financial balance.
- We will be working closely with Great North Healthcare Alliance (GNHA) partners to ensure that collectively we develop plans that enable us to deliver safe and equitable services for our patients.

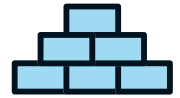
Strategic Aim 4: We will be an effective partner and be ambitious in our commitment to improving health outcomes

- In December we worked with local partners to bring a **mobile women's health service** to various locations across the Gateshead area. The service is being developed as part of the Gateshead Women's Health Hub with the bus provided by Newcastle GP Services. The bus provides a number of services to women and girls such as menopause support, cervical screening, gynaecological care and contraception.
- Our **Homelessness Nurse Practitioner**, Angela Weeks, was given the prestigious title of Queen's Nurse (QN) by community nursing charity The Queen's Nursing Institute. This demonstrates Angela's commitment to high standards of patient care, learning and leadership, as well as a real focus on addressing health inequalities in our local community.
- Over the festive period we were delighted to welcome colleagues and partners providing some festive cheer to the QE hospital. Patients, visitors and colleagues enjoyed performances from our own band and choir, Newcastle College's Musical Theatre students, Lobley Hill Primary School choir and a special appearance from TV presenter and architect George Clarke who switched on our Christmas tree lights. The lights switch-on was part of our Light Up a Life remembrance service to honour and celebrate the lives of loved ones who have passed away, in partnership with our Gateshead Health Charity.

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



NHS
Gateshead Health
NHS Foundation Trust

- The **Great North Healthcare Alliance (GNHA)** partners have continued to meet since the last Chief Executive's report. We have considered and agreed on the proposal to move towards a **shared Chair** across Gateshead, Newcastle and Northumbria. This is an excellent opportunity to work more closely in the future and benefit from our collective expertise and influence.
- The process of designing the mechanism to appoint and secure a shared Chair commenced in December with Governors from all three Trusts meeting together for the first time. The appointment of the shared Chair will be a Governor appointment, in line with the Provider Code of Governance.
- Our Chair, Alison Marshall, ends her second term with us on 30 September 2025. Governors have approved the option to extend Alison's term for up to 12 months to support the transition, should this be needed. This is an exciting opportunity for Gateshead, providing cohesive leadership at the most strategic level, which in turn should support effective patient pathways, better patient outcomes/experiences and reducing health inequalities, as well as the sharing of best practices and technologies.
- Work is commencing on the **development of our 5-year strategy**. Our Medical Director for Strategic Relations and Director of Strategy and Partnerships will be leading on this work, and an outline plan for the development of the strategy has been created and shared with our clinical colleagues. This is part of our commitment to be clinically-led and management-supported.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 9i

Report Title:	**Physician Associates and Anaesthesia Associates Update**			
Name of Meeting:	Trust Board			
Date of Meeting:	January 2025			
Author:	Carmen Howey, Medical Director 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:** ☒
	Enter purpose here			
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*	Letter received from NHS England in December 2024 to announce an independent review of physician associates (Pas) and anaesthesia associates (AAs) ahead of the GMC regulation of the roles from 12.12.24. Position statement: We don't employ PAs or AAs at Gateshead and that we would not look to employ any at least until this review is published when we would consider as part of our wider Medical Workforce Strategy. We have considered utilising these roles on a number of occasions previously via the Medical Workforce group and have agreed they were not in line with our medical workforce strategies at the time.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	Board are asked to the note the update for information.			

Trust Strategic Aims that the report relates to:	**Aim 1** ☐	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust strategic objectives that the report relates to:	SA2.2: Growing and developing our workforce				
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	4525 - 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				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

To:
- NHS trusts and integrated care boards
  - medical directors
  - chief people officers
- Primary care networks

cc.
- NHS trusts and integrated care boards
  - chief executives

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

2 December 2024

Dear colleagues,

Update on physician associates and anaesthesia associates

We are writing to update you following the Secretary of State for Health and Social Care's announcement of an independent review of physician associates (PAs) and anaesthesia associates (AAs) and ahead of the General Medical Council (GMC) regulation of these roles from 13 December 2024.

Scope of the government's evidence review

While we have always been clear that PA and AA roles are not replacements for doctors but are there to support doctors in their work, there are clear and ongoing concerns that we are listening to carefully and taking action to address. We welcome this independent review. It marks our pledge, together with the government, to getting this right.

It's only correct that where there are concerns, they are investigated, and it's essential that we establish and assert the evidence base. This is important so we learn from all the available evidence to protect patient safety and staff welfare, as well as maintain public and professional confidence.

We are pleased that this review will gather insight from across the NHS, hearing from hospital teams, patients, professional bodies and academics so that we have the evidence we need to find a way forward that is right for patients and our staff.

Support for colleagues working as PAs and AAs

We know that PAs and AAs come to work every day wanting to do their best for patients, just like any other staff member, and we see them as valued members of the NHS team who deserve support, care and respect.

We expect employers to continue to support their PA and AA workforce and to adhere to NHS England's existing guidance on the deployment of medical associate professions in NHS healthcare settings.

Regulation by the GMC

We have been clear that regulation of healthcare professionals is fundamental to a safe and effective workforce. We welcome the progress that will see the General Medical Council (GMC) begin to regulate the AA and PA roles from 13 December this year, which will help to strengthen patient safety, professional standards and accountability.

We strongly encourage PAs and AAs currently practising in England to join the GMC register as soon as possible once regulation starts. This will underpin continued safe and effective practice.

The GMC has previously confirmed that a 2-year transition period will commence when regulation starts. This will enable already qualified PAs and AAs to continue to work while their registration applications are completed and processed.

From December 2024 onwards, anyone graduating and passing the necessary examinations to qualify as a PA or AA should join the GMC register prior to employment. Working with the GMC, we will provide clear and timely guidance on this requirement for current students and education institutions.

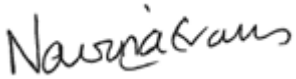
Future expansion of the use of AA and PA roles

There are over 3,500 PAs and around 100 AAs working alongside over 180,000 full-time equivalent doctors and GPs in the NHS in England.

The future of the NHS will need a larger medical workforce, supported by and working with multidisciplinary teams across a range of professions to deliver high-quality care for patients. This review has come at the right time as we look at how our workforce plans align with the delivery of the forthcoming 10 Year Health Plan.

NHS England will collaborate fully with Professor Leng as she carries out this important work, and we look forward to its conclusions.

Yours sincerely,



Professor Sir Stephen Powis
National Medical Director
NHS England

Dr Navina Evans CBE
Chief Workforce, Training and Education Officer
NHS England

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 10

Report Title:	**Clinical Leadership Review**			
Name of Meeting:	Trust Board			
Date of Meeting:	29/01/2025			
Author:	Carmen Howey Group Medical Director			
Executive Sponsor:	Carmen Howey, Group Medical Director			
Report presented by:	Carmen Howey, Group Medical Director			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	This paper is intended to provide assurance and information regarding Clinical Leadership investment in the organisation to ensure that our clinical leaders have the skills, time, capacity, supporting structures and expertise to deliver in a Clinically Led, Management Supported organisation.			
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*	Presentation shared at Clinical Strategy Group 4th December 2024. Paper presented to GHLG 09/01/25.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	In order to embed the organisational ethos of "Clinically Led, Management Supported" it was identified that there needed to be a review of the medical clinical leadership within the organisation with a focus on the roles of Clinical Leads, SafeCare roles and AMDs. This work was initiated through the reformed Clinical Strategy Group in July 2024 and progressed through engagement with the clinical leaders across the divisions. It was recognised that clinical leaders needed the following in place in order to deliver the benefits of a clinically led, management supported organisation: • Structure and Governance • Time and Capacity • Training and Capability			

<table>
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- Expert support

This paper describes how each of those elements will be addressed going forwards.

Key benefits of this should include greater clinical engagement with and effective participation in decision making across a range of matters.
</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 members are asked to consider the following:

The principles of the reviewed and refined Job Descriptions for Clinical Lead roles and the restructuring of these in line with our organisational restructure, governance and clinical priorities.

The financial investment to the Clinical Leadership model as a way to give time and capacity to the Clinical Leaders.

The Clinical Leadership development programme as a way to provide skills, training and therefore capability to or Clinical Leaders.

The use of expert support from corporate services and Divisional Business Partners embedded as part of a servant leadership model.

The governance and review processes.</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>
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<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
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<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="6">n/a</td></tr>
</table>

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

Clinical Leadership Review

Background

In order to embed the organisational ethos of “Clinically Led, Management Supported” it was identified that there needed to be a review of the medical clinical leadership within the organisation with a focus on the roles of Clinical Leads, SafeCare roles and Associate Medical Directors.

This work was initiated through the reformed Clinical Strategy Group in July 2024 and progressed through engagement with the clinical leaders across the divisions with initial feedback shared in the September CSG Away Day where a plan for investment in clinical Leadership was outlined and a final proposal presented at the December CSG Away Day.

GHLG and Trust board have received verbal updates on the progress of this work as it has progressed.

It was recognised that clinical leaders needed the following in place in order to deliver the benefits of a Clinically Led, Management Supported organisation:

- Structure and Governance
- Time and Capacity
- Training and Capability
- Expert support

Structure and Governance:

Findings:

The Job Descriptions for Clinical Leads, AMDs and Safecare lead roles did not reflect the new organisational structures with some inconsistency across Divisions and lack of clarity in relation to the roles.

Actions:

- Refreshed Clinical Lead job descriptions focussed on clinical leadership, working in partnership with the SLM and Matron to achieve service delivery and improvement and to ensure the professional line management of medical staff is clear. Clear reference to contributing to collective decision making within CSG. Allowance for Clinical Lead roles to be fulfilled by AfC staff where this is the best model of leadership for a service.
- Refreshed AMD job descriptions focussed on their expert roles and responsibilities with clear reference to contributing to collective decision making at CSG.
- Significant changes to the AMD Cancer job description recognising the importance of clinical leadership to our Cancer services.
- Significant changes to the AMD Safety and Quality job description recognising a need to devolve activity to the Divisions and increase SafeCare capacity across the Divisions in a way which is equitable.
- Significant changes to the Divisional SafeCare Lead Job Descriptions and allocation of distinct Safecare Lead time to services where this was a gap to reflect the devolution of activity as described as above.

Time and Capacity:

Findings:

The Clinical Lead role is an important one but there was agreement across clinical leads that there is not a one size fits all approach to the time that is required for this role. Factors such as the regulatory requirements for a service eg Mental Health services, the size and configuration of the service, the number of medical staff who require professional line management will all create complexity.

Actions:

- Increased time allocation for Clinical Lead role across most specialties from 1 to 1.25PA and to 1.5PA where there are 10 or more senior medical staff to line manage or where there are additional complexities or responsibilities associated with the role.
- SafeCare Leadership structure reviewed to ensure clear routes of clinical governance.
- Disestablishment of Clinical Leadership roles where these are no longer required due to structure and governance changes.

This has led to a planned investment across the Divisions and AMD roles as follows:

- Surgery:
    - Additional 3.5 PA distributed across existing Clinical Lead roles
    - Additional 1PA to Divisional SafeCare Lead role
    - 3PA disestablished from current leadership roles no longer required by the Division

- Medicine and Community:
    - Additional 3 PA distributed across existing Clinical Lead roles and incorporating Clinical Lead role for UTC with ED Clinical Lead.
    - Additional 2.5PA to establish SafeCare Lead roles across all services
    - Additional 1PA to Divisional SafeCare Lead role
    - Reduction in 0.2 WTE AfC Clinical Leadership to Community Services

- CSS
    - Additional 0.75PA PA distributed across existing Clinical Lead roles
    - 0.2WTE AfC to be incorporated into a Chief Scientist role
    - Additional 4.5PA Divisional SafeCare Lead role and SafeCare Lead roles across all services

- AMD roles
    - Additional 2 PA to increase AMD Cancer role to 3PA (corporate role hosted by Surgery).
    - Reduction in 1PA to AMD Patient Safety and Quality role to 2PA as increased activity in relation to SafeCare is managed at Divisional and service line level.

Overall this represents a total of 14.25PA of investment the exact cost of which is dependent upon the individual paypoint and circumstances of the individuals in each of the leadership posts but the below costings demonstrates the range of investment should all additionality be taken up by the medical workforce.

			Mid Point	Mid Point	Top of Scale	Top of Scale
	PAs	**WTE**	**Pensionable**	**Non-pensionable**	**Pensionable**	**Non-pensionable**
Additional PAs	14.25	1.43	229,539	187,402	254,990	210,145

In some areas, particularly CSS, it is highly likely that the appropriate clinical leadership model will include some staff employed on AfC contracts taking up leadership posts. In these circumstances either the leadership element will form part of an existing job role or where this is not the case the member of staff would be eligible for a responsibility payment set at midpoint of B8b scale for the hourly equivalent of the PA allocation associated with the leadership activity. Eg A role with an allocation of 1PA taken on by an AfC member of staff would equate to 4 hours at B8b midpoint, equivalent to £8972/annum including on-costs. This is less than the cost of 1PA even at the lowest point on the consultant pay scale.

This means that the overall financial investment would be reduced and the final sum will be below the £250,000 which enables internal agreement.

Training and Capability:

Findings:

The role of Clinical Lead is one which requires a different skill set to the clinical expertise that clinicians utilise in delivery of patient care. Historically there has been limited opportunity for development in the role and limited succession planning with colleagues taking on the role or not feeling able to hand it on due to a sense of responsibility rather than a desire to continue leading to feelings of burnout.

Actions:

- Clinical Leadership development prospectus formulated by AMD Workforce and POD practitioner to include the following elements:
    - Online resources collated on Trust intranet to provide easily accessible information pertinent to the Clinical Lead role.
    - Monthly Peer Support Network facilitated by AMD Workforce for Clinical Leads and aspiring Clinical Leads.
    - Rolling 12 month programme of in person and online training opportunities covering the “core skills” of the Clinical Lead role as set out in the updated Job Description and linked to the GMC Good Medical Practice Leadership domain.
    - Personalised PDP related to Clinical Leadership role for each Clinical Lead.
- Agreement that Clinical Leadership roles will have a fixed tenure with a clear review and readvertisement process in order to encourage succession planning from an early stage in the appointed term.

Expert support:

Whilst training and development for clinical leads is important so is the easy availability of expert advice and engagement from corporate services and Divisional Business Partners and this has not always been readily available.

Actions:

- Explicit adoption of the servant leadership approach across the organisation led by the CEO.
- Recognition that for some corporate services this may represent a significant change which will need to be supported by Executive colleagues to ensure success.
- Transformation team reorganised to support Divisional teams to facilitate activity to deliver CRP and team members to be explicitly linked to Divisions to support with service transformation.

Benefits

Collectively it is anticipated that these actions will achieve or contribute to the following benefits for the organisation:

- Alignment of clinical leadership job descriptions with the organisational structures bringing clarity around responsibility and accountability of clinical leaders in meetings and other forums.
- Increased clinical voice and engagement in decision making in a context of financial challenge and regional changes across the GNHA footprint.
- An enhanced level of focus on patient safety and quality across the divisions recognising the need for equity of resource.
- Clear professional responsibility for the line management of medical staff with ultimate responsibility sitting with the MD in the RO role.
- Increased expertise available at Clinical Lead level enabling more appropriate local decision making and escalation with succession planning giving a pathway to progression for clinical leaders.
- Improvement in the Staff Survey results particularly for medical staff.

Governance

Implementation of the investment will require minor change to PP47 Job Planning Policy for Senior Medical Staff where this references time/PA allowance for leadership roles.

In recognition of the level of investment and the work that that has been done to determine this structure of clinical leadership going forwards clinical leaders appointed to roles of Clinical Lead and Divisional SafeCare Lead will be recruited to by the senior leadership team of the relevant Division who will then recommend their appointment to the Executive Triumvirate of Group Medical Director, Group Chief Nurse and Group Chief Operating Officer for final agreement.

Any proposed change to the structure of clinical leadership within a service or Division will need to be considered by and agreed at GHLG.

New appointments to AMD posts will go through a recruitment process led by the Group Medical Director and with the involvement of at least one of the Group Chief Nurse or Group Chief Operating Officer or their nominated deputy.

Monitoring and Review

It is intended that a paper will come back to GHLG in April 2026 outlining how the investment has delivered the intended benefits over the first year of implementation.

A further comprehensive review should be completed in a planned way to be presented to GHLG after five years (April 2030) to consider if this model of Clinical Leadership remains appropriate for the organisation at that time.

Summary

This paper is intended to summarise the Clinical Leadership Review and how the four key elements of clinical leadership within the organisation should be addressed.

The organisational restructure is now complete and the intention is that all new roles and the significantly changed AMD posts will be appointed to by the start of the 25/26 financial year with disestablishment of roles, where outlined above, taking place in the same time scale. To enable this Gateshead Health Leadership Group is asked to agree that investment of no more than £250,000 is approved in the 25/26 financial year and thereafter on a recurrent basis.

Aligned with this the Clinical Leadership development programme will be launched to start from April 2025.

The work to support the servant leadership model across the organisation has started and this will continue across 25/26 supported broadly by POD colleagues.

The governance arrangements reflect the importance of the clinical leadership model to the organisation.

A review of the benefits delivered for the investment will be presented back to the group in one year, with a further comprehensive review for April 2030.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 11i

Report Title:	**Board Assurance Framework (BAF) 2024-25**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29 January 2025			
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 – November 2024 Board committees between November 2024 and January 2025			
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. • For two summary risks the target scores have now been achieved (maternity and business growth). • Reductions in summary risk scores are also noted in relation to quality improvement and growing and developing our people. • For a number of risks the current score has remained static all year, although there have been actions taken to improve the control and assurance environments. • A new summary of progress is appended to this cover sheet to provide the Board with a more detailed overview of Committee decisions regarding the consideration of current risk scores.			

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- The BAF key is as follows:

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

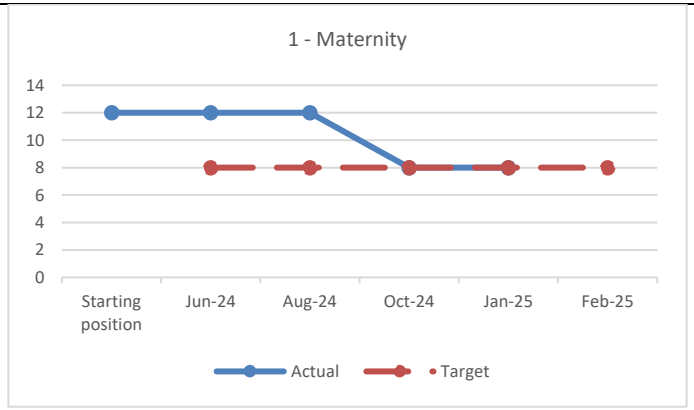
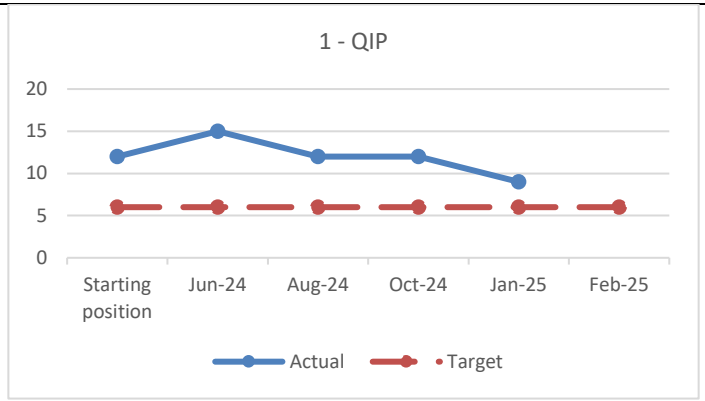
</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">To review the BAF for completeness, accuracy and triangulation against the assurances and risks discussed as part of the Board meeting.

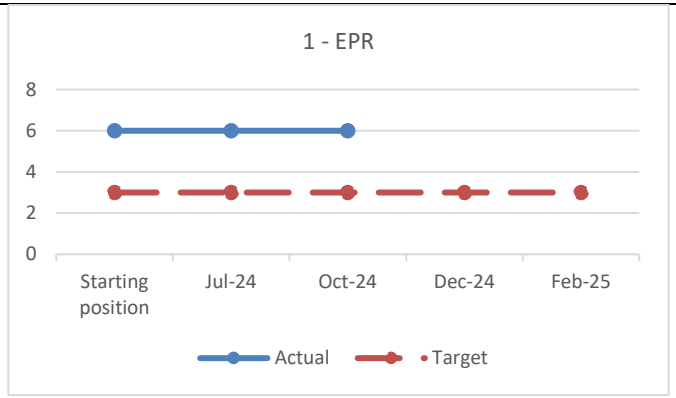
The Board is asked to specifically review whether based on the assurances and risks identified through the meeting the current risks scores continue to reflect the current operating environment.

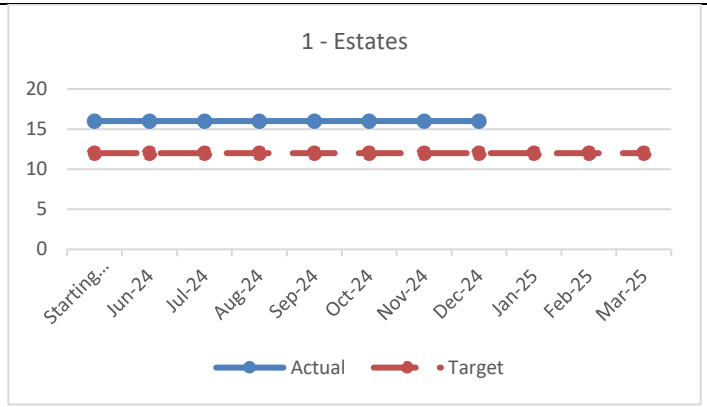
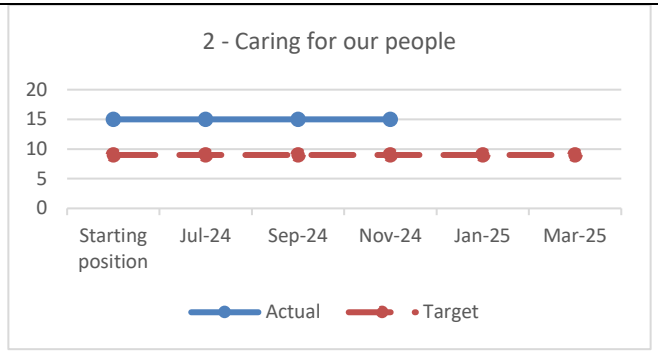
As the Alliance BAF extract is monitored directly at Board, it is for the Board to consider whether the current risk score can be reduced based on the progress made to-date in managing the risk.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="5">We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

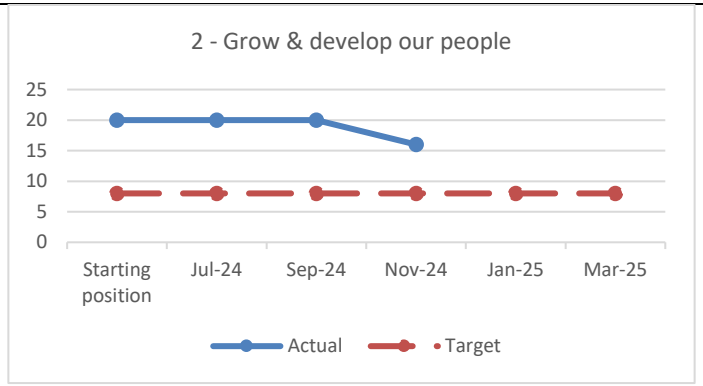
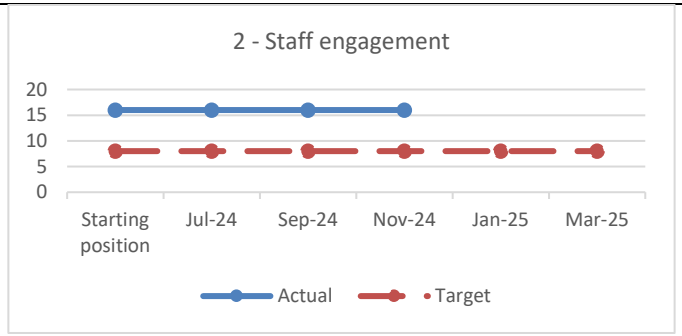
Has a Quality and Equality Impact Assessment (QEIA) been completed?	Yes ☐	No ☐	Not applicable ☒

Board Assurance Framework 2024/25 – January 2025 - Summary

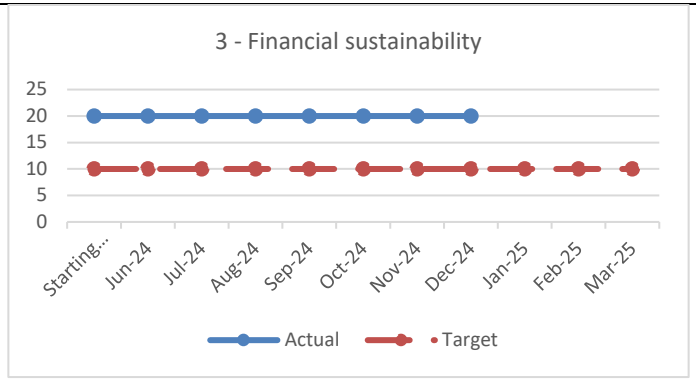
Strategic Objective	Summary risk	Risk scores	Overview
Evidence full compliance with the Maternity Incentive Scheme (MIS) and the Ockenden actions	There is a risk that the Trust is not able to comply with the MIS and Ockenden actions, caused by pressures on resources (finance, workforce, estates and demand), resulting in a negative impact upon the quality of maternity services and a decline in performance against the maternity metrics and patient outcomes.		Target risk score of 8 achieved in October 2024. The Quality Governance Committee (QGC) felt assured that the summary risk had been mitigated down to the target level given the evidence available to support compliance. This included maternity assurance visits and the CQC maternity patient survey outcome. QGC queried whether the target score had been set too high and would reflect on this as part of the setting of target scores for 25/26.
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.	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.		Since June 2024 the current score for this risk has been gradually reducing down towards the target score. The target score of 6 has not yet been reached, with the current score being 9 following a reduction in the likelihood to 3 in January 2025. A significant number of level 3 external assurances have been received during the year, providing assurances over quality and outcomes for patients. The new governance structure simplifies and streamlines quality reporting, and QGC has received additional

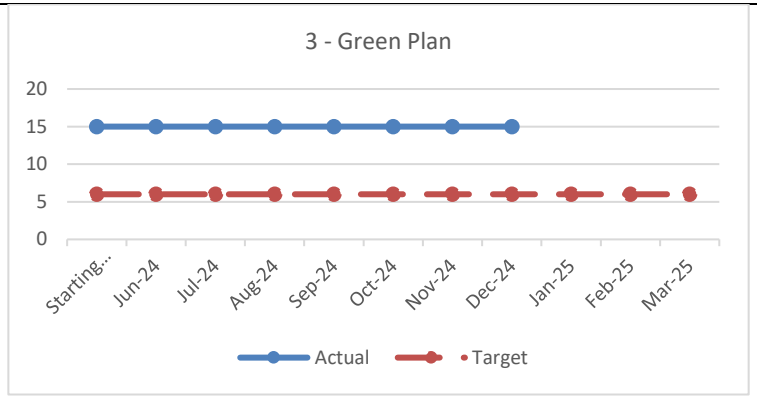
Strategic Objective	Summary risk	Risk scores	Overview
			assurance over risk areas such as complaints and falls during the year.
Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.	There is a risk that the Trust does not develop 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.		The EPR summary risk score has remained at 6 throughout the year, noting that this is a low score, with EPR seeking to achieve the lowest target score of 3 across the whole BAF. The Digital Committee agreed to maintain the score of 6 recognising that the strategic approach had not yet been agreed, but there was confidence that this would be achieved by year-end. Maintaining the current risk score also reflected the continued Chief Digital Information Officer vacancy.

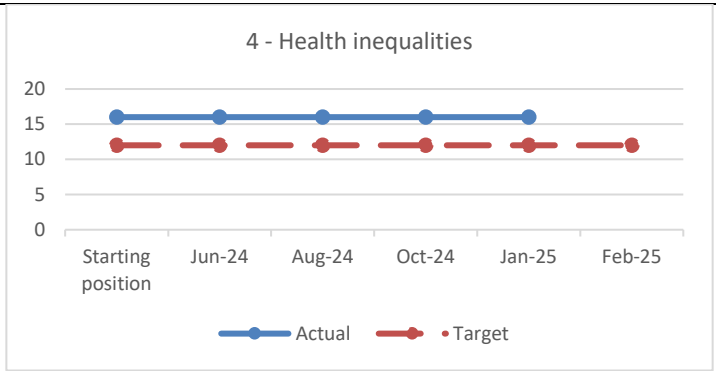
Strategic Objective	Summary risk	Risk scores	Overview
Development and implementation of an Estates strategy that provides a 3 year capital plan to address the key critical infrastructure and estates functional risks across the organisation by March 2025	There is a risk that the Trust is unable to deliver 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)		The current risk score has remained at 16 and has not reduced towards the target score of 12. The Finance and Performance (F&P) Committee agreed to maintain the score of 16, but recognised that progress has been made in developing the estates strategy and strengthening the controls and processes that underpin this. This has included productive collaborative discussions with Alliance partners. The Committee are comfortable that the risk here is not increasing, but the availability of cash and affordability of the plan constrains the ability to reduce the likelihood of the risk occurring.
Caring for our people in order to achieve the sickness absence and turnover standards by March 2025	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		The current risk score has remained at 15 and has not reduced towards the target score of 9. The People and OD (POD) Committee has received a number of deep dives on sickness absence and turnover. The Committee noted that work is ongoing to target specific hotspots and there are also plans to triangulate the information with other intelligence. As turnover and sickness absence rates remain above target, the Committee agreed to maintain the current score of 15.

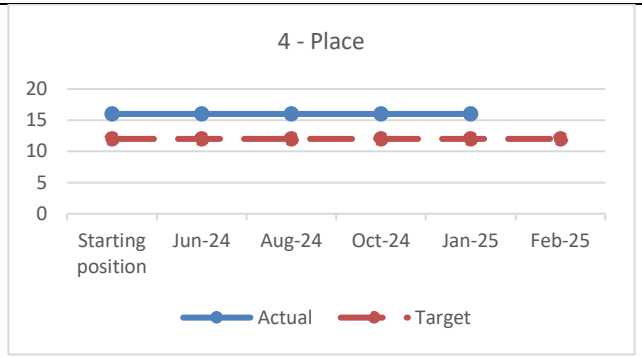
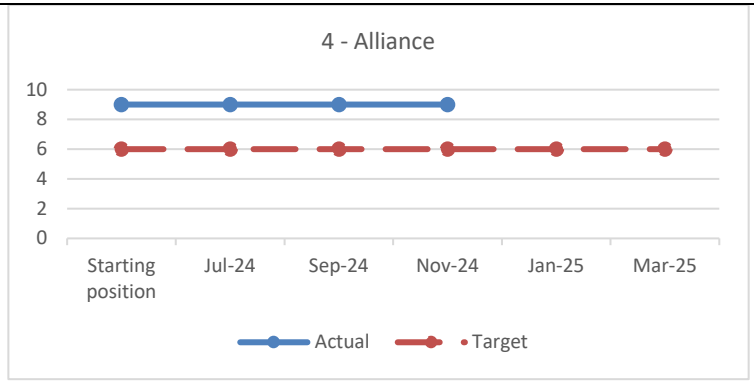
Strategic Objective	Summary risk	Risk scores	Overview
	deliver high quality care to our patients		
Growing and developing our people in order to improve patient outcomes, reduce reliance on temporary staff and deliver the 24-25 workforce plan	There is a risk that the composition of our workforce does 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.		The current score for this risk reduced to 16 in November 2024. Whilst this remains one of the highest BAF risks, the reduction in score does reflect that a number of identified gaps in control and assurance have been addressed. POD Committee took assurance from the reduced reliance on temporary staffing, the improved supporting governance structure for POD and the changes made to the medical staffing function.
Evidence an improvement in the staff survey outcomes and increase staff engagement score to 7.3 in the 2025 survey	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		The current risk score has remained at 16 and has not reduced towards the target score of 8. There has been a drive to improve culture and focus on speaking up during the year. This has led to a number of external reviews and emerging historical issues which colleagues have raised. Colleagues have been encouraged to be ‘comfortable with the uncomfortable’ and the growing confidence of colleagues to speak up is welcomed.

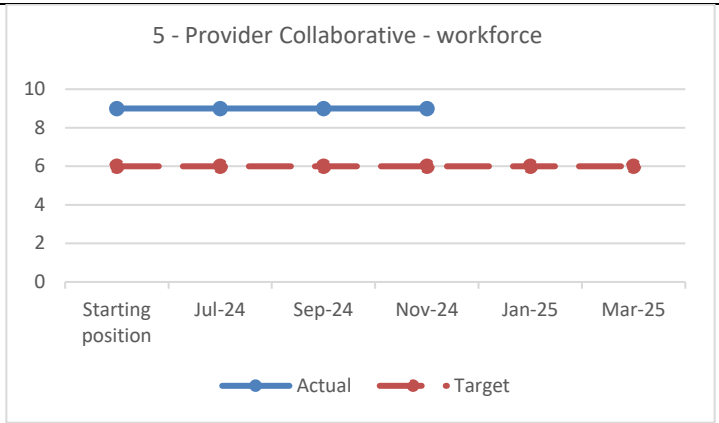
Strategic Objective	Summary risk	Risk scores	Overview
	ability. The result is that our people may feel disengaged, disempowered or discriminated against, leading to reduced retention rates, loss of reputation and poor staff survey results - ultimately impacting on our ability to be a good employer delivering excellent care to our patients.		The score remains static to reflect the level of work emerging from the reviews and speaks ups.
Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025.	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		Given current levels of pressure and demand the current risk remains at 16. This aligns with the winter-related risk being named as one of the top 3 risks for the Trust overall. In December 2024 the F&P Committee did reflect that a number of improvements in controls and assurances had been delivered. This included the implementation of the new governance structure, improvements in reporting / information and deep dive reports into 4 hour and 12 hour performance in A&E.

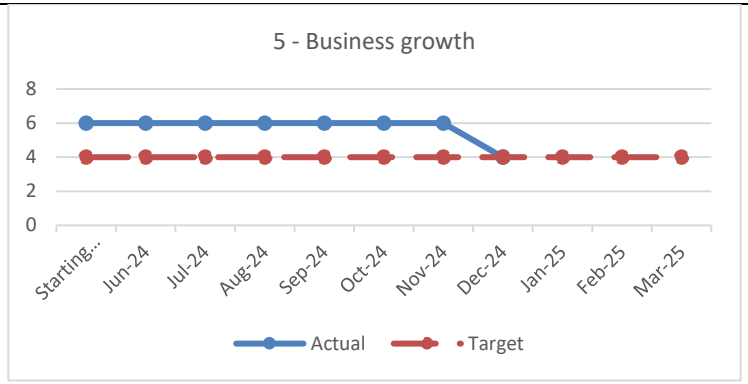
Strategic Objective	Summary risk	Risk scores	Overview
	confidence in the organisation		
Evidence of reduction in cost base and an increase in patient care related income by the end of March 2025 leading to a balanced financial plan for 2025-26.	There is a risk that the Trust does not achieve its activity, 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		This risk remains at 20, which is the highest current rated risk on the BAF. This aligns with finance being one of the top 3 risks for the Trust. The risk rating recognises that whilst the Trust is forecasting achievement of the planned deficit for 24/25, the longer-term financial risk remains significant. F&P Committee recognise the strengthened controls in relation to the development of the Cost Reduction Programme (CRP) as well as strengthened approaches to capital planning.

Strategic Objective	Summary risk	Risk scores	Overview
Review and revise the 22-25 Green Plan and align with the group structure by the end of Q2	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.		The risk in relation to the Green Plan has remained at 15. This reflects that progress has been constrained by vacancies, although F&P Committee note that a new Safety, Health, Environment and Quality manager (SHEQ) has now been recruited. A peer review of environmental sustainability which is being conducted by Newcastle and Northumbria counter-parts will support the revision of the Green Plan and sustainability arrangements.

Strategic Objective	Summary risk	Risk scores	Overview
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	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		The health inequalities summary risk has remained at 16. Recent work has been undertaken to review health inequalities arrangements within the Trust. This was reported to QGC in October 2024. It identified the need to raise the profile of health inequalities across the Trust, embed this as a responsibility for colleagues to address and refresh the strategy. In January 2025 QGC agreed to maintain the risk at 16 until the impact of the review recommendations can be demonstrated.

Strategic Objective	Summary risk	Risk scores	Overview
Work collaboratively as part of the Gateshead system to improve health and care outcomes to the Gateshead population	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.		The summary risk in relation to place-based working remained at 15. When discussed at the January 2025 QGC meeting it was agreed that further narrative would need to be evidenced to justify a reduction in the risk level. It was noted that this was more in relation to being able to articulate the progress made, rather than being indicative of concerns regarding addressing place-related risks.
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'	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		The summary risk in relation to Alliance working has remained at 9, which is above the target risk of 6. Regular Alliance updates have been provided at Board and via F&P Committee. A number of additional controls are in place, including the development of the 4-3-2 model and joint committee approach. In addition plans are being progressed in relation to the Shared Chair. **As this BAF extract is monitored directly at Board, it is for the Board to consider whether the current risk score can be**

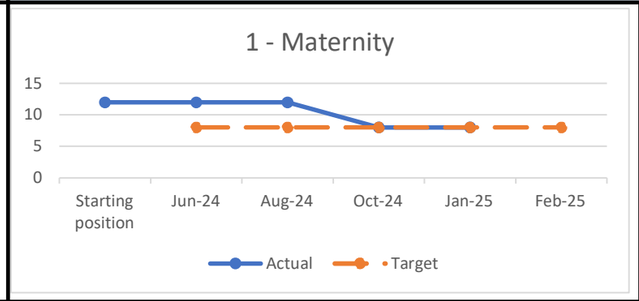
Strategic Objective	Summary risk	Risk scores	Overview
	involvement in key Alliance discussions and meetings. This may result in poorer patient outcomes and an inability to meet performance and finance targets, impacting upon sustainability		**reduced based on the progress made to-date in managing the risk.**
Contribute effectively as part of the Provider Collaborative to maximise the opportunities presented through the regional workforce programme	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		The summary risk in relation to the contribution to the Provider Collaborative regional workforce programme has remained at a score of 9. Progress has been made in influencing this agenda (for example through the Community Diagnostic Centre's contribution to the regional workforce programme and the Chief Operating Officer leading the medicine workforce workstream), although POD Committee reflected that capacity has impacted upon this area. It was noted that further discussions need to be held at a regional level to support regional sickness reductions by 1%. As such, the score remains at 9.

Strategic Objective	Summary risk	Risk scores	Overview
Evidenced business growth by March 2025 with a specific focus on Diagnostics, Women's health and commercial opportunities	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		The current score was reduced to 4 at the December 2024 F&P Committee, which means the target score has been achieved. The control environment has recently been strengthened by the appointment of a Commercial Director at QE Facilities. The Committee recognised the over-achievement against the business growth target, although noted that this was not necessarily through the delivery of a fully developed commercial plan.

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:	Jan-25
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	**4**	**8**	**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

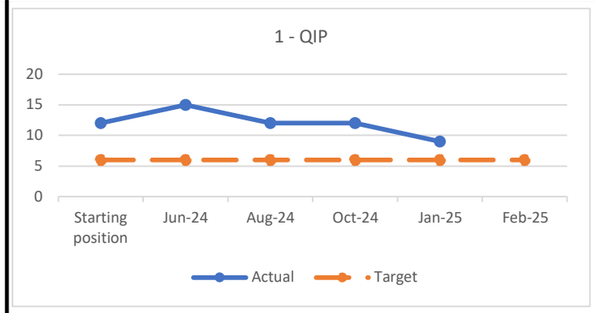
2438 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures – 8

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

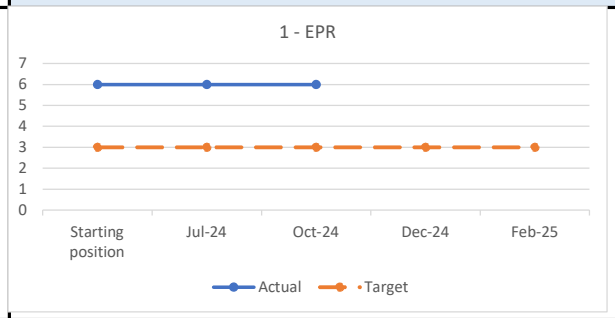
Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Core maternity roles substantively filled	Increased birth rates and increasing acuity / interventions observed over 2023/24. Working being undertaken to formulate recommendations on midwifery workforce requirements	Head of Midwifery	TBC	Oct 24 - work being undertaken with other local trusts and the ICB re: managing demand from out of area patients. Dec 24 - actions have been taken manage out of area bookings in order to effectively manage demand and maintain patient safety and experience. Communicated to key stakeholders and performance information to be shared as part of maternity reporting to monitor impact. **Action recommended for closure**	
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 the best in the country for 2024						
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:	Jan-25							
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	
		3 (was 4)	**3**	**9**	**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 4635 - Risk of inability to deliver services over winter due to variations in the forecast assumptions used to develop the plan, resulting in an increased clinical, financial and reputational risk profile (16)							

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	[redacted]	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	[redacted]	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.	
	[redacted]					
	[redacted]					
Assurance (Level 2: Reports / metrics seen by Board / committee etc)	[redacted]					
Leading indicator report reviewed at Quality Governance Committee and Board	[redacted]					
Patient / staff story presented to every Board and Council of Governors' meeting	[redacted]					
Safe staffing reports presented to Board and Quality Governance Committee	[redacted]					
Clinical audit outcomes reported to Quality Governance Committee	[redacted]					
Quality and safety reporting on QEF non-core contract now in place	[redacted]					
Assurance deep dives reports into complaints and falls reviewed by QGC	[redacted]					
Quality Account	[redacted]					
Assurance (Level 3 – external)	[redacted]					
Awarded National Joint Registry (NJR) Quality Data Provider – reflects high standards of patient safety	[redacted]					
Awarded Gold Standard for Autism Acceptance by the North East Autism Society.	[redacted]					
External accreditations	[redacted]					
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	[redacted]					
ICB inpatient review visit and RcPsych Psychiatric Liaison Accreditation Review for Older Persons Mental Health Services	[redacted]					
CQC Mental Health Act Monitoring Visits to Cragside and Sunniside	[redacted]					
ADQM assessment	[redacted]					
Annual CBRN audit	[redacted]					
Cancer Patient Experience Report provides good assurance	[redacted]					

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:	Dec-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 - (was 16 now 8) 4402 - Inability to support legislation and best practice associated with records management - 16 2424 - Risk that efficiency requirements are not met - (was 16 now 12) 4554 - risk of cyber threats and vulnerabilities - 15							

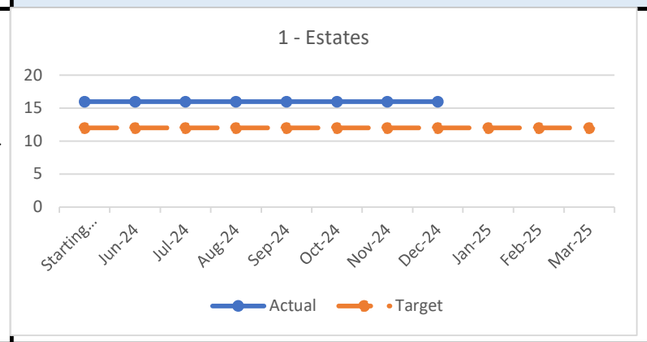
Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
EPR engagement event held in December 2023	The EPR business case has not yet been completed	Group Director of Finance & Digital	Mar-25	Oct 24 - business case to be presented at Board in January 25 Dec 24 - progressing in line with timescales Jan 25 - business case not ready for Board in Jan. Update paper to be presented to Board	
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 Dec 24 - post remains vacant with cover being provided from within the team. Discussions being held via 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)	[redacted]	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:	Dec-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)

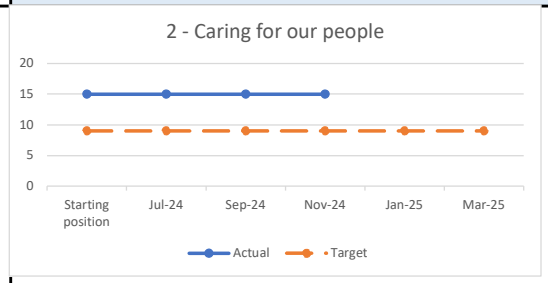
Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Asset condition survey carried out by external specialists resulting in risk based condition scoring of all fixed assets.	The current Estates Strategy 2023-2028 has not been agreed by Board and no longer reflects the 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. Dec 24 - capital planning process is now in place and work continues with the Alliance in support of the Big Build project. Action agreed as closed.	

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. Dec 24 - action agreed as closed.	
Capital plan for 2024/25 in place following Board approval					
New governance structure implemented which strengths the controls environment in relation to the process for reporting and escalating estates related issues, risks and assurances					
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. Dec 24 - action agreed as closed with reporting process now embedded	
	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. Jan 25 - reporting route now agreed and streamlined under the structure. Action recommended for closure	
	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					

Regular reporting in place to Gateshead Health Leadership Group	[redacted]					
Estates option paper for Bensham site discussed and agreed at Trust Board	[redacted]					
Assurance (Level 3 – external)	[redacted]					
External Assessment of the Estate against the 6 facets identified in Estatecode including, Estate condition.	[redacted]					
	[redacted]					
	[redacted]					
	[redacted]					

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:

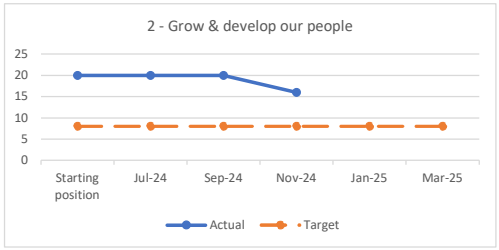
2425 - Activity is not delivered in line with planned trajectories, leading to reduction in income - 16

4417 - Increase in incivility and disrespectful behaviours being reported - 15 (was 12)

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

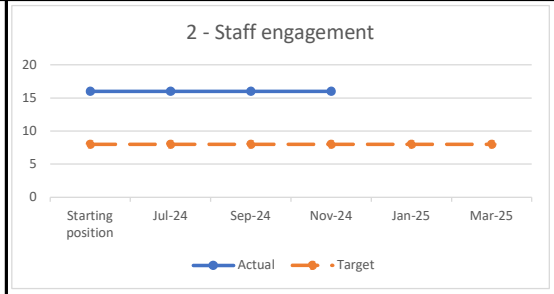
Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Health and wellbeing lead in place	New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24	Sept - tier 2 meetings now in place alongside 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	Jan 25 - Uptake levels still low 33% - Dec '24 date passed	
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. Jan 25 - Dec '24 date passed	
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. Jan 25 - Complete Action to be considered for closure	
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	Jan 25 - Complete Action to be considered for closure	
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 Jan 25 - 6 step methodology being implemented as part of the current Trust planning process, where possible. Update controls to reflect approach rolled out, and update gaps to reflect effectiveness of approach.	
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. Jan 25 - Team transitioned on 1st December 2024 - recommend for closure	
Planning group in place to respond to industrial action	Workforce alignment to strategic intent not yet completed.	Executive Director of POD	Jan-25	Jan 25 - Recommend change in timescale to start of new financial year	
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. Jan 25 - Propose to extend timescale as no national info yet available	
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	Jan 25 - Propose to extend timescale as currently undergoing planning process so specific challenges not yet clear	
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 Jan 25 - Propose to amend timescale as currently no capital budget for 25/26 to cover training provision	
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 - 15 (was 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. Jan 25 - 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	Jan 25 - Recommend extension of timescales as networks review ongoing	
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	Jan 25 - Recommend extension of timescales as we include more recent staff survey feedback	
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. Jan 25 - Action complete, recommend for closure	
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. Action complete, recommend for closure	

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	Jan 25 - Recommend to extend timescales as currently undergoing panning process	
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:	Dec-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

4591 - Risk of significant service disruption due to GP collective actions including reduction in shared care service provision - 15

4635 - Risk of inability to deliver services over winter due to variations in the forecast assumptions used to develop the plan, resulting in an increased clinical, financial and reputational

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. Dec 24 - action agreed as closed.	
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. Dec 24 - Action recommended for closure as the required changes have been implemented	

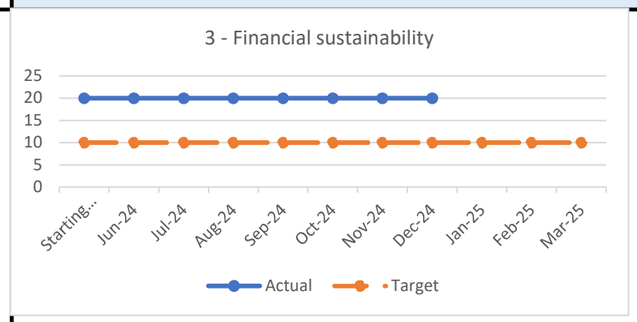
Membership and participation in the UEC strategic board		Patient Access Policy to be reviewed and updated	Chief Operating Officer	Sep-24	Oct 24 - work ongoing to streamline the Patient Access Policy with other organisations	
Membership and participation in the Strategic Elective Care Board						
Leadership of the Theatres and Perioperative Medicine regional workstream						
Weekly performance meetings in place						
New governance structure implemented which strengths the controls environment in relation to the process for reporting and escalating performance related issues, risks and assurances						
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	Jan 25 - Tier 3 groups now established. Action recommended for closure.	
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. Dec 24 - agreed that the action can be closed as deep dives and follow up received.	
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	[redacted]					
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:	Dec-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 4577 - Achievement of 24/25 revenue financial plan - 20 2424 - Risk that efficiency requirements are not met - (was 16 now 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 (16) 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
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 Jan 25 - efficiency planning process is underway for 25/26 with a new CRP lead in place to support the development of the plans	
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**	Jan 25 - planning process is underway with an update due to be presented to Board	
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. Dec 24 - action agreed as closed.	
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.	

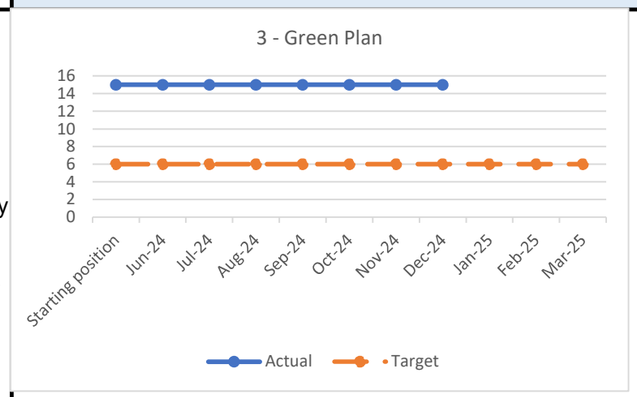
New business intelligence post in place		Gaps in controls identified in relation to medical staffing	Medical Director	**TBC**	Strategic workstream identified with Medical Director as the Exec lead Oct 24 - new Associate Director post now in place. Senior Medical Staffing Manager also in post with new procedures developed and increased team capacity. Risk reduced from 20 to 16. Dec 24 - agreed to keep this action open as the impact of this action has not yet been evidenced	
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 Dec 24 - action agreed as closed given post now recruited to	
Financial sustainability framework in place						
Medical staffing team increased with new Associate Director post and Senior Medical Staffing Manager in place. New SOPs developed						
New governance structure implemented which strengths the controls environment in relation to the process for reporting and escalating finance related issues, risks and assurances						
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)	[redacted]					

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:	Dec-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

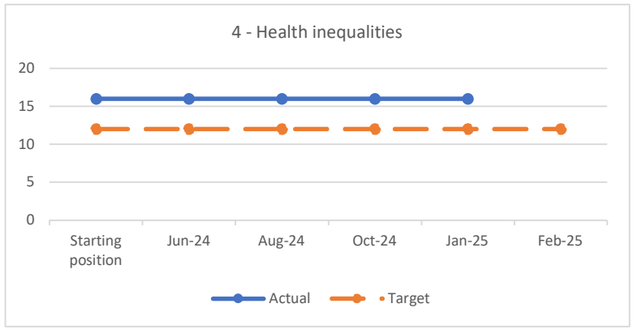
Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
The Green Plan has been agreed by Board covering the period for 22-25.	The governance arrangements detailed in the Green Plan are not reflected in the new Governance arrangements - A new reporting structure is to be agreed.	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. Dec 24 - action agreed as closed as the postholder is now in place	
Identified senior management with specific responsibility for the Environment and sustainability.					

SHEQ post recruited to and appointee now in place					
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:	Jan-25
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**

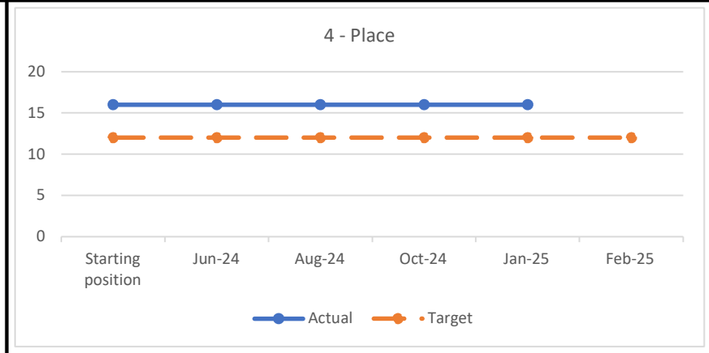
Links to risks on the ORR:	4402 - Inability to support legislation and best practice associated with records management - 16

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	Dec 24 - paper was presented at the Oct 24 meeting. Resulting discussion identified the need to ensure that women's health was a key priority for the refreshed HE Group. **Action recommended for closure.**	
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. **Action recommended for closure.**	
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 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:	Jan-25
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:

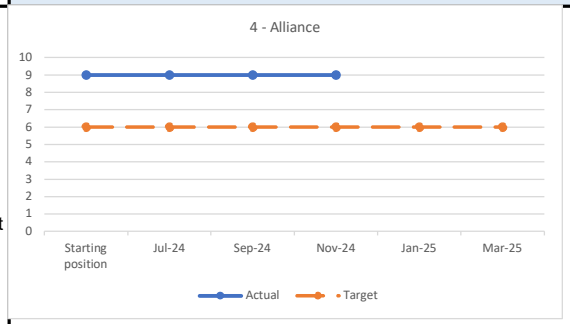
2424 - Risk that efficiency requirements are not met - 16
2438 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures – 8
2425 - Activity is not delivered in line with planned trajectories, leading to reduction in income – 16
4635 - Risk of inability to deliver services over winter due to variations in the forecast assumptions used to develop the plan, resulting in an increased clinical, financial and reputational risk profile (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
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 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

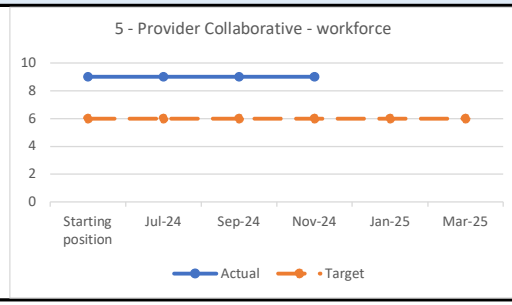


CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
3	3	9	2	3	6

Links to risks on the ORR:	2424 - Risk that efficiency requirements are not met - (was 16 now 12) 2425 - Activity is not delivered in line with planned trajectories, leading to reduction in income – 16

Controls		Gap in controls and corrective action	Owner	Timescale	Update	Action status
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 - Director of Strategy and Partnerships						
Weekly CEO meeting in place for Alliance						
Risk management framework and risk register in place at Alliance level						
Committees in Common established						
Joint Committee model developed to cover 3 Trusts - terms of reference and Collaboration Agreement in place for this						
4-3-2 model agreed and in place						
Joint Nominations Committee forming to lead the Shared Chair recruitment						

Extension of GHFT Chair agreed to provide stability and continuity towards the move to a Shared Chair model						
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						
Alliance updates provided at Finance and Performance Committee						
Alliance updates provided to COG on quarterly basis						
Alliance update monthly at PLB						
Alliance workplan shared with the Board						
Assurance (Level 3 – external)						
ICB engaging with Alliance leaders - Dec 24						

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:	Jan-25						
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 - (was 16 now 12) 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 - 16 (was 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	Lack of regional discussions on regional sickness reduction by 1%. Director to lead discussions on this asap.	Executive Director of POD	Mar-25		
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:	Dec-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
				2 (was 3)	**2**	**4**	**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. Dec 24 - Commercial Director now in place. Action agreed as closed	

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.	
Commercial Director now in place						
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: 11ii

Report Title:	**Organisational Risk Register (ORR)**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29th January 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, the Executive Risk Management Group meeting every month, as well as relevant committees.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience*	Risks on the ORR were comprehensively discussed at previous ERMG meetings in December and January. The following updates and movements agreed. 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 was 1 risk added, 2 escalations, 3 reductions, 0 risks removed, 0 closures.
-Analysis of risk movement in 6-month period is detailed within the report.
-Compliance with reviews is static in period and sits at 95% for risks and 81% 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.
• Note movements over 6-month period.
• Take assurance that risks are reviewed in line with risk management arrangements.
• Be cited 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

1. 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, including movement over the previous 6 months.

This report covers the period 19th November 2024- 19th January 2025 (extraction date for this report).

Organisational Risk Register

2. Movements in period

Following ERMG meetings in December 2024 and January 2025, 1 risk has been added to the ORR.

There have been 2 escalations, 3 reductions, 0 risks removed from the ORR and 0 closures.

There are currently 19 risks on the ORR, agreed by the group as per enclosed report.

New Risks:
There has been 1 risk escalated to the ORR and increased in score:

- **4635 (COO)** The winter plan is built on a set of underpinning forecasts and principles. There is a risk that the actual position varies from these to such an extent that is results in an inability for the plan to be delivered in whole or in part. (16)
    - Initially added to local risk register in October 2024, as score of 12, the score has now been increased to 16 given challenges to meet winter plan forecast.
    - Added as a top organisational risk.

Risks increased:
There has been 1 further risk increased in period:

- **4417 (POD)** Increase in incivility and disrespectful behaviours being reported (15)

    - We continue to see significant numbers of incidents and concerns related to culture and have unearthed historical and complex incidents/concerns which require dedicated time to address.
    - Increased from 12 to 15

Risks reduced:

3 risks have reduced in period:

- **4405 (Digital)** 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. (16)
    - Compliance with information Asset Registers and Data Flows has improved significantly.
    - Management plan in place to ensure continuation of compliance with close monitoring undertaken, noting that work is still required around training/ownership/culture.
    - Risk reduced from 16 to 8

- **4576 (Digital)** Risk that the trust is failing to meet the mandated turnaround time for Subject Access Requests (below 95% tolerance). 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. (16)
    - Significant improvement in performance noted.
    - Reduced from 16 to 12

- **2424 (Finance)** Risk that Efficiency requirements are not achieved on a recurrent basis.
    - Creation of CRP steering group in place to monitor and report CRP into appropriate committees.
    - Reduced from 16 to 12

Risks closed:

0 Risks have been closed

3. Movements over 6-month period 1st July 2024 - 1st January 2025

We have seen active mitigation undertaken over the 6 months period, resulting in a reduction of 7 ORR risks as demonstrated in the below table.

Risk ID	Risk Stage	Risk Title	Owner	Business Unit	Service	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025
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	Medical Director's Office	Medical Directorate	20	20	20	16	16	16	16
2424	Current Risk	Risk that efficiency requirements are not achieved on a recurrent basis.	Kris Mackenzie	Finance	Finance	16	16	16	16	20	16	12
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	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	12	12	12	12
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	12	12
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	12	12
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	8	8

We have seen two risks escalated in period:

Risk ID	Risk Stage	Risk Title	Owner	Business Unit	Service	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025
4635	Current Risk	Risk of inability to safely deliver services over Winter due to variations in the forecast assumptions used to develop the plan resulting in an increased clinical, financial and reputational risk profile	Jo Halliwell	Chief Operating Officer	Emergency Planning				12	12	16	16
4417	Current Risk	Increase in incivility and disrespectful behaviours being reported	Amanda Venner	People & OD	Workforce Development	12	12	12	12	15	15	15

Organisational risks with no change to score in last 6 months.

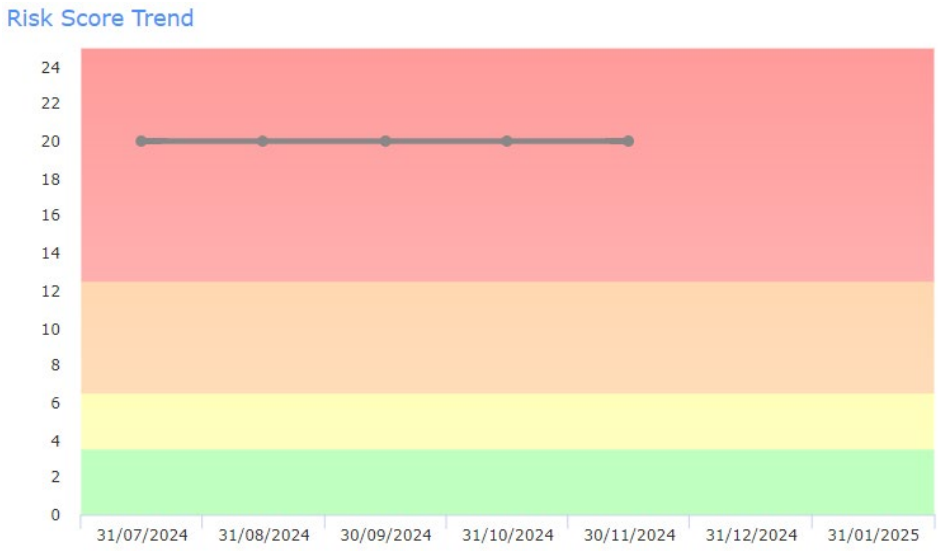
There are 10 risks on the ORR with no movement in the past 6 months (July 2024-January 2025).

Risk ID	Risk Stage	Risk Title	Owner	Business Unit	Service	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025
4577	Current Risk	Achievement of 2024/25 revenue financial plan	Kris Mackenzie	Finance	Finance	20	20	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	16
4402	Current Risk	Inability to support legislation and best practice associated with records management	Catherine Bright	Digital	Health Records	16	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	16
3132	Current Risk	Exposure to incidents of violence and aggression	Gavin Evans	QE Facilities	Facilities	15	15	15	15	15	15	15
4554	Current Risk	Cyber Threats and Vulnerabilities	Kris Mackenzie	Digital	IT	15	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	15
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	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	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	8

Further detailed trends as follows:

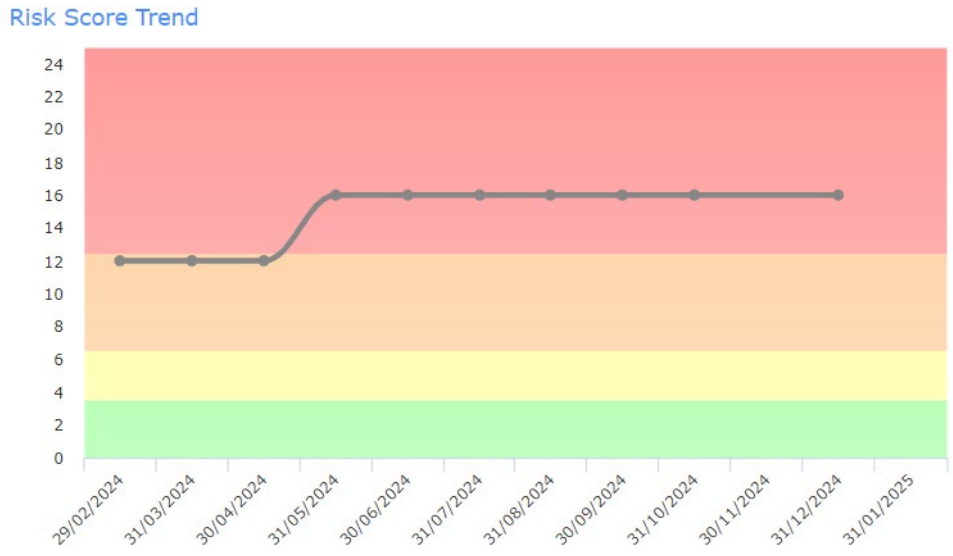
- **Risk 4577 Finance-** Risk that the trust does not achieve its 2024/25 planned deficit totalling £7M and does not deliver its CRP, resulting in significant impact on financial sustainability. (20)

Added in July 2024 at score of 20. No change to score since its addition.



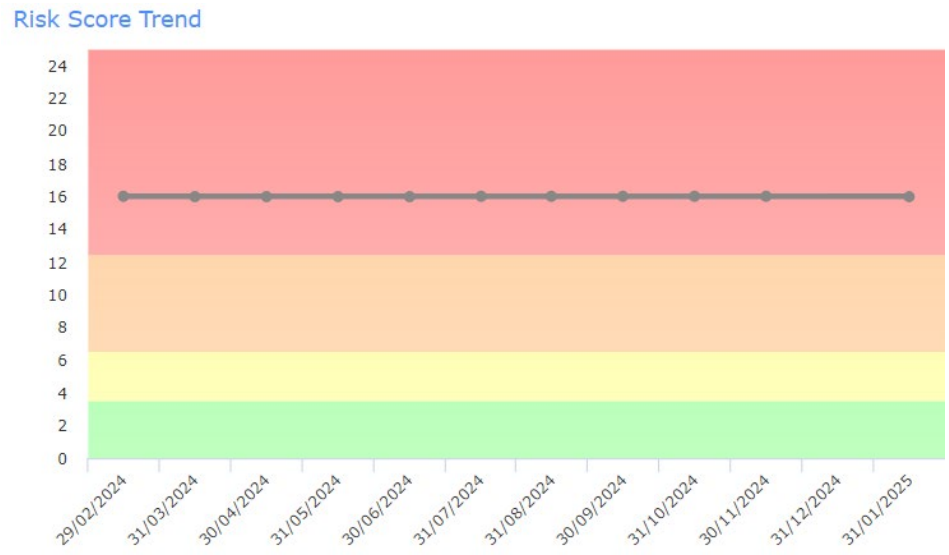
- **Risk 2341 QEF**- Risk to ongoing business continuity of service provision due to ageing trust estate. (16)

Added February 2023 at score of 12. Increased to 16 in April 2024. No change in 6 months.



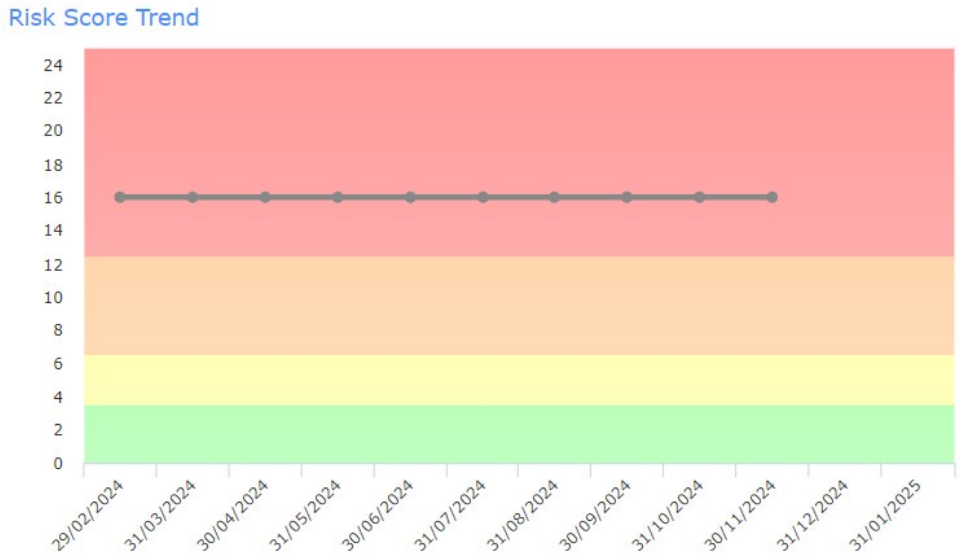
- **Risk 4402 Digital**- Inability to support legislation and best practice associated with records management (16)

Added November 2023 at score 16. No change since its addition.



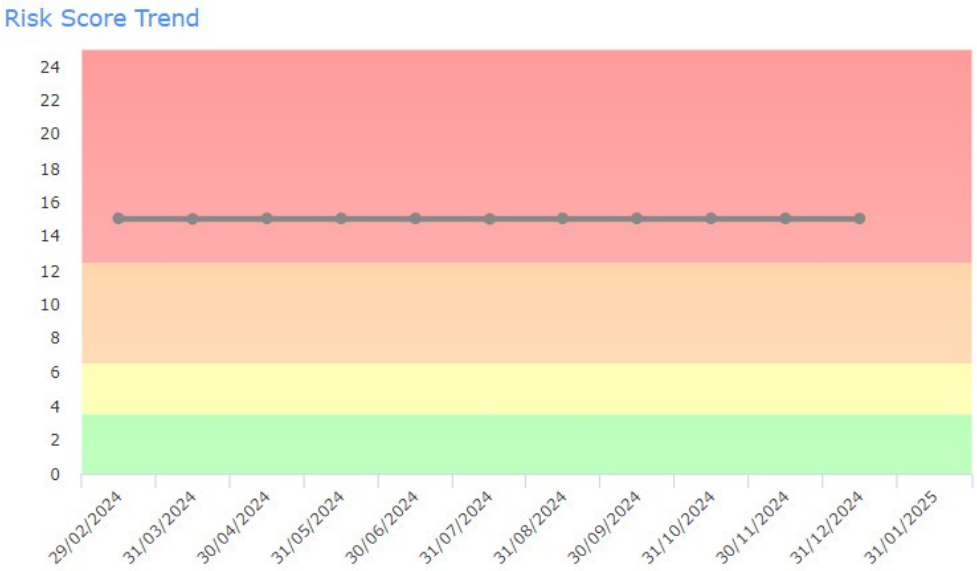
- **Risk 2425 Finance -** Activity is not delivered in line with planned trajectories, leading to reduction in income. (16)

Added in November 2022 at score 16. No change since its addition.



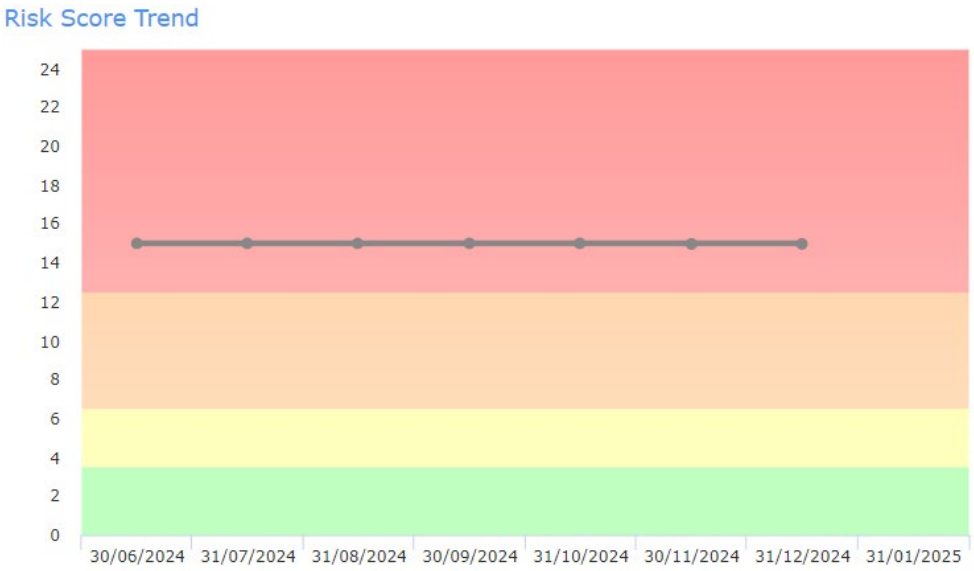
- **Risk 3132 POD** -Exposure to incidents of violence and aggression (15)

Added October 2023 at score of 15. No change since its addition.



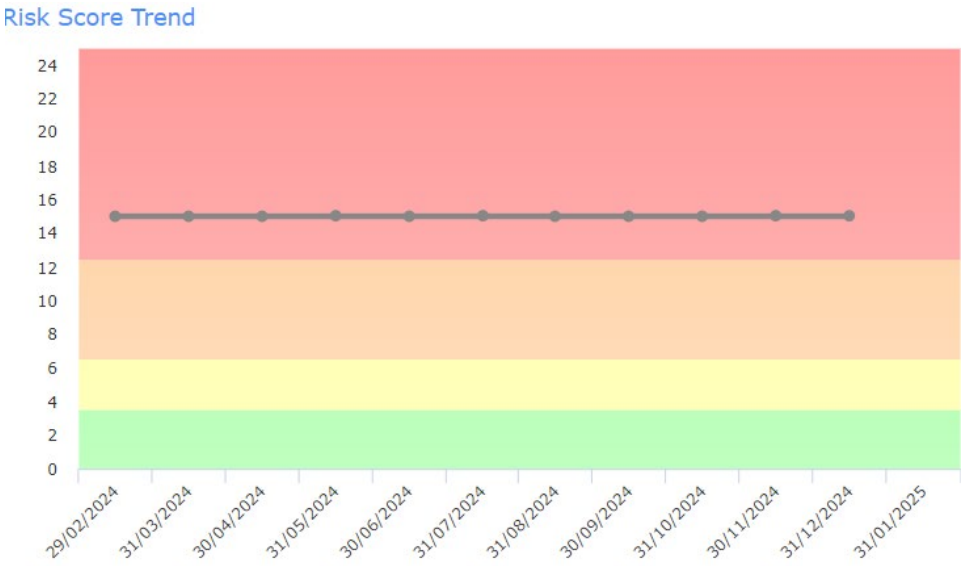
- **Risk 4554 (Digital)** There is a risk that the trust is not sufficiently protected against the current and evolving cyber threats (15)

Added June 2024 score of 15. No change since its addition



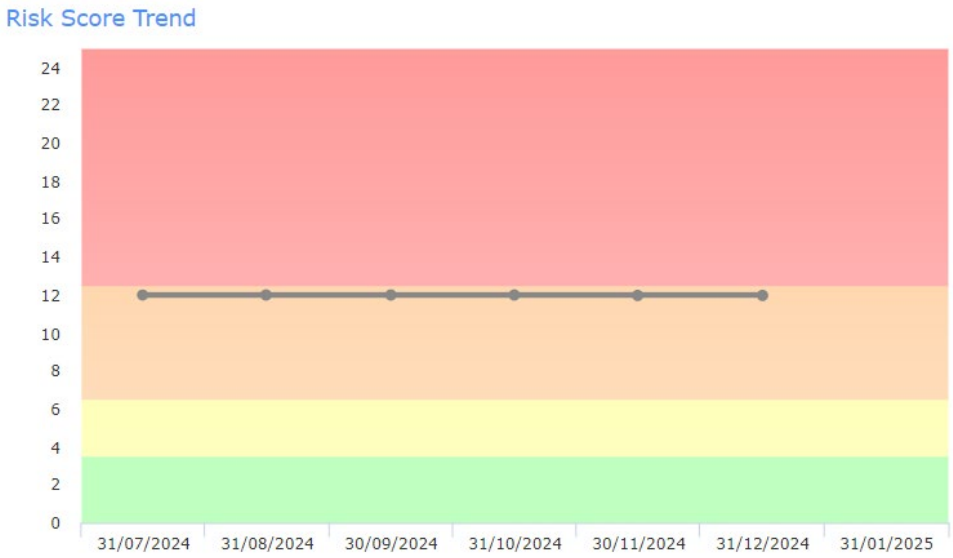
- **Risk 3107 Surgery**- Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings (15)

Added November 2022 at 15. No change in the last 12 months.



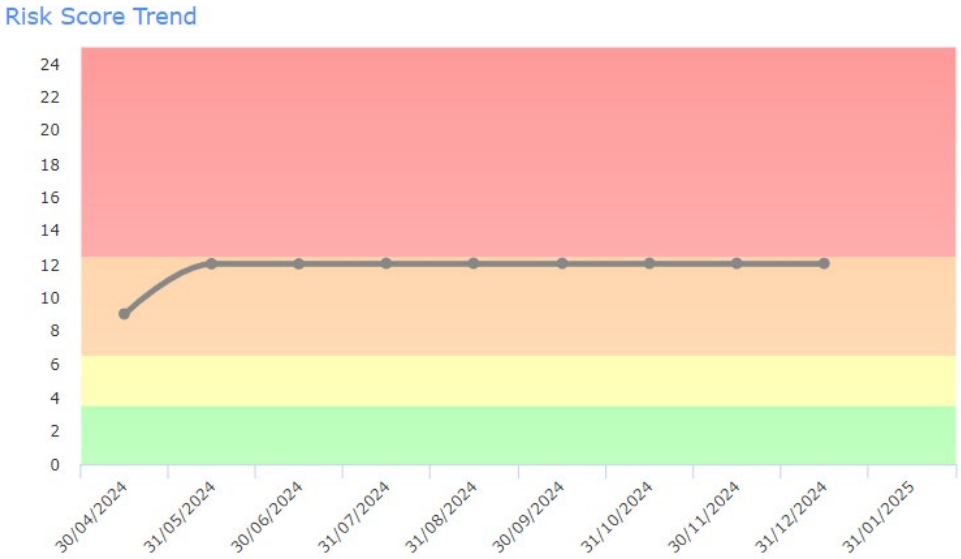
- **4574 COO** A risk of being unable to relocate in the event of an evacuation due to capability and capacity issues within the estate that may potentially result in patient safety issues (12)

Added to august 2024 score of 12. No change since its addition



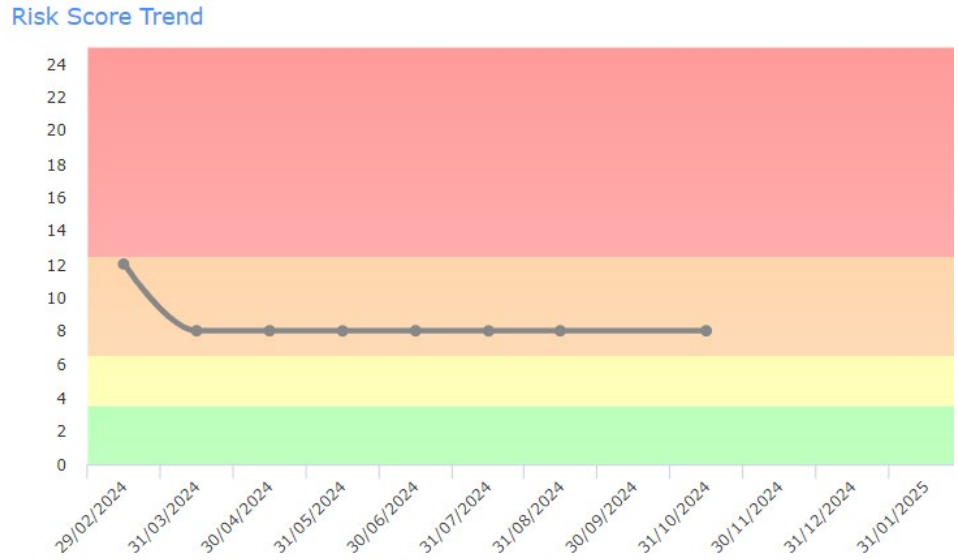
- **Risk 4525 (POD)** Risk of Lack of a strategic workforce planning (12)

Added May 2024 score 12. No change since its addition.



- **Risk 2438 (NMQ)** Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures. (8)

Added July 2022 score reduced from 12 to 8 March 2024. No change since March 2024.



4. **Top Organisational Risks:**

The following 3 risks were agreed at January's meeting:

1- **Finance-** Risk that the trust does not achieve its 2024/25 planned deficit totalling £7 M.
2- **Winter planning-** Risk of inability to safely deliver services over winter.
3- **POD-** Increase in incivility and disrespectful behaviours being reported.

- **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)
- **4635 (COO)** The winter plan is built on a set of underpinning forecasts and principles. There is a risk that the actual position varies from these to such an extent that is results in an inability for the plan to be delivered in whole or in part. (16)
- **4417 (POD)** Risk that promoting an environment that encourages speaking out and creating a psychologically safe culture has led to increased reports of poor behaviour. This could have a negative impact on staff and require additional time and capacity to appropriately address the concerns. This could result in further health and well-being concerns and staff absence. (15)

5. Current compliance with Risk reviews:

Risk review compliance is currently at 95%. Action review compliance is 81%. This is on trend with November's data.

Support with reviews continue to be offered by Corporate and Clinical Risk Lead where able.

6. Recommendations

The Board of Directors are asked to:

- Review the risks and actions and discuss and seek further information relating to risks as appropriate.
- Note risk movements over the last 6 months.
- Take assurance over the development and review of the Organisational Risk Register as per risk governance framework.

Organisational Risk Report- January 2025. Board of Directors

Total Risks (Current/Managed)
19

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	QE Facilities	3132	Exposure to incidents of violence and aggression	15
Wellbeing	People & OD	4417	Increase in incivility and disrespectful behaviours being reported	15

Quality

5

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Effectiveness	Chief Operating Officer	4635	Risk of inability to safely deliver services over Winter due to variations in the forecast assumptions used to develop the plan resulting in an increased clinical, financial and reputational risk profile	16
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 achieved on a recurrent basis.	12
Business Continuity	QE Facilities	2341	There is a risk to ongoing business continuity of service provision due to ageing trust estate	16

Regulation

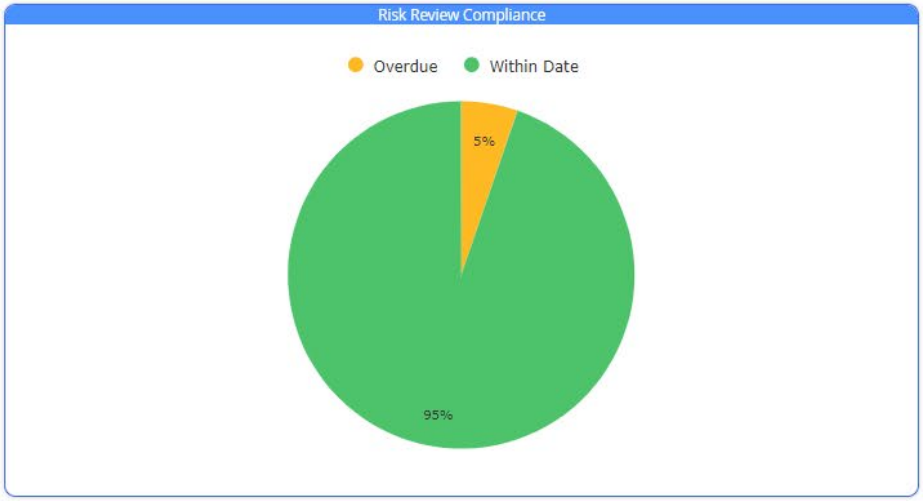
5

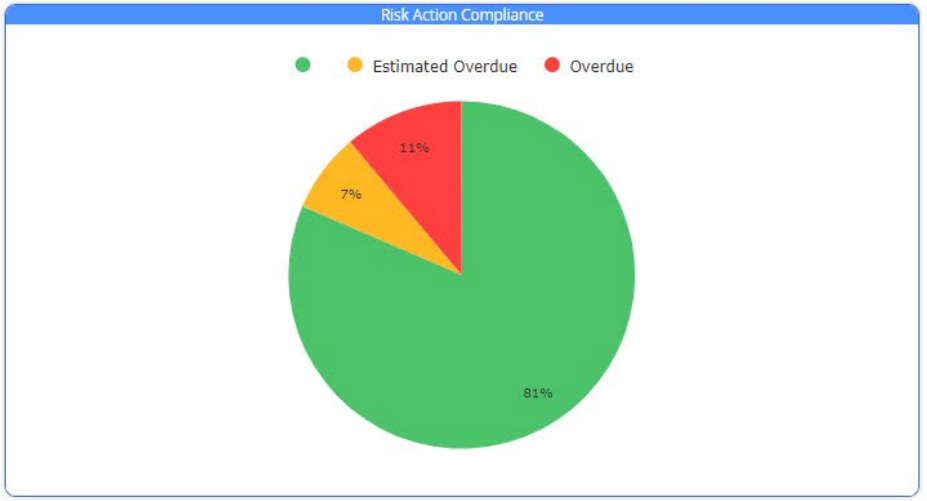
Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Compliance	Digital	4402	Inability to support legislation and best practice associated with records management	16
Compliance	Digital	4575	Non compliance with FoI response turnaround time could result in ICO imposed penalties.	12
Compliance	Digital	4576	Non compliance with SARs response turnaround time could result in ICO imposed penalties.	12
Compliance	Digital	4405	Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure.	8
Compliance	Nursing, Midwifery & Quality	4541	Risk of governance failure as we transition to new governance arrangements	12

Changes to Current Score over 12 Months

Risk ID	Risk Stage	Risk Title	Owner	Business Unit	Service	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025
4577	Current Risk	Achievement of 2024/25 revenue financial plan	Kris Mackenzie	Finance	Finance						20	20	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	12	12	12	16	16	16	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	Medical Director's Office	Medical Directorate					20	20	20	20	16	16	16	16
4402	Current Risk	Inability to support legislation and best practice associated with records management	Catherine Bright	Digital	Health Records	16	16	16	16	16	16	16	16	16	16	16	16
4635	Current Risk	Risk of inability to safely deliver services over Winter due to variations in the forecast assumptions used to develop the plan resulting in an increased clinical, financial and reputational risk profile	Jo Halliwell	Chief Operating Officer	Emergency Planning									12	12	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	16	16	16	16	16	16
3132	Current Risk	Exposure to incidents of violence and aggression	Kate Clark	QE Facilities	Facilities	15	15	15	15	15	15	15	15	15	15	15	15
4417	Current Risk	Increase in incivility and disrespectful behaviours being reported	Amanda Venner	People & OD	Workforce Development	12	12	12	12	12	12	12	12	12	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	15	15
4554	Current Risk	Cyber Threats and Vulnerabilities	Kris Mackenzie	Digital	IT					15	15	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	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	16	12	12	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	12	12
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	12	12
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	12	12
2424	Current Risk	Risk that efficiency requirements are not achieved on a recurrent basis.	Kris Mackenzie	Finance	Finance	16	16	16	16	16	16	16	16	16	20	16	12
4525	Current Risk	Risk of Lack of a strategic workforce planning	Sophia Grainger	People & OD	Human Resources			9	12	12	12	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	12	8	8	8	8	8	8	8	8	8	8	8
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	16	16	16	16	8	8

Risk review and action review compliance. January 2025





Committee Escalation and Assurance Report

Name of Board Committee	Finance and Performance Committee
Date of Board Committee:	17 December 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)

- To Alert the Board to concerns in relation to a number of performance measures, including:
  - DM01 – recovery trajectory is being developed with costed options for each of the key areas.
  - Non elective length of stay
  - RTT waiting times
  - Sickness absence in ED medicine and lack of assurance in relation to gaps which is having an impact on finance and performance.

- To Alert the Board to concerns in relation to Finance, including:

  - Cash forward look – this is likely to become an issue in the summer.
  - Approach to the planning round for 2025/26 – there may be a need for tough decisions around service delivery.
  - CDC Delivery – utilisation is not at the level agreed and the forward look at the tariff might be a risk.

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)

- CRP – The Committee have not yet seen the details of the CRP plans and therefore cannot be fully assured on this.

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

The Committee received the following assurances:

- Paediatric Autism Pathway – changes have been implemented and improvements to wait times and a reduction in the waiting list have been seen – one further report to be received by the Committee before moving to business as usual reporting.

• QEF Business Growth – The Business Development Strategy was noted and the BAF risk score for this strategic objective has been reduced from 6 to 4 as a result of a reduction in the likelihood score. • Urology – improvements in urology as a result of mutual aid via the Alliance.
Risks (any new risks / proposed changes to risk scores)
• The committee noted the Winter Plan has been identified as one of the top risks with a score of 16 and that there has been a change to the methodology of the plan with a number of factors feeding into this risk.
Cross-referrals to Executive Directors
• There were no cross referrals.

Committee Escalation and Assurance Report

Name of Board Committee	Quality Governance Committee
Date of Board Committee:	7 January 2025
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 – the request for additional funding to address capacity issues had been escalated to the ICB but the request was not approved by the ICB Investment Committee. The report is being revised and strengthened and will be re-submitted in the next two weeks. This is an issue impacting on the most vulnerable Children. The Committee are awaiting an update from the ICB.

- Extended and sustained waiting times in ED compounded by an increase in diverts from across the region.

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
  - The number of births during 2024 was 2004 and this has had implications for the service if that number were to be sustained.
  - The Perinatal Action Plan was considered and discussed and the action plan may need to be strengthening in the light of the discussion at the Committee.
- NED involvement in patient safety incidents reports is being considered in line with national recommendations.
- Internal Audit actions approved for closure.
- The Committee was made aware of the £1.3m deficit in funding for the Diabetes Hybrid Closed loop service and challenging decisions may be needed to address this.
- Q4 recovery plan on Elective Care.

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

Positive assurances were agreed in relation to:

- Paediatric Hearing Services – the Committee received assurances on the progress with the action plan and the successful relocation of services to Blaydon.
- Progress with the Quality Account Priorities.
- Research and Development Department Annual Report – recognition of work of the team and that visibility could be raised across the organisation.
- Maternity Incentive Scheme Compliance.
- Freedom to Speak Up progress.
- 2 BAF scores have been reduced.
- PHSO thematic review.

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

- There were no changes to risks on the ORR.
- BAF scores were reduced for:
  Maternity Incentive Scheme – score reduced from 12 to 8
  Quality Improvement Plan – score reduced from 12 to 9

Cross-referrals to Executive Directors

- There were no cross referrals.

Escalation and Assurance Report

Name of Committee / Group:	Digital Committee
Date of Committee / Group:	12 December 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)

- Cyber Assessment Framework (previously the DSPT) – to alert the Board that this will flow through to the Board in March, for submission in April, with the Digital Committee receiving an update at the next meeting in February.

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)

- AI – the Committee had an extensive discussion about AI and recognised the significant opportunities for the Trust and reflected on how this can be progressed. The Committee are looking to receive clearer information on possible immediate deliverables and a longer term strategy by the end of March.

- Subject Access Requests (SARs)/Freedom of Information (FOIs) – the Committee noted that the Trust is still not compliant with statutory requirements – the Committee wished to remind the Board of potential risks/consequences.

Assure
(key assurances received and any highlights of note)

The Committee received assurance in relation to:

- Improvements in Digital KPIs
- Compliance with the work plan/delivery plan

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

There were no changes to risks.

Cross-referrals to Tier 1 Board Committees

- None

Committee Escalation and Assurance Report

Name of Board Committee	Group Audit Committee
Date of Board Committee:	3 December 2024
Chair of Board Committee:	Mr A Moffat

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

QEF Audited Accounts – the accounts are received but further action is required and the external audit report is not yet available for the Committee – an extraordinary meeting of the Audit Committee to be held on 11 December 2024 to receive these reports and enable a recommendation to be made to the QEF Board the following day. (For information this meeting was held and the Accounts were subsequently recommended for approval to the Board of QEF).

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)

Counter Fraud – the Counter Fraud Annual Report for 2023-24 noted the following three areas for improvement based on the ratings in the report:

- Counter fraud and bribery policy and response plan,
- Raising awareness, and
- Gifts and hospitality and conflicts of interest.

The Committee noted that raising awareness of counter fraud should be seen as a priority.

Accounts and Reporting Timetable – to ensure the dates set out in the report align with the dates of the Audit Committee for the new financial year.

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

The Committee received assurance in relation to:

- Executive Risk Management Group Update
- 2023/24 National Cost Collection Assurance Report in respect of the process undertaken and the closure of actions identified in the previous year
- Charitable Fund Accounts – recommending approval to the Board of Trustees.
- Internal Audit progress update – some of the information in the report was not up to date but it was established that there was improvement in the position in relation to the implementation of recommendations.
- Counter Fraud update

- Schedule of losses and special payments

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

There were no changes to risks.

Cross-referrals to Tier 1 Board Committees

Digital Committee - Reference Costs Report - to discuss the review of the process for clinical coding and how this is reported via the Digital Committee.

Executive Risk Management Group (ERMG) – in relation to the discussion on the tracking of new / changed risks noted on the Tier 1 Board Committee 3A reports through the process - to ensure the process is working and there is transparency.

Charitable Funds Board of Trustees – the Committee noted unspent monies accumulating and it was noted this needs to be discussed by the Board of Trustees and a plan developed.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 13

Report Title:	**Board Walkabout Feedback**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29 January 2025			
Author:	Dr Gill Findley, Chief Nurse / Deputy Chief Executive Dr Gerry Morrow, Non-Executive Director Amanda Venner, Executive Director of People and OD Andrew Moffat, Non-Executive Director			
Executive Sponsor:	Dr Gill Findley, Chief Nurse / Deputy Chief Executive			
Report presented by:	Dr Gill Findley, Chief Nurse / Deputy Chief Executive			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To provide Board Members with an overview of observations and reflections from Board walkabouts, supporting triangulation with other sources of information and assurance			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☒
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	-			

Key issues:
Briefly outline what the top 3-5 key points are from the paper in bullet point format
 	
Consider key implications e.g.
• *Finance*
• *Patient outcomes / experience*
• *Quality and safety*
• *People and organisational development*
• *Governance and legal*
• *Equality, diversity and inclusion*
	• This report seeks to formally share the feedback from Board Member walkabouts at public Board.
	• This supports Board Members in their triangulation of information from different sources and will feature on every Board agenda.
	• Over time this will enable key themes and trends to be identified, as well as any material actions from visits.
	• This report covers two visits:
	  • Procedure Investigation Unit (PIU) and the Discharge Lounge – 20 November 2024; and
	  • Maternity – 18 December 2024 as part of Dr Gerry Morrow's induction as a Non-Executive Director and Board Maternity Safety Champion.			

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- Both visits were concluded as being positive, with both reports commenting on areas being clean and tidy. This is consistent with previous Board walkabout reports.
- Both reports also commented on the environment, noting in particular the work of volunteers and fundraisers in furnishing the bereavement suite.
- As Board Members will be aware, the maternity estate presents a number of challenges and this has been reported as presenting issues in previous walkabout reports. On this visit colleagues spoke positively about the support from the estates team in managing the issues as effectively as possible.
- There were some issues raised as part of the PIU and Discharge Lounge visit which were discussed with the team, as outlined on the report.
- One theme which was consistent with the previous Board report on walkabouts was the scope to consider closer working and integration where separate teams are in place across linked areas. In the last report this was raised in relation to ED, SDEC, PEAPOD and UTC and a similar observation is made in respect of PIU and the Discharge Lounge.
- Both reports noted the positive, welcoming and engaging approach of colleagues.

</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="2">Board Members are requested to review the feedback from the walkabout process and consider this in the context of other items on the Board’s agenda for consistency and triangulation.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td>We will continuously improve the quality and safety of our services for our patients</td></tr>
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<tr><td>Trust strategic objectives that the report relates to:</td><td colspan="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.

Evidence an improvement in the staff survey outcomes and increase staff engagement score to 7.3 in the 2025 survey</td></tr>
</table>

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

Board of Directors' Walkabout Feedback

Board Members in attendance:	Amanda Venner – Executive Director of People & OD Andrew Moffat – Non Executive Director
Area visited:	Procedure Investigation Unit (PIU) and the Discharge Lounge
Date of visit:	20 November 2024
Observations about the environment visited if applicable (e.g. clean, tidy, welcoming, health and safety considerations, colleague wellbeing or patient wellbeing considerations)	Very positive visit. PIU was quite busy when we visited, however the discharge lounge was quiet. Both areas were clean and tidy. Detailed whiteboards showing patient details and good understanding from the team of what was happening that day.
What were you impressed by?	Impressed by the care and dedication of the teams we met – nice space – bright and welcoming. PIU – regular patients that have clearly built a relationship with the clinical teams. Staff seemed engaged.
Any areas of concern / things to follow up?	- PIU frustrations over unpredictability and consultant clinics often being held on the same day meaning some days the unit is quiet and others really busy - Concerns raised over relationships with QEF, over the HCA rebanding and implications for discharge team - Concerns raised over pharmacist availability in the discharge lounge - Separate teams across both areas – could be an opportunity to think more broadly about staffing.
Overall summary	2 distinct areas/teams with a very passionate ward manager. Different challenges in each area

Board Members in attendance:	Gill Findley – Chief Nurse and Deputy Chief Executive Gerry Morrow – Non Executive Director
Area visited:	Maternity
Date of visit:	18.12.24
Observations about the environment visited if applicable (e.g. clean, tidy, welcoming, health and safety considerations, colleague wellbeing or patient wellbeing considerations)	We visited the maternity department and saw pregnancy assessment unit, labour ward, ante/post natal ward and SCBU. The departments were clean and tidy and the staff were welcoming and friendly. We met with the Head of Midwifery and discussed the role of the patient safety champion.
What were you impressed by?	We visited the bereavement suite and were informed about the significant work of the volunteers and fundraisers who have furnished the room. We also talked to the staff about the use of Vocera.
Any areas of concern / things to follow up?	The building is obviously old, but the staff were confident that estates were helping to manage the building defects as much as possible.
Overall summary	This was an introductory visit for Gerry as the new maternity patient safety champion.

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:	28th January 2025			
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 December 2024, the Trust has reported an actual deficit of **£6.536m** after adjustments for donated asset depreciation. This is a favourable variance of **£0.100m** from the year-to-date target for reasons detailed in the body of this report. The Trusts updated approved annual 2024-25 capital plan totals **£17.257m**, including **£7.371m** PDC			

<table>
<tr><td></td><td colspan="5">supported. As of December 24, the Trust has reported net capital spend totalling £10.827m, which is £3.219m less than planned.

As of December 24 the Trusts is forecasting achievement of its planned deficit totalling £7.088m for the reasons detailed in the body of this report.

The Trust also continues to forecast delivery of its capital programme totalling £17.257m for the reasons detailed in the body of this report.

Cash balances are forecast at £12.897m at 31st March 25 informed by the delivery of the forecast deficit and capital programme.</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 recommendation to the 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, financial risks and forecast scenario modelling.

To note the summary of performance as of December 2024 (Month 9) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds).</td></tr>
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<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">Ensuring robust governance structures to enhance our productivity and efficiency to make the best use of resources</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">Financial Risks</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>

1 Introduction

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

1.2 The Trust is planning to achieve a revised planned deficit of **£7.333m** in 2024-25 financial year inclusive of an annual cost reduction target of **£22.806m** and Elective Recovery Fund (ERF) income totalling £2.721m and other internal mitigations totalling £15.689m.

2 Key Financial Performance Indicators

2.1 Performance against key performance indicators is detailed in Table 1

Finance KPIs	Dec-24 Plan	Dec-24 Actual	Dec-24 Variance	RAG	Apr-24 to Dec-24 Plan	Apr-24 to Dec-24 Actual	Apr-24 to Dec-24 Variance	RAG
I&E (Surplus) / Deficit (adjusted perf.) £m	0.4	0.3	(0.2)		6.6	6.5	(0.1)	
Operating Income £m	(35.0)	(35.8)	(0.8)		(307.2)	(309.9)	(2.7)	
Pay Expenditure £m	22.0	23.0	1.0		202.8	206.5	3.7	
Non Pay Expenditure £m	13.1	12.7	(0.4)		107.3	106.6	(0.7)	
Non Operating Income £m	(0.1)	(0.1)	(0.0)		(0.9)	(1.4)	(0.5)	
Non Operating Expenditure £m	0.5	0.6	0.0		4.8	5.0	0.2	
Agency Expenditure £m	0.4	0.1	(0.4)		3.6	1.4	(2.2)	
CRP Delivery £m	(2.5)	(2.1)	0.5		(14.7)	(11.7)	3.0	
Capital Expenditure £m	0.6	0.3	(0.3)		14.0	10.8	(3.2)	
Cash position £m	(1.0)	(0.9)	0.1		9.6	26.4	16.8	
Liquidity (days)	(15.1)	(6.0)	9.1		(15.1)	(6.0)	9.1	
Better Payment Practice Code (BPPC)								
NHS Number of Invoices	95.0%	92.4%	-2.6%		95.0%	93.3%	-1.7%	
Non NHS Numbe of Invoices	95.0%	97.7%	2.7%		95.0%	95.8%	0.8%	
Aged Debt								
Receivables over 90 days NHS	10.0%	32.3%	22.3%		10.0%	32.3%	22.3%	
Receivables over 90 days non NHS	10.0%	35.0%	25.0%		10.0%	35.0%	25.0%	

Table 1: Finance KPIs

2.2 For the period of December 24 only the Trust has reported a deficit of **£0.043m** after the adjustment for donated asset depreciation which is a **£0.100m** favourable variance against plan. Year-to-date the Trust has reported a deficit of **£6.526m** which is a favourable variance of **£0.100m** 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.

2.4 The key drivers of this adverse variance are use of escalation beds, including overnight boarders in EAU escalation area, 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 all Divisions totalling **£3.487m** of which medicine **£2.799m** and surgical business units **£0.914m** driven by approved junior medical rota's, premium rate payments on bank, agency and WLI to cover sickness and elective recovery; with additional pressures on clinical supplies.

2.5 Offsetting the key issues and risks include additional system support **(£1.500m)**, overachievement of internal flexibilities **(£2.185m)**, variable clinical income over performance **(£3.932m**) inclusive of **(£0.502m),** relating to 2023-24, depreciation underspend **(£1.735m)** and higher than planned interest receivable **(£0.489m).**

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

STATEMENT OF COMPREHENSIVE INCOME

December 24-25	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)	(31,852)	(32,621)	(277,280)	(279,332)	(2,053)	(235)	(1,818)
Income From Local Authority Care Contracts	(90)	22	21	(215)	(231)	(15)	(14)	(1)
Private Patient Revenue	(684)	(57)	(18)	(514)	(610)	(96)	(135)	39
Injury Cost Recovery	(504)	(42)	(14)	(375)	(257)	118	90	27
Other non-NHS clinical revenue	(1,700)	(19)	36	(168)	(118)	49	(5)	54
Total Operating Income From Patient Care activities	**(352,930)**	**(31,947)**	**(32,597)**	**(278,551)**	**(280,549)**	**(1,997)**	**(299)**	**(1,699)**
Other Operating Income								
Education and Training Income	(11,257)	(1,033)	(957)	(9,366)	(8,775)	591	514	**77**
R&D Income	(564)	(93)	(104)	(879)	(897)	(18)	(7)	**(11)**
Funding outside of System Envelope	0	0	0	0	0	0	0	-
Other Income	(21,790)	(1,957)	(2,177)	(18,330)	(19,724)	(1,394)	(1,182)	**(212)**
Donations & Grants Received	0	(8)	0	(75)	0	75	67	**8**
Cost Improvement Programme - Income	0	0		0	0	0	0	-
Total Other Operating Income	**(33,611)**	**(3,092)**	**(3,237)**	**(28,650)**	**(29,396)**	**(746)**	**(609)**	**(137)**
Total Operating Income	**(386,541)**	**(35,039)**	**(35,833)**	**(307,202)**	**(309,945)**	**(2,743)**	**(907)**	**(1,836)**
Operating Expenses								
Employee Expenses - Substantive	242,176	20,792	22,077	192,062	196,797	4,735	3,451	**1,285**
Employee Expenses - Bank	7,502	647	720	6,351	7,280	928	855	**74**
Employee Expenses - Agency	3,993	447	85	3,575	1,415	(2,159)	(1,797)	**(362)**
Employee Expenses - Other	1,104	92	117	857	1,036	179	153	**26**
Cost Improvement Programme - Pay	0	0		0	0	0	0	-
Total Employee Expenses	**254,775**	**21,977**	**23,000**	**202,845**	**206,528**	**3,683**	**2,661**	**1,022**
Purchase of Healthcare - NHS bodies	8,172	678	853	6,098	6,467	368	193	**175**
Purchase of Healthcare - Non NHS bodies	3,300	270	254	2,576	3,084	509	525	**(16)**
Purchase of Social Care	0	0	0	0	0	0	0	-
NED's	192	16	15	140	135	(5)	(5)	**(0)**
Supplies & Services - Clinical	37,782	3,870	3,674	31,261	33,276	2,015	2,211	**(196)**
Supplies & Services - General	2,943	240	239	2,223	2,299	76	77	**(1)**
Drugs	24,772	2,070	2,243	18,958	18,635	(323)	(496)	**173**
Research & Development expenses	0	0	(0)	1	(2)	(2)	(2)	**(0)**
Education & Training expenses	1,488	149	106	1,406	1,290	(116)	(73)	**(43)**
Consultancy costs	276	23	41	242	538	295	278	**17**
Establishment expenses	4,344	365	321	3,318	3,170	(148)	(104)	**(44)**
Premises	19,123	1,496	1,807	13,932	14,432	500	189	**311**
Transport	1,545	108	171	1,236	1,077	(159)	(222)	**63**
Clinical Negligence	9,120	758	760	6,826	6,520	(306)	(308)	**2**
Operating Leases	1,212	217	(12)	1,952	1,150	(802)	(573)	**(229)**
Other Operating expenses	5,513	1,654	773	6,538	5,435	(1,103)	(1,457)	**354**
Cost Improvement Programme - Non Pay	0		0		0	0	0	-
Reserves	0	0	0	0	0	0	0	-
Operating Expenses included in EBITDA	**119,782**	**11,914**	**11,244**	**96,706**	**97,505**	**799**	**234**	**1,587**
Depreciation & Amortisation - Purchased / Constructed	10,287	864	883	7,699	6,150	(1,550)	(1,568)	**18**
Depreciation & Amortisation - Donated / Granted	245	19	24	175	214	39	35	**4**
Depreciation & Amortisation - Finance Leases	3,540	295	285	2,655	2,430	(225)	(216)	**(10)**
Impairment & Revaluation	96	8	274	75	263	188	(77)	**265**
Operating Expenses excluded from EBITDA	**14,168**	**1,187**	**1,465**	**10,604**	**9,057**	**(1,548)**	**(1,826)**	**278**
Total Operating Expenses	**388,725**	**35,078**	**35,709**	**310,156**	**313,090**	**2,934**	**1,068**	**1,866**
(Profit)/Loss from Operations	**2,184**	**39**	**(125)**	**2,954**	**3,145**	**191**	**161**	**30**
Non Operating								
Non-Operating Income								
Finance Income	(1,220)	(102)	(125)	(918)	(1,407)	(489)	(466)	**(23)**
Total Non-Operating Income	**(1,220)**	**(102)**	**(125)**	**(918)**	**(1,407)**	**(489)**	**(466)**	**(23)**
Non-Operating Expenses								
Finance Costs	824	69	65	618	529	(89)	(85)	**(4)**
Gains / (Losses) on Disposal of Assets	0	0	0	0	0	0	0	-
PDC dividend expense	4,420	368	368	3,315	3,315	(0)	(0)	**(0)**
Total Finance Costs (for non-financial activities)	**5,244**	**437**	**433**	**3,933**	**3,844**	**(89)**	**(86)**	**(4)**
Other Non-Operating Expenses								
Misc. Other Non-Operating expenses	0	0	0	0	0	0	0	
Total Non-Operating Expenses	**5,244**	**437**	**433**	**3,933**	**3,844**	**(89)**	**(86)**	**(4)**
(Surplus) / Deficit Before Tax	**6,208**	**374**	**184**	**5,969**	**5,582**	**(387)**	**(390)**	**3**
Corporation Tax	1,125	94	137	844	1,158	315	271	**43**
(Surplus) / Deficit After Tax	**7,333**	**468**	**321**	**6,811**	**6,740**	**(71)**	**(117)**	**47**
(Surplus) / Deficit After Tax from Continuing Operations	**7,333**	**468**	**321**	**6,811**	**6,740**	**(71)**	**(117)**	**47**
Remove capital donations / grants I&E impact	(245)	(20)	(24)	(185)	(214)	(29)	(25)	(4)
Adjusted Financial Performance (Surplus) / Deficit	**7,088**	**448**	**297**	**6,626**	**6,526**	**(100)**	**(143)**	**43**

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 December £13.209m is forecast to be achieved which is a shortfall of £9.591m.

Business Unit	2024-25 Annual Target £000	2024-25 Annual Achieved £000	2024-25 Updated Forecast Schemes £000	2024-25 Shortfall £000	RECURRING ACHIEVEMENT Recurring Achieved £000	Recurring Forecast £000	Recurring Shortfall £000
Chief Executive	138	0	15	(123)	0	0	(138)
Chief Operating Officer	138	195	195	56	0	0	(138)
Clinical Support & Screening Services	4,307	1,782	3,419	(887)	43	89	(4,218)
Community Services	1,475	1,009	1,364	(111)	187	542	(933)
Estates & Facilities	233	0	360	127	0	360	127
Finance and Digital	800	763	763	(37)	213	213	(586)
Medical Director	58	59	59	1	4	4	(55)
Medicine & Elderly	3,861	180	212	(3,648)	180	212	(3,649)
Nursing & Midwifery	239	146	161	(79)	86	101	(139)
People & Organisational Development	251	127	241	(10)	87	159	(92)
Surgical Services	4,231	1,921	1,921	(2,310)	628	525	(3,707)
Trust Financing	4,069	704	1,499	(2,570)	276	276	(3,793)
Sub-total Trust Performance	19,800	6,885	10,209	(9,591)	1,703	2,480	(17,320)
QEF	3,000	2,470	3,000	0	3,000	3,000	0
Sub-total QEF Performance	3,000	2,470	3,000	0	3,000	3,000	0
Total Group Performance	**22,800**	**9,355**	**13,209**	**(9,591)**	**4,703**	**5,480**	**(17,320)**

Table 3: Cost Reduction Target Performance

4 Capital

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

4.2 Variations to the approved programme at December 2024 include an additional PDC award totalling £0.634m relating to Digital Diagnostics, with charitable funded schemes now totalling £0.076m, resulting in available capital funding of £17.257m as summarised in Table 8 below.

Capital Funding	£'000s	£'000s
Net Depeciation*		9,324
Cash		486
PDC Funded Schemes		
- CDC	6,737	
- Digital Diagnostics	634	7,371
Charitable Funds		76
Total		17,257

* After principal loan repayments

Table 4: Capital

5 Cash and Liquidity

5.1 Group cash as of 31st December totalled £26.401m, a reduction of £0.908m from November (£27.308m). The cash balance is the equivalent to an estimated 24.79 days operating costs (November 25.64 days).

5.2 The liquidity metric for December was (6.02) days; 9.07 days better than plan of (15.09) days.

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

Statement of Position - December 2024

	2024/2025 November 2024 Group	2024/2025 December 2024 Group	Movement from Prior Month	2024/2025 December 2024 QEF	2024/2025 December2024 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	167,279	166,672	(607)	1,101	165,571
Right of Use Assets	6,800	6,515	(285)	3,501	3,014
Trade and Other Receivables, Net	2,086	2,065	(22)	705	1,359
Finance Lease - Intragroup				40,579	0
Trade and Other Receivables - Intragroup Loan	0	0	0		2,988
Total Non Current Assets	176,245	175,332	(914)	45,966	189,757
Current Assets					
Inventories	5,114	5,046	(68)	2,789	2,257
Trade and Other Receivables - NHS	3,215	2,085	(1,130)	561	1,524
Trade and Other Receivables - Non NHS	9,075	8,736	(339)	5,250	3,486
Trade and Other Receivables - Intragroup				11,098	695
Trade and Other Receivables - Other	0	0	0	0	0
Prepayments	6,297	6,322	25	546	5,776
Cash and Cash Equivalents	27,308	26,401	(908)	3,977	22,424
Other Financial Assets - PDC Dividend	0	0	0	0	0
Accrued Income - NHS	7,482	8,344	862	582	7,761
Accrued Income - Other	1,476	1,837	361	1,083	754
Finance Lease - Intragroup				189	0
Trade and Other Receivables - Intragroup Loan					1,118
Total Current Assets	59,967	58,770	(1,197)	26,074	45,795
Liabilities					
Current Liabilites					
Deferred Income	10,728	9,443	(1,284)	41	9,403
Provisions	4,169	4,133	(36)	612	3,521
Current Tax Payables	5,454	4,856	(597)	25	4,832
Trade and Other Payables - NHS	293	2,311	2,018	0	33
Trade and Other Payables -Intragroup				695	11,098
Trade and Other Payables - Other	9,711	9,611	(100)	4,342	5,270
Lease Liabilities	1,723	1,468	(255)	370	1,099
Trade and Other Payables - Capital	997	678	(319)	0	678
Other Financial Liabilities - NHS Accruals	7,162	5,051	(2,110)	724	6,612
Other Financial Liabilities - Accruals	22,554	22,697	143	8,361	14,330
Other Financial Liabilities - Borrowings FTFF	499	499	0	0	499
Other Financial Liabilities - PDC Dividend	737	1,105	368	0	1,105
Other Financial Liabilities - Intragroup Borrowings	0	0		1,118	0
Finance Lease - Intragroup	0	0		0	189
Total Current Liabilities	64,026	61,854	(2,171)	16,287	58,667
NET CURRENT ASSETS (LIABILITIES)	(4,059)	(3,085)	974	9,787	(12,872)
Non-Current Liabilities					
Deferred Income	2,010	2,010	(0)	1,719	291
Provisions	2,471	2,445	(26)	0	2,445
Trade and Other Payables - Other	-	0	0	0	0
Lease Liabilities	5,397	5,823	426	3,564	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	20,891	21,291	400	8,270	56,588
TOTAL ASSETS EMPLOYED	**151,295**	**150,956**	(339)	**47,483**	**120,297**
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)	(32,519)	(32,858)	(339)	30,659	(63,517)
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	151,295	150,956	(339)	47,483	120,297
TOTAL ASSETS EMPLOYED	**151,295**	**150,956**	(339)	**47,483**	**120,297**

Table 5: Statement of Financial Position

6 Conclusion

6.1 Following the allocation of an additional **£5.317m** non-recurring deficit support the Trust has a revised planned deficit of **£7.333m** before adjustments for donated asset depreciation, and **£7.088m** after.

6.2 reported an adjusted deficit of **£6.536m** for the period up to December, which is a favourable adverse variance of **£0.100m** from its year-to-date target.

6.3 The Trust has reported externally the achievement of cost reduction programme totalling **£11.706m** and is forecasting to achieve **£13.209m** for the year, resulting in an under-shoot against the annual target of **£9.592m**. On a recurring basis the Trust is forecasting a total of £5.480m, equivalent to 24%, with a total unachieved target of £17.320m to be carried forward to 2025-26.

6.4 The Trust is forecasting delivery of its planned deficit totalling £7.088m partly as a result of non-recurring benefits including technical adjustments totalling £14.965m, system deficit support of £5.317m and system support totalling £6.000m.

6.5 Cash modelling confirms the Trust will not require access revenue cash support in 2024-25

6.6 The Trust is forecasting delivery of its capital programme within its Capital Delegated Expenditure Limit.

Kris Mackenzie, Group Director of Finance & Digital
January 2025

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:	29th January 2025			
Author:	Deborah Renwick			
Executive Sponsor:	Kris Mackenzie			
Report presented by:	Kris Mackenzie & Joanne Halliwell			
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 M9 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:** Continues on an improvement trajectory: Ockenden recommendations has improved to 98% in month from 97.4%. Maternity Incentive Scheme (MIS) has also improved to 96% from 89%. Delivery of the **Quality Improvement Plan** reduced compliance in month from 68% to 56% of all actions on track for delivery. Key delivery improvement areas include: Resus checks & safe storage of COSHH and appraisal rates. **PSIRP**: The volume of falls and falls harm rates have increased in month and remains above target reduction levels. Implementation of the actions from the falls PSIRP workstream are outstanding. **QA**: The Trust has reported two cases of C. difficile in M9 and a total of 30 year to date against our annual threshold is 37. In month rates per 100k bed days have reduced to 13.2.			

• *Equality, diversity and inclusion*	**QA**: Performance against learning disability and autism training remains below target levels of 85%, although improving in month from 57.36% to 59.9%. Challenges remain re: regional hub delivery model and digital updates to monitoring systems. Mental Health Act Policy training remains static at 84.2% and below target levels of 90%. Training and delivery challenges are anticipated when RGN's are included within the roll out plans. Medicines management indicators remain under review to support high impact SMART and measurable KPI's. The **agreed strategic approach to EPR** and the outline business case (OBC) is planned to be presented to Board in Jan-25. Work is continuing to align plans with a shared Digital Alliance Strategy and establish core digital standards. **Development & implementation of an Estates strategy** has now been deferred, awaiting further clarity on the direction of the GNHA Big Build. The headline metrics underpinning and related to the development of the strategy are detailed below: • A clinically prioritised capital plan is now in place. • Baseline risk assessments from Inphase has been undertaken. In M9 there remains 22 estate risks with a combined risk score of 272 – a slight reduction from the previous month. • At the end of M9, the Trust is above the target reduction of safety incidents reported linked to estate issues. There were 5 estates related safety incidents reported in December. There are no consistent themes in incidents reported to date. • Multi-disciplinary PLACE audits have taken place in four areas across the Trust in December. No major concerns were raised; resulting work from the audit include clearer signage and general redecoration of estate. Scoring systems remain 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 continue on an upward trajectory, increasing 0.3% in month from 3.2% to 3.5%, below the target of 2.5% this is primarily attributed to recruitment in the Community Diagnostic Centre and tighter vacancy controls. Vacancy pressures remain in key service delivery areas. • Staff engagement score increased from 6.63 to 6.8 and remains below target levels of 7.3. Targeted work is on-going to improve rates via multiple routes.

- Turnover rates overall are demonstrating a downward trajectory, however the M9 position has increased to 11.5% remaining higher than our internal target of <9.7%.
- Sickness absence rates have increased slightly in M9 to 5.7% and continue to be above target levels of 4.9%.
- Temporary staffing spend as a proportion of pay bill is at 0.4% 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.

Pressures in Urgent and Emergency care continue into the winter, this position is mirrored across the ICS.

- Whilst our average daily attendances remained static at circa 320 per day - Type 1 attendances were 108% over planned levels, UEC and Blaydon were both below planned levels at 93% and 36%.
- Ambulance arrivals were high at 2,238 – averaging 72 per day.
- Continued mutual support for patch wide pressures 24 ambulance diverts were received in month. Pre-M9 Trust average monthly divert rate was 6 ambulances per month. We received 5 diverts in December last year.
- 93% of ambulance diverts were from south & east of the patch.
- The Trust was supported with 12 diverts away from the department, primarily NUTH.
- 10% of patients in ED spent more than 12 hours in the department.
- There were 30 reportable 12-hr delays for admission.
- The ED 4-hr standard deteriorated in month to 65.6% in M9, below national target level of 78% and planned improvement levels – both admitted and non-admitted are also below their differential standards.

A revised improvement trajectory supported by key improvement activities is in place to support recovery in Q4.

- Higher levels of norovirus/Flu A in the hospital have also impacted on the ability to create flow.
- Average NEL length of stay reduced in month to 7.24 days in December.
- The daily average of patients no longer meeting the criteria to reside was 40 in December.
- In December there were 477 beds open, on average 22 beds more per day than previous month and 3 beds more per day open than last year.

	Additional multi-disciplinary daily flow meetings were urgently instigated to support daily operational pressures and recovery strategies. The Trust has a targeted improvement elective recovery plan to achieve zero > 52 week waiters and prevent/reverse the increase in RTT waiters in Q4. Targeted themes include: Maximising productivity, increasing additional capacity and improving internal administrative processes with speciality driven targeted improvements in support increased capacity in key deliverable areas. Forecast modelling is underway, tracked to key recovery delivery areas in support of minimising year end risks. Sustained improvements have been maintained across all key cancer measures. Risks continue in our year-end achievement of DM01. Revised H2 trajectory forecast M9 performance at 89%, M9 actual is at 83.7%, with echocardiology, audiology and non-obstetric ultrasound all below planned performance levels. NOUS and Audiology are significantly below planned activity levels, re: workforce issues. Echocardiology has experienced increased demand. All challenged modalities are reviewing and revising Q4 improvement plans. Significant recovery and performance improvements have been made in MRI and are back on track. **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 M9 we are reporting a deficit position of £6.5m against revised planned levels of £6.6m representing a positive variance of £100k. 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 £3m, with £11.7m transacted at M8 against a plan of £14.7m. Risks remain in the proportion of non-recurrent savings made to date & the CRP plan heavily weighted towards Q3 and Q4. £1.5m recurrent CRP has been delivered against a plan of £6.8 to date. Focus remains in recurrent savings to support financial sustainability.

<table>
<tr><td></td><td colspan="5">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 in September. The Trust is planning to achieve £5m more than £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. Digital teams will continue to support efforts to reduce digital exclusion by repurposing hardware in 2024/25 and have achieved target levels of recyclable hardware to date. Gynaecology outpatient waiting times reduced to 39 weeks in month. Service plans to support recovery are in development to improve waiting times. Paediatric autism assessments and diagnosis waiting times have reduced in-month to a median of 64 weeks, the revised clinical model has significantly increased capacity, and the Team are now on track to deliver median waits <30weeks by the end of the year.

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

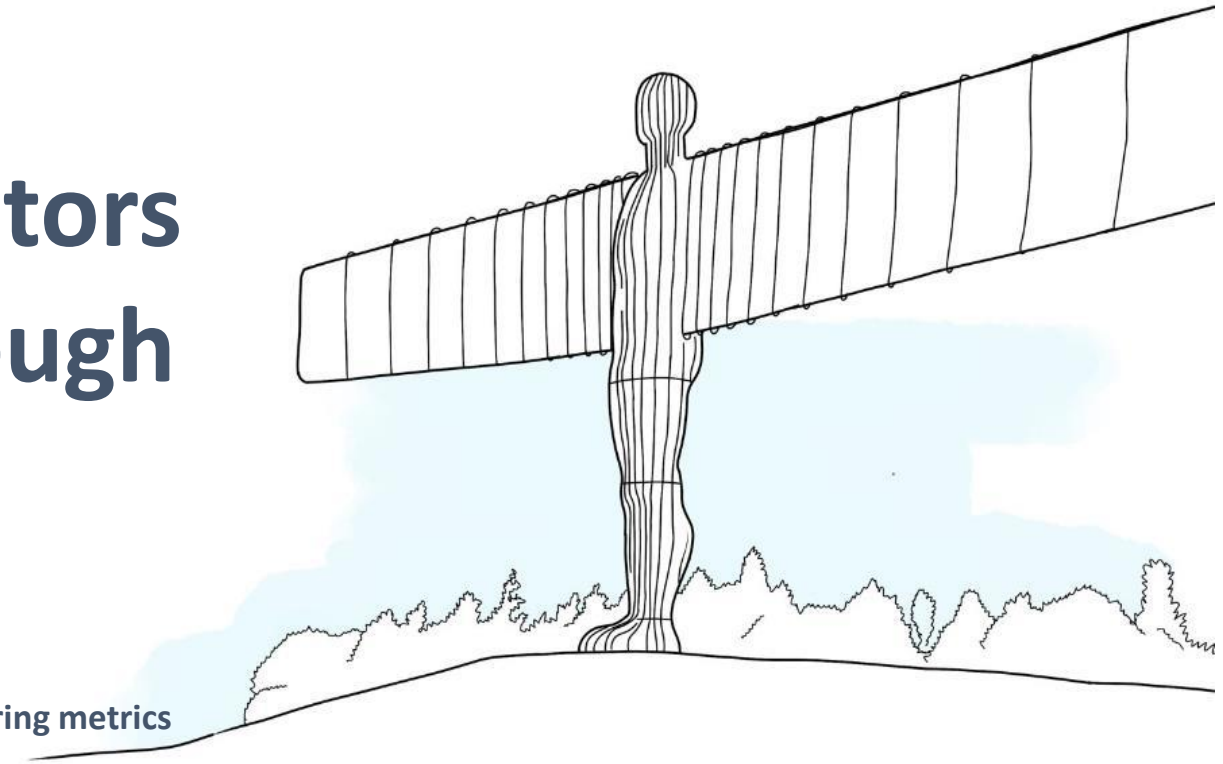
Plans to increase QEF externally generated income by 0.5% are ahead of schedule with Month 9 delivery at 1%.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The recommendations to the Committee are to receive this 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="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">All 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>Safe
☒</td></tr>
</table>

Risks / implications from this report (positive or negative):			
	Key areas to establish reporting: • PLACE audit scores not yet generated from PLACE Lite • Medication updates are included in the narrative section. No movement in key areas: • 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. Areas requiring attention: **Quality & Safety:** • Increase in risk scores linked to Estates to understand drivers. • Harm rates from falls • C.Difficile cases against annual threshold **Workforce:** Staff engagement, turnover rates, vacancy & sickness absence rates. **Productivity & Efficiency:** Risk in achieving zero 52 week waiters and increase in RTT waiting lists. Year end achievement of DM01 95% standard: Non-obstetric ultrasound, audiology & echocardiology. Outpatients with procedures below target percentage of 33% - although demonstrating an improving trajectory. Winter and region wide pressures are impacting on bed availability and flow across the Trust and impacting on Urgent and Emergency Care metrics and 4hr A&E target. Risk in achieving financial plan & reducing expenditure and achieving CRP. Risk in reducing waiting times in gynaecology with current workforce pressures		
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

NHS
Gateshead Health
NHS Foundation Trust

Strategic Objectives 2024/25

Leading Indicators and Breakthrough Objectives



Including Constitutional standards monitoring metrics

Reporting Period: December 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

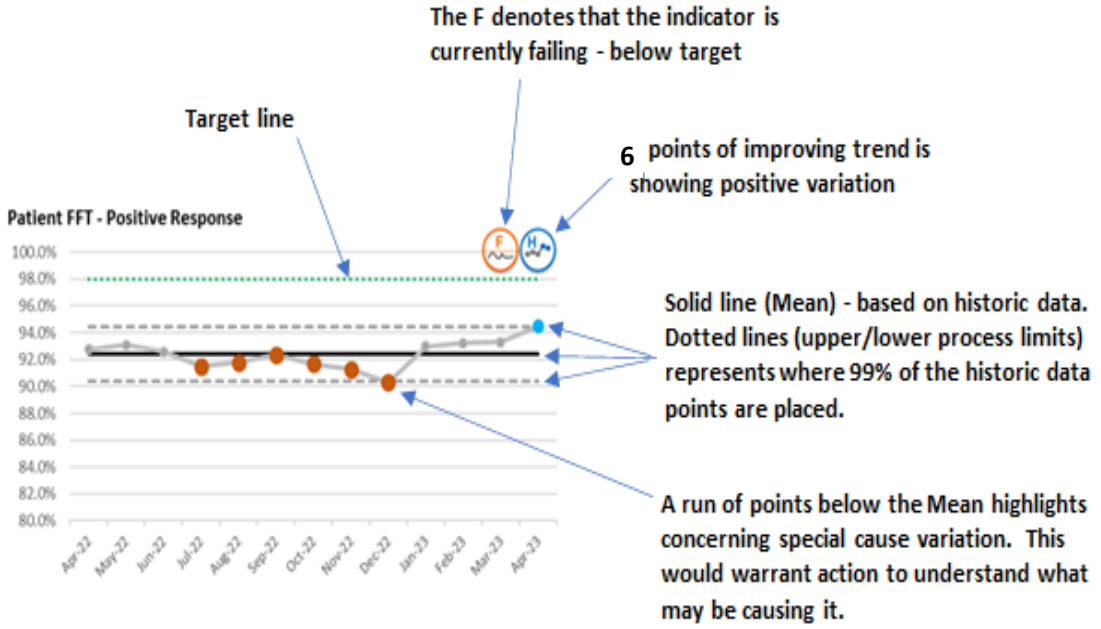
Improved	No Change	Needs further attention
We will continuously improve the quality and safety of our services for our patients		
Compliance with Level 1 training plans for learning Disability & Autism training improved to 59.97%	Mental Health Act Training requires a training package for all registered staff remains at 84.2%	Strategic approach to development of EPR is behind schedule by a month
Ockenden recommendations compliance improved to 98%	Scoring in domains in areas of PLACE inspection not available	Severity of risk scores linked to estates to 272 has decreased however remains high
Maternity Incentive Schemes Compliance increased to 96%	Reduction in patient safety incidents linked to estate issues: remained at 5	Quality Improvement Plans reduced to 56% compliance Harm rate from falls increased to 4.87 C.Difficile rate has reduced to 13.2.
We will be a great organisation with a highly engaged workforce		
	Improve the staff engagement score to 7.3 (currently at 6.63) Reduction in temporary staffing spend evidenced early month reduction to 0.4% of pay bill.	Achievement of the internal turnover standard of 9.7% (currently at 11.5%) Internal sickness absence standard at 5.7% Maintain the vacancy rate at <=2.5%, currently at 3.5%
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 (December - 40) 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 32.2% in December)
We will be an effective partner and be ambitious in our commitment to improving health outcomes		
	Evidence a reduction in the number of 'fragile' and 'vulnerable' services as a direct outcome of Alliance working Evidence in an improvement in health inequalities in the key focus areas linked to the determinants of Health for Gateshead No further change in the number of digital devices repurposed to the local community	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 Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients by March 2025
We will develop and expand our services within and beyond Gateshead		
	Increase in QEF externally generated turnover to 4%	

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 concem.

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

NHS Gateshead Health NHS Foundation Trust

	P	?	F	
Improving			Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 by March 2025 Achievement of the internal turnover standard of 9.7% Increase % of Outpatient % with procedures Ockenden Recommendations % compliance with Total Recommendations	
Neither improving or deteriorating		Harm falls rate per 1000 bed days Achievement of the 4 hours trajectory C.Diff Healthcare associated rate per 100,000 occupied bed days Reduction in the wait for gynaecology outpatients to no more than 26 weeks Reduction in patient safety incidents related to estates issues	Reduce the number of patients with no Criteria to Reside Achievement of the trajectory to reduce >12 hour total time in Emergency Department Achievement of the 52 week RTT standard 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%	
Deteriorating		Maintain the vacancy rate at <=2.5% Achievement of the % to reduce >12 hour total time in Emergency Department	Average Length of Stay Non-Elective <4 days Achievement of the trajectory to achieve RTA to Bed within 1 hour Compliance with the quality improvement plan indicated by the % of actions on track	
	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

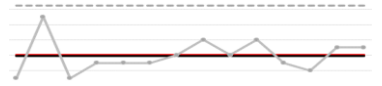
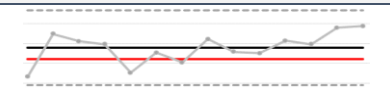
NHS Gateshead Health NHS Foundation Trust

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	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Ass/Var	Trend
LEADING INDICATORS																	
Ockenden Recommendations % compliance with Total Recommendations	100%	88.8%	88.8%	77.7%	77.7%	77.7%	78.0%	78.0%	74.0%	74.0%	89.0%	90.0%	95.2%	97.4%	98.0%	H F	
Maternity Incentive Schemes % compliance with Total Recommendations	100%						62.9%	70.8%	76.4%	77.5%	83.0%	89.0%	89.0%	89.0%	96.0%		
Reduction in patient safety incidents linked to estate issues	<=4	1	9	1	3	3	3	4	6	4	6	3	2	5	5	?	
Compliance with the quality improvement plan indicated by the % of actions on track	100%	84%	80%	84%	88%	88%	88%	88%	76%	84%	88%	84%	72%	68%	56%	L F	
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	280	272		
Harm falls rate per 1000 bed days (5% reduction)	3.2	2.31	4.48	4.10	3.96	2.51	3.53	3.03	4.21	3.57	3.50	4.13	3.95	4.79	4.87	?	
C.Diff Healthcare associated rate per 100,000 occupied bed days	<=3.20	7.0	33.5	20.1	36.5	21.0	21.1	20.9	22.1	28.4	27.8	42.0	6.7	28.6	13.2		
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%	84.2%	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%	54.95%	57.36%	59.97%		

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 98%. Areas non-compliant are Informed Consent and RA throughout pregnancy. Progress made includes MIS compliance with all elements of Saving Babies Lives Care Bundle confirmed. Audits are ongoing for IAEs 5&7, LMNS requested full review of Ockenden 1 actions in anticipation of full compliance - no need for ongoing monitoring going forwards.
	Maternity incentive schemes % compliance with total recommendations	The Trust is reporting compliance at 96%. Only outstanding action is final ratification of updated Maternity Risk Management Guideline – January Safecare - Safety action 7. Annual LMNS assurance report received, Q2 LMNS assurance meeting completed, MIS compliance reporting period ended 30/11/2024. 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 December 2024 with 56% of the Improvement Plan actions on track to deliver, The newly developed Quality Improvement Plan monitors 25 leading indicators covering Patient Safety, Patient Experience and Quality. Decembers 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. To note there has been a marked improvement 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 uptake rates remain significantly below the 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.
	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.	Discussions continue regarding next steps with regards to LD and Autism awareness training, with scoping on going as to delivery models when national guidance is 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, however the team are supporting to update compliance as required.
	Improve Mental Health Act Policy Training Compliance to 90% for all *registered* staff via training and audit.	Performance remains at 84.2%. Percentage has been negatively affected by rotational OT's coming into post who require training. CPN team and Memory Hub staff are 100% compliant. 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). Additional sessions have been put in place but staff are unable to be released from the ward, training sessions in October and December were cancelled due to lack of participants. It is hoped that the competencies can be added to ESR as a mandatory training module in the New Year.
	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 reporting 30 cases. A rate of 13.2 per 100,000 occupied bed days is observed in December 2024, third best performing within the region (8 Trusts). Resulting from 2 cases (compared to a rate of 6.7 resulting from four observed case last month) 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. Community prevalence continues to be higher than normal levels, reflecting national and local elevated levels of C.Diff.
	Medicines	The Women's Health and Childrens Services Pharmacist has been in post since April and is now well established, presenting the role to the Great North Pharmacy Conference in July. Work to review IV iron infusions is ongoing this financial year and guidelines will be introduced in December 24. Further development of mandatory e-Learning for syringe drivers and the development of a Palliative Care presentation for preceptorship training are hoped to be implemented for the next financial year. Iron IV guidelines have been updated in December 24.
	Harm related falls will reduce by 5% by March 2025.	The number of falls and falls with harm has increased this month. The changes to the incident reporting system questions have been fully implemented, along with updating of the falls categories. This has been positively supported by staff. We have engaged with the new expanded National Audit of Inpatient Falls (NAIF) which now includes all inpatient falls with harm. This will give us wider data as to how we are performing nationally, and potential areas for further improvement. Pilot work continues on the COTE wards, however significant challenges due to winter pressures have delayed progress. Continued staffing challenges continue, in particular around enhanced care, and these are reported on InPhase when wards are unable to provide this. The Falls Steering group continues to meet and provide insight, support and oversight of all issues, challenges, and progress with falls prevention and management.
3	Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.	Progression with alliance discussions, while positive, have impacted the delivery date of the OBC. 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 Jan 2024 to allow sufficient time for procurement of a solution, including due diligence. It has therefore been agreed that the case will be considered at the January Trust board. 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	December position, 22 Risks with combined critical infrastructure risk score of 272 (reduced from 280 in November. 1 new risk (4529- ventilation failure in QEH Mortuary score 16). 1 closed risk (2575) Paediatric Audiology score 16. 2 risks reduced- (2412 Bariatric Mortuary storage score 12) and (2984 Maternity Estate score 16)
	Reduction in patient safety incidents linked to estate issues	There are 5 estates related incidents reported in December. There are no consistent themes with the current incidents. These figures currently exclude incidents related to pressure damage and incidents reported as Harm not related to Gateshead on Inphase.
	Scoring in domains in areas of PLACE inspection composite score > 95%	PLACE lite implementation is still awaited to produce percentage scores. In December Ward 12, main OPD & fracture, and well woman's area have been reviewed. No concerns raised, signage could be better at MOPD & fracture clinic, estates aware. Staff are happy with areas, although well woman's area lacked atmosphere and felt outdated and decorating has been logged with estates.
	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	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Ass/Var	Trend
LEADING INDICATORS																	
Maintain the vacancy rate at <=2.5%	<=2.5%	2.5%	2.5%	2.3%	2.2%	2.4%	1.7%	1.7%	1.6%	3.2%	3.1%	2.7%	3.4%	3.2%	3.5%		
Improve the staff engagement score to 7.3	>=7.3			6.60			6.60			6.63							
BREAKTHROUGH OBJECTIVES																	
Achievement of the internal turnover standard of 9.7%	<=9.7%	13.2%	13.2%	12.8%	12.9%	12.5%	12.0%	11.8%	12.1%	11.7%	11.7%	11.7%	11.2%	11.4%	11.5%		
Achievement of the internal sickness absence standard of 4.9%	4.90%	5.9%	6.0%	6.3%	5.6%	5.2%	5.5%	5.7%	5.8%	5.8%	5.7%	5.6%	5.6%	5.6%	5.7%		
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%	0.5%	0.4%		

Measures requiring focus this month

Measure	Summary
Maintain the vacancy rate at <=2.5%	Vacancy rate is at 3.5% a 0.3% increase compared to November 24. The increase since Oct24 is primarily due to a budgeted establishment increase for Community Diagnostic Centre. Vacancies add pressure to the group and our ability to provide a safe and high-quality service. There are 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.
Improve the staff engagement score to 7.3	Annual Engagement score had been declining since 2018, 2023 saw engagement raise to 7.0 from 6.9 in 2022. So this is slightly increasing. The quarterly pulse survey results for July was 6.63, with a 7% completion rate for the group. October24 survey scores has been added to this month's report, engagement increased to 6.8 from 6.6 in July24, but is down 0.2 compared to the 2023 Annual Staff Survey. Low levels of engagement with both Annual and Pulse Survey Results bring validity of measure into question. A refreshed approach to increasing completion rates will take place for the July quarterly people pulse, with an aim to increase completion which will better allow the Trust to measure engagement on a quarterly basis. 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 increased by 0.1% from 11.4% in November. 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. Deep dive presented to People and OD committee and a clear plan in place for targeted interventions for those teams with high turnover.
Achievement of the internal sickness absence standard of 4.9%	High levels of deprivation and external factors along with challenging roles are driving some of our sickness absence. Sickness increased to 5.7% for a rolling 12 months in December. 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. Continue with monthly case management approach of all long-term absence cases. Business Units provided with monthly short term absence reports highlighting all employees who have triggered short term absence procedure. Ongoing training and development on the new absence management policy.
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%. Off framework agency usage has dramatically decreased but additional pay spend remains high. Challenges in that temporary staffing spend is continuing, further controls to be put in place for the Bank and Agency reduction monitoring group. The bank and agency reduction monitoring group has extended the metrics reported through this group to include all temporary staffing figures.

Strategic Objectives 2024/25

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

NHS Gateshead Health NHS Foundation Trust

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

Evidence of reduction in cost base and an increase in patient care related income by the end of March 2025 leading to a balanced financial plan for 2025-26

Metric	Target	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Ass/Var	Trend
LEADING INDICATORS																	
Average Length of Stay Non-Elective <4 days *Revised to align with operational guidance definitions*	<=4	5.23	5.31	5.38	5.26	4.46	5.19	7.62	6.87	7.17	7.73	7.96	7.24	8.26	7.24		
Achievement of the 4 hours trajectory	≥78% (Local ≥80%)	70.5%	66.1%	68.6%	69.0%	72.2%	71.8%	72.0%	76.3%	71.0%	72.2%	71.4%	67.8%	73.0%	65.6%		
Achievement of the 52 week RTT standard	Apr 24 - 58 May 24 - 42 Jun 24 - 18 Jul 24 - 0	263	143	113	112	76	72	109	88	81	108	123	106	111	102		
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	(0.143)	(0.1)		
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	7,088	7,088		
BREAKTHROUGH OBJECTIVES																	
Achievement of the trajectory to reduce >12 hour total time in Emergency Department	0	453	750	692	458	362	358	413	225	531	391	395	749	495	1036		
	2.0%	4.9%	7.4%	7.0%	4.9%	3.6%	3.8%	4.1%	2.3%	5.4%	4.4%	4.4%	7.6%	5.1%	10.5%		
Reduce the number of patients with no Criteria to Reside	<10	42	41	39	44	36	35	35	55	48	46	38	45	41	40		
Achievement of the trajectory to achieve RTA to Bed within 1 hour	60.0%	12.3%	10.0%	10.6%	8.8%	13.6%	9.7%	5.5%	6.1%	5.2%	5.6%	6.3%	3.7%	4.7%	4.2%		
Increase % of Outpatient % with procedures	>=33%	28.9%	28.5%	27.9%	28.4%	27.9%	31.4%	32.0%	31.6%	30.5%	28.9%	28.7%	30.5%	32.8%	31.8%		
2024-25 CRP Delivery Variance	Figure in brackets favourable						0	0	98	0	(570)	680	1,157	2,539	2,994		
No less than £5m cash as per forecast at March 2025	>=£5m						£5m	£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

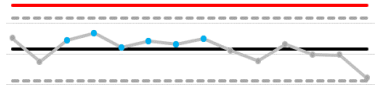
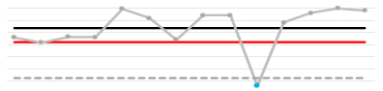
Measure		Summary
1	**Average Length of Stay Non-Elective <4 days**	Length of stay has decreased during December but remains out with the target for the year. Ongoing work to fully utilise the Intermediate Care beds, targeting those with no criteria to reside and ensuring they are discharged appropriately as well as focusing on those with a stay of 7, 14 or 21 days continues to be the focus of improvement work to further reduce this target.
	Achievement of the 4 hours trajectory	Performance at 65.6 % shows a deterioration. 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. Further enhanced patients flow meetings have been introduced to support better flow and improve this target.
	Achievement of the trajectory to reduce >12 hour total time in Emergency Department	Performance at 10.5% showed a deterioration. December saw a significantly challenging period of 5 days from Boxing Day onwards, where all planned and unplanned escalation capacity was used to accommodate the peak of seasonal illnesses, this contributed to the figure above. To achieve the planned reduction availability of beds on EAU and back of house is key. 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 4.2%. 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 40. There has been a significant push on reducing these numbers. 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 December was not achieved; delivery challenges remain in two specialties; T&O and Gynaecology due to capacity and demand imbalances and challenged shared pathways in key service areas, this is being managed through the access and performance weekly meeting and weekly service meetings. Review of waiting lists by consultant, pooling and alternative ways of releasing capacity. Additional theatre lists where possible and ongoing validation of pathways. On track to achieve zero 52 weeks for Urology by end of Q3. Service modelling and revised trajectories with plans to meet target by year end.
	Increase in New Outpatient activity	A further increase in December to 32.2% but still 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 M9 of £6.626m and actual performance of £6.526m deficit which is a favourable variance of £0.10m. In month 6 the Trust received notification it will receive £5.317m non-recurrent deficit support funding resulting in a revised outturn deficit of £7.088m, and forecast to achieve this position. However, risks remain around overspending against delegated budgets and identification and delivery of CRP targets. The Trust has a planned CRP target at M9 of £14.700m and actual performance of £11.706m which is a negative variance of £2.994m. There is £1.557m delivered recurrently which is £6.816m 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, including the receipt of additional funding, cash is forecast to be c. £10mwhich is £5m ahead of plan, and be no less than the £5m target at the financial year end.
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	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 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	0	0		
Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients by March 2025	>=98%	92.6%	88.7%	92.2%	93.4%	91.1%	92.1%	91.6%	92.5%	90.5%	88.8%	91.6%	89.9%	89.8%	86.0%		
Reduction in the wait for gynaecology outpatients to no more than 26 weeks	<=26	27.9	25.9	28.1	28.0	39.7	35.9	27.0	37.0	37.0	8.0	34.0	38.0	40.0	39.0		
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 by March 2025	<=30	75	75	77	76	78	80	81	83	85	82	78	78	72	64		

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 86% against this measure.
Reduction in the wait for gynaecology outpatients to no more than 26 weeks by March 2025.	The median wait has decreased slightly to 39 weeks from 40 weeks in December. The position was impacted by the loss of 2 consultants over the Summer (one now back to work and replacement for other post started November 24) 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 complete with one new consultant started Nov 24 and a further new consultant starting Jan 25. Capacity and Demand imbalance for New OP. Workshop undertaken with Gynae team in October to look at additional opportunities to manage demand and action plan underway. This includes a full job planning, clinic template and pathway review.
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 weeks by March 2025	Current waits are at 64 weeks for autism assessment pathways, which is a further 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

NHS Gateshead Health NHS Foundation Trust

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

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

Metric	Target	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Ass/Var	Trend
LEADING INDICATORS																	
0.5% increase in QEF externally generated turnover	>=0.5%						0.2%	0.0%	0.0%	0.6%	1.0%	0.4%	0.8%	1.0%	1.0%		

Measures requiring focus this month

Measure	Summary
0.5% increase in QEF externally generated turnover	Current cumulative performance is 5% 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: December 2024

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

				
Improving				 
Neither improving or deteriorating	Achievement of the 31 day cancer standard	Achievement of the A&E 4 hour standard Achievement of the 28 day cancer standard Achievement of the 62 day cancer standard Ambulance handover delays 30 - 60 minutes	Achievement of the 52 week RTT standard Achievement of the 18 week RTT standard Achievement of the 6 week diagnostic standard	
Deteriorating		Ambulance handover delays 60 minutes+ 12 hour trolley waits (DTA to left department) % of ED attendances >12 hours in department		 
	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

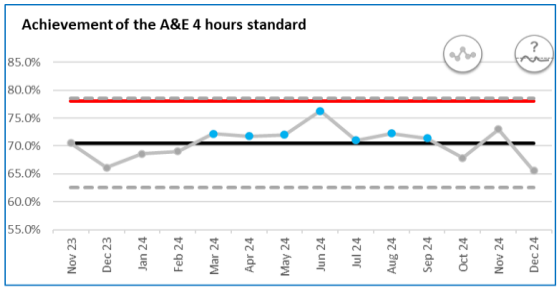
Metric	Target	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Ass/Var
Achievement of the A&E 4 hours standard	>78%	70.5%	66.1%	68.6%	69.0%	72.2%	71.8%	72.0%	76.3%	71.0%	72.2%	71.4%	67.8%	73.0%	65.6%	
12 hour trolley waits (DTA to left department)	0	0	7	1	0	0	1	4	0	3	0	0	3	1	30	
% of ED attendances > 12 hours in department	<2%	4.9%	7.4%	7.0%	4.9%	3.6%	3.8%	4.1%	2.3%	5.4%	4.4%	4.4%	7.6%	5.1%	10.5%	
Ambulance handover delays 30-60 minutes	0	80	110	25	1	0	0	2	1	10	4	3	3	10	43	
Ambulance handover delays 60 minutes +	0	51	50	2	0	0	0	0	0	13	0	0	0	1	51	
Achievement of the RTT 18 week standard	>92%	67.7%	67.2%	68.3%	67.8%	67.9%	68.9%	70.6%	70.6%	70.3%	69.2%	68.6%	68.5%	69.2%	69.8%	
Achievement of the 52 week RTT standard	0	263	143	113	112	76	72	109	88	81	108	123	106	111	102	
Achievement of the 6 week diagnostic standard	>95%	94.1%	91.4%	90.0%	92.1%	91.2%	88.8%	86.0%	83.8%	84.7%	84.3%	86.4%	88.3%	86.8%	83.3%	
Achievement of the Cancer 28 day standard	>77%	78.5%	80.4%	75.9%	83.0%	81.1%	79.7%	82.1%	80.7%	80.5%	79.7%	77.8%	82.2%	84.4%	85.3%	
Achievement of the Cancer 31 day standard	>96%	99.4%	99.4%	99.6%	100.0%	97.9%	99.1%	100.0%	100.0%	98.9%	99.8%	100.0%	99.1%	98.5%		
Achievement of the Cancer 62 day standard	>70%	70.0%	64.6%	72.4%	71.2%	73.9%	75.7%	67.6%	71.4%	69.8%	74.2%	67.5%	81.0%	74.2%		

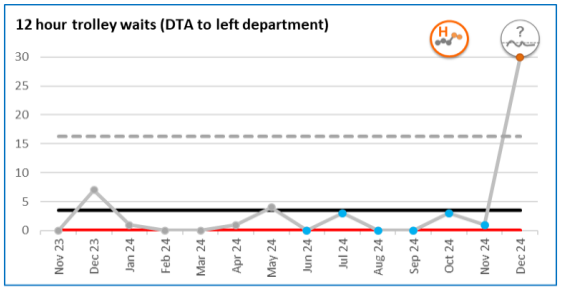
Validated data unavailable at time of report

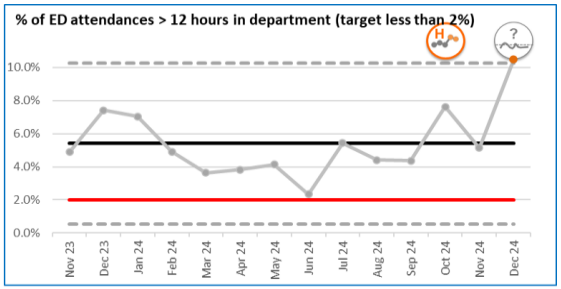
Constitutional Standards

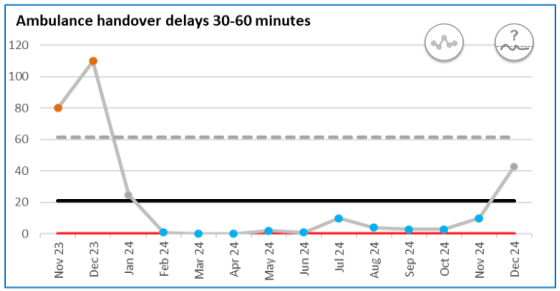
Metrics (SPC)

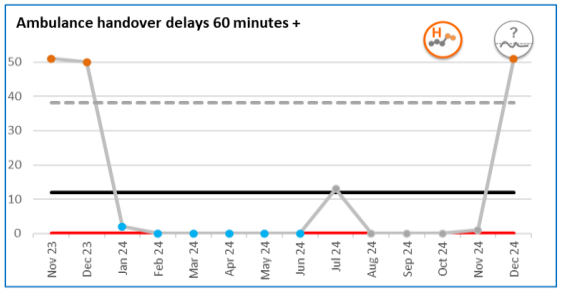
NHS Gateshead Health NHS Foundation Trust

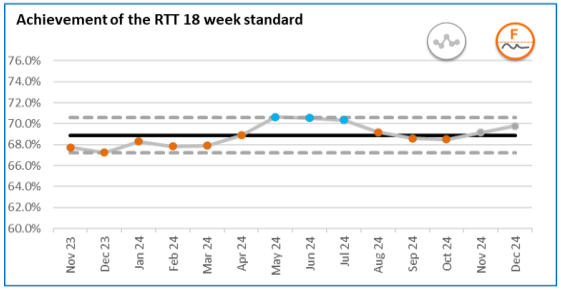


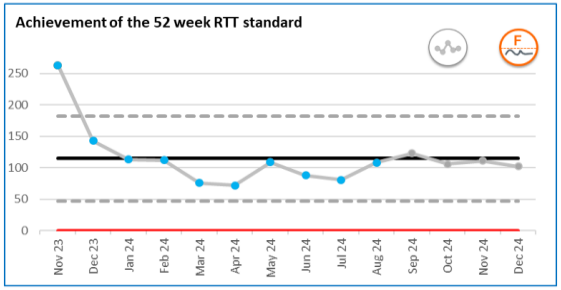


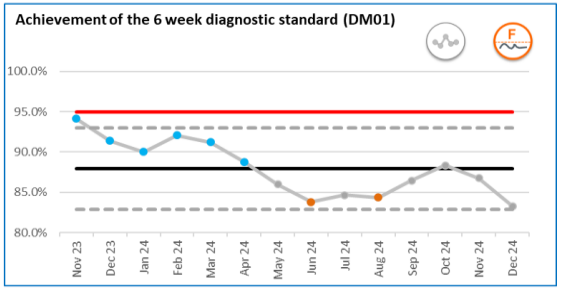


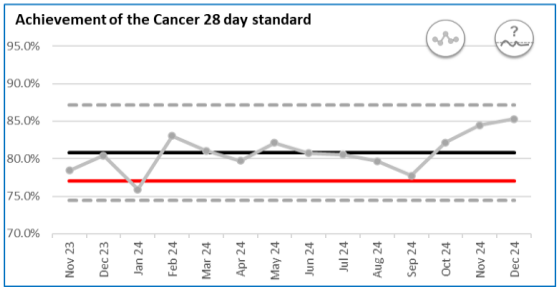


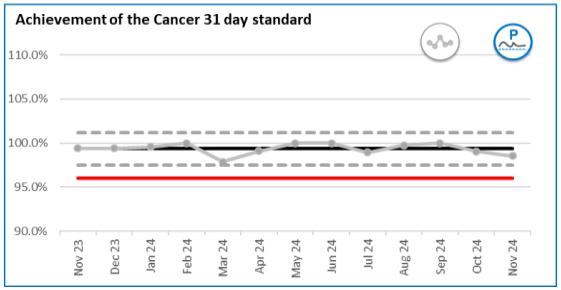


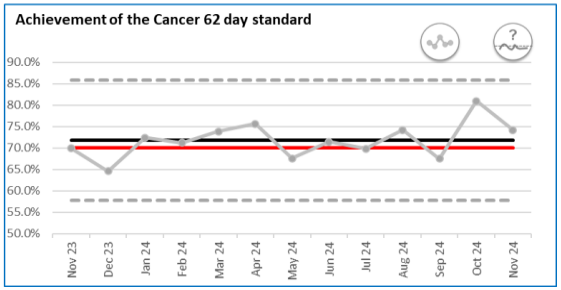












Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 16

Report Title:	**EPRR annual assurance report 2024 including NHSE Core Standards self-assessment final submission.**			
Name of Meeting:	Trust Board			
Date of Meeting:	29 January 2025			
Author:	David Patterson, Head of Emergency Preparedness, Response and Response (EPRR)			
Executive Sponsor:	Jo Halliwell, Group Chief Operating Officer and Accountable Emergency Officer (AEO)			
Report presented by:	Jo Halliwell, Group Chief Operating Officer and Accountable Emergency Officer (AEO)			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	The purpose of this report is to present the EPRR annual assurance report 2024 including the NHSE Core Standards self-assessment final submission.			
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:	Business Resilience Group (18 Dec 2024 & 9 Jan 2025) Operations Oversight Group (21 Jan 2025) Gateshead Health Leadership Group (23 Jan 2025) North East North Cumbria (NENC) ICB EPRR team (Dec 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*	• It is a requirement that NHS Providers submit an annual self-assessment statement of assurance against the EPRR core standards to their board. • There were no significant changes to the core standards assurance process nationally in 2024, however there were changes to the local submission and check and challenge process. • The North East North Cumbria (NENC) Integrated Care Board (ICB) implemented a revised local check and challenge timeline and submission governance process that included: ○ All organisations to submit their core standards self-assessments to the NENC ICB for 2024.			

<table>
<tr><td></td><td colspan="5">

The focus was on the core standards where an organisation has assessed that their compliance has increased from red (non-compliant) or amber (partially compliant) to green (compliant)

This was complemented with a robust internal check and challenge process with executive oversight from the Accountable Emergency Officer prior to the submission.
Following this robust check and challenge process, the self-assessment of the EPRR core standards resulted in a compliance rating of substantial compliance.
The trust’s EPRR annual assurance report for 2024 including the Core Standards final submission is enclosed.

</td></tr>
<tr><td>Recommended actions for this meeting:</td><td colspan="5">The Trust Board are asked to:
a) acknowledge the way in which the self-assessment process has been conducted resulting in an improvement in Trust compliance rating from partial compliance in 2023 to substantial compliance for 2024.
b) be assured that the self-assessment will be used to prioritise the trust EPRR development work-plan for 2025
c) endorse the assurance provided within the 2024 Annual Assurance Report and;
d) support the inclusion of the compliance rating in the Trust’s annual report for 2024.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
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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">Ensuring that there is a strong control environment in place to mitigate and manage risks relating to EPRR should support the overall delivery of the 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>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks:</td><td colspan="5">Ref 4571 - Failure to comply with EPRR NHS Core Standards Resulting in breach in compliance, reputational risk.</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
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Emergency Preparedness, Resilience and Response (EPRR)

Annual Assurance Report 2024

[EPRR Team]
Published: January 2025
Review date: July 2025

Contents

1. Introduction

The Civil Contingencies Act 2004 (CCA) (UK Government, 2004) imposes a statutory duty on Gateshead Health NHS Foundation Trust (known as the Trust) to have in place arrangements to respond to incidents and emergencies. Under the terms of the CCA the Trust is a Category 1 Responder. This places a statutory duty upon the Trust to be able to respond to internal or external disruptive events that might impact on the Trust's ability to deliver its services.

The CCA also places other duties on Category 1 responders, including the requirement to:

- Assess the risk of emergencies - identify potential emergencies or incidents and their effects, then put plans into place to mitigate the effects or avoid it all together.
- Undertake Business Continuity Management - create methods to ensure a swift return to business as usual.
- Plan for emergencies - develop planned strategies that will mitigate the effects of an incident.
- Warn, inform and advise the public - share information relevant to the public to raise awareness of actions before, during and after an incident.
- Cooperate - through the Local Resilience Forum (LRF), category 1 and 2 responders establish best practice and common principles of action (JESIP)
- Share information - all relevant information that can support all responders must be shared to ensure a coherent and coordinated response.

The NHS Emergency Preparedness, Resilience and Response (EPRR) Guidance (NHS England, 2015) requires the Trust to:

- Have suitable and up-to-date incident response plans which set out how the Trust would respond to and recover from a major incident/emergency which is affecting the wider community or the delivery of services; and
- Have business continuity plans that enable the Trust to maintain or recover the delivery of critical services in the event of a disruption.

The minimum requirements which the Trust must meet regarding EPRR are set out in the NHS England Core Standards for EPRR (Core Standards). These standards are in accordance with the CCA 2004 and the NHS Act 2006 (as amended). The standards are published annually, and the Trust undertakes a self-assessment against these standards as part of the annual national assurance process and submits results to the Board for approval along with a summary of EPRR activities from the previous 12 months.

This report covers the period from **January 2024 to December 2024.**

2. Purpose of this report

This annual assurance report is intended to update on progress with the Trust's compliance level with the NHS England's Emergency Preparedness, Resilience and Response (EPRR) Core Standards and other statutory requirements placed upon the Trust by the Civil Contingencies Act (CCA) (2004) and the NHS England EPRR Framework.

It will summarise the NHS Core Standards annual self-assessment for 2024 submission and will demonstrate the Trust's assurance position using information from multiple sources, independent reviews and organisational learning.

3. What are the NHS EPRR Core Standards?

It is a requirement that NHS providers submit an annual self-assessment statement of assurance against the Emergency Preparedness, Resilience and Response (EPRR) core standards to their board.

The purpose of the NHS core standards for emergency preparedness, resilience and response (EPRR) is to:

- enable health agencies across the country to share a common approach to EPRR,
- allow co-ordination of EPRR activities according to the organisation's size and scope,
- provide a consistent and cohesive framework for EPRR activities, and
- inform the organisation's annual EPRR work programme.

The EPRR assurance process is based on the NHS England (NHSE) Core Standards for EPRR that cover ten core domains:

1. Governance
2. Duty to risk assess.
3. Duty to maintain plans.
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Co-operation
9. Business continuity
10. Chemical biological radiological nuclear (CBRN) and hazardous material (HAZMAT).

A deep dive review is also conducted each year to gain additional assurance into a specific area, the subject for this year's submission was 'Cyber security and IT related incident response'.

4. How are we assessed?

The overall EPRR assurance rating is based on the percentage of core standards that trusts can self-assess against. NHS provider organisations are required to provide a RAG-rating for each applicable standard and comment on the evidence that supported this assessment.

This is explained in further detail in figure 1:

Organisational rating	Criteria
Fully compliant	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non- compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

Figure 1 – NHS EPRR Core Standard ratings (November 2024)

The Trust's previous self-assessment position from 2023 was **Partial compliance (77%).**

5. What are the changes to NHS Core Standards Assurance Process 2024?

The national letter and excel template from NHS England setting out the process for the 2024 core standards assurance was received on 16 July 2024.

There were no significant changes to the core standards assurance process nationally in 2024, however there were changes to the local submission and check and challenge process.

In August 2024, the North East North Cumbria (NENC) Integrated Care Board (ICB) outlined a revised process and timeline that was ratified by the NENC Local Health Resilience Partnership (LHRP) that included:

- Organisations to submit their core standards self-assessments to the NENC ICB
- The focus was on the core standards where an organisation has assessed that their compliance has increased from red (non-compliant) or amber (partially compliant) to green (compliant).
- Organisations underwent local peer reviews in October 2024 and submitted their initial self-assessment to NENC ICB on 31 October 2024.
- NENC ICB undertook a locally agreed assurance process with providers with meetings with Accountable Emergency Officers (AEOs) and EPRR leads
- Organisations presented their core standards ratings at the NENC Local Health Resilience Partnership (LHRP) on 18 November 2024
- Organisations submitted their final self-assessments to the NENC ICB with the statement of compliance by 21 November 2024
- The NENC ICB submitted all self-assessments to the NHS England North East and Yorkshire Regional Team by 22 November 2024
- NENC ICB attended the Regional Health Resilience Partnership (RHHP) on 2 December 2024 to present the NENC final core standards ratings

6. What is the Trust position and how has governance been managed?

As a trust we continue to recognise the principles of this core standards process and acknowledge that this is important in light of the recent recommendations from the public enquiries into Covid-19, Manchester Arena and the Grenfell Tower fire.

The Trust has continued to work with the NENC ICB to review the self-assessment position to provide context, support and leadership.

A robust internal governance process was implemented to ensure there was appropriate risk assessment of the Trust self-assessment. This included an internal check and challenge with oversight and agreement from the Trust's Accountable Emergency Officer on the evidence and self-assessment compliance rating.

In the interests of an open and transparent organisational culture, the Trust has ensured that the corporate governance structure was kept fully appraised. This included oversight at Business Resilience Group throughout the year and the Operations Oversight Group (October 2024) before the submission to the NENC ICB.

The NENC ICB undertook a review of the initial self-assessment and met with the Accountable Emergency Officer and Head of EPRR to understand the self-assessment position. The purpose of this discussion was to support more objective local assurance and highlight areas for further work to strengthen arrangements with the changes in compliance rating of standards.

7. What is the Trust's final compliance assurance position?

The Trust has accepted a number of recommendations from the check and challenge process from 2023 that were included as part of the EPRR work programme.

Our headline position for 2024:

- 8 standards have increased from partially compliant to fully compliant from 2023.
- 3 standards have remained as partially compliant from 2023 – (14) Countermeasures within the Duty to maintain plans domain; (29) Decision-logging within the Response domain and; (53) Assurance of commissioned providers / suppliers BCPs within the Business Continuity domain
- 1 standard has reduced from compliant to partially compliant from 2023 - (49) Data Protection & Security Toolkit within the Business Continuity domain
- All other standards have remained as fully compliant from 2023
- There are no non-compliant standards to report

The Trust's final reported self-assessment for 2024 was:

Overall assessment:	Substantially compliant

A summary of the standards submission assessment scores against the respective core standards is provided below:

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non-Compliant
1 **Governance**	6	6	0	0
2 **Duty to Risk Assess**	2	2	0	0
3 **Duty to Maintain Plans**	11	10	1	0
4 **Command and Control**	2	2	0	0
5 **Training and Exercising**	4	4	0	0
6 **Response**	7	6	1	0
7 **Warning and informing**	4	4	0	0
8 **Cooperation**	4	4	0	0
9 **Business Continuity**	10	8	2	0
10 **Hazmat/CBRN**	12	12	0	0
Total	**62**	**58**	**4**	**0**
Deep-dive Cyber Security	**11**	**8**	**3**	**0**

Figure 2 – final Trust self-assessment (November 2024)

A final check and challenge session with the Local Health Resilience Partnership (LHRP) took place on 21 November 2024. The final Gateshead Health self-assessment and compliance rating was verified by the partnership.

8. What does this mean and how do we compare regionally?

As a trust there continues to be a clear ambition and intent to continue to develop and enhance our capabilities and capacity in line with the NHSE EPRR Framework.

The Trust continues to meet the requirements of the Civil Contingencies Act 2004, the NHS Act 2006, the Health and Care Act 2022, the NHS standard contract and NHS England business continuity management framework.

A regional comparison of the **final** self-assessment ratings highlighted below demonstrates that the Trust is amongst the highest achieving final provider self-assessment ratings (in no particular)

Organisation	Assurance rating 2024
Northumbria Healthcare	Substantial
Northeast Ambulance Services (NEAS)	Substantial
Gateshead Health NHS Foundation Trust	**Substantial**
South Tyneside and Sunderland NHS Foundation Trust	Substantial
County Durham and Darlington NHS Foundation Trust	Substantial
North Cumbria Integrated Care Foundation Trust (CIC)	Substantial
North Tees NHS Foundation Trust	Substantial
Cumbria, Northumberland, Tyne and Wear Mental Health Trust (CNTW)	Partial
South Tees NHS Foundation Trust	Partial
Newcastle upon Tyne Hospitals NHS Foundation Trust (NuTH)	Partial
Tees, Esk and Valley Mental Health Foundation Trust (TEWV)	Partial
North East North Cumbria Integrated Care Board (NENC ICB)	Partial

9. How can we demonstrate assurance?

The Trust can demonstrate a number of specific examples from various internal and external sources highlighting our EPRR approach during 2024, this includes:

- a strengthening of **governance and resilience** arrangements within the EPRR Team and at an Executive level
- a successful response to periods of **industrial action** in early 2024 maintaining patient safety.
- a response to a number of **issues and incidents**, internally and externally – with one having a significant organisational impact involving System Coordination Centre (SCC) support
- a number of **reviewed plans, policies and protocols** to strengthen our response arrangements
- a strong focus on **training and exercising** to ensure our staff are competent and confident
- the launch of the **Health Commander Portfolios** at a Strategic and Tactical level to evidence continuous professional development
- continued **engagement and development of strengthened relationships** with the NENC ICB and other health provider organisations
- an **external CBRN/Haz Mat audit** undertaken by North East Ambulance Service (NEAS) demonstrating a **full compliance rating**
- a trajectory of **trust self-improvement**

The following section provides a summary of progress within the core standard domain areas:

Domain 1 – Governance

- The Trust has identified a formal deputy at an Executive level to provide resilience to the Accountable Emergency Officer.
- The Trust has an up-to-date EPRR Policy aligned to requirements of the core standards with supporting work programme and resource; an embedded process for continuous improvement; an annual report presented to Trust Board; with oversight from the Accountable Emergency Officer that demonstrates a strong approach to governance.
- A governance review of EPRR was completed in March 2024 with the additional of a full time EPRR Project Support Officer to provide additional resource within the EPRR Team
- The newly established Business Resilience Group provides assurance that the Trust is delivering on its statutory responsibilities' duties under Civil Contingencies Act 2004 and is compliant with the responsibilities as a Category One responder as part of the corporate governance structure.
- The EPRR Team have coordinated 25 debriefing programmes during 2024 on a range of issues from training and exercising feedback and from response to issues, identifying organisational learning.

Domain 2 – Duty to risk assess

- A robust risk assessment and management process can be illustrated that regularly assesses threat and risk from a national, community and Trust perspective; monitored within EPRR with appropriate escalation as an organisation when required
- The EPRR/Business Resilience Group Risk Register takes account of the Northumbria Local Resilience Forum community risk register and includes reasonable worst-case scenarios specific to the Trust.
- Actions to mitigate the assessed risks where required are agreed and form part of the EPRR Work Programme.

Domain 3 – Duty to maintain plans

- There is a continuous programme of review to ensure that the duty to maintain plans remains current.
- Plans are reflective of national guidance and risk assessments, as well as national planning assumptions and are developed in collaboration with other partners.
- Strong engagement and collaboration arrangements can be emphasised internally and externally to develop and review plans in a balanced and proportionate approach dependent upon the level of threat and risk.

Domain 4 – Command and control

- A resilient and dedicated 24:7 on-call mechanism can be highlighted to appropriately respond and escalate issues with ongoing professional development of on-call staff.
- The trust has developed a formal training and exercising plan for on-call teams to ensure annual training to support the delivery of the NHS England Principles of Health Command and a dynamic training needs analysis underpins this.
- The Strategic and Tactical health commander portfolios were launched to on-call teams during 2024

Domain 5 – Training and exercising

- A robust training and exercising programme was implemented with a number of exercises held during 2024.
- Exercise Beacon was a clinically led, management supported live major trauma simulation exercise that was held in the early evening of 18 September 2024.
- Local exercising to test local risks has continued to take place with teams and services throughout this year.

Domain 6 – Response

- The Trust can demonstrate a number of robust arrangements in place to support the response element – this has been evidenced in our response to a number of internal and external issues including:

    - Industrial action (3 periods) (January 2024 to June 2024)
    - Internal theatres incident (March 2024)
    - Internal estates/network issue (June 2024)
    - Internal Care flow interface issue (June 2024)
    - Internal Maternity estates issues (June to July 2024)
    - Global IT outage (July 2024)
    - Paediatric audiology issue (July 2024 onwards)
    - Amber blood shortage alert (July 2024 onwards)
    - Internal theatres incident (July to August 2024)
    - Internal breast data issue (August 2024 onwards)
    - GP collective action (August 2024 onwards)
    - Civil unrest (August 2024)
    - Internal PACs system outage including SCC support (September 2024)
    - External NECS IT outage issue (October 2024)
    - Internal PACs system performance issues (December 2024)

Domain 7 – Warning and informing.

- There are effective arrangements in place to warn and inform; communicate with partners and stakeholders and liaise with the media when required.
- The arrangements have been reviewed, extensively tested and demonstrated in the Trust response to the national civil disorder during August 2024.

Domain 8 – Co-operation

- The Trust continues to co-operate with partner organisations within the Northumbria Local Resilience Forum (NLRF) and Local Health Resilience Partnership (LHRP), and as part of recognised arrangements regional and locally with NHS England (NHSE) and the North East North Cumbria Integrated Care Board (ICB)

Domain 9 – Business Continuity

- A review programme of business continuity is ongoing
- The Trust is continuing to transition from a paper-based Business Continuity system to a software solution that will enable us to strengthen monitoring of plans and arrangements, regularly review, test and exercise with a clear direction of travel for 2025

- During this review period, a number of internal audits have taken place and local tests of the revised business continuity plans.

Domain 10 – CBRN/HazMat

- A substantial review of the trust approach to CBRN/HazMat incidents was undertaken completed that is based upon a local/national assessment of threat and risk.
- This was demonstrated in the external audit demonstrating a full compliance rating

10. What are the priority areas for development?

Providing the self-assessment process remains consistent, the Trust has a clear picture of the expectations and development required for 2025 submission.

Our priority areas and direction of travel for 2025 include:

- A focus on sustaining a substantial compliance rating
- A clear trust ambition to continue to develop and enhance our EPRR capabilities and capacity, strengthening our quality of evidence
- A continued focus on training and exercising across all domains
- Implementation of the business continuity software solution to allow us to provide consistency to alleviate and assist with the day-to-day management of issues
- A continued review of plans, frameworks and protocols to strengthen our arrangements
- An embedding of identified organisational learning
- Use of the self-assessment as a benchmark for prioritisation of the trust EPRR development work-plan for 2025
- A trajectory to continue to work collaboratively with the NENC ICB and other health providers to identify best practice and enhance threshold of evidence

11. Conclusion and next steps

The evidence provided within this report should provide assurance that the Trust continues to anticipate; assess; prevent; prepare; respond and recover from any disruptive events or incidents, as part of the Integrated Emergency Management cycle.

There is a recognition that this self-assessment process is a constantly evolving journey and pathway of organisational learning. The EPRR Team have continued to use the core standards as a benchmark for directing the priorities of the Trust EPRR workplan; indicate a measure of progress, and to identify and embed internal organisational learning and opportunities for improvement.

12. Further information

For further information, please contact:

David Patterson, Head of Emergency Preparedness, Resilience and Response,
Gateshead Health NHS Foundation Trust

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 17

Report Title:	**Maternity Integrated Oversight Report – December 2024**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29 January 2025			
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 November 2024			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Maternity Safecare 14/1/2025 SBU Ops Board 29/1/2025 Safecare Steering Group 21/1/2025 Trust Board 29/1/2025			
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 December 2024, there were 153 births, 0 MNSI cases and 1 perinatal loss. • Exceptions reported – positive outlier continues for breastfeeding rates, smoking & PPH, high SPC remains for emergency caesarean sections • Moderate harm incidents – 2 incidents reported **Q3 Complaints summary** **Saving Babies Lives** • Fully compliant for MIS reporting • QIP update – fetal well-being			
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 December 2024

Maternity IOR contents

- Maternity Dashboard 2024/25:
  - December 2024 data

- Exception reports:

- Items for information:
  - Strategic Objectives
  - Perinatal Quality Surveillance minimum dataset
  - Incidents
    - 0 MNSI (Maternity & Neonatal Safety Investigation) cases reported in December 2024
    - 1 perinatal loss in December 2024
  - Q3 Complaints & incidents summary
  - Saving Babies Lives Care Bundle full MIS compliance report

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	9	9			
Areas Not Applicable												
No. Compliant	7	7	5	5	3	4	4	4	2			
No. Non Compliant	2	2	4	4	6	5	5	5	7			
Percentage Compliance	78%	78%	74.0%	74%	89%	90%	95%	97.40%	98%			

Areas compliant: (List domains compliant)
1. Enhanced Safety, 2. Listening to families 3. Staff training & MDT working, workforce, 4.Managing Complex Pregnancy, 6. Monitoring Guidelines.

Areas Non compliant: (List domains non-compliant)
7. Informed Consent, 5. RA throughout pregnancy

How are we performing or Progress Made?
MIS compliance with all elements of Saving Babies Lives Care Bundle confirmed

What is driving performance or what are the challenges

What actions is being taken or future risks & planned developments
Audits ongoing for IAEs 5&7
LMNS requested full review of Ockenden 1 actions in anticipation of full compliance - no need for ongoing monitoring going forwards

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	89	89			
Areas not Applicable	6	6	6	6	6	6	6	6	6			
No. Compliant	56	63	68	69	74	79	79	79	80			
No. Non Compliant / Unassessed	35	26	15	14	15	4	4	4	3			
Percentage Compliance	63.0%	71.0%	76.0%	78%	83%	89%	89%	89%	96%			

Areas compliant: (List domains compliant) Safety actions 1, 2, 3, 4, 5, 6, 8, 9, 10

Areas Non compliant/Not Assessed: (List domains compliant)
N/A - 6 areas as only required if not compliant
Only outstanding action is final ratification of updated Maternity Risk Management Guideline – January Safecare - Safety action 7

How are we performing or Progress Made?
Annual LMNS assurance report received, Q2 LMNS assurance meeting completed, MIS compliance reporting period ended 30/11/2024

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

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Strategic priorities 2024/25

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Births	Dec 24	153	-			164	120	207
Spontaneous vaginal deliveries	Dec 24	65	-			76	51	101
Assited births	Dec 24	88	-			88	57	118
Induction of Labour	Dec 24	45	-			61	32	91
Maternity Readmissions	Dec 24	1	-			3	-3	9
Neonatal Readmissions	Dec 24	3	-			5	-1	10
Smoking at time of booking	Dec 24	5.30%	15.00%		P	8.18%	1.58%	14.78%
Smoking at time of delivery	Dec 24	5.33%	6.00%			6.49%	0.12%	12.85%
In area CO at booking	Dec 24	94.70%	90.00%			90.09%	77.13%	103.04%
In area CO at 36 weeks	Dec 24	77.87%	80.00%			82.14%	70.78%	93.49%
Admitted directly to NNU (SCBU) (>37 weeks)	Dec 24	7	4			8	-1	16
Percentage Admitted directly to NNU (SCBU) (>37 we	Dec 24	4.86%	6.00%			4.94%	-0.69%	10.57%
Preterm birth rate <=36+6 weeks at birth	Dec 24	0.00%	6.00%			5.42%	-1.03%	11.87%
Continuity of Carer: Percentage placed on pathway (2	Dec 24	15.98%	-			16.86%	7.76%	25.96%
Continuity of Carer: Percentage from BAME backgrou	Dec 24	19.51%	-			25.93%	-0.24%	52.10%
Spontaneous Vaginal Births (%)	Dec 24	42.48%	-			46.62%	34.68%	58.55%
Induction Rate	Dec 24	30.00%	-			38.15%	24.53%	51.76%
Instrumental Delivery Rate	Dec 24	11.33%	-			13.12%	3.68%	22.57%
Elective C Section Rate	Dec 24	24.18%	-			18.51%	8.16%	28.86%
Emergency C Section Rate	Dec 24	22.22%	-			21.92%	11.46%	32.38%
C Section Rate	Dec 24	46.41%	-			40.43%	27.75%	53.11%
3rd or 4th degree tear (Total) Precentage	Dec 24	1.33%	3.00%			1.07%	-1.47%	3.60%
Massive PPH >=1.5L (All births)	Dec 24	7	2			9	0	18
Breastfeeding: Percentage of Initiated Breasfeeding	Dec 24	78.67%	66.20%			76.07%	65.02%	87.12%
Breastfeeding: Breasfeeding at Discharge (Transfer to	Dec 24	59.59%	56.20%			58.12%	43.98%	72.27%

Safe

Responsive

Maternity

NHS Gateshead Health NHS Foundation Trust

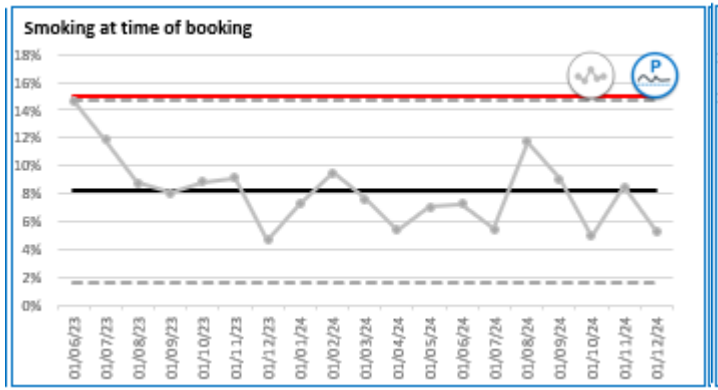
Maternity Dashboard 2024/25

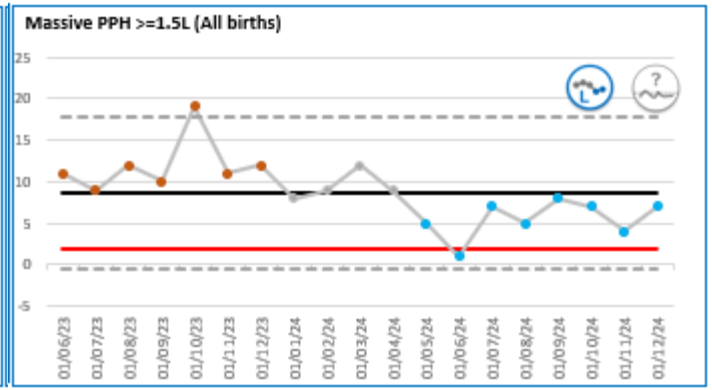
Maternity Dashboard 2024/25

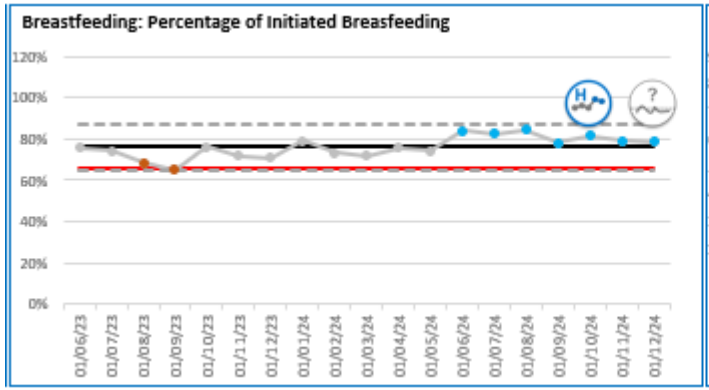
Maternity

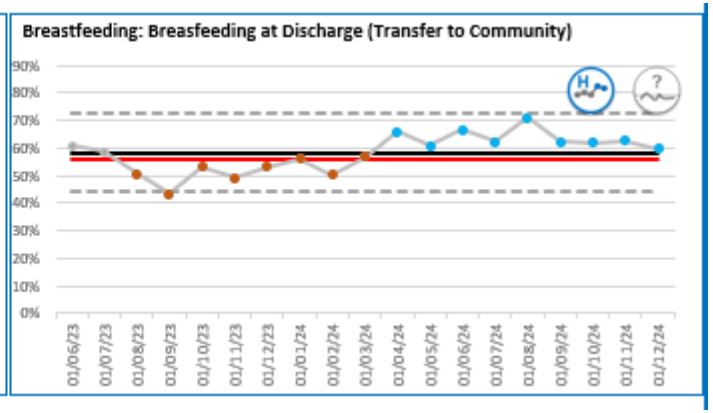
NHS Gateshead Health NHS Foundation Trust

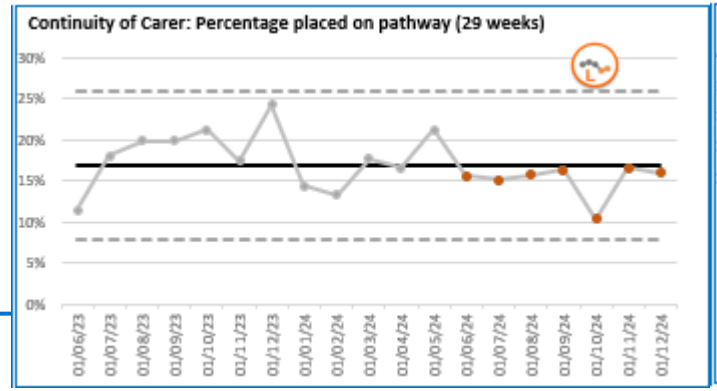
- **Background**
  - No significant changes from pervious IOR report
- **Assessment**
  - Remain positive outliers for smoking at time of booking, breastfeeding initiation and sustained low PPH rates
  - Continuity of Carer rates low however this is no longer required to be reported & MCOC team no longer operational
- **Actions**
  - None
- **Recommendations**
  - Remove COC data from future SPC monitoring

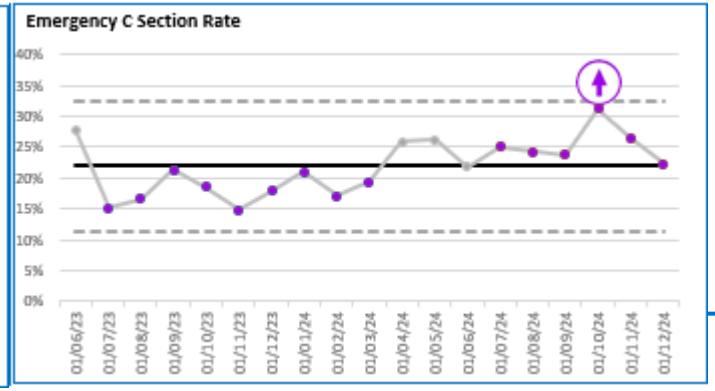












2024/25		April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Number of perinatal losses		0	0*	1	0	0	0	1	2	1			
Number of MNSI cases		1	0*	0	0	0	0	1 (August birth)	0	0			
Number of incidents logged as moderate harm or above		1	0	0	0	0	2	0	2 plus screening	2			
Minimum obstetric safe staffing on labour ward		100%	100%	100%	100%	100%	100%	100%	100%	100%			
Minimum midwifery safe staffing including labour ward (average fill rates)	Day shift	107.7	110.0%	98.4%	99.3%	100%	97.8%	94.6%	90.0%	89.9%			
	Night shift	105.2	109.7%	102.8%	103.6%	103.1%	105.6%	99.9%	100.3%	98.1%			
	CHP PD*	18.3	18.7	18.4	11.9	12.2	10.1	12.2	12.3	12.2			
Service user feedback	FFT “Overall how was your experience of our service” – total score for very good and good responses	100%	90%	100%	Reports not received		100%	100%	100%				
	Complaints	2	1	1	3	0	3	1	4	3			
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust		0	0	0	0	0	0	0	0	0			
Coroner Reg 28 made directly to Trust		0	0	0	0	0	0	0	0	0			

Exception report

InPhase report #10146

Maternity NHS Gateshead Health NHS Foundation Trust

Summary:

- Syntocinon infusion commenced at incorrect rate
- Recognised within 15 minutes, CTG (cardiotocograph – fetal heart) abnormalities – infusion stopped
- CTG recovered but ongoing periods of suspicious trace resulted in being unable to restart syntocinon & caesarean section required
- Baby born in good condition with normal cord gases
- Mum made well-informed antenatal decision not to have elective caesarean section

Learning:

- Yellow stickers to highlight syntocinon infusion line not available
- Drug correctly prescribed, checked & made-up
- No 2nd person check completed at “start” point
- Hartmans solution commenced at same time – lines attached to incorrect pumps

Maternity

NHS

Gateshead Health

NHS Foundation Trust

Exception report

InPhase report #10214

<u>Summary:</u>

- No fetal heart & placental abruption
- Class 3 emergency LSCS (lower segment caesarean section)
- Return to theatre with ongoing bleeding
- B-lynch suture, hysterectomy, MOHP (major obstetric haemorrhage protocol)
- Overall MBL (measured blood loss) 2418ml
- Transferred to critical care for recovery

<u>Learning:</u>

- Good support from theatre team – impact on wider Trust/theatre cases
- Geography of separate building exacerbated this

Saving Babies Lives Care Bundle

Maternity NHS
Gateshead Health
NHS Foundation Trust

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%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Partially implemented	60%	Partially implemented	60%	CNST Met
Element 5	Preterm birth	Partially implemented	74%	Partially implemented	81%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Partially implemented	70%	Partially implemented	74%	CNST Met

Fully compliant for MIS Safety Action 6 on 11/12/2024

Work continues to meet 100% compliance in all remaining elements – 1, 2 4 & 5

Complaints: Q3 24/25 closed complaints

Responsive

NHS Gateshead Health

Final primary subject	Final sub-subject	Lessons learnt	Actions taken
Communication	Scan appointments	Community midwives not to give out mobile phone numbers as raises unrealistic expectations – community team base & PAU numbers to be given Confusion re scan appointments – fetal medicine	Message to all community midwives Apology
Communication	Sharing increased risk screening results LSCS date	Community midwives not to give out mobile phone numbers as raises unrealistic expectations – community team base & PAU numbers to be given Breaking bad news New process for elective LSCS booking	Message to all community midwives Apology Embed new process – changing process during pregnancy
Delays to results Clinical advice	Bereavement follow-up	Delays to receive post-mortem result Query if aspirin should've been advised No bereavement counselling	Apology – external capacity, ensure advice given when discussing investigations Aspirin not indicated Accessed through GP, charity offers
Postnatal care	Delays Conflicting messages Debrief after traumatic birth	Allow time for meaningful debrief – too soon after birth & it may not be understood, may need repeat offer	Refer to Birth Reflections
Term admission to SCBU		Clear discussions with parents about reasons for admission	

Incidents: Q3 summary of learning

Gateshead Health NHS Foundation Trust

Safe

Responsive

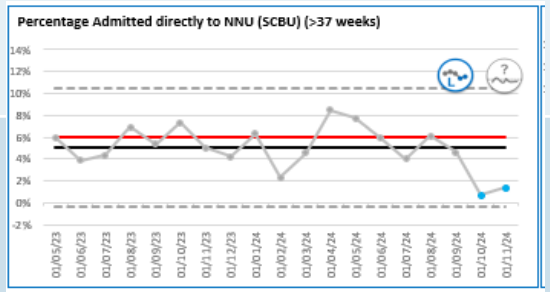
Perinatal - Key Themes from Incident Reviews	Perinatal - Key Safety Interventions Implemented
Golden Hour	Auditing first feed within 120 minutes Poster developed and shared on social media and within the unit Promoting colostrum harvesting
CTG interpretation and escalation	CTG cases used for teaching RCOG escalation tool kit implemented Staff attended Babylifeline CTG interpretation training
Escalation of neonatal concerns	Development of a clear pathway of escalation when concerned about a neonate.

Top 5 Perinatal DATIX Themes (combined obstetrics and neonatology)	Top 5 PMRT Themes (combined obstetrics and neonatology)	Top 5 HSIB Themes (combined obstetrics and neonatology)
Cord Prolapse	Ensure use of appropriate BP cuff	NA
2nd theatre opened	Ensure LFT's taken when IUD identified	
PPH		
Screening		
Maternal Readmissions		

ATAIN QI Project (MIS Standard 3) Project Update

North East and North Cumbria
Local Maternity and Neonatal System
NHS Foundation Trust

Project Title: Fetal well-being (Gateshead)	
Brief Outline	In Q1 2024/25 – the service saw an increase in term admissions to NNU – at 8% compared with Q4 2023/24 rate of 4% Review of this identified monitoring as the 2nd highest cause of admission. This QIP was aligned to changing audit standards for fresh eyes & fetal monitoring
Progress	In Q1 Fresh eyes compliance 31% Risk assessment 34.6% In Q2 Fresh eyes compliance 67% Risk assessment 53% In Q3 Fresh eyes compliance 75% Risk assessment 68.9% In August 24 new process was introduced to performing fresh eyes and risk assessments. Escalation was seen as a theme through ATAIN and risk reviews. RCOG each baby counts escalation tools were implemented into practice 'AID' 'Teach and treat'. Implemented by tea trolley teaching, notice board on delivery suite, newsletter, incorporated within 1 hour CTG teaching and on fetal wellbeing full day training.
Highlights/achievements	Sustained low SPC flag for term admissions Improvement in fresh eyes audits
Risks	Update & capital replacement of monitoring equipment – underway Workforce – recruitment underway
Escalations	None



Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 18

Report Title:	**Maternity Incentive Scheme update – December 2024**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29 January 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 Incentive scheme compliance for theTrust from the month of December 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*	Quality Governance Committee 7 January 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 maternity service is reporting 96% compliance at the end of December 2024 for Year 6 of the Maternity Incentive Scheme. Final compliance is to be declared to NHS Resolution following board & LMNS sign-off by 3 March 2025 Outstanding actions – midwifery & neonatal staffing papers & perinatal culture report on agenda for January QGC, ratification of updated maternity risk management guideline			
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** ☒

Maternity Incentive Scheme (MIS) Assurance Framework

Gateshead Health NHS Foundation Trust

December 2024 – Year 6

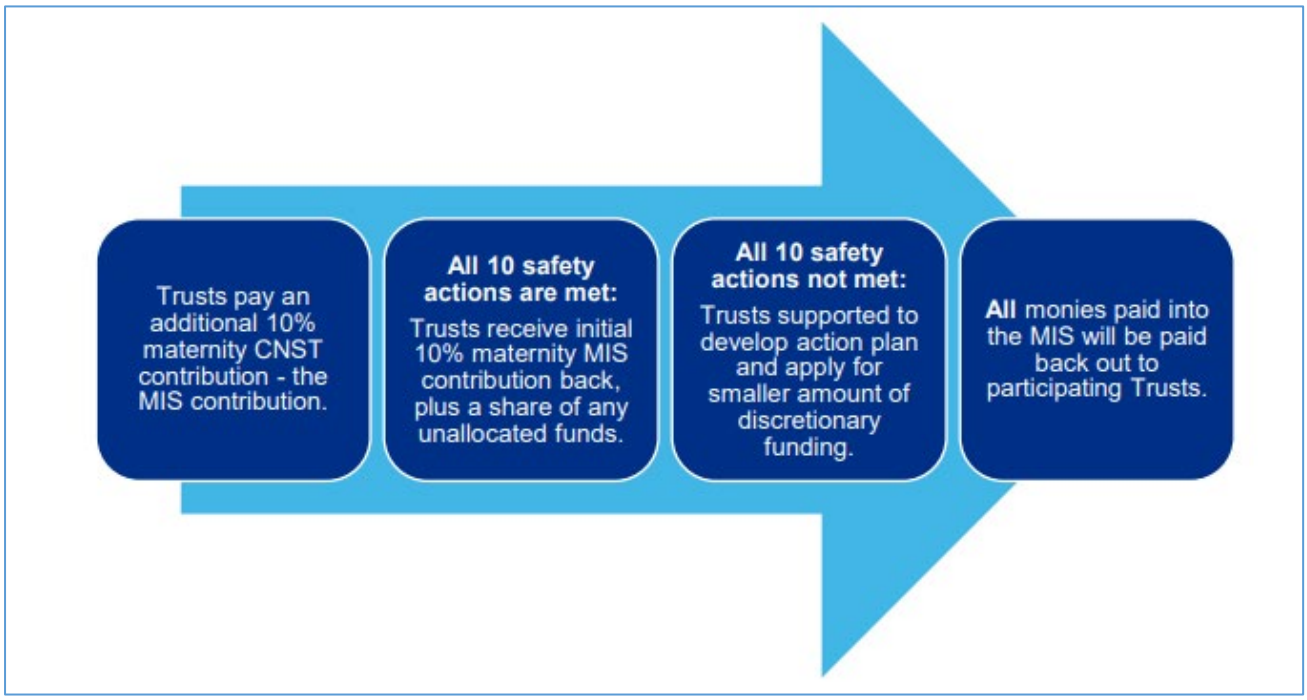
Karen Parker – Head of Midwifery

Executive Summary

This report from Gateshead Maternity services gives a monthly assurance of position of the service in relation to compliance with the 10 safety actions set out by NHS Resolution in the Maternity Incentive Scheme (MIS) year 6, launched on 2nd April 2024 (MIS-Year-6-guidance.pdf)

This report describes the criteria for the 10 safety actions and a summary of evidence and progress each action.

NHS Resolution operates the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. This will be the 6th year of the scheme which applies to all acute trusts that deliver maternity services and are members of the CNST. Trusts that can demonstrate they have achieved all ten of the safety actions will recover the element of their contribution relating to the CNST maternity fund and will also receive a share of any unallocated funds. The Maternity service declared full compliance in the previous three years of the scheme but there are year-on-year additional changes and requirements in order to achieve 2024/25 compliance.



Any monies recovered by achieving full compliance must be ring-fenced for use in the maternity service and this has been agreed by the Trust board in accordance with CNST and Ockenden requirements.

Background

The 10 safety recommendations are aligned to what a safe and responsive maternity service should be able to demonstrate.

This year, NHSR has provided an audit tool to support Trusts with evidence gathering and Trust board assurance. A baseline assessment has been completed using the audit tool and all evidence to support the declaration of compliance is held in a shared repository by the maternity service to enable review and assurance.

The Safecare Risk and Safety council is the designated monitoring committee for the safety actions and is asked to accept this report as evidence/assurance that the Maternity service is working towards achievement of all the actions and the group that the service will escalate any problems or support required to enable compliance.

To be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution by **12 noon on 3rd March 2025.**

the form must be signed by Trust CEO and Accountable Officer for the CCG/ICS

Recommendation

The Risk and Safety Council are asked to review this report and the evidence listed to demonstrate ongoing work towards compliance with the ten safety actions and are satisfied that these meet the required standards. Minutes of the Risk and Safety Council will be held as evidence of assurance of compliance at the end of the MIS year 6 reporting timeframe.

Monitoring and Compliance

Progress against the 10 Maternity Safety actions will be monitored via service level and business unit level meetings. This is documented in our Maternity Service operational risk management strategy.

Detailed action plan can be viewed and is attached with evidence held in a shared repository by the maternity service.
The Maternity team have undertaken an assurance review by AuditOne of the evidence submitted for Year 4 during this year of the scheme.

This report has been reviewed at the Obstetric and Gynaecology Safecare meeting which took place on 14th January 2025.

Safety Action	Summary of required standard	On track	Concern	At risk	Actions required
1.1	Have all eligible perinatal deaths from 8 December 2023 onwards been notified to MBRRACE-UK within seven working days?				
1.2	For at least 95% of all deaths of babies who died in your Trust from 8 December 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?				
1.3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8 December 2023 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.				
1.4	Were 60% of the reports published within 6 months of death?				
1.5	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 8 December 2023 including reviews and consequent action plans.				
1.6	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?				
2.1	Was your Trust compliant with at least 10 out of 11 MSDS-only Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024? Final data for July 2024 will be published during October 2024.				
2.2	Did July's 2024 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)				
3.1	Was the pathway(s) of care into transitional care which includes babies between 34+0 and 36+6 in alignment with the BAPM Transitional Care Framework for Practice jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies? **Evidence should include:** - Neonatal involvement in care planning - Admission criteria meets a minimum of at least one element of HRG XA04 - There is an explicit staffing model - The policy is signed by maternity/neonatal clinical leads and should have auditable standards. - The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.				
3.2	**Or** Is there an action plan signed off by Trust and LMNS Board for a move towards the TC pathway (as above) based on BAPM framework for babies from 34+0 with clear timescales for implementation and progress from MIS Year 5.	N/A			
Drawing on insights from themes identified from any term admissions to the NNU, undertake at least one quality improvement initiative to decrease admissions and/or length of stay.					
3.3	By 6 months into MIS year 6, register the QI project with local Trust quality/service improvement team.				QI projects approved at Q1 LMNS meeting – smoking & fetal well-being
3.4	By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.				Update at end of reporting period – 12/2/2025
Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas following an audit of 6 months activity :					
4.1	Locum currently works in their unit on the tier 2 or 3 rota?				

4.2	OR They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual review of Competency Progression (ARCP)?				
4.3	OR They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?				
Has the Trust ensured that the following criteria are met for employing long-term locum doctors in Obstetrics and Gynaecology.					
4.4	Implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance?				
RCOG compensatory rest (not reportable in MIS year 6)					
4.5	Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, and can the service provide assurance that they have evidence of compliance?				
4.6	OR Has an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings?	N/A			
Consultant Attendance					
4.7	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service when a consultant is required to attend in person?				
4.8	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance?				
4,9	Do you have evidence that the Trust position with the above has been shared with Trust Board?				Q2 in November IOR
4.10	Do you have evidence that the Trust position with the above has been shared with Board level Safety Champions?				Q2 in November IOR
4.11	Do you have evidence that the Trust position with the above has been shared with the LMNS?				Q2 shared at 12/11/24 LMNS quarterly review meeting
Anaesthetic Workforce					
4.12	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) - Representative month rota acceptable.				Rotas for 1 month
Neonatal Medical Workforce					
4.13	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?				
4.14	Is this formally recorded in Trust Board minutes?				Neonatal staffing report – QGC January 2025
4.15	If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.	N/A			
4.16	Was the above action plan shared with the LMNS?	N/A			

4.17	Was the above action plan shared with the ODN?	N/A			
Neonatal Nursing Workforce					
4.18	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing?				Neonatal staffing report – QGC January 2025
4.19	Is this formally recorded in Trust Board minutes?				
4.20	If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.				
4.21	Was the above action plan shared with the LMNS?				
4.22	Was the above action plan shared with the ODN?				
5.1	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six reporting period. It should also include an update on all of the points below.				
5.2	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.				
5.3	Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated? Evidence should include: ● Midwifery staffing recommendations from Ockenden and of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on the above, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. ● Where deficits in staffing levels have been identified must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall. ● The midwife to birth ratio ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.				BR+ 2024 recommendations approved by EMT October 2024
5.4	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator on duty **at the start of every shift.**				6-monthly staffing reports
5.5	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with the provision of one-to-one care in active labour				
5.6	A plan is in place for mitigation/escalation to cover any shortfalls in the two points above.				Escalation guideline
6.1	Have you provided a signed declaration from the Executive Medical Director declaring that Saving Babies' Lives Care Bundle, Version 3 is fully / will be in place as agreed with the ICB ? (where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours – and sufficient progress – have been made towards full implementation, in line with the locally agreed improvement trajectory.)				Q2 LMNS assurance meeting held 12/11/2024 All elements CNST met & validated by LMNS 11/12/2024
6.2	Have you continued the quarterly QI discussions between the Trust and the LMNS/ICB (as commissioner) from Year 5, and more specifically be able to demonstrate that at least two quarterly discussions have been held in Year 6 to track compliance with the care bundle? **These meetings must include agreement of a local improvement trajectory against these metrics for 24/25, and subsequently reviews of progress against the trajectory.**				

6.3	Have these quarterly meetings included details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.				
6.4	Is there a regular review of local themes and trends with regard to potential harms in each of the six elements.				
6.5	**Following these meetings, has the LMNS determined that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory?**				Update at end of reporting period – 11/2/2025
6.6	Is there evidence of sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate?				MPSLN, fetal monitoring, preterm birth groups
7.1	Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.				Annual workplan approved by LMNS
7.2	Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member (Trusts should work towards the MNVP Lead being a quorate member), **such as**: • Safety champion meetings • Maternity business and governance • Neonatal business and governance • PMRT review meeting • Patient safety meeting • Guideline committee				Ongoing review of Maternity risk management guideline & associated TORs
7.3	Evidence of MNVP infrastructure being in place from your LMNS/ICB, such as: • Job description for MNVP Lead • Contracts for service or grant agreements • Budget with allocated funds for IT, comms, engagement, training and administrative support • Local service user volunteer expenses policy including out of pocket expenses and childcare cost				
7.4	**If evidence of funding support at expected level (as above) is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.**	N/A			
7.5	Evidence of a joint review of annual CQC Maternity Survey data, such as documentation of actions arising from CQC survey and free text analysis, such as a coproduced action plan.				
7.6	Has progress on the coproduced action above been shared with Safety Champions?				
7.7	Has progress on the coproduced action above been shared with the LMNS?				
Fetal monitoring and surveillance (in the antenatal and intrapartum period) training					
8.1	90% of obstetric consultants				Signed up to NENC TNA – anticipate meeting required standard
8.2	90% of all other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)				
8.3	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres				
Maternity emergencies and multiprofessional training					
8.4	90% of obstetric consultants				

8.5	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows,foundation year doctors and GP trainees contributing to the obstetric rota				
8.6	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives				
8.7	90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum).				
8.8	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors				
8.9	90% of all other obstetric anaesthetic doctors (including anaesthetists in training, SAS and LED doctors) **who contribute to the obstetric anaesthetic on-call rota in any capacity**. This updated requirement is supported by the RCoA and OAA.				
8.10	70% of non-obstetric anaesthetic doctors (including anaesthetists in training, SAS and LED doctors) **who contribute to the obstetric anaesthetic on-call rota in any capacity**. This updated requirement is supported by the RCoA and OAA.				
8.11	Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in a clinical area or at point of care during the whole MIS reporting period?				
Neonatal basic life support					
8.12	90% of neonatal Consultants or Paediatric consultants covering neonatal units				
8.13	90% of neonatal junior doctors (who attend any births)				
8.14	90% of neonatal nurses (Band 5 and above who attend any births)				
8.15	90% of maternity support workers, health care assistants and nursery nurses *dependant on their roles within the service - for local policy to determine.				
8.16	90% of advanced Neonatal Nurse Practitioner (ANNP)				
8.17	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)				
8.19	Is a formal plan in place demonstrating how you will ensure a minimum of 90% of neonatal and paediatric medical staff who attend neonatal resuscitations have a valid resuscitation council NLS certification by year 7 of MIS and ongoing.				
9.1	Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded (including the following)?				
9.2	Has a non-executive director (NED) has been appointed and is visibly working with the Board safety champion (BSC)?				
9.3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) at every meeting using a minimum data set, and presented by a member of the perinatal leadership team to provide supporting context.				Monthly IOR
9.4	Does the regular review include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.				
9.5	Do you have evidence of collaboration with the local maternity and neonatal system (LMNS)/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.				
9.6	Ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.				Monthly safety champion walkabouts & bi-monthly quad/safety champion meetings

9.7	Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?				Increase in scorecard/legal reporting required to quarterly
9.8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.				Monthly safety champion walkabouts & bi-monthly quad/safety champion meetings
9.9	Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.				Culture improvement plan following completion of perinatal quad programme & SCORE results Jannuary board
10.1	Have you reported of all qualifying cases to MNSI from 8 December 2023 to 30 November 2024.				
10.2	Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 until 30 November 2024.				
10.3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme				
10.4	Has there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.				
10.5	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution.				
10.6	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?				
10.7	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?				
10.8	Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.				
Total	Out of 83 (6 N/A)	80 (96%)	6 N/A 1 concern 2 not yet assessed	0	

Summary

Gateshead Health NHS Foundation Trust compliance against the ten Maternity Incentive Scheme Safety Actions is as follows:

Progress since November 2024:

- Compliance period met for MID Year 6 reporting therefore several actions now completed
- Staffing & perinatal culture reports to go toe January QGC meeting
- Only outstanding action is final ratification of updated Maternity Risk Management Guideline – January Safecare

Action Plan: to achieve continued compliance into Year 6 of MIS

Safety Action	Action	Lead	Timescale
1	None required – continue to report all PMRT cases as required & quarterly reports.	Abbie McCready	Complete
2	None required	Mark Scobie	Complete
3	None required – continue to work with MDT leads to embed robust review process & monitor resultant action plan to completion. Quarterly reports.	Shilpa Ramesh	Complete
4	Medical staffing rotas RCOG attendance audit	Kate Hewitson Mel Pearce	January 2025 – staffing report
5	Completion of BR+ process/board reporting Continue 6-monthly staffing reporting	Karen Parker, Claire Cameron, Mary Jobson	January 2025 – Q1 & Q2 staffing report
6	Continue quarterly reporting/LMNS assurance meetings	Abbie McCready	Complete
7	Continued support for Gateshead MNVP to achieve their workplan	LMNS (Amanda Tester), MNVP leads & Karen Parker	Complete
8	Continue to engage with NENC training faculty & monitor attendance	Practice development team	Complete
9	None required – continue with monthly walkabouts,	Safety Champions	January 2025 Culture report
10	None required – continue to report/inform families as indicated	Karen Parker/Legal team	Complete

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	89	89			
Areas not Applicable	6	6	6	6	6	6	6	6	6			
No. Compliant	56	63	68	69	74	79	79	79	80			
No. Non Compliant / Unassessed	35	26	15	14	15	4	4	4	3			
Percentage Compliance	63.0%	71.0%	76.0%	78%	83%	89%	89%	89%	96%			

Areas compliant: (List domains compliant) Safety actions 1, 2, 3, 4, 5, 6, 8, 9, 10

Areas Non compliant/Not Assessed: (List domains compliant)
N/A - 6 areas as only required if not compliant
Only outstanding action is final ratification of updated Maternity Risk Management Guideline – January Safecare - Safety action 7

How are we performing or Progress Made?
Annual LMNS assurance report received, Q2 LMNS assurance meeting completed, MIS compliance reporting period ended 30/11/2024

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

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

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Total Areas	89	89	89	89	89	89	89	89	89			
Areas not Applicable	6	6	6	6	6	6	6	6	6			
No. Compliant	56	63	68	69	74	79	79	79	80			
No. Non Compliant / Unassessed	35	26	15	14	15	4	4	4	3			
Percentage Compliance	63.0%	71.0%	76.0%	78%	83%	89%	89%	89%	96%			

Areas compliant: (List domains compliant) Safety actions 1, 2, 3, 4, 5, 6, 8, 9, 10

Areas Non compliant/Not Assessed: (List domains compliant)
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Annual LMNS assurance report received, Q2 LMNS assurance meeting completed, MIS compliance reporting period ended 30/11/2024

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Update of maternity governance structure in line with Trust, recruitment to midwifery vacancies

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 19

Report Title:	**Nursing Staffing Exception Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29 January 2025			
Author:	Helen Larkin, Clinical Lead E-rostering			
Executive Sponsor:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
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:	SafeCare Steering Group 21 January 2025			
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 December 2024. December has demonstrated some areas with staffing challenges relating to sickness absence and enhanced care requirements. During December, we continued to experience periods of increased patient activity with surge pressure resulting in escalation areas open in Ward 11 and SDEC. Additionally escalation beds continue to be open on wards 22, 24 and 25. 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			

<table>
<tr><td></td><td colspan="5">documented. A staffing escalation protocol is now in operation across all areas within the organisation and assurance of this operating as expected, is provided by the number of staffing incident reports raised through the incident reporting system.</td></tr>
<tr><td>Recommended actions for this meeting:</td><td colspan="5">The Board of Directors is asked to:
receive the report for assurance
note the work being undertaken to address the shortfalls in staffing</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5"></td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☐</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">There was 14 nurse-staffing incidents raised via InPhase during the month of December, of which 0 incidents recorded physical harm, four incidents recorded low psychological harm.</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

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

1. Introduction

This report details the staffing exceptions for Gateshead Health NHS Foundation Trust during the month of December 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 December 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 December 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 (%)**
94.4%	**97.8%**	**97.2%**	**97.4%**

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 2024.

Contextual information and actions taken

Through the month of December ward 11 was used to support patients through the busiest times and peaks in activity. However, Ward 11 is not an established area with an allocated financial budget. The Ward 11 environment is used for escalation beds. The Ward was not open and fully occupied for the full month and was staffed from across the organisation through staff redeployment. This area was assessed daily for safe de-escalation.

Ward 28 present a fill rate of 52.3% for healthcare support worker on nights. Through the month of December ward 28 closed for 3 days, staff with over contracted hours as a result will work to correct these balances in coming months. Additionally Health care support workers have been rostered in line with periods where there is a peak in elective activity therefore on some nights there are no healthcare support workers on duty.
Ward 28 have a 14.2 WTE band 3 establishment with 6.3 WTE contacted, leaving a 6.8 WTE vacancy. 1.64WTE are currently off on long term sick and often Ward 28 still continue to support HCA redeployment overnight. SNCT suggest review of establishment required.

Ward 23 showed a healthcare support worker shortage on nights, this was mitigated with additional qualified member of staff on some occasions, and this did not compromise day shift cover as currently over recruited with qualified staff. Ward 23 in addition have had some long-term sickness through the month of December and are running with a 1.4 WTE healthcare support worker vacancy.

St Bedes highlighted an overfill rate of 150.1% through December for health care support worker nights. Additional resource was required for patient care overnight and agreed by Matron / Chief Matron and Service Line Manager.

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 December are as below:

December 2024	
Registered Nurse Days	**%**
No exceptions <75%	
Registered Nurse Nights	**%**
No exceptions <75%	
Healthcare Support Worker Days	**%**
No exceptions <75%	
Healthcare Support Worker Nights	**%**
Ward 28	52.3%
Ward 23	64.7%

In December, 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 December, 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:

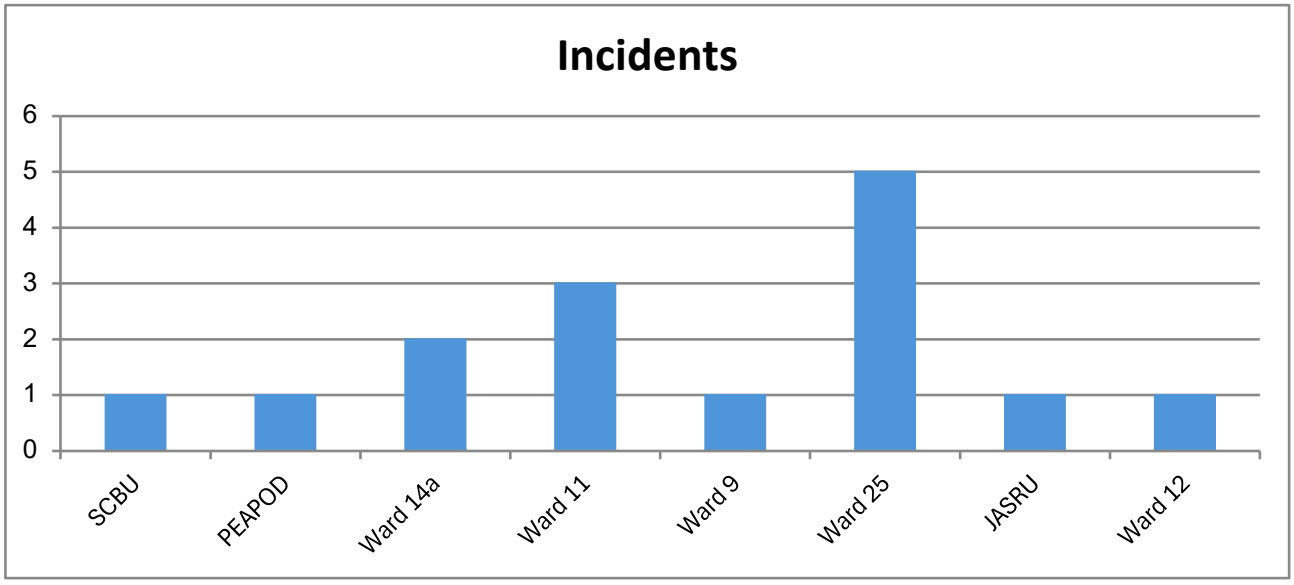
- Patient acuity and dependency
- Patients required enhanced care and support
- Bed occupancy (activity)

Ward level CHPPD is outlined in Appendix 1. For the month of December, the Trust total CHPPD was 7.5. 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 14 nurse-staffing incidents raised via the incident reporting system.

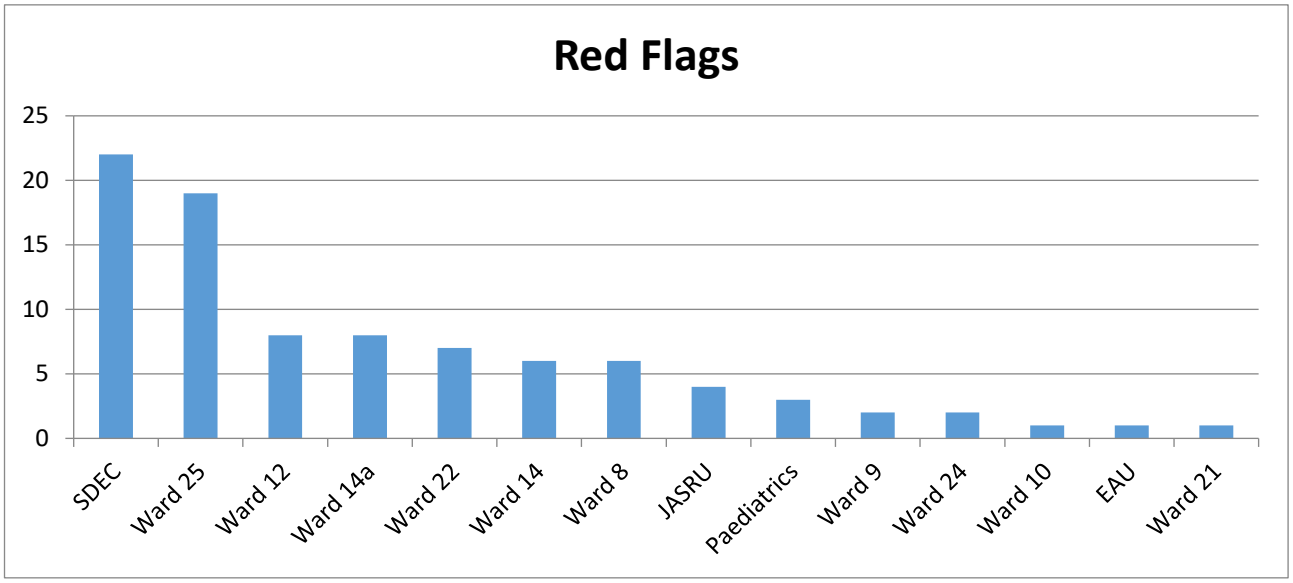


Ward 25 and ward 11 (escalation beds) report the highest number of incidents. Ward 25 incidents all relate to staff redeployment to other areas leaving insufficient nurses for 30 beds + 3 occupied escalation beds.
Ward 11 incidents relate to insufficient medical and nurse staffing.

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 December there were 90 nursing red flags reported. This compares to 40 red flags reported in November. Additional to raising a red flag on the system, the owner of the red flag escalates this timely to the Matron of senior nurse for mitigation.

The Bar Chart below outlines the number of red flags raised per department through the month of December.

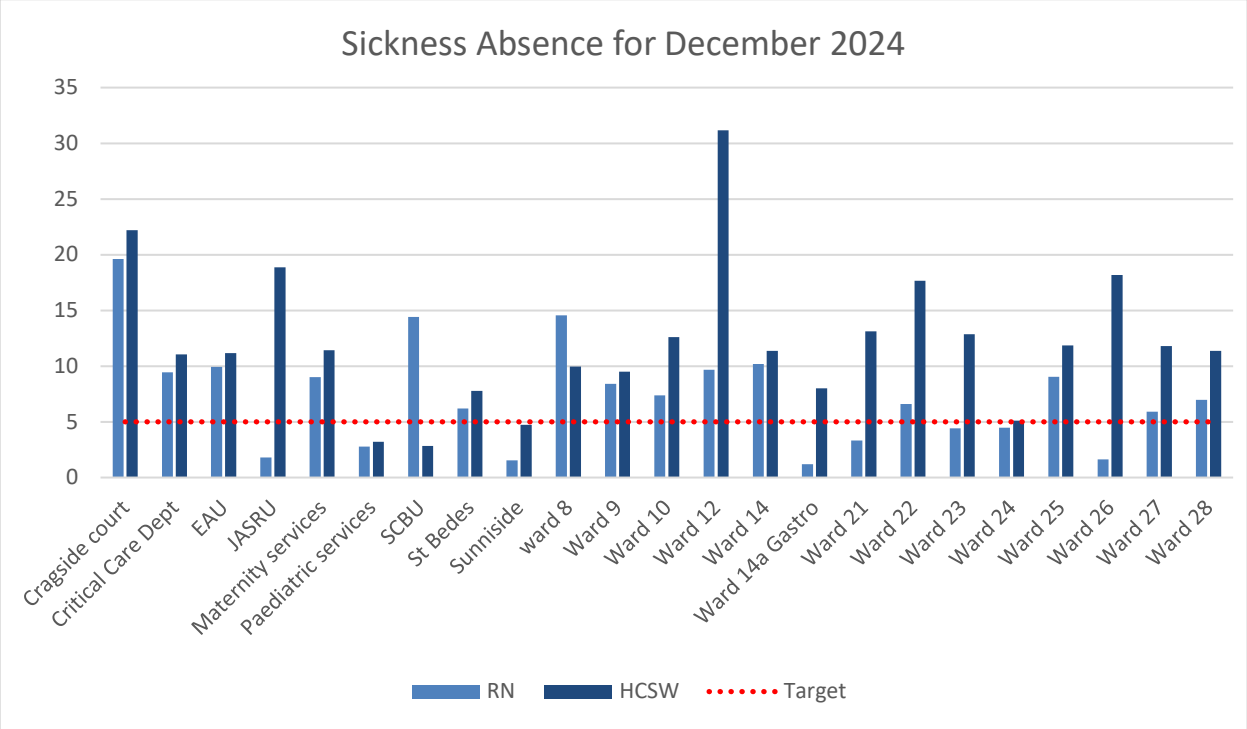


There were no Red Flags raised through the month of December for those areas that report fill rates below 75%.

5. Attendance of Nursing workforce

The below table displays the percentage of sickness absence per staff group for December. Data is extracted from Health Roster.

Notably through December Ward 12 report significant sickness absence. There is ongoing Matron, HR and POD support working to support employees both currently absent and at work.



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 December 2024 and provides assurance of ongoing work to triangulate workforce metrics. Head of Nursing Workforce and Clinical Lead for E-rostering are proactively working with colleagues to create monthly dashboard metrics, triangulating vacancy, sickness absence, bank spend with ward quality measures and patient safety.

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 December 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	85.2%	99.6%	87.8%	149.5%	342	5.4	6.9	12.4
Critical Care Dept	80.5%	104.7%	97.8%	85.2%	282	27.8	4.9	32.7
Emergency Care Centre - EAU	85.8%	88.4%	98.5%	91.2%	1437	5.5	4.1	9.6
JASRU	105.4%	75.2%	107.5%	76.7%	618	3.9	3.4	7.4
Maternity Unit	89.9%	102.6%	98.1%	92.9%	637	12.2	4.4	16.6
Special Care Baby Unit	86.3%	96.9%	100.9%	90.5%	125	14.0	3.7	17.7
St. Bedes	86.0%	101.0%	101.5%	150.1%	285	5.3	5.0	10.3
Sunniside Unit	80.8%	158.8%	98.3%	110.9%	292	5.4	5.3	10.7
Ward 08	111.2%	109.7%	91.5%	107.0%	631	3.7	3.3	7.0
Ward 09	101.8%	88.4%	106.7%	103.1%	877	2.7	2.0	4.7
Ward 10	85.3%	110.5%	100.3%	106.1%	789	2.6	2.7	5.2

	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	77.1%	77.8%	102.9%	102.5%	811	2.4	2.3	4.7
Ward 14 Medicine	111.3%	85.6%	83.9%	96.8%	778	2.9	2.3	5.3
Ward 14a Gastro	110.0%	131.3%	97.1%	155.8%	793	3.0	3.8	6.8
Ward 21 T&O	147.4%	114.8%	103.8%	96.4%	879	3.5	3.0	6.5
Ward 22	100.8%	85.2%	91.3%	75.2%	938	2.6	2.5	5.1
Ward 23	96.8%	106.5%	122.4%	64.7%	737	3.0	3.1	6.0
Ward 24	115.1%	82.1%	85.5%	91.0%	949	2.7	2.6	5.4
Ward 25	105.8%	108.1%	89.1%	92.5%	937	2.6	3.2	5.8
Ward 26	109.4%	102.6%	103.1%	104.0%	852	3.2	3.0	6.2
Ward 27	99.1%	100.5%	91.8%	108.8%	886	2.8	2.9	5.7
Ward 28	81.8%	82.7%	85.7%	52.3%	181	7.6	5.2	12.8
QUEEN ELIZABETH HOSPITAL - RR7EN	**94.4%** ↑	**97.8% %** ↓	**97.2%** ↓	**97.4%** ↓	**15351**	4.3	3.2	7.5 ↓

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 20

Report Title:	**Inpatient Safer Nursing Care Staffing Bi-Annual Report- October 2024**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29th January 2025			
Author:	Laura Edgar, Head of Nursing Workforce			
Executive Sponsor:	Dr Gillian Findley, Chief Nurse			
Report presented by:	Dr Gillian Findley, Chief Nurse			
Purpose of Report	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☒
	This paper provides an overview of the Safe Staffing Nursing review undertaken at Gateshead Health in April and August 2024, reported in October 2024. The purpose of this paper is to provide the board with assurance that the nursing workforce at the Gateshead Health is safe, competent, and compliant with National Institute for Clinical Excellence (NICE), National Quality Board (NQB) and NHSI Safer Staffing guidelines and standards at a time when nationally nursing is facing the greatest recruitment and retention challenges.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by:				
Key issues:	A bi-annual review of nurse staffing using Safer Nursing Care Tool (SNCT) has been undertaken in line with national recommendations. The newest version of the tool has been used for this report. The SNCT is a recognised, evidence-based tool approved by the National Institute for Health and Care Excellence and NHSE for calculating staffing establishments. The paper highlights current challenges across the nursing workforce and mitigations on how we are monitoring and working to provide safe, effective patient care.			

<table>
<tr><td></td><td colspan="6">Individual ward areas have been reviewed using a triangulated approach to safer staffing as described in the paper. Results have been discussed within the divisions.

There is a concurrent piece of work being led by the provider collaborative looking at benchmarking the use of safe staffing tools across the region. The Trust is fully engaged in this work.

Recommendations from the report are as follows:

1. The Trust should re-run the SNCT as required in January 2025 and compare with this report to ensure the consistent application of the new tool before further recommendations are made.

2. Until there has been a further discussion in relation to headroom calculations and requirements for enhanced care no change to staff numbers is recommended</td></tr>
<tr><td>Recommended actions for this meeting:</td><td colspan="6">The Board is asked to:
• Note the content of the report
• Note the assurance that SNCT is being used in line with national guidance
• Note that no change to staff is recommended at this stage
• Note the need for further review of the current enhanced care approach</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">Supports the majority of objectives</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td 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">No risks link directly to this paper.</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td colspan="2">Not applicable
☒</td></tr>
</table>

Safe Staffing – Bi Annual Review

Adult Inpatient Safer Nursing Care Staffing Report

October 2024

Contents Page

Introduction

The need to recruit and retain a suitable health workforce has been described as the greatest challenge currently facing the NHS. Care Quality Commission's State of Care report for 2018/19 stated that workforce problems are having a direct impact on care. Having the right number of nurses, with the right mix of skills and experience is essential if organisations are to provide safe, high-quality care for patients. It is well recognised within nursing workforce literature of the link between optimal staffing levels and high quality patient outcomes as well as staff experience (Griffiths et al 2020, Ball and Griffiths, 2022).

The purpose of this paper is to provide the board with assurance that nursing workforce at Gateshead Health is reviewed and compliant with National Institute for Clinical Excellence (NICE), National Quality Board (NQB) and NHSI Safer Staffing guidelines, Developing Workforce Safeguards (2018). This report will review the data collated using a triangulated approach to provide assurance and recommendations to ensure we have a safe and competent workforce who will provide high quality patient care.

This report provides an overview of the Safer Nursing Care Tool Staffing reviews undertaken in April and August 2024.

National and Local context

Nursing continues to face ongoing challenges with recruiting and retaining nurses, with a reported figure of over 43,000 vacant nursing posts in England as of July 2024.

The Government made several pledges relating to the nursing workforce, including an additional 50,000 nurses in the NHS by 2024/2025, introducing a nursing grant and devising a fast-track visa for NHS workers including nurses. This target has been achieved, with the majority of those nurses being successfully recruited internationally, accounting for one in five of the professionals on our register. Locally, we have successfully recruited to the Registered Nursing workforce which now finds us with an over establishment of 2.0%, contributory to a productive International Recruitment programme. This has enabled our workforce to be more ethnically diverse, making a vital and welcome contribution to Gateshead Health.

It is important we continue to have the right number of nurses, with the right mix of skills and experience, in the right areas at the right time, to ensure high quality patient care and staff wellbeing. This is increasingly important as we are caring for patients with greater health complexities.

Analysis of Gateshead Health Safer Staffing Nursing Review August 2024

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

A refreshed SNCT tool was launched nationally in December 2023, including additional levels of acuity and dependency to support the identification of enhanced care needs in adult in patient wards, as well as

those cared for within single side room wards. Matrons, ward managers and ward sisters were trained and assessed to use the revised SNCT prior to data collection. Data was collected for all adult in-patient wards during the months of April and August, with Inter Rater Reliability reviews undertaken by staff outside of the division. This process enhances the validity of the data collated. Establishment review meetings were held with each ward area to present and discuss the SNCT data, patient quality outcomes and professional judgement. Data presentations can be found within Appendix 2.

Figure 1. Triangulated approach used to ensure safe staffing.

Evidence based tools

Gateshead Health utilises the SNCT, as well as Mental Health Optimal Staffing Tool (MHOST) and Emergency Department SNCT. These tools are specialty specific and are assessed differently. Therefore, the MHOST review will be presented in a separate report. A separate ED SNCT report is currently under review.

Adult Inpatient Wards Safer Nursing Care tool (AIPW SNCT) – A revised evidence-based tool, was released in December 2023, which includes the identification of enhanced care requirements within ward areas. The tool also includes the opportunity to recommend nurse staffing establishments for wards/departments made up of single side rooms.
All inpatient wards have used the current SNCT to record patient acuity and dependency over a 30 day period, as recommended. The tool is easy to use by frontline nursing staff but must be applied correctly and consistently for data to be valid, and to allow benchmarking against agreed standards. It should be combined with nurses' professional judgement and account for local factors.

SNCT Audit – The SNCT audit is required to be presented biannually to board. The previous report presented in January can be found here. To note this previous report demonstrated the first data collection for the revised SNCT.
Z:\SNCT\board papers\Jan 24\Gateshead Health - SNCT report January 24.docx

Care Hours per Patient Day (CHPPD)
CHPPD is a recognised standard of measurement for calculating staffing requirement on inpatient wards. It does not reflect patient acuity, staff skills or size of the ward. The Trust CHPPD (target range 10-12) averaged 8.4 for the previous 12 months. Although reduced Gateshead Health benchmarks well with other regional trusts with NUTH (8.3) CDDFT (8.0) and NSECH (7.9).

Monthly Fill Rates
Each month the senior leadership team and Board are presented with The Nursing Staffing Exception report. This report highlights the monthly fill rates broken down by ward area in line with safer staffing. Overall fill varies depending on vacancies, gaps in rosters and number of patients. Between September

23 and August 24, Gateshead Health has averaged 97.2% fill rate for registered nursing and 110.1% fill rate for care staff. The increased fill rate for care staff is largely attributable to support with additional enhanced care needs along with the inclusive capture of support staff as per national guidance. An increased average fill rate is also attributable to the number of apprenticeship positions we have in the Organisation as well as those progressing from the international recruitment programme to Registrant status over the past 12 months.

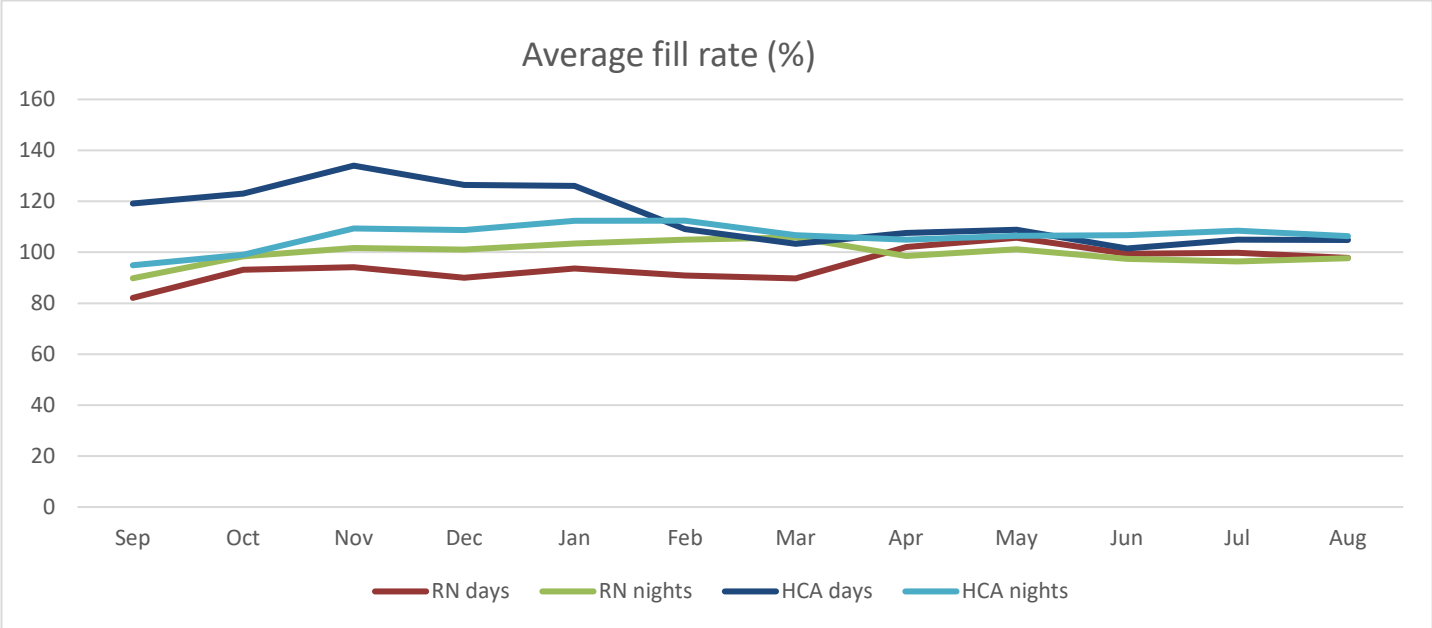


Figure 2: monthly fill rate

Red Flags

Red flags are used by staff when staffing levels have been identified as impacting safety on the ward either by reduced staff numbers, skill shortfall or delay to care. The Red Flags included in the chart below are recommended by NICE (2018) to identify and escalate safer staffing concerns. The main key themes recorded over the past 12 months are:

- Shortfall in Registered Nurse time (107)
- Missed 'intentional' rounding (84)
- Less than 2 RNs on shift (65)

It is important to note that whilst red flag reporting is evident, continued work with the ward teams to empower usage, low reporting is likely linked to staff being too busy to raise a red flag. Matrons continue to support red flag reporting to ensure accurate documentation. Further work is ongoing in relation to intervention and de-escalation of red flag reports to mitigate safer staffing incidents.

It has been identified the need for local red flag in relation to nurse staffing, for example Level 2 high acuity patients within general ward areas.

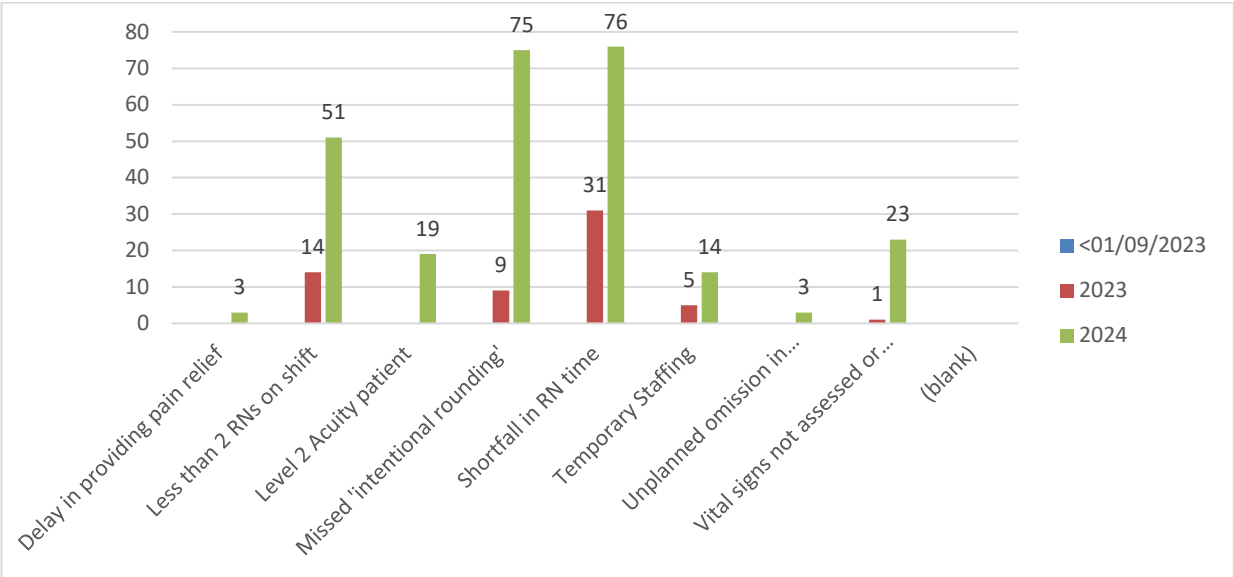


Figure 3: Red Flags

Right staff

Recruitment and retention
Recruitment and retention remain a key priority for Gateshead Health, with a current overall nursing workforce vacancy rate of 0.7% inclusive of all nursing workforce groups. This is favourable against the Organisational target of 8%. We do know, however that within our Registered Nursing workforce, we have a 2.0% over establishment. This position is largely attributable to the successful international recruitment programme along with substantive recruitment into temporary vacancies. There are no further plans to engage in International Recruitment programme, nationally or locally, therefore it is really important we continue to closely monitor the nursing workforce position as a whole, with consideration of both attrition rates and pipeline routes into the profession. Recruitment into specialist areas such as paediatrics and clinical nurse specialist roles remains an ongoing focus for the organisation and a separate review of the paediatric nursing establishment will be presented separately to this report.

International recruitment
The international recruitment programme is now coming to an end at Gateshead Health, with only 5 of our displaced nurses to progress onto the NMC register. Nationally, there is no indication of further international recruitment programmes to take place. Therefore consideration and focus on sustainable domestic pipeline recruitment is essential, which includes growing our own workforce and the support of Apprenticeship routes into nursing will be key.

Nursing Turnover
Regionally, Gateshead has reduced Registered Nursing turnover rate and now demonstrates in the lowest quartile, with this at 8.2% for August 24, comparative to the provider median at 9.8%. This has reduced since the previous staffing review (9.2% in January 2024).

Unavailability – sickness/staff absence
Sickness absence levels within nursing remain high and above the NHS target of 5%. Currently Sickness absence is 6.7% rolling 12-month average. Work continues with POD to review sickness and absence reasons and work with staff to support them to return to work safely, however it is challenging operationally with limited to no supervisory time allocated for nurse managers to safely and supportively bring staff back to the workplace.

Unavailability - Annual leave
Annual leave remains to be monitored monthly by the Matron team, Ward managers have worked hard trying to facilitate 13% of leave for the workforce while balancing vacancies and ensuring safe staffing levels on the wards to ensure that staff will be able to attend training and be available to be clinical shifts.

Right skills

Core Skills (CS): across the workforce CS is compliant at 84.06% in August 24, compared to 83.97% in August 23. Business units are working together with ward teams to facilitate time for staff to complete all core skills training. With a high proportion of new recruits there are shifts with the right staff numbers of staff but not necessarily the correct skill level. Where these occur, the senior nursing team are supporting clinical areas and staff may be redeployed to ensure care is not compromised.

Leadership: There have been new appointments into ward manager and matron leadership roles within the organisation, via internal opportunities for development. Currently at Gateshead Health all ward leaders are not budgeted for allocated management time or clinical supervisory time to support ward staff. The Trust completed a pilot for full time supervisory management time last year and was successful in seeing a marked improvement in ward metrics as well as seeing improved staff rostering compliance and a reduction in bank and agency spend during this period. Although this is not fully implemented across all ward areas, it is noted that ward managers are allocating some supervisory time to undertake management duties when safe staffing levels permit. The ability for ward manager supervisory status supports core skilsl and medical device compliance across the workforce, enabling a skilled and competent workforce. Management of attendance at work is a key role of the ward manager to support employees safely back into the workplace, and reduce the financial impact of absence.

Healthcare Assistants (HCA): National guidance around the differentiation between band 2 and 3 HCA and skills has required Gateshead Health to review this role and each clinical area requirement, which has resulted in the up-banding of many staff within the organisation. The Trust has previously supported over establishment of HCA due to the increased vacancies within the Registered Nursing workforce. As the RN gap reduced, work to reduce the over established HCA workforce mirrored. As of August 2024, it is reported a vacancy rate of 7.9% in this workforce group. This has been challenging to monitor as our Internationally Educated Nurses are reported within this budget line until the point of NMC registration when they are moved to the Registered Nurse budget. Further work is ongoing to map the pipeline entry of those within apprenticeship programmes, to mitigate any shortfall within this workforce group.

Right place, right time

Redeployment: Staffing is reviewed daily by the senior nursing team and staff are redeployed to the areas of greatest need whilst maintaining patient safety throughout the Trust. Providing oversight and supporting the decision-making process is through SafeCare Live, which provides a live update of staffing and acuity levels on the ward. Staff continue to be flexible and supportive of being redeployed; however, this has led to increase in anxiety and concerns over the frequency it can occur especially on nights. Notably, redeployment from staff from Critical Care and theatres has been particularly challenging for staff in those areas, both of which are specialist areas being moved to support surgical and medical wards. Ensuring we have the right staffing establishments and meeting planned staffing levels reduces the need for staff redeployments.

Headroom
Gateshead Health headroom is currently calculated at 21%, which is broken down by annual leave 13%, Study leave & training 4% and Sickness absence 4%. This is less than the recommended headroom of 22% within the new version of SNCT. It is recognised that some clinical areas will have a requirement for additional training and study leave which is not factored into budgeted establishments. Areas such as Critical Care, Emergency Department and Theatres have additional training needs along with national

training requirements before being competent to complete the role independently. The SNCT does not allow for a headroom calculation of less than 22% within the multipliers, which are derived from evidence based testing, and endorsed by NHS England and NICE.

Bank/agency use:

The use of nursing agency has reduced significantly over the past 12 months and is currently only utilised within Theatres at time of the report. Off framework agency has not been used within the Nursing workforce since June 2024. There has been no HCA agency used since April 24.

Alongside this, there has been concentrated work to reduce the utilisation of unwarranted bank shifts, with additional authorisation required for shifts to be generated.

Gateshead Health spent £4,464,189 on bank staffing expenditure between October 23 and October 24, and £1,165,564 on agency staff.

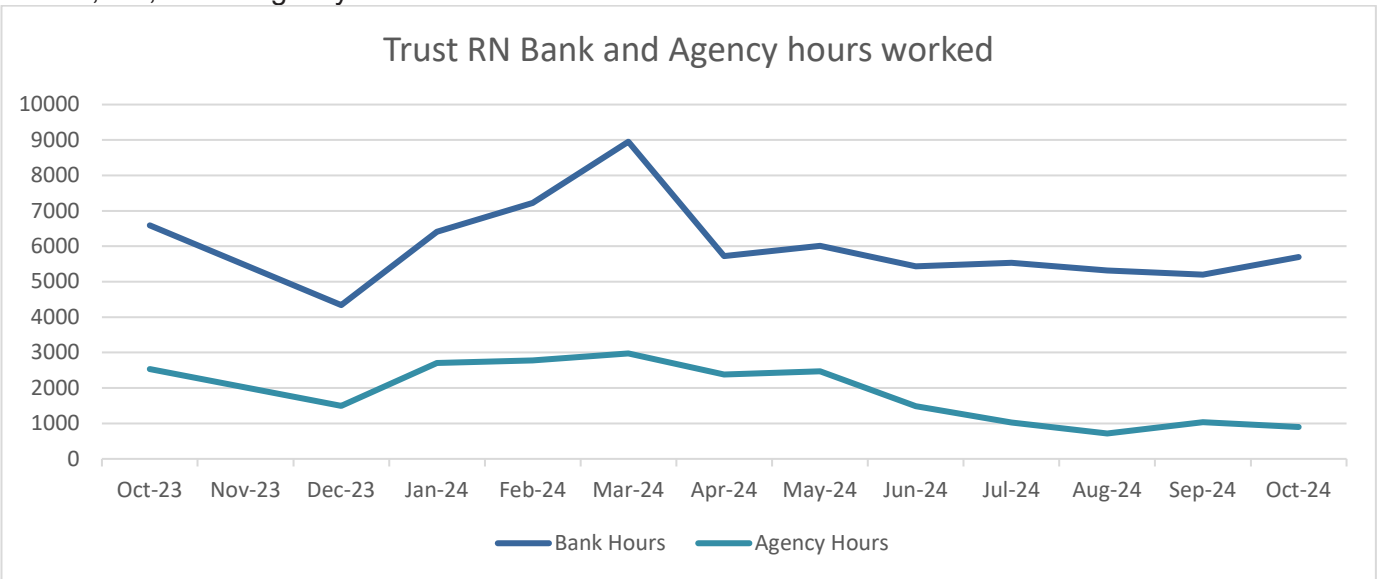


Figure 8 Registered Nurse Bank and Agency Filled hours 23/24

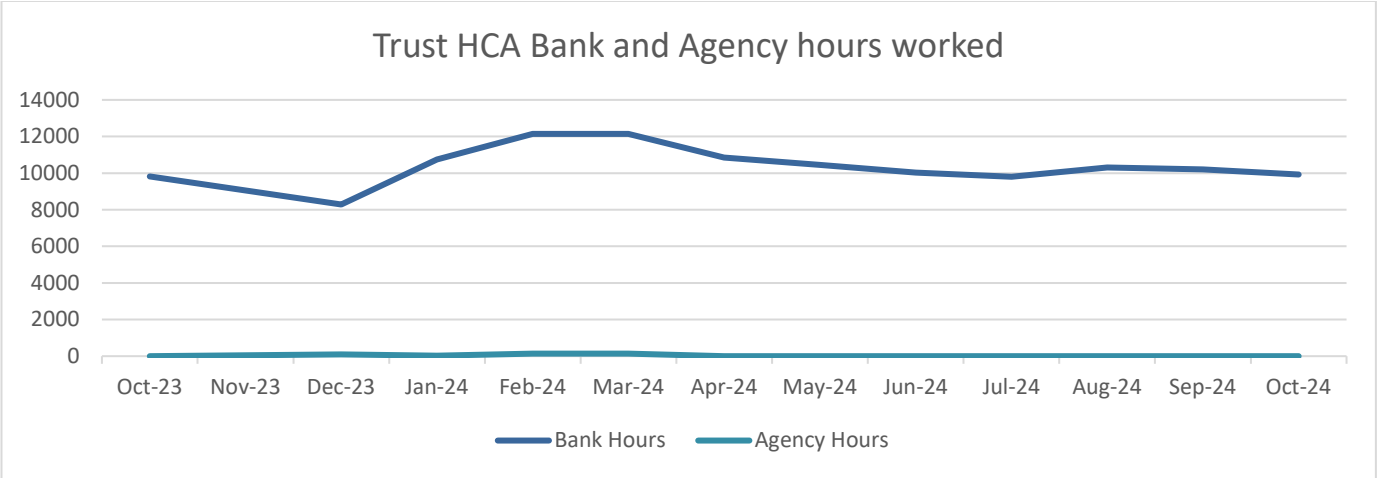


Figure 9 HCSW Bank and Agency filled hours in 23/24.

SNCT Staffing Review Results:

The table below outlines the funded establishment, contracted establishment and recommended establishment based on the triangulation of information included within the report.

The financial ledger for 24/25 month 6 was used to identify both the funded and actual establishments across the audited areas.

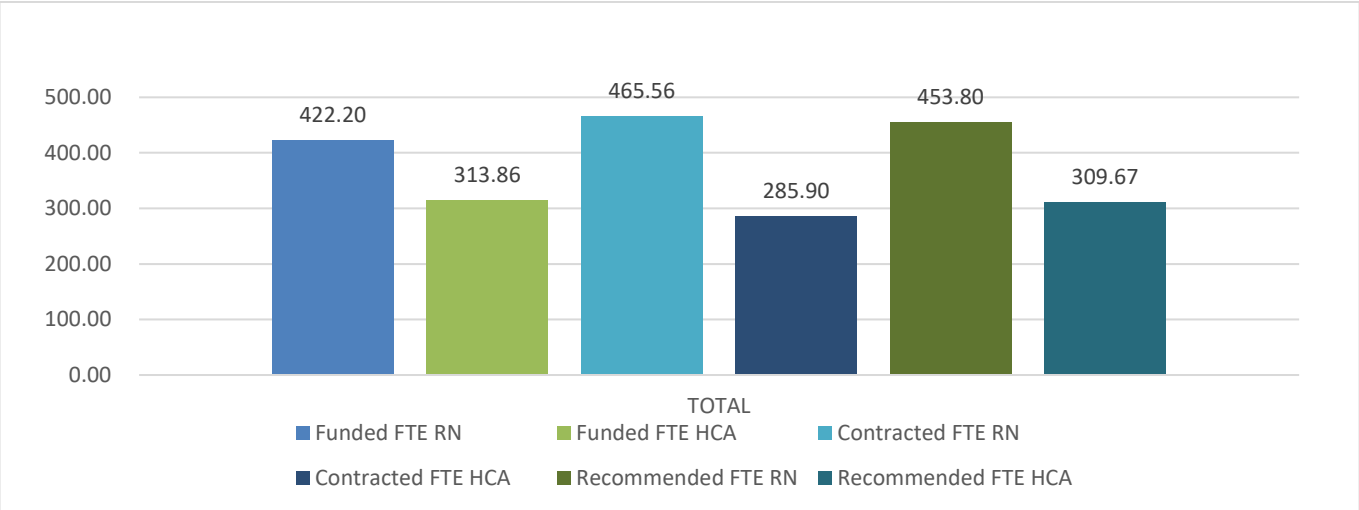
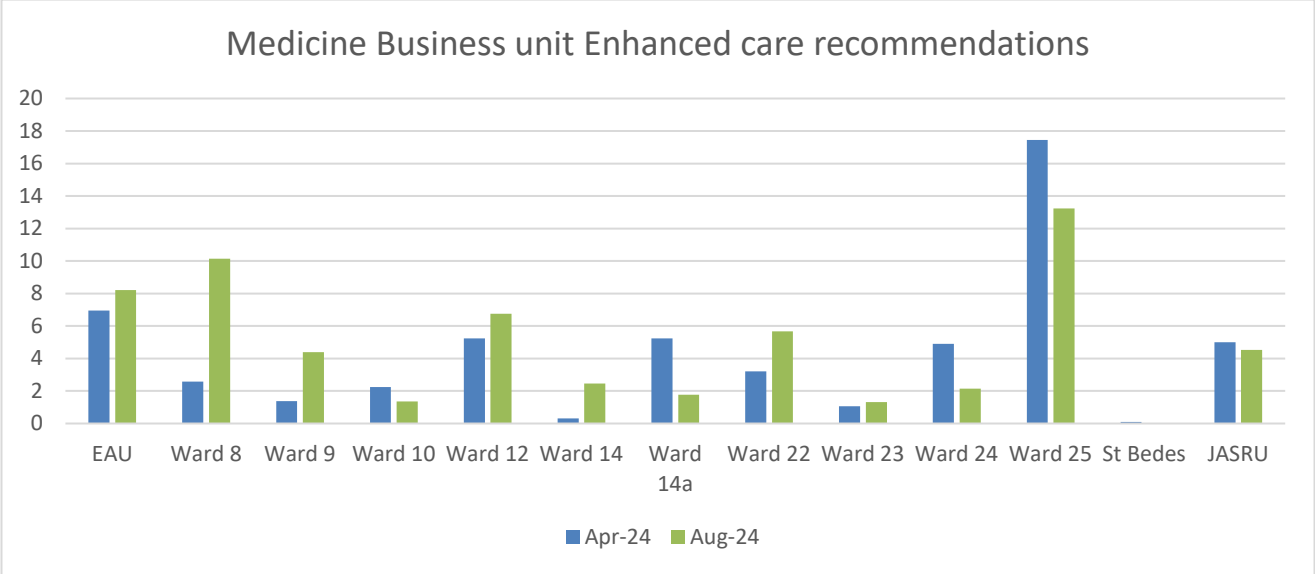


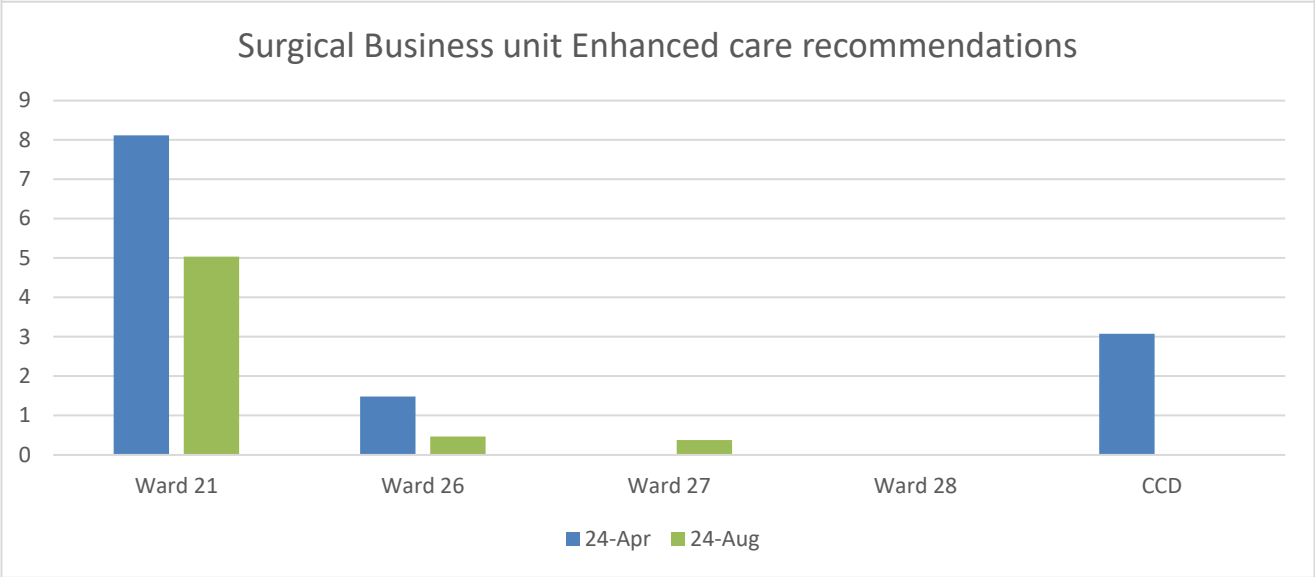
Table 1 results

For each ward, the comparison does not include a supervisory post of 1.0 WTE. Current practice within the majority of in-patient areas is to staff the ward with 2 registered nurses at night. This is outside of the recommended guidance for 1 registered healthcare per 10 patients at night, therefore the recommended registered nursing numbers includes an uplift in areas to comply with at 1:10 ratio for safe staffing levels at night.

Enhanced Care recommendations:

Identification of enhanced care within the SNCT has demonstrated that a recommended 68.35 FTE from the audit completed in April 24 and 67.89 FTE from the audit completed in August 24 would be required to provide 1:1 care. There is ongoing work within the Trust to review 1-1 enhanced care and delivery of therapeutic intervention. It is recommended to review further safer staffing data to triangulate this with ongoing additional work.





Peer review process

Gateshead Health FT and County Durham and Darlington FT undertook a peer review process to compare the SNCT audit process and schedule, the collated data and application of professional judgement, within the triangulation process. This process concluded the use of, analysis of, and interpretation of results within the SNCT application was consistent across both Trusts. There was acknowledgement in the value of conducting this work, and further agreement has been reached to conduct external inter rater reliability testing across both Trusts in future SNCT establishment reviews.

Bed base NOM v. Current Operational Bed Base

During the establishment reviews, it was identified that occupied beds within some wards/departments differed from the funded beds within the new operating model. Some wards, such as ward 9, 10, 21, 22, 24, and 25 have additional beds open and occupied consistently over the past 12 months. This equates

to an additional 15 in-patient beds open against the new operating model and funded establishment (app 1).

For consideration:

There are a number of points to note when considering the findings from this SNCT report:

- The new version of the SNCT tool has only been used twice within the Trust.
- Current headroom across the trust is set at 21%. The national recommendation for headroom is set at 22% as a minimum at present. This is set within the revised evidence based safer staffing tool and is endorsed by NICE and NHS England as a minimum percentage of unavailability for staff. Work to review headroom calculations, using an evidence based approach is ongoing and on target for completion by July 25.
- Within national guidance recommendations, and triangulation of data included within the report, ward establishments for areas, ward 21, ward 14a, and ward 25, requires bespoke review.
- When possible, within funded establishments, three RN are rostered on nightshift to support patient safety and enhanced care requirements. However, practice is inconsistent and requires consideration to standardise.
- Where possible within funded establishments, the Ward Management team are able to work shifts in a supervisory capacity, to support attendance management, clinical compliance and ward quality metrics. Again, practice is inconsistent across areas and requires consideration to standardise.

Recommendation:

- The Trust should re-run the SNCT as required in January 2025 and compare with this report to ensure the consistent application of the new tool before further recommendations are made.
- Until there has been a further discussion in relation to headroom calculations and requirements for enhanced care no change to staff numbers is recommended

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Conclusion:

The Trust continues to closely monitor staffing levels and comply with national guidance and recommendations on safer staffing. However, it must be acknowledged that sustained demand and capacity issues present ongoing challenges with regards to ensuring safe staffing across all areas. The nursing workforce within Gateshead Health is in position, where we have Registered Nurses above our funded establishment, and this has resulted in levels of high quality care being delivered by a skilled workforce. It is evident we are caring for patients with higher levels of acuity and dependency, and there are a considerable number of patients being assessed as requiring enhanced care. The process for identification of these patients and enhanced care delivery is currently being reviewed.

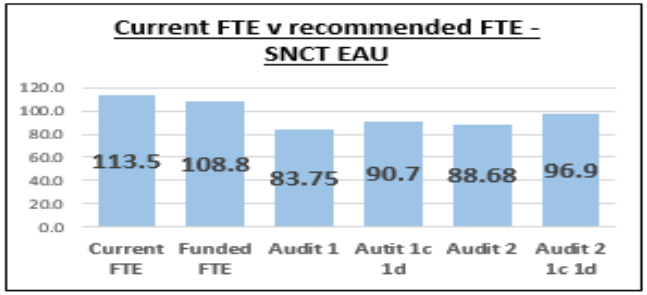
References

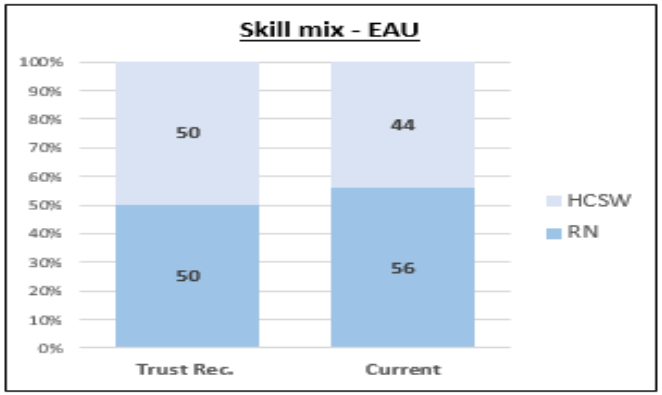
NHSI: (2018) Developing workforce safeguards.
NQB: (2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time.
The Kings Fund (2022) The NHS nursing workforce – have the flood guards opened.
Shelford Group: (2023) Safer Nursing Care Tool.
Griffiths, P., Saville, C., Ball, J., Jones, J., Pattison, N., Monks, T., Safer Nursing Care Study Group (2020) Nursing Workload, nurse staffing methodologies and tools: A systematic scoping review discussion. International Journal of Nursing Studies.
Ball, J.E, and Griffiths, P. (2022) Consensus Development Project (CDP): An overview of staffing for safe and effective nursing care. Nursing Open, 9 (2).

Appendix 1: New Operating Model bed base vs. Current operational bed base

	New operating model bed base	Current bed base
EAU	48	48 plus 1 escalation
Ward 8	21	21
Ward 9	26	26 plus 3 escalation beds
Ward 10	21	23 plus 3 escalation beds
Ward 12	25	26 plus 1 escalation bed
Ward 14	26	26
Ward 14a	23	26 beds
Ward 21	28	
Ward 22	29	29 plus 2 escalation beds
Ward 23	24	24
Ward 24	29	29 plus 2 escalation beds
Ward 25	30	30 plus 3 escalation beds
Ward 26	30	30
Ward 27	30	30
Ward 28	15	15
JASRU	20	20
St Bedes	20	20
Critical Care Dept.		
Total beds	**445**	**460**

Appendix 2: SNCT Data Analysis: **Medical Service Line 1 EAU**





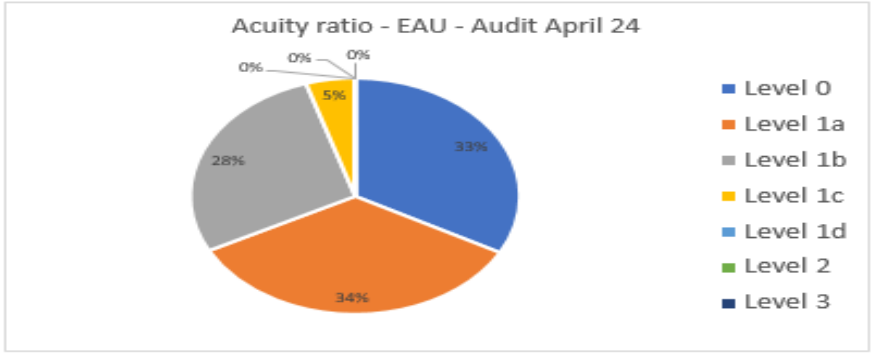
EAU SNCT results 2024

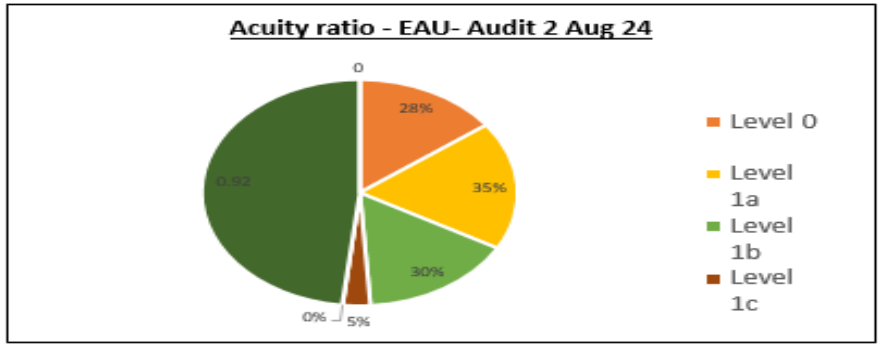
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1.

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

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

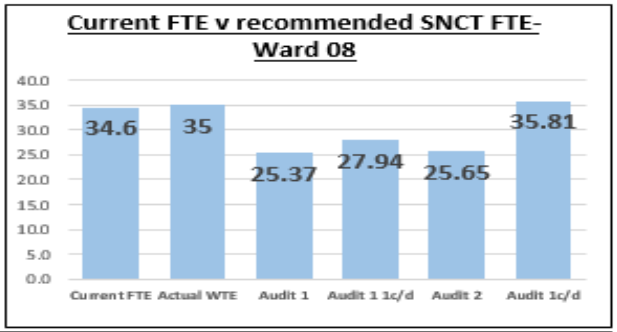
Table below:
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff outcomes.

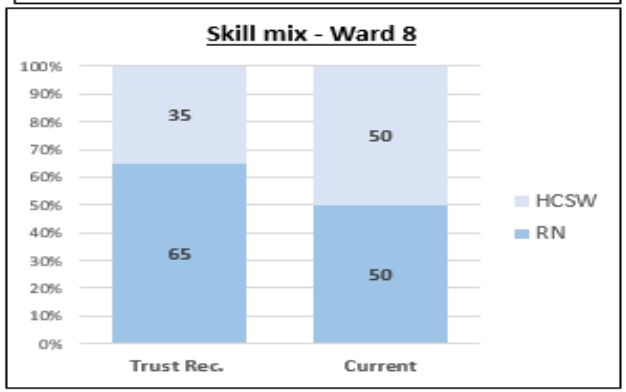




Nursing & Midwifery Care Quality Indicators														
			nput staffin	put - process of ca		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience				
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
EAU	Surgery	Audit 1	100.00%	0.00%	72.60%	5	2	10	71.40%	0	-5.5	12.80%	7.80%	10.5	
		Audit 2	100.00%	81.80%	71.50%	8	2	8		0	-4.3	16.90%	4.90%	10.4	

Medicine Service Line 2- Ward 8





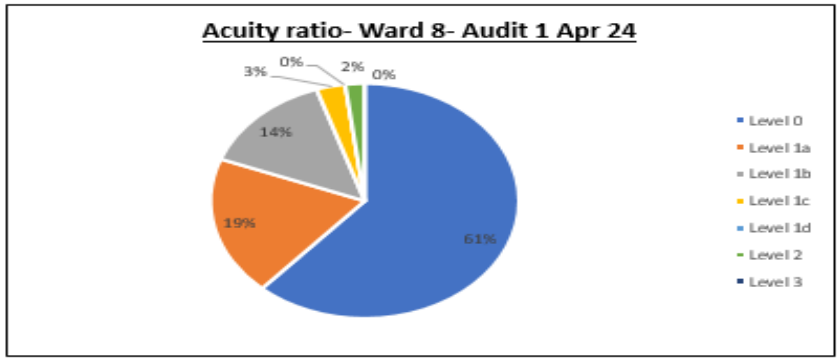
Ward 8 SNCT results 2024

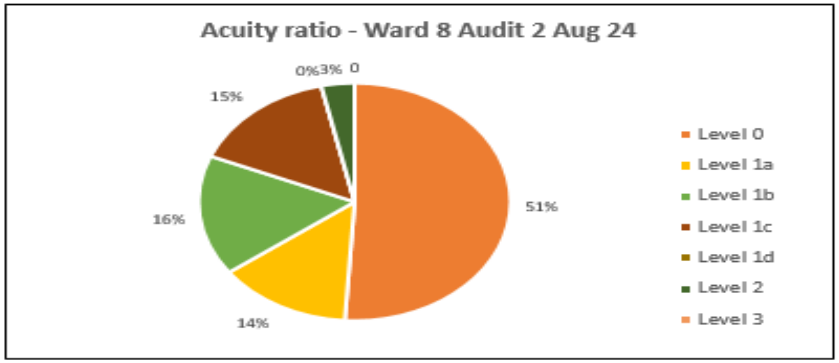
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

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

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

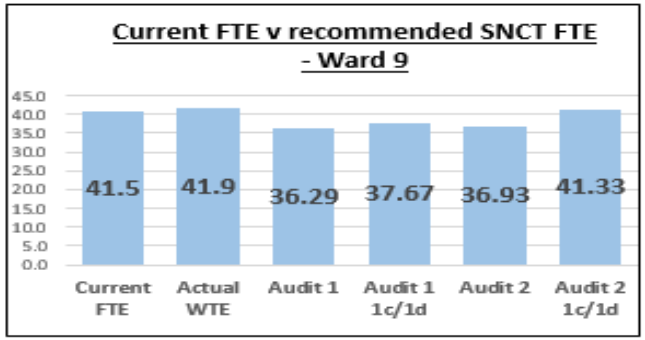
Table below:
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff

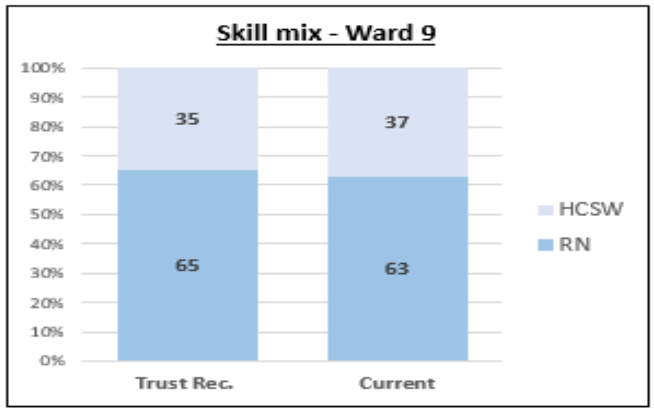




Nursing & Midwifery Care Quality Indicators														
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience				
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer CHPPD
Ward 8	Medicine	Audit 1	100.00%	100.00%	78.80%	0	0	0	100.00%	0	0.1	14.10%	6.30%	7.8	7.27
		Audit 2	100.00%	92.90%	66.50%	2	0	0		14	0.4	12.10%	5.80%	7.7	

Ward 9





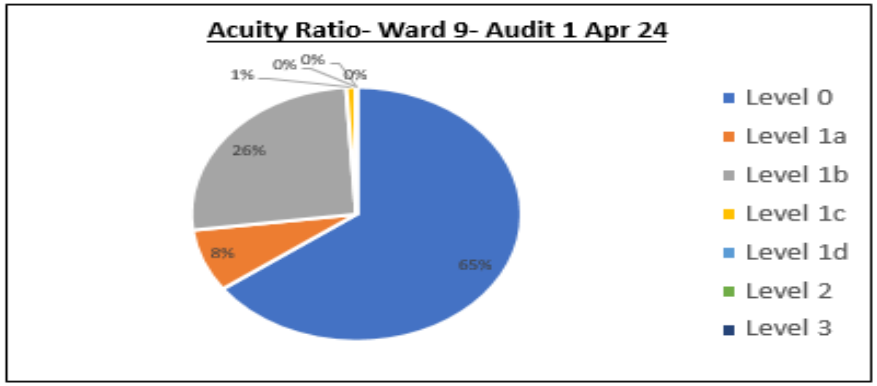
Ward 9 SNCT results 2024

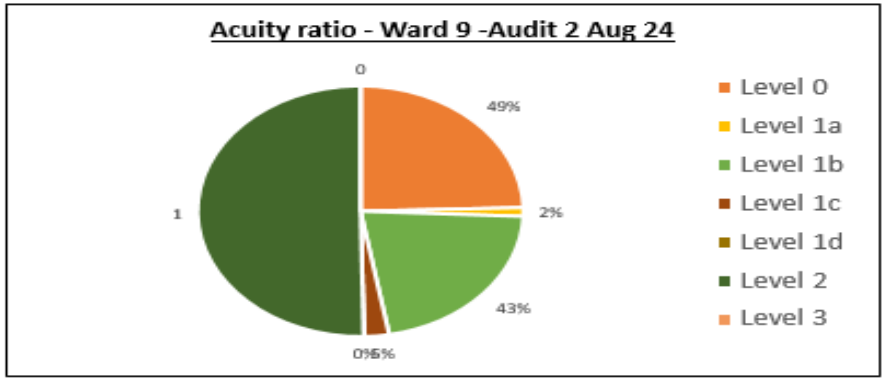
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

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

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

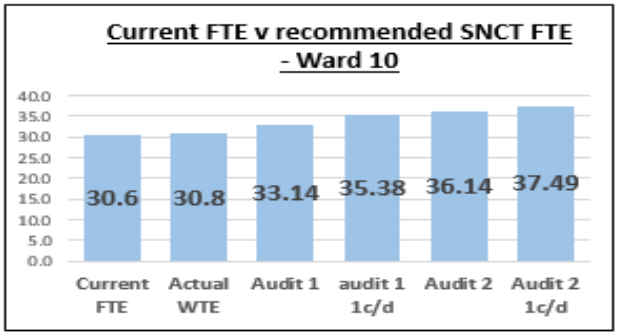
Table below:
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff outcomes.

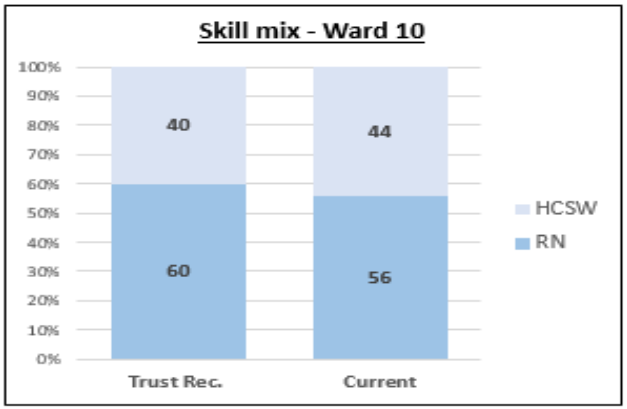




Nursing & Midwifery Care Quality Indicators														
			nput staffin	put - process of ca		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience				
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer CHPPD
Ward 9	Medicine	Audit 1	88.30%	85.70%	88.30%	2	1	1	93.00%	0	0.5	14.50%	6.90%	5.4	6.63
		Audit 2	100.00%	85.70%	88.20%	2	4	2		0	-0.9	16.50%	7.00%	5.4	

Ward 10





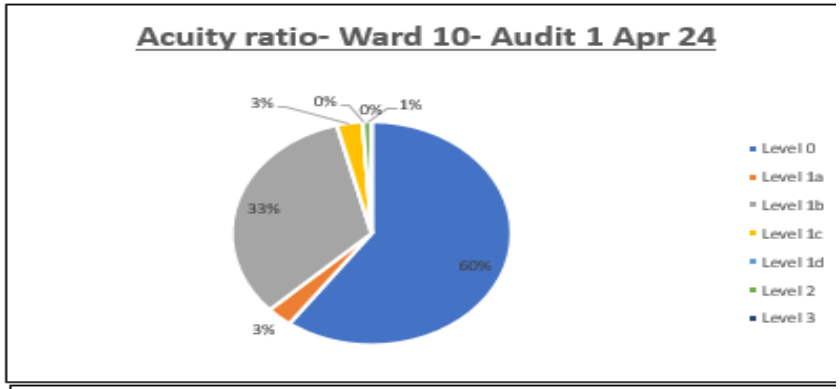
Ward 10 SNCT results Apr 2024

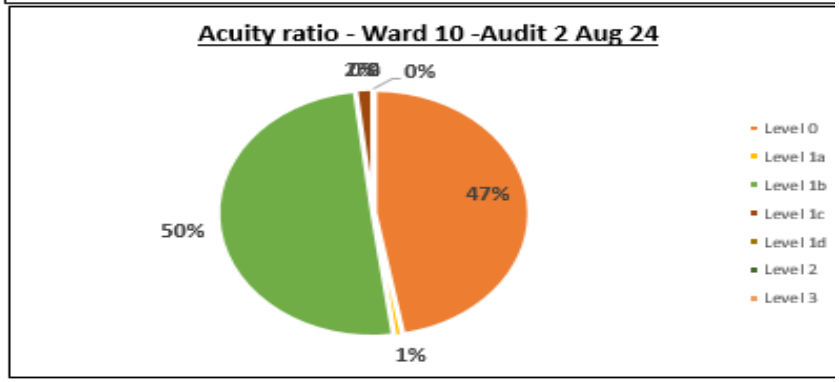
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1.

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

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

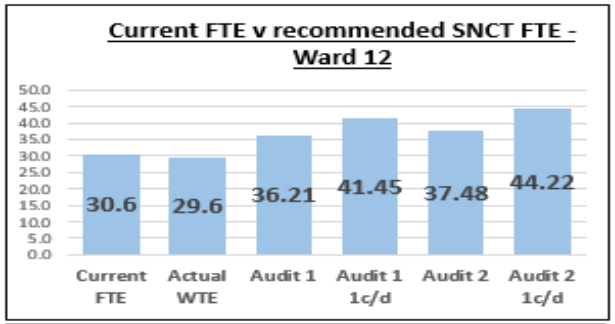
Table below:
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff

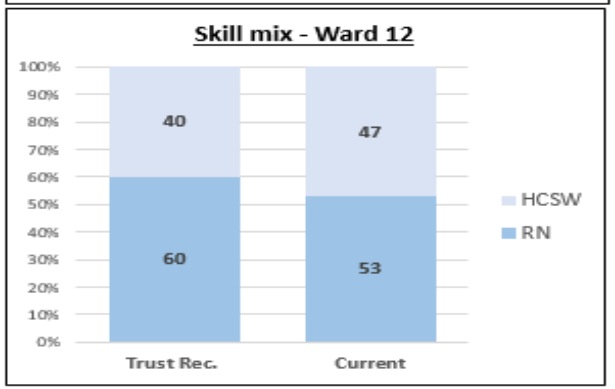




Nursing & Midwifery Care Quality Indicators														
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience				
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer CHPPD
Ward 10	Medicine	Audit 1	100.00%	100.00%	86.80%	2	4	2	100.00%	0	2.1	7.90%	8.90%	7.8	6.9
		Audit 2	100.00%	79.20%	84.30%	2	0	0		0	-0.2	13.50%	8.10%	5.7	

Ward 12

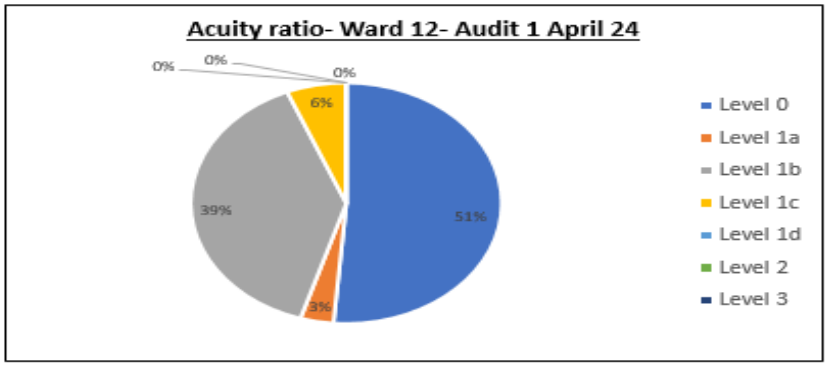


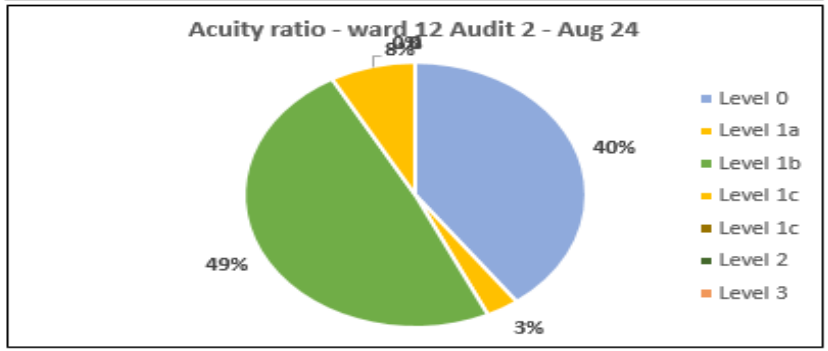


Ward 12 SNCT results 2024 Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.
Bottom graph on the left:
Compares the current and Trust recommended skill mix required.

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

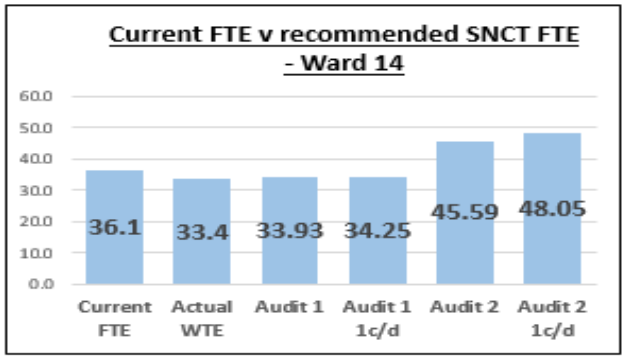
Table below:
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff outcomes.

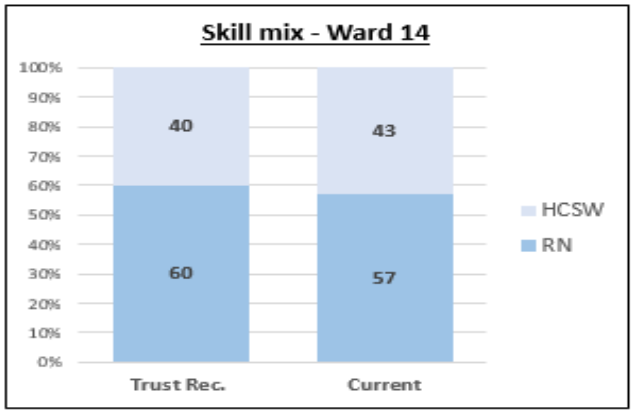




Nursing & Midwifery Care Quality Indicators															
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward 12	Medicine	Audit 1	100.00%	0.00%	80.70%	2	1	0	100.00%	1	0.7	10.20%	7.50%	5.7	7
		Audit 2	100.00%	77.20%	74.90%	2	1	0		3	1	12.40%	9.80%	5.7	

Ward 14





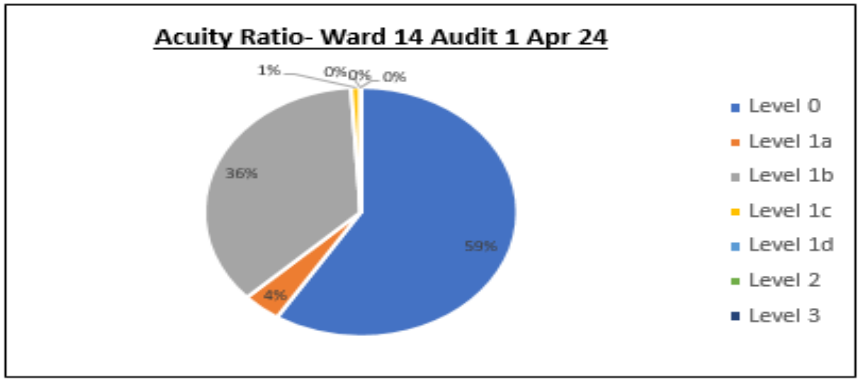
Ward 14 SNCT results 2024

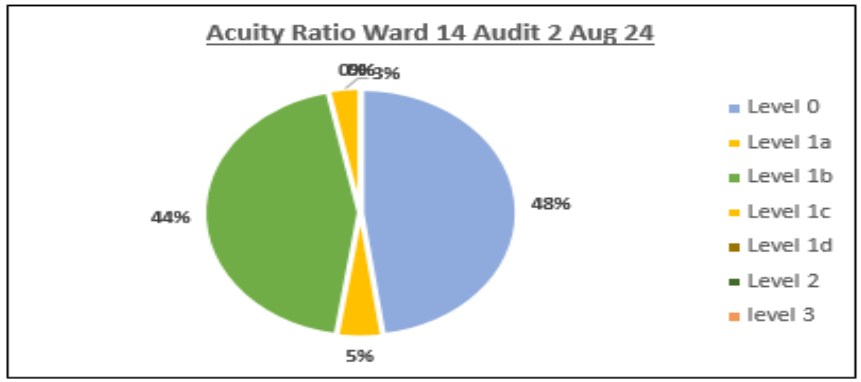
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

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

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

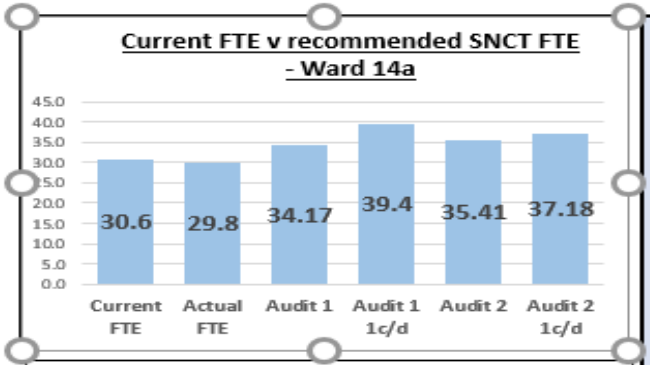
Table below:
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff outcomes.

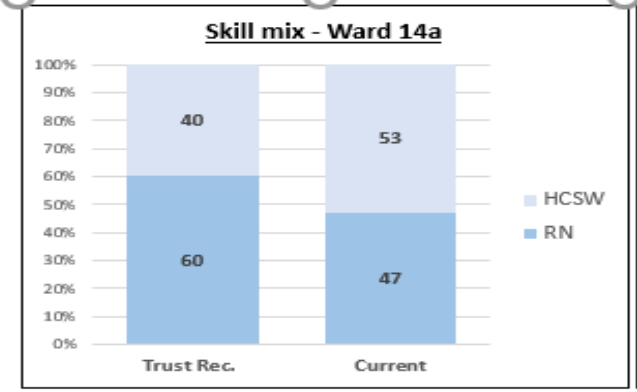




Nursing & Midwifery Care Quality Indicators															
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward 14	Medicine	Audit 1	100.00%	100.00%	81.40%	2	3	0	100.00%	0	2.1	9.80%	9.20%	5.8	7
		Audit 2	100.00%	100.00%	81.20%	4	3	2		2	2.7	14.20%	6.10%	6	

Ward 14a





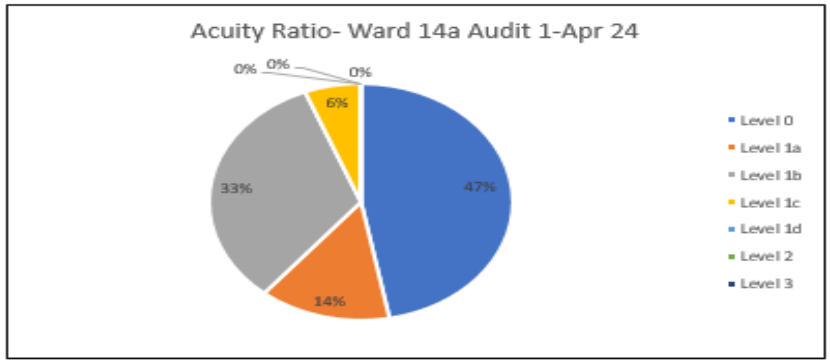
Ward 14a SNCT results 2024

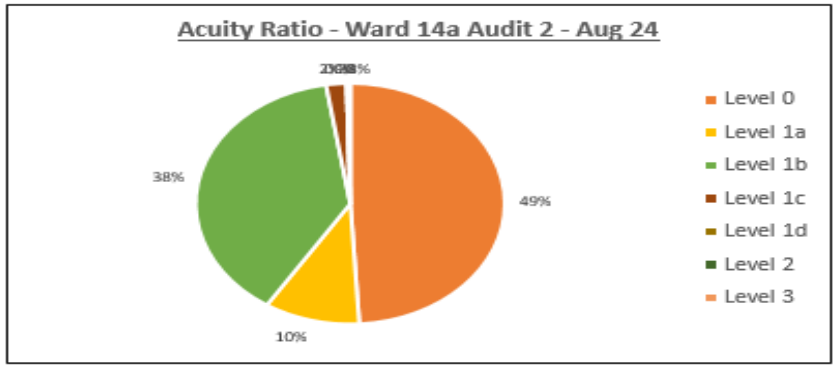
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

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

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

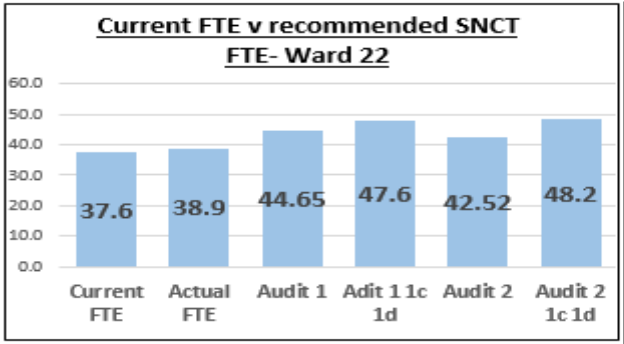
Table below:
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff outcomes.

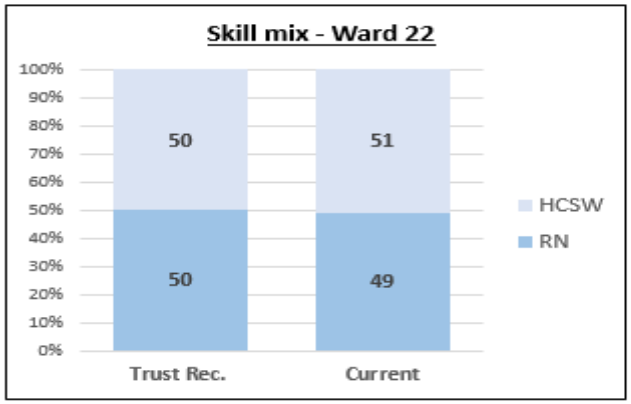




Nursing & Midwifery Care Quality Indicators														
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience				
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward 14a	Medicine	Audit 1	100.00%	100.00%	83.30%	0	0	1	100.00%	2	2.8	12.60%	15.30%	5.8	6.06
		Audit 2	100.00%	85.90%	85.50%	2	1	0		0	0.9	15.40%	4.60%	6.3	

Medicine Service Line 3- Ward 22





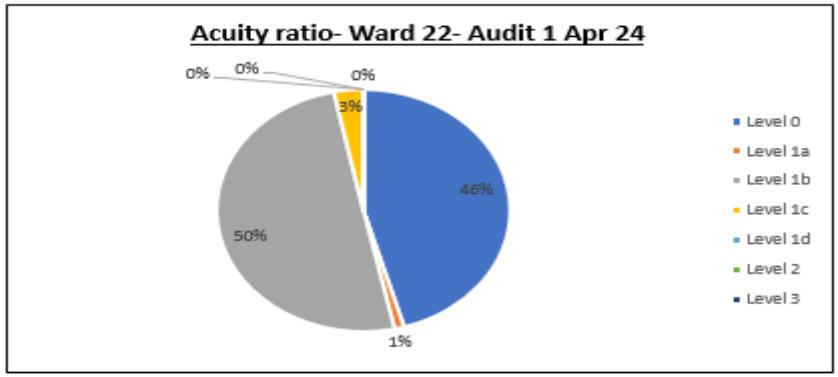
Ward 22 SNCT results 2024

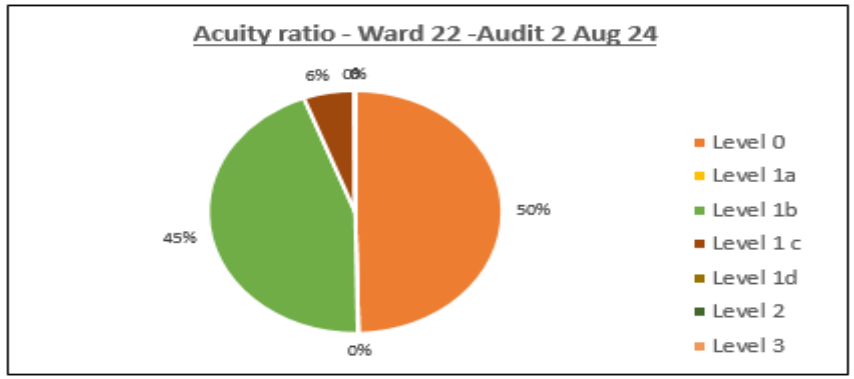
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

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

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

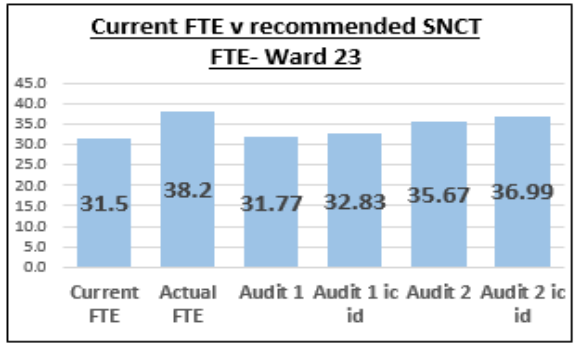
Table below:
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff outcomes.

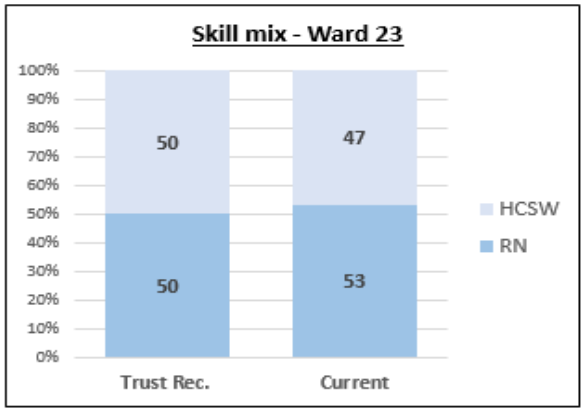




Nursing & Midwifery Care Quality Indicators														
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome–Staff Experience				
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer CHPPD
Ward 22	Medicine	Audit 1	100.00%	95.80%	87.00%	2	1	1	100.00%	0	-1.7	12.50%	3.70%	5.9	
		Audit 2	100.00%		87.00%	2	0	2	100.00%	0	-1.3	14.80%	6.50%	5.8	

Ward 23





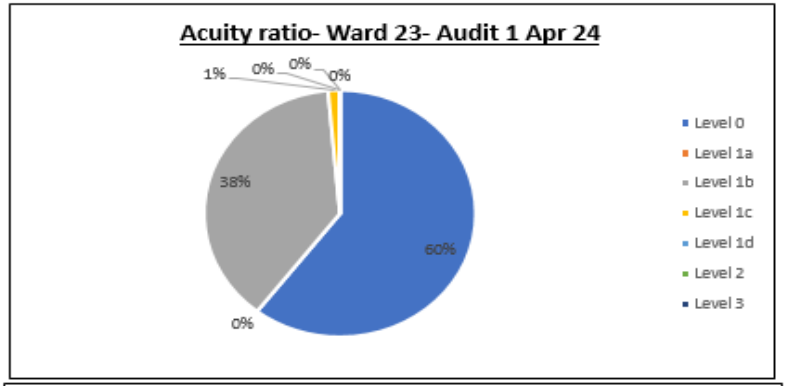
Ward 23 SNCT results 2024

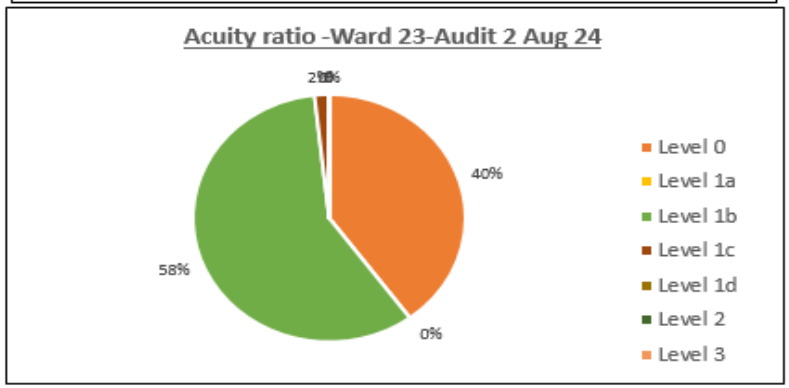
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

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

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

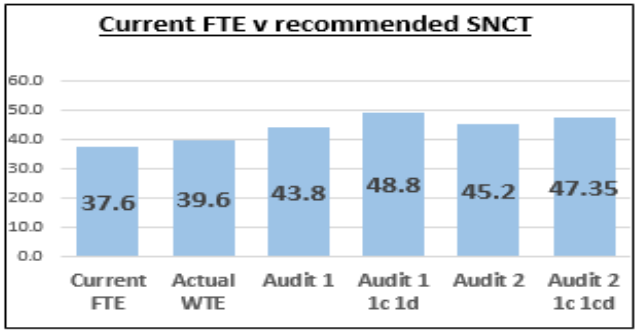
Table below:
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff outcomes.

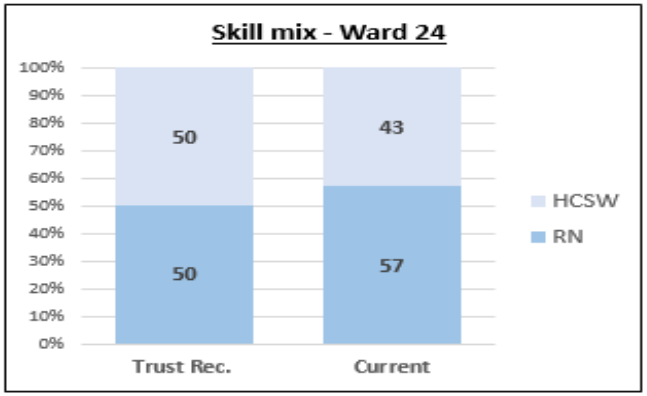




Nursing & Midwifery Care Quality Indicators														
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome–Staff Experience				
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer CHPPD
Ward 23	Medicine	Audit 1	100.00%	100.00%	89.30%	6	0	0	100.00%	0	-7.9	14.80%	8.50%	6.8	
		Audit 2	100.00%		88.60%	4	3	0		0	-6.7	13.40%	5.20%	6.7	

Ward 24





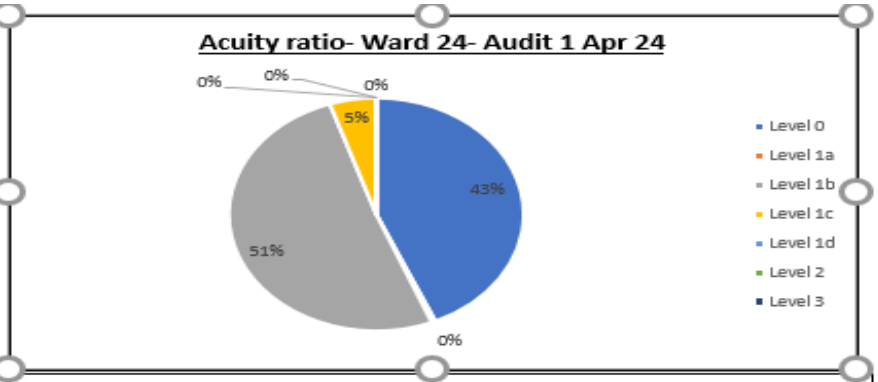
Ward 24 SNCT results 2024

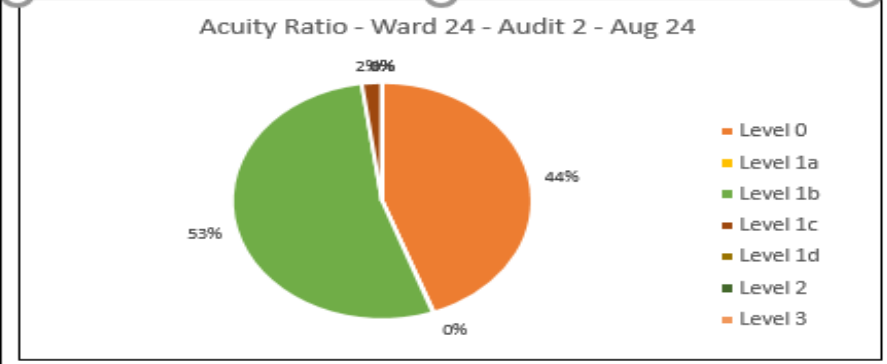
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1 and Audit 2.

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

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

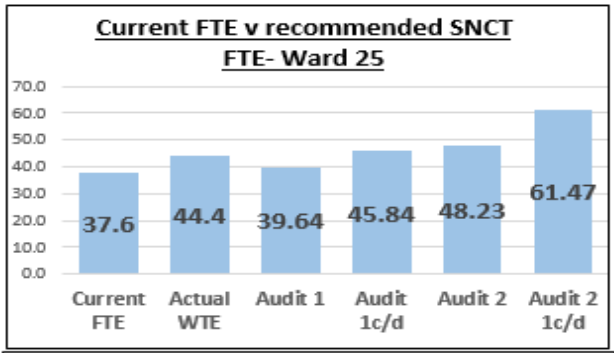
Table below:
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff outcomes.

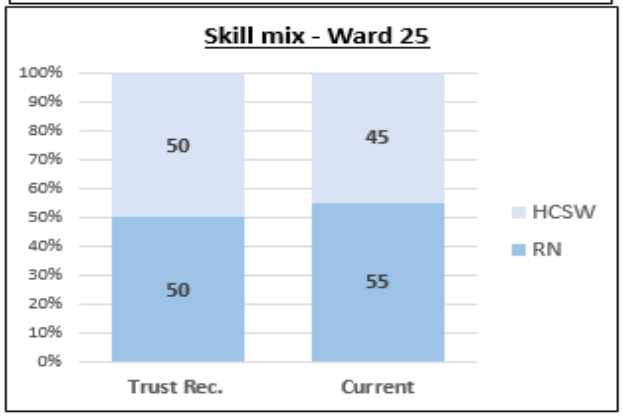




Nursing & Midwifery Care Quality Indicators														
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome–Staff Experience				
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer CHPPD
Ward 24	Medicine	Audit 1	100.00%	100.00%	90.50%	5	1	1	100.00%	0	-0.4	12.50%	3.90%	6.3	
		Audit 2	100.00%	100.00%	92.90%	3	2	1		0	-2	13.90%	0.50%	5.9	

Ward 25





Ward 25 SNCT results 2024

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

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

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

Table below:
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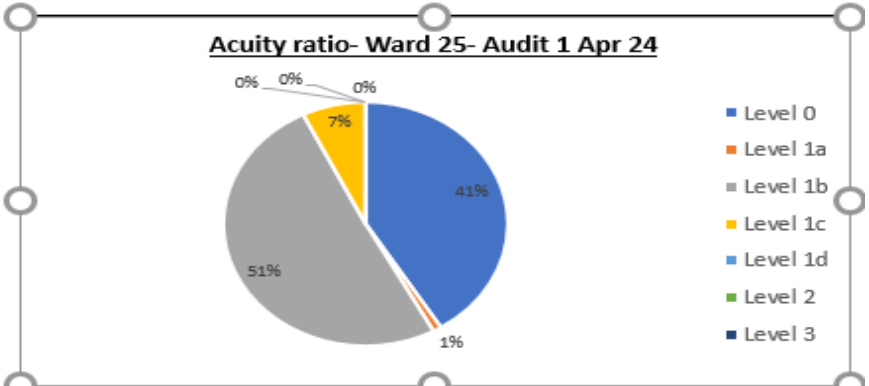
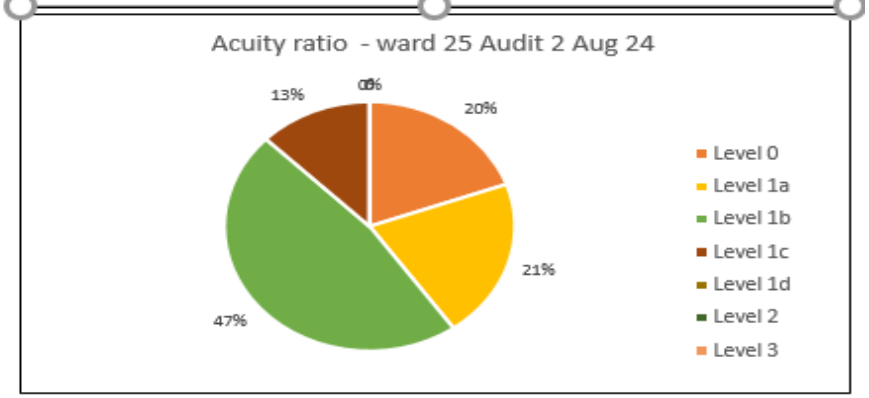
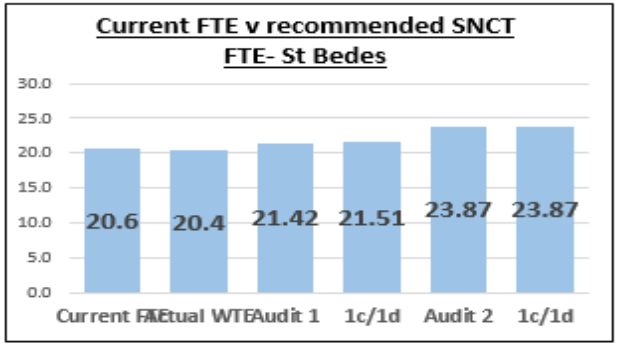
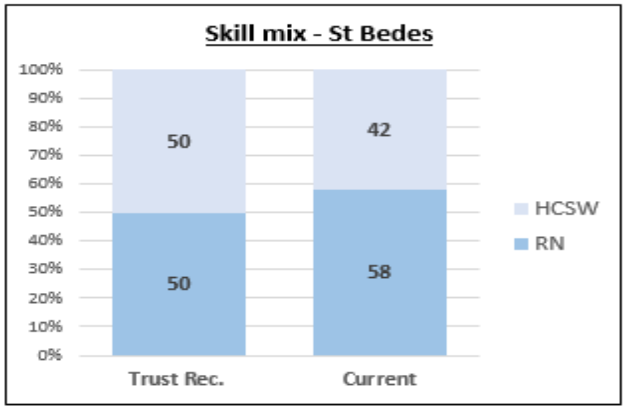




Nursing & Midwifery Care Quality Indicators														
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience				
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer CHPPD
Ward 25	Medicine	Audit 1	100.00%	78.90%	79.30%	8	1	0	100.00%	1	-3.2	9.40%	13.40%	6.8	
		Audit 2	100.00%	63.60%	73.60%	9	1	2		10	-6.8	14.70%	5.50%	6	

St Bedes





St Bedes SNCT results 2024

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

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

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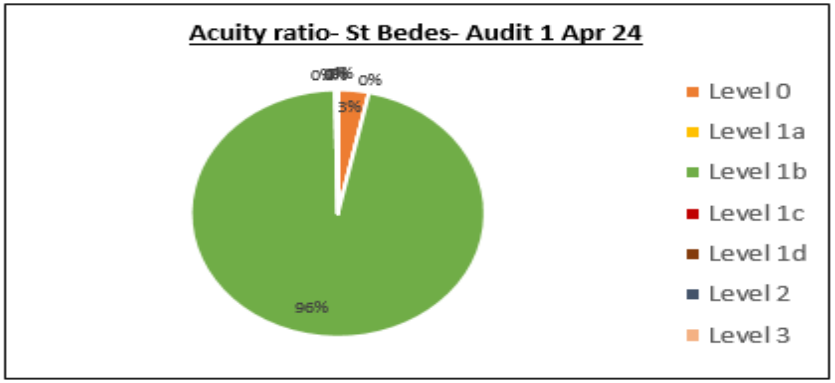
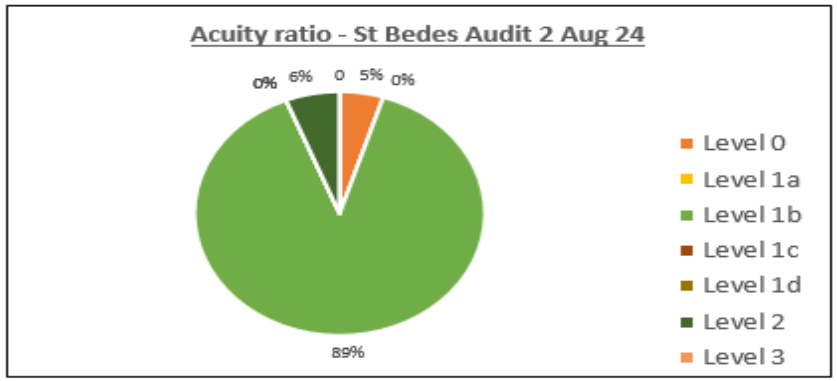
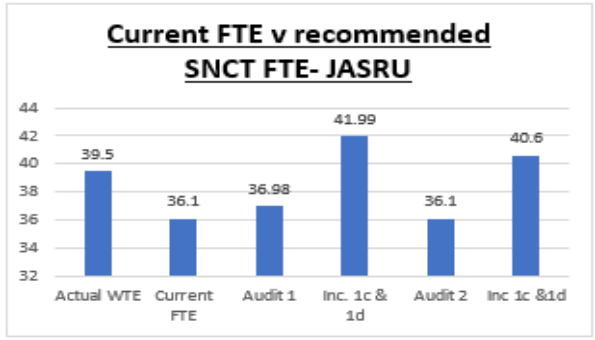


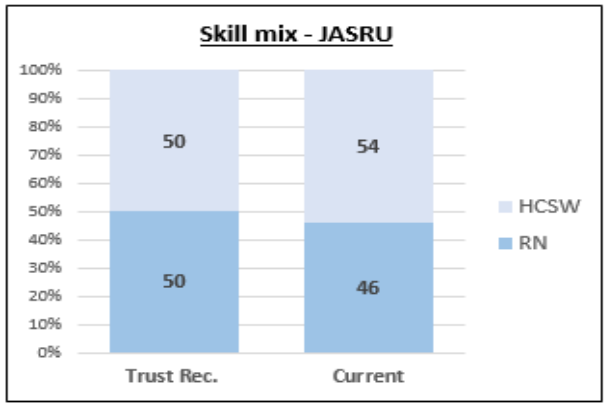


Nursing & Midwifery Care Quality Indicators

			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome–Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer CHPPD
St Bedes	Medicine	Audit 1	100.00%	100.00%	85.40%	1	2	0	0.00%	0	0.2	13.70%	7.30%	11.6	
		Audit 2	100.00%	100.00%	83.20%	0	1	1		0	0.2	14.00%	4.10%	9.6	

JASRU





JASRU SNCT results 2024

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

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

Graphs on the Right:
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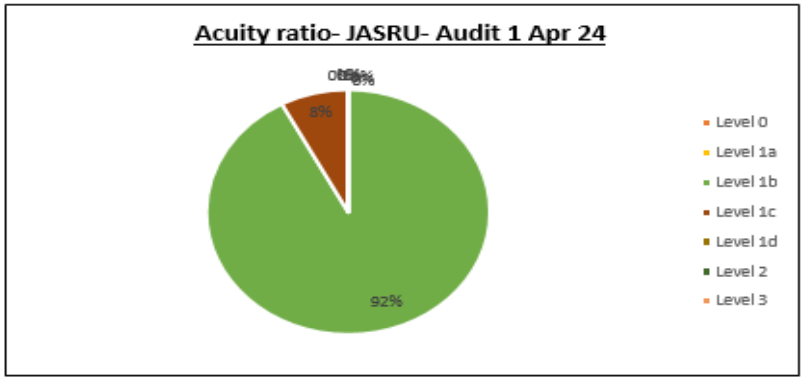
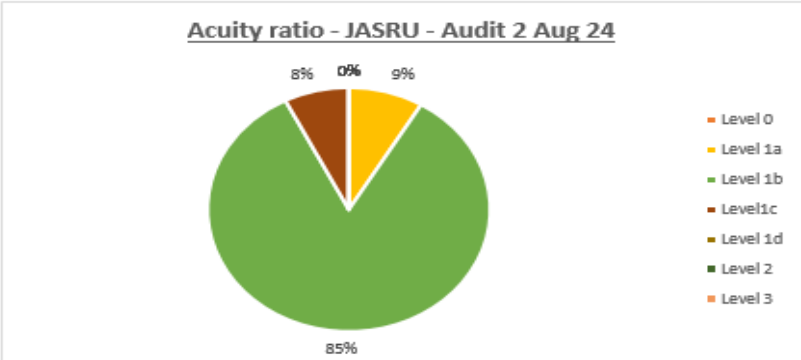
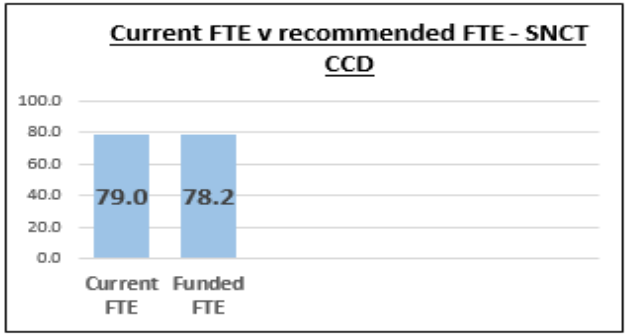
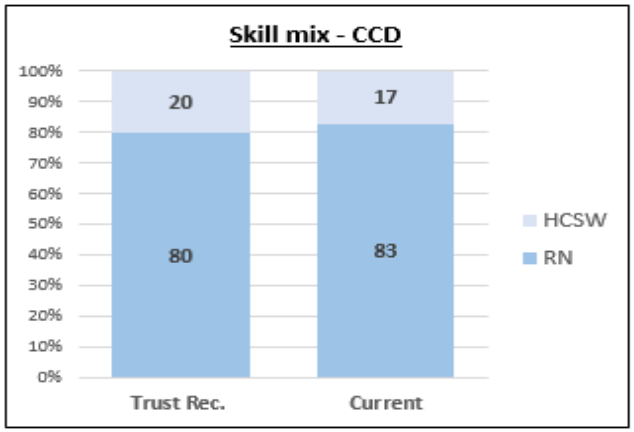




Nursing & Midwifery Care Quality Indicators														
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience				
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer CHPPD
JASRU	Medicine	Audit 1	100.00%	100.00%	87.00%	2	0	1	100.00%	0	-2.6	9.70%	13.30%	7.8	
		Audit 2	100.00%	100.00%	84.00%	0	0	0	25.00%	0	-3.4	17.80%	6.60%	8.2	

Surgery Service Line 1- Critical Care Department





CCD SNCT results 2024

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

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

Graphs on the Right:
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Table below:
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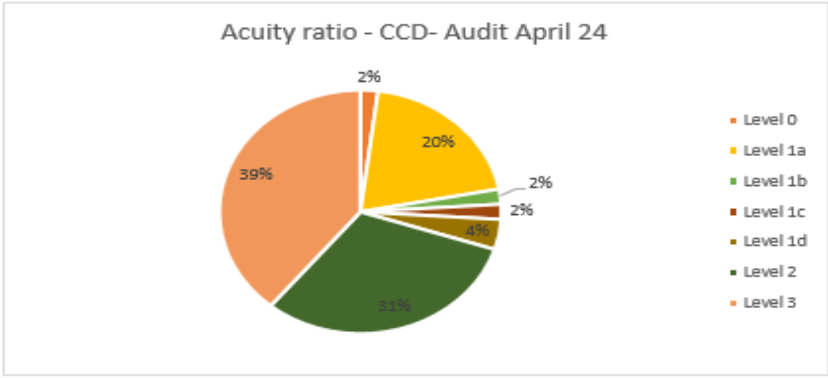
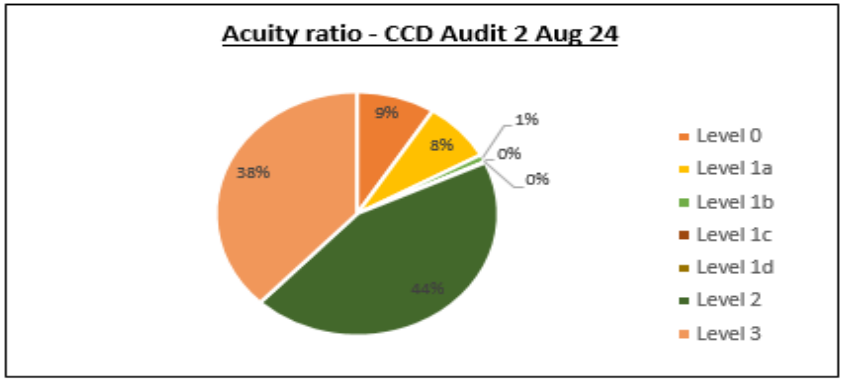
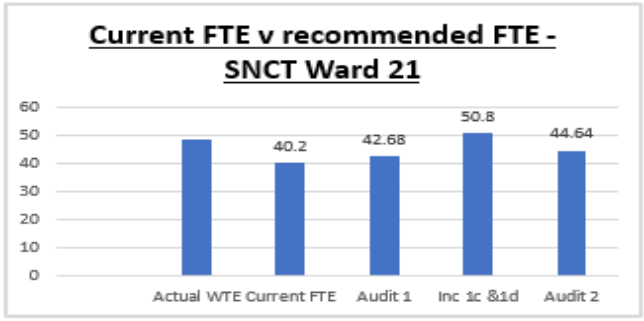
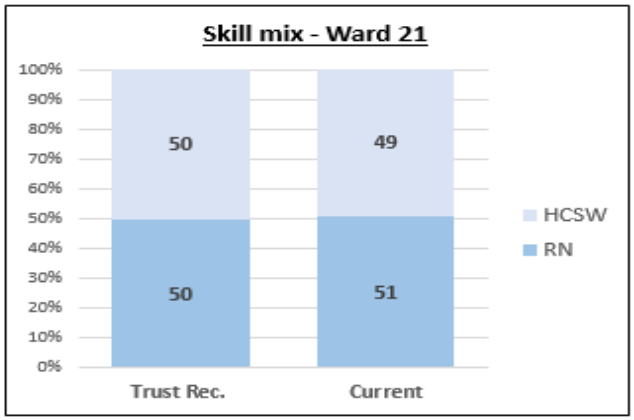




Nursing & Midwifery Care Quality Indicators														
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome–Staff Experience				
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
CCD	Surgery	Audit 1	100.00%	100.00%		1	1	1		0	0.8	11.7%	11.8%	38.3	
		Audit 2	100.00%	100.00%		1	3	1		0	0.8	13.5%	6.0%	34.7	

Ward 21





Ward 21 SNCT results 2024

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

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

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

Table below:
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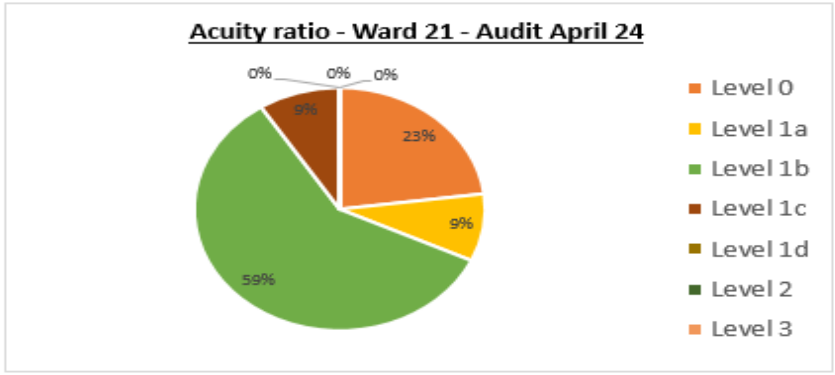
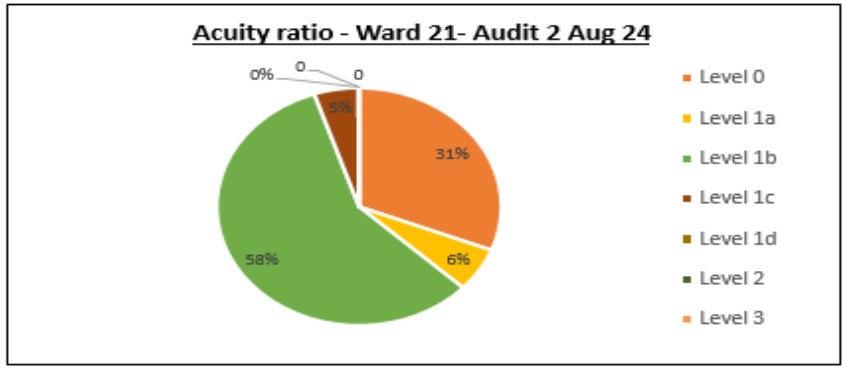
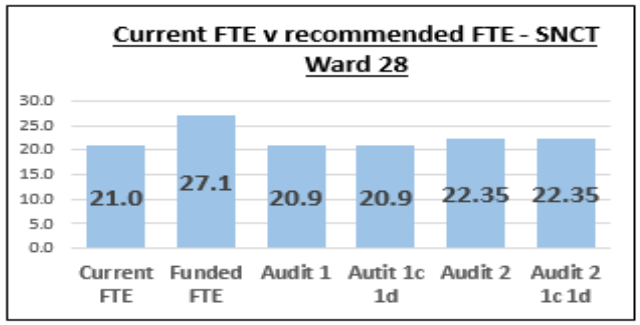
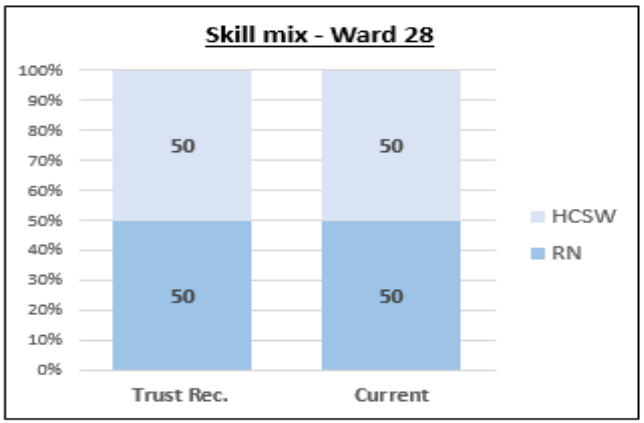




Nursing & Midwifery Care Quality Indicators															
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward 21	Surgery	Audit 1	100.00%	100.00%	67.20%	2	2	0	100.00%	0	-7	11.00%	6.40%	7	7.62
		Audit 2	100.00%	83.30%	61.00%	3	2	2		0	-8.2	15.70%	3.90%	6.9	

Ward 28





Ward 28 SNCT results 2024

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

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

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

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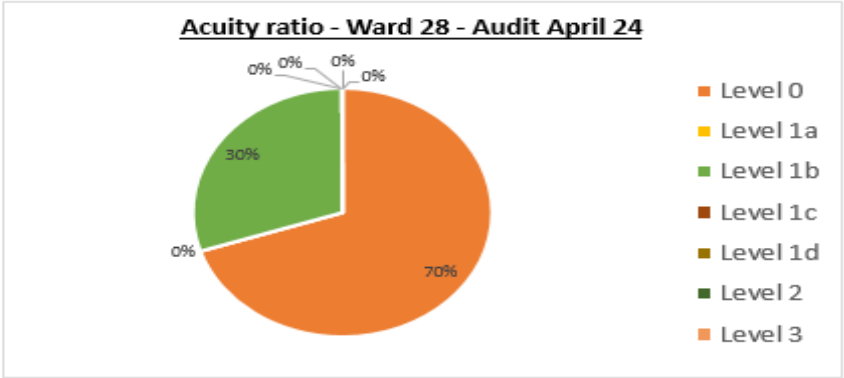
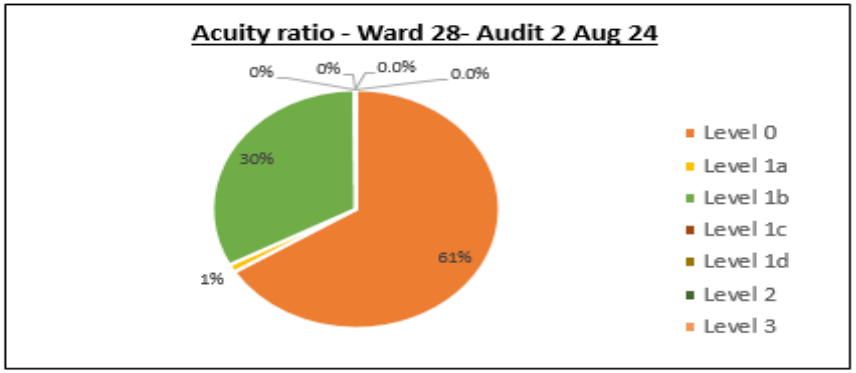
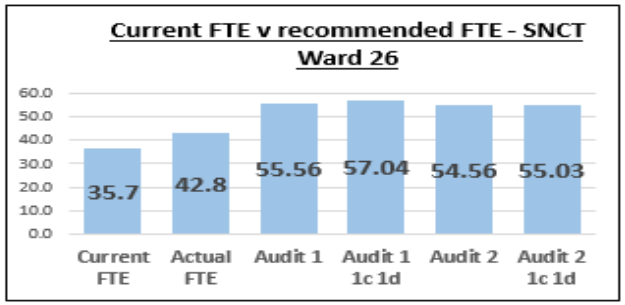
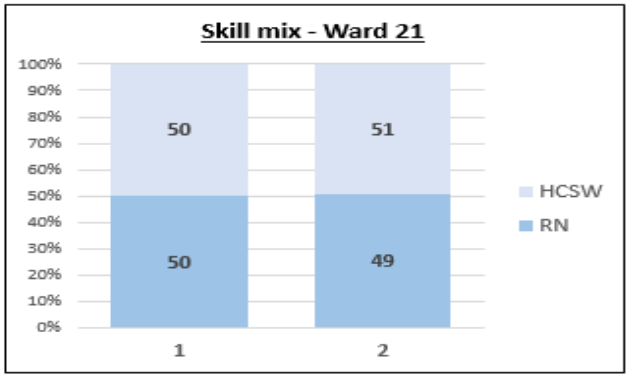




Nursing & Midwifery Care Quality Indicators															
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome–Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward 28	Surgery	Audit 1	100.00%	100.00%	94.2%	1	0	1	100.00%	0		12.9%	8.2%	15.8	
		Audit 2	100.00%	100.00%	94.0%	0	0	0	0.00%	0	6.1	13.0%	7.5%	14.3	

Surgery Service Line 3- Ward 26





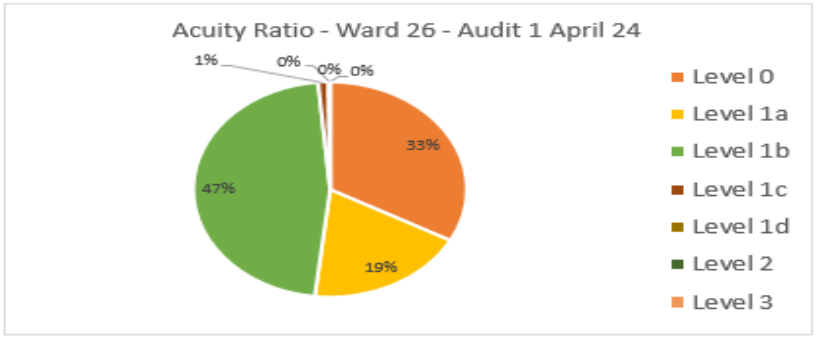
Ward 26 SNCT results 2024

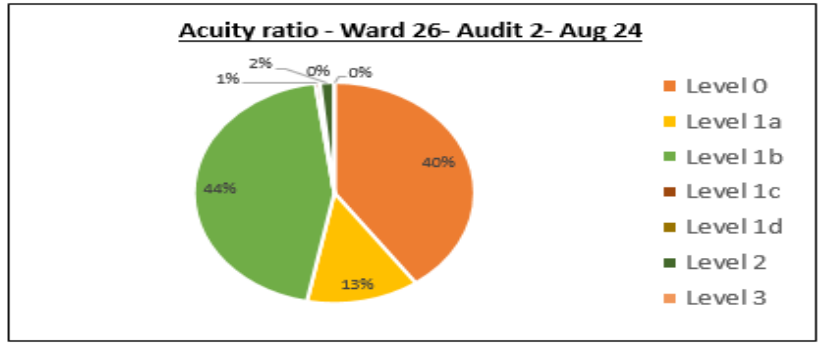
Top Graph on the left:
Demonstrates the comparison between the budgeted staffing, the recommended staffing according to the SNCT in Audit 1.

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

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

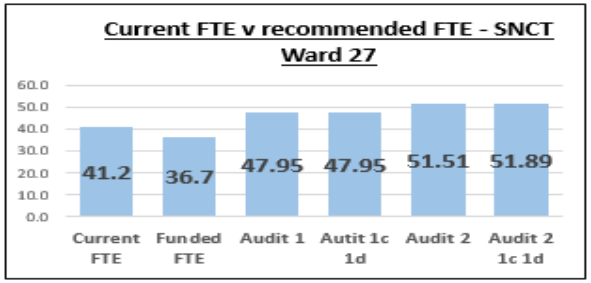
Table below:
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff outcomes.

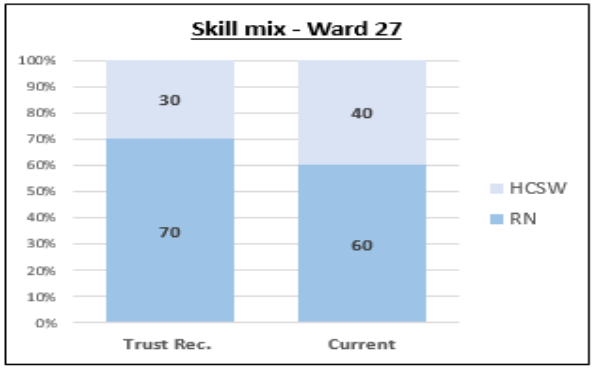




Nursing & Midwifery Care Quality Indicators														
			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience				
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward 26	Surgery	Audit 1	100.00%	98.30%	78.40%	1	1	0	100.00%	0	-6.8	9.40%	7.20%	6.4	9.46
		Audit 2	100.00%	0.00%	73.70%	0	1	2		0	-6.1	12.00%	7.40%	6.7	

Ward 27





Ward 27 SNCT results 2024

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

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

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

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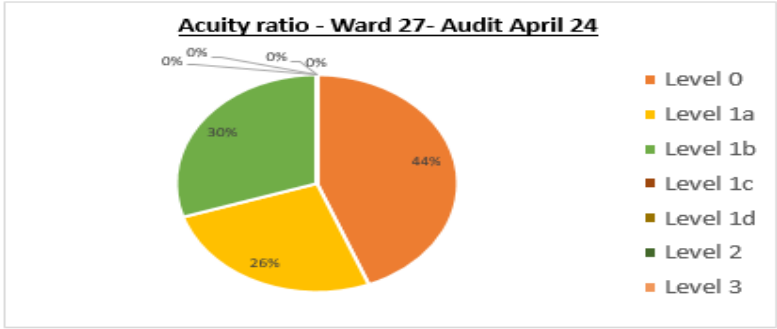
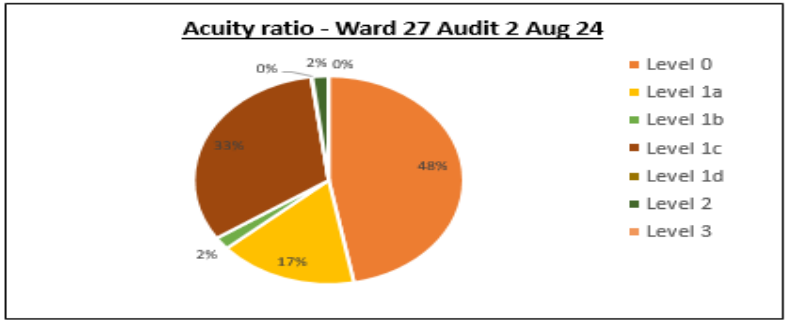
Shows the data compliance, variance between the current funded establishment and the recommended establishment alongside the patient outcomes, patient experience and staff outcomes.





Nursing & Midwifery Care Quality Indicators

			input staffing	Input - process of care		Outcome - Incidence of harm			Outcome - Patient Experience	Outcome-Staff Experience					
Ward	Division	Audit	data compliance	Hand Hygiene	Observations on time	inpatient falls with harm	Hosp. acquired pressure ulcers	Reportable Medication errors	Friends and family test	Safer Staffing red flags	No. vacancies	% AL used	% sickness	CHPPD	Peer median CHPPD
Ward 27	Surgery	Audit 1	100.00%	100.00%	82.7%	0	1	4	97.50%	0		8.0%	7.3%	6.9	
		Audit 2	100.00%	70.00%	76.3%	2	0	3		0	4.5	13.8%	6.9%	6.2	

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

	Lead	Type of item	Public/Private	Jan-25	Mar-25
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	Deferred	√
Calendar of Board Meetings	Company Secretary	Item for Decision	Part 1		
Winter Plan	Chief Operating Officer	Item for Decision	Part 1		
Board Committee Annual Reviews of Effectiveness and Terms of Reference Update	Company Secretary	Item for Decision	Part 1		√
CQC Statement of Purpose and Registration	Chief Nurse	Item for Decision	Part 1		√
SID and Deputy Chair Appointment	Company Secretary	Item for Decision	Part 1 & Part 2		
Items for Assurance			Part 1 & Part 2		
Board Committee Assurance Reports	Committee Chairs	Item for Assurance	Part 1	√	√
~~Trust Strategic Objectives - updates.~~ Now covered via the Leading Indicator reports rather than a separate report	~~Director of Strategy and Planning~~	~~Item for Assurance~~	~~Part 1~~	~~√~~	~~√~~
Board Assurance Framework - updates	Company Secretary	Item for Assurance	Part 1	√	
Organisational Risk Register	Chief Nurse	Item for Assurance	Part 1	√	√
Annual Staff Survey Results	Exec Director of People & OD	Item for Assurance	Part 1 & Part 2	√	√
Finance Report	Group Director of Finance	Item for Assurance	Part 1	√	√

Leading Indicator Report	Group Director of Finance	Item for Assurance	Part 1	√	√
Maternity Integrated Oversight Report	Chief Nurse	Item for Assurance	Part 1	√	√
Maternity Staffing Report	Chief Nurse	Item for Assurance	Part 1		
Nurse Staffing Exception Report	Chief Nurse	Item for Assurance	Part 1	√	√
Bi-annual Inpatient Safer Nursing Care Staffing Report	Chief Nurse	Item for Assurance	Part 1	√	
Learning from Deaths (6 monthly report)	Medical Director	Item for Assurance	Part 1		√
EPRR Core Standards Self-Assessment Report	Chief Operating Officer	Item for Assurance	Part 1	√	
CNST Maternity Compliance Report	Chief Nurse	Item for Assurance	Part 1	√	
QEF 6 monthly update report	QEF Managing Director	Item for Assurance	Part 1		
Freedom to Speak Up Guardian Report	Exec Director of People & OD	Item for Assurance	Part 1		√
WRES and WDES Report	Exec Director of People & OD	Item for Assurance	Part 1		√
Green Plan	QEF Managing Director	Item for Assurance	Part 1		√
Board Walkabout Feedback	Chief Nurse	Item for Assurance	Part 1	√	√
Great North Healthcare Alliance Progress Report	Director of Strategy and Planning	Item for Assurance	Part 1	√	√
Items for Information			Part 1 & Part 2		
Register of Official Seal	Company Secretary	Item for Information	Part 1		
Ad Hoc Items (i.e. items emerging during the year)			Part 1 & Part 2		
Organisational Structure - Clinical Leadership	Group Medical Director	Item for Assurance	Part 1	√	