MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

Gateshead Health NHS Foundation Trust

Date: Wednesday 31st January 2024
Time: 9:30 am
Venue: Room 3, Education Centre/Teams

AGENDA

	TIME	ITEM	STATUS	PAPER
1.	9:30 am	**Welcome and Chair's Business**		
2.	9:33 am	**Declarations of Interest** To declare any pecuniary or non-pecuniary interests *Check – Attendees to declare any potential conflict of items listed on the agenda to the Company Secretary on receipt of agenda, prior to the meeting*	Declaration	Verbal
3.	9:34 am	**Apologies for Absence** *Quoracy check: (s3.3.31 SOs: No business shall be transacted at a meeting unless a minimum of **4** members of the Board (including at least **one** Non-Executive and **one** Executive Member of the Board are present)*	Agree	Verbal
4.	9:35 am	**Minutes of the meeting held on 29 November 2023** To be agreed as an accurate record	Agree	Enclosure 4
5.	9:40 am	**Matters Arising / Action Log**	Update	Enclosure 5
6.	9:45 am	**Patient & Staff Story**	Assurance	Presentation
		ITEMS FOR DECISION		
7.	10:00 am	**Standing Financial Instructions and Delegation of Powers Annual Review** To approve the reports presented by the Group Director of Finance and Digital	Approval	Withdrawn
8.	10:15 am	**EPRR Core Standards Self-Assessment Report** To receive the report presented by the Group Chief Operating Officer	Approval	Enclosure 8
9.	10:25 am	**Board Committee Terms of Reference** To approve the amended terms of reference presented by the Company Secretary	Approval	Enclosure 9
		ITEMS FOR ASSURANCE		
10.	10:35 am	**Chief Executive's Update Report** To receive a briefing report from the Chief Executive	Assurance	Enclosure 10
11.	10:50 am	**Governance Reports** i. **Organisational Risk Register** To receive the report presented by the Chief Nurse/Deputy Chief Executive	Assurance	Enclosure 11
12.	11:00 am	**Assurance from Board Committees** i. Finance and Performance Committee – December 2023 and January 2024 ii. Quality Governance Committee – December 2023 iii. Digital Committee – January 2024 iv. POD Committee – January 2024 v. Audit Committee – December 2023	Assurance	Enclosure 12

		vi. Group Remuneration Committee – November 2023 and January 2024 vii. QE Facilities Board – January 2024		
13.	11:30 am	**Finance Report** To receive the report, presented by the Group Director of Finance and Digital	Assurance	Enclosure 13
14.	11:40 am	**Leading Indicators** To receive the report, presented by the Group Director of Finance & Digital	Assurance	Enclosure 14
15.	11:55 pm	**Maternity Update** i. **Maternity Integrated Oversight Report** ii. **Maternity Incentive Scheme Assurance Framework Compliance Report** To receive the report, presented by the Head of Midwifery	Assurance	Enclosure 15
		ITEMS FOR INFORMATION		
16.	12:10 pm	**Nurse Staffing Update:** i. **Monthly Exception Report** To receive the reports, presented by the Chief Nurse	Assurance	Enclosure 16
17.	12:15 pm	**Cycle of Business** To receive the cycle of business outlining forthcoming items for consideration by the Board, presented by the Company Secretary	Information	Enclosure 17
18.	12:20 pm	**Questions from Governors in Attendance** To receive any questions from governors in attendance		Verbal
19.	12:30 pm	**Date and Time of the next Meeting** The next scheduled meeting of the Board of Directors to be held in public will be Wednesday 27th March 2024		Verbal
20.	12:30 pm	**Chair Declares the Meeting Closed**		Verbal
21.	12:30 pm	**Exclusion of the Press and Public** To resolve to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed		Verbal

Gateshead Health NHS Foundation Trust

Trust Board

Minutes of a meeting of the Board of Directors
held at 9.30 am on Wednesday 29th November 2023, in
Room 3, Education Centre, Queen Elizabeth Hospital and via MS Teams

Present:	
Mrs A Marshall	Chair
Mr A Crampsie	Non-Executive Director
Mrs T Davies	Chief Executive
Dr G Findley	Chief Nurse and Deputy Chief Executive
Mr N Halford	Medical Director of Operations
Mrs J Halliwell	Group Chief Operating Officer
Mr S Harrison	Interim Managing Director for QE Facilities
Mrs K Mackenzie	Group Director of Finance and Digital
Mr A Moffat	Non-Executive Director
Mrs H Parker	Non-Executive Director
Mrs M Pavlou	Non-Executive Director
Mr M Robson	Vice Chair / Non-Executive Director
Mrs A Stabler	Non-Executive Director
Mrs A Venner	Group Director of People & Organisational Development
In Attendance:	
Mrs J Boyle	Company Secretary
Ms N Bruce	Director of Strategy, Planning and Partnerships (23/244)
Mrs J Conroy	Head of Midwifery (23/249)
Mr M Graham	Operations Director for Clinical Support and Screening (23/241)
Ms D Heslop	Senior Ward Manager (23/241)
Ms D Waites	Corporate Services Assistant
Governors and Observers:	
Mrs H Adams	Staff Governor
Mr R Dennis	Public Governor – Western
Ms L Hall	Care Quality Commission Engagement Officer
Mr M Learmouth	Public Governor – Central
Ms M Ndam	Staff Governor
Ms S Neilson	Head of Education, Learning and Development
Apologies:	
Mr A Beeby	Medical Director
Mr M Hedley	Non-Executive Director

Agenda Item	Discussion and Action Points	Action By
23/236	**CHAIR'S BUSINESS:** The meeting being quorate, Mrs A Marshall, Chair, declared the meeting open at 9.30 am and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. She welcomed those present including the Trust's Governors and Ms L Hall, CQC Engagement Officer who was observing the meeting.	
23/237	**DECLARATIONS OF INTEREST:** Mrs Marshall requested that Board members present report any revisions to their declared interests or any additional declaration of interest in any of the items on the agenda.	

Agenda Item	Discussion and Action Points	Action By
23/238	**APOLOGIES FOR ABSENCE:** Apologies for absence were received from Mr A Beeby and Mr M Hedley.	
23/239	**MINUTES OF THE PREVIOUS MEETING:** The minutes of the meeting of the Board of Directors held on Wednesday 27th September 2023 were approved as a correct record.	
23/240	**MATTERS ARISING FROM THE MINUTES:** The Board reviewed the action tracker as below: • Action 23/64 re. rescheduling of committee meetings. Mrs J Boyle, Company Secretary, explained that this related to discussions around whether committee meetings should be held on the same day. Mrs A Stabler, Chair of the Quality Governance Committee explained that the Quality Governance Committee dates have now been agreed however the People and Organisational Development Committee dates are yet to be approved. It was therefore agreed that this action will remain open until all Committee dates have been approved. • Action 23/120 re. suggestion to include links to litigations and Getting It Right First Time in next iteration of mortality report. This is included in the report being presented at the meeting today (Agenda item 15) therefore it was agreed that this action will be closed. • Action 23/157 re. next steps for the Electronic Patient Record (EPR) development. It was noted that a wider strategic discussion has been held and EPR engagement day scheduled for 13 December 2023 therefore it was agreed that this action will be closed. • Action 23/158 re. contractual obligations for Mental Health Services. Dr G Findley, Chief Nurse and Deputy Chief Executive, reported that a review of the service line agreement is taking place with the Chief Nurse at Cumbria, Northumberland, Tyne and Wear (CNTW) therefore this will be picked up as these discussions. It was therefore agreed that this action will be closed. • Action 23/204 re. summary of perinatal mortality review tool reports to be included in next report. Dr Findley reported that this is now being included in reports going forward therefore it was agreed that this action will be closed. • Action 23/206 re. providing details of Freedom To Speak Up training to Board members. Mrs A Venner, Group Director for People and Organisational Development, reported that this had been shared with the People and Organisational Development	

Agenda Item	Discussion and Action Points	Action By
	Committee however a reminder will be sent to Board members. The action will remain open until complete. • Action 23/207 re. options around sharing information with the violence and aggression group in relation to bullying and harassment. Dr Findley reported that a toolkit has been developed for staff and this will be monitored via the People and Organisational Development Committee and Quality Governance Committee therefore it was agreed that this action will be closed. Mrs Venner provided an update on the updated national profiles for Healthcare Support workers from their current Band 2 to Band 3, based on their current role and responsibilities in relation to Action 23/199. She reported that following the submission of a collective grievance, an agreement was made with Unison that work was to continue as planned as responding to the grievance would delay this work. The Health Care Assistant job description was evaluated via an Agenda for Change panel on 10th November 2023 and the regional Unison and staff side have been updated with the outcome. She highlighted that regional meetings continue with People and Organisational Development Directors, Directors of Finance, as well as Directors and Deputy Directors of Nursing. The Trust is keen to continue to work collaboratively with regional partner trusts on this complex workforce agenda and a full project initiation document (PID), is being developed with the Deputy Director of Corporate Services and Transformation. A working group has also been established and a progress report is expected at the January People and Organisational Development Committee. Mrs Venner reiterated the challenges around this and a communications plan is also being developed. Mrs T Davies, Chief Executive, felt that further clarity was required around the principles which have been agreed around fair pay and the commitment to ensure that staff are placed on the correct pay grade. She felt that an updated position should be provided following further discussions with the People and Organisational Development Directors including timelines. Following a query from Mr A Moffat, Non-Executive Director, in relation to pay rates, Mrs Venner explained that details around base rates and enhancements have been presented to the People and Organisational Development Committee however an evaluation of all roles is required to fully understand the financial implications. Mr Moffat raised a further query in relation to resourcing the review and Mrs Venner explained that a working group has been set up and will be monitored via the People and Organisational Development Committee. 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.	AV

Agenda Item	Discussion and Action Points	Action By
23/241	**PATIENT STORY – ENDOSCOPY JAG ACCREDITATION:** The Board welcomed Mr M Graham, Operations Director for Clinical Support and Screening, and Ms D Heslop, Matron, who provided a presentation on the Endoscopy Joint Advisory Group (JAG) accreditation process. They explained that the JAG accreditation programme works with endoscopy services across the UK to improve the quality of patient care. Accreditation is awarded to services which have demonstrated they meet best practice quality standards covering all aspects of an endoscopy service including quality and safety, patient experience and the workforce. A multidisciplinary approach is undertaken across the unit to prepare for the assessment to provide evidence against the defined standards. This is clinically led and management-supported with the matrons aligned across business units. The assessment took place in March 2023 however the unit did not meet all of the standards and therefore accreditation was deferred for six months to allow time to provide further evidence. Ms Heslop highlighted that the unit was congratulated on a number of areas however an action plan was developed to meet the outstanding standards and as a result of the hard work of the team, the unit was awarded the accreditation in October 2023. The Board thanked the team for their hard work and motivation in achieving the accreditation following the earlier disappointment and acknowledged the impact this had had on the team. Ms Heslop highlighted that the team celebrated the good feedback and built on this to achieve the final outcome. Mrs A Venner, Group Director of People and Organisational Development, felt that this provided a good example of organisational learning and would be beneficial to link with the compliance team in advance of future inspections. Following a query from Mr A Crampsie, Non-Executive Director, in relation to maintaining the waiting time standards, Mr Graham reported that the team now had full establishment of nurse endoscopists and weekly manager meetings take place to review current standards. Mrs Marshall thanked Mr Graham and Ms Heslop and congratulated the team on their achievements. Mr Graham and Ms Heslop left the meeting.	
23/242	**CALENDAR OF BOARD MEETINGS 2024/25:** Mrs J Boyle, Company Secretary, informed the Board of the planned Board meeting dates for 2024/25.	

Agenda Item	Discussion and Action Points	Action By
	She highlighted that 9 public meetings including the Annual General Meeting will take place during 2024/25 and Board Development Sessions will also be arranged during the period. After consideration, it was: **RESOLVED:** to approve and receive the dates of the Board of Directors' meetings to be held in 2024/25.	
23/243	**CHIEF EXECUTIVE'S UPDATE REPORT** Mrs T Davies, Chief Executive, gave an update to the Board on current issues which have aligned to the Trust's Strategic Aims. She drew attention to the following updates in relation to Strategic Aim 1: *we will continuously improve the quality and safety of our services for our patients* – which highlights the achievement of the Endoscopy unit being JAG-accredited for the next 5 years. In relation to Strategic Aim 5: *we will develop and expand our services within and beyond Gateshead* – Mrs Davies highlighted that the bid which was submitted to the Integrated Care Board (ICB) to support a Women's Health Hub has been successful and thanked Ms N Bruce, Interim Director of Strategy, Planning and Partnerships and clinical teams for their hard work around this. She reported that this is a collective ambition across Gateshead and is an important step in becoming the Northern Centre of Excellence for Women's Health. **Thematic Review update:** Mrs Davies provided an update on the work that has been taking place following the review and reported that further updates have been proposed in advance of the Executive Management Team meeting. Currently 52.5% of actions are confirmed as being completed, which would rise to 80%, should the actions recommended for closure be approved at the Executive Management Team meeting. She drew attention to the key risk areas which includes those actions which have exceeded their target dates and are therefore marked as off track. This includes Action 4 which relates to addressing the backlog of complaints and Dr G Findley, Chief Nurse and Deputy Chief Executive, reported that a new process has been implemented to escalate any overdue complaints and this is being monitored via the Quality Governance Committee. All outstanding complaints are being addressed and plans are in place however Dr Findley highlighted that these are now back within normal targets. In relation to Action 13 around the development of digital displays to support key communication and promotion of Board visibility, Mrs Davies reported that this is being taken forward via the communications review and alternatives are being considered, given that digital solutions were not feasible due to cost. Action 31 relates to the promotion of a	

Agenda Item	Discussion and Action Points	Action By
	zero-tolerance approach to bullying and harassment and it was noted that this is a priority area and there has been a significant focus on this over the last couple of months and progress is being made. Mrs Davies explained that the Executive Team will continue to routinely monitor progress against the plan and escalate areas of concern to the Board via the Board committees. The Board acknowledged the work being undertaken by the Executive Team in relation to the review and the progress being made. **North East and North Cumbria Collaborative Governance update:** Mrs Davies highlighted that the paper has been prepared directly by the Provider Collaborative Managing Director to provide an update to all NHS Foundation Trust Boards in the Integrated Care System around the Responsibility Agreement and the strategic partnership between the Collaborative and NECS (North of England Care System) and is received for information. Following discussion, it was: **RESOLVED:** to receive the report for assurance.	
23/244	**GOVERNANCE REPORTS** **Board Assurance Framework (BAF) quarterly update**: Mrs J Boyle, Company Secretary, provided the Board with the current Board Assurance Framework 2023/24 for review and assurance, following scrutiny by each of the mapped Board committees. She explained that the report demonstrates that 3 risks have been managed effectively to achieve the target risk score and that active updates are being made to the BAF at each committee to reflect to identification of new controls or assurances and any gaps. Areas with the highest current scores relate to performance, finance and our people (culture and health and wellbeing). This triangulates with the information reported to Board as part of other formal reports on the agenda. Updates have also been provided in relation to financial sustainability via the Finance and Performance Committee which has resulted in the reduction of the risk score. Mrs A Stabler, Non-Executive Director, and Mr A Crampsie, Non-Executive Director, recently attended the NHS England training for the Patient Safety Incident Response Framework and Mrs Stabler highlighted that this would impact upon the BAF and risk scoring more broadly once all Board Members had received their training. Following discussion, it was: **RESOLVED:** to receive the report for assurance.	

Agenda Item	Discussion and Action Points	Action By
	Trust Strategic Objectives quarterly update: Ms N Bruce, Interim Director of Strategy, Planning and Partnerships, presented a Quarter 2 update on the delivery of the strategic objectives for 2023/24 and highlighted that strategic objective delivery plans have been developed by the Executive Director owners of each of the objectives and are reviewed at the relevant Board committee meetings. She reported that there are 34 objectives in total and as reported in Quarter 1, 2 are complete (one in SA1.1 around configuration of the maternity team and one in SA3.2 around the finance team). 12 objectives have some risk to delivery identified which is an increase of 2 since the last Quarter however all objectives are now underway and good progress is being made. Following discussion at the Finance and Performance Committee, it was felt that further work is required around correlation against the leading indicators and overall Trust performance and this will be considered when setting next year's objectives. Ms Bruce highlighted that there has been a request to amend the delivery date on three of the actions associated with objective SA1.3 that is aligned to the Digital Committee. This is in relation to the digital maturity assessment, delays with supplier engagement and stakeholder feedback and development of the EPR outline business case. She reported that there is also a request to split actions associated with the digital skills and inclusion plan for staff and patients which will be tracked via two workstreams to better reflect the work that is underway. After consideration, it was: **RESOLVED:** to approve the request to amend the delivery dates for SA1.3 and split the actions associated with delivery and note progress towards delivery of the strategic objectives in 2023/24. **Organisational Risk Register (ORR)**: Dr G Findley, Chief Nurse and Deputy Chief Executive, presented the updated ORR to the Board which shows the risk profile of the ORR, including a full register, and provides details of reviewed compliance and risk movements. This report covers the period 16th September to 16th November 2023. Dr Findley reported that there are currently 19 risks on the ORR, one with a high score of 20 relating to the risk of MRI service interruption, and 7 with a score of 16. There have been 3 additions to the ORR following the Executive Risk Management Group meetings in October and November, and 3 reductions and one risk has been removed. Compliance with actions reviews is currently at 94% and demonstrates the work being undertaken to review risks. Dr Findley highlighted that the new incident management module of InPhase is now live, however the Enterprise Risk Management module for InPhase, has not yet been able to go live as the training requirements have not yet been met. Current performance is 60% compliance and go	

Agenda Item	Discussion and Action Points	Action By
	live cannot take place until a minimum of 80% is reached, therefore work is ongoing to ensure the training is completed. The Board noted the Top 3 organisational risks identified by the Executive Risk Management Gorup relating to finance, performance, and maintaining trust and confidence in services. Mrs Marshall highlighted that discussions took place in relation to the risk of MRI service disruption at the Finance and Performance Committee and Mrs J Halliwell, Group Chief Operating Officer, reported that this has been discussed with the Operations Director and risk mitigations will be included to address the high risk score. Mr A Crampsie, Non-Executive Director, queried whether the issue relating to Health Care Assistant banding was reflected on the ORR however Dr Findley reported that this is currently being locally managed due to plans being in place to address this. After consideration, it was: **RESOLVED:** to receive the report for assurance.	
23/245	**ASSURANCE FROM BOARD COMMITTEES** **Finance and Performance Committee (F&P):** Mr M Robson, Chair of the F&P Committee, provided a brief verbal overview to accompany the narrative report following the October 2023 meeting and provided a verbal update of the meeting held yesterday (28 November 2023). There were no items for escalation however key areas of discussion during the November meeting included: • The leading indicators continue to develop however further improvements were highlighted in relation to the executive summary and areas of risk therefore this will be focussed on at the next meeting. • Forecast outturn – NHS England have identified a set of assumptions and mitigations to address the impact of industrial action. • Greater detail around the cash balance will be included in future plans. • Overspend against the Medical Business Unit financial performance was identified therefore this will be looked at in more detail at the next meeting. • The Committee noted that the NHS England agreement around the Community Diagnostic Centre capital is still outstanding. • The Committee received a report on the elective recovery programme highlighting progress and risks.	

Agenda Item	Discussion and Action Points	Action By
	• Referral to treatment time (RTT) improvements were noted however there is a deterioration against the 18 weeks target and audiology continues to be the biggest long-term risk in relation to diagnostics performance. • Planned care information including new appointments and follow-ups will be aligned with the leading indicator reports. • The Committee received an update from QE Facilities which demonstrates strong performance including plans of over-achievement of efficiency plans and Mr Robson congratulated the team for their efforts. • Discussions took place in relation to the NHS England monthly meetings in relation to the System Oversight Framework (SOF) segment 3 rating. Mrs A Stabler, Non-Executive Director, noted that the audiology team took part in a quality improvement week and queried the confidence levels for the target being reached by March 2024. Mrs J Halliwell, Group Chief Operating Officer, responded that further work was required to link the outputs of the quality improvement exercise to the potential impact on wait times. Until this work is complete the confidence level in achieving the target could not be ascertained. Mr A Moffat, Non-Executive Director, queried the progress in relation to the Community Diagnostic Centre (CDC) and the outstanding decision from NHS England regarding additional capital allocation. Mrs K Mackenzie, Group Director of Finance and Digital, confirmed that the risk in relation to the capital departmental expenditure limit (CDEL) cover remains however discussions with Newcastle-upon-Tyne Hospitals NHS Foundation Trust is taking place to develop a memorandum of understanding around shared risks and rewards. Mrs M Pavlou, Non-Executive Director, raised some concerns around the outstanding decision on capital and the impact of this on the CDC, however Mrs T Davies, Chief Executive, reminded the Board of previous discussions and the agreement that progressing with the CDC in the meantime was in the best interests of the Gateshead population. Mr S Harrison, Interim QE Facilities Managing Director, highlighted that significant discussions have taken place in relation to the cost of the project and assurances can be provided that this continues to develop. **Quality Governance Committee (QGC):** Mrs A Stabler, Chair of QGC, provided a brief verbal overview to accompany the narrative report following the October 2023 meeting and highlighted that a representative from the Integrated Care Board (ICB) was in attendance. Good feedback was provided and the Terms of Reference will be updated to include an ICB representative going forward, noting that this will reduce duplication with the Quality Review Group. She drew attention to the matters for escalation which included the increase in the number of children in care and subsequent report to the ICB in relation to additional funding. The Committee noted that some of the key performance indicators are now behind target and the ICB Chief	

Agenda Item	Discussion and Action Points	Action By
	Nurse has agreed to look into this. Following a query from Mr Robson in relation to whether increased numbers of looked after children was a local trend, Mrs Stabler reported that this was a national issue. **People and Organisational Development (POD) Committee** Mrs M Pavlou, Chair of POD Committee, provided a brief verbal overview to accompany the narrative report following the November 2023 meeting. She drew attention to the items for escalation which included some historic bullying issues highlighted in the General Medical Committee survey however this is being managed locally via the Director of Medical Education and local teams. The other item for escalation related to the low levels of vaccination uptake however Mrs A Venner, Group Director of People and Organisation Development, reported that the Trust is currently within the top ten Trusts within the sample area. Following a query from Mr A Moffat, Non-Executive Director, relating to whether this correlated to sickness levels, Mrs Venner reported that 7% of current absences relate to infectious diseases. Mrs Pavlou reported that the Committee received an Executive Director summary report for the first time which provides a triangulated summary of the People and OD issues articulated within the reports presented to the summary. She felt that this may be beneficial for other Board Committees going forward and this will be considered by the Committee Chairs. Mrs Marshall thanked the Committee Chairs for their reports and after consideration, it was: **RESOLVED**: to receive the reports for assurance	
23/246	**FINANCE REPORT:** Mrs K Mackenzie, Group Director of Finance and Digital, provided the Board with a summary of financial performance as of 31st October 2023 (Month 7) for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds). Mrs Mackenzie highlighted some of the key points around revenue and noted that the Trust is reporting an actual deficit of £10.248m which is an adverse variance of £1.943m from its year-to-date target. The Trust is forecasting achievement of its planned deficit totalling £12.588m. Discussions around this took place at the Finance and Performance Committee and it was highlighted that the main reason around this is due to being unable to access the expected income. She reported that teams are working hard to increase activity and this is beginning to increase as highlighted within the Integrated Oversight Report and there is confidence that the financial plan will be met.	

Agenda Item	Discussion and Action Points	Action By
	The Trust has a fully costed cost reduction plan and changes to spending are being embedded however teams are working closely with the senior team to ensure there is no detrimental impact on patient care. Mrs Mackenzie drew attention to the letter attached the report which highlights the response from NHS England addressing the significant financial challenges created by industrial action in 2023/24. It states that extra funding has been released to support the achievement of spending plans in key priority areas. It is expected that the Trust will receive an additional £2.5m which will support the delivery of the financial plan and Mr M Robson, Chair of the Finance and Performance Committee confirmed that the Committee will continue to review details around the forecast outturn. Following a query from Mr A Moffat, Non-Executive Director, in relation to cost reduction plans, Mrs Mackenzie reported that there were approximately £2m recurrent plans in place however further work is taking place to try to reduce further costs on a recurrent basis and gaining more access to income. She explained that this is being driven via the Delivery Oversight Group and relevant workstreams. Following consideration, it was: **RESOLVED:** to receive Month 7 financial position and note partial assurance for the achievement of the forecast 2023/24 planned deficit as a direct consequence of the reported year to date position and financial risks.	
23/247	**INTEGRATED OVERSIGHT REPORT AND LEADING INDICATORS:** Mrs K Mackenzie, Group Director of Finance and Digital, introduced the Integrated Oversight Report (IOR) for September and October 2023. Mrs Mackenzie provided the following key messages by exception from the Integrated Oversight Report: **Caring Domain:** • The number of overdue complaints at the end of October fell to the lowest level since May 2022 with 4 overdue complaints at the end of October **Safe Domain**: • There were no Serious Incidents (SIs) reported to in October and the number of patient safety incidents also continues to fall. • The Healthcare Associated Infections (HCAI) 2023/24 national objective for Clostridium difficile infection (C.Diff) remains a challenge and the Trust is now above the trajectory for this point in the year.	

Agenda Item	Discussion and Action Points	Action By
	Effective Domain: • The number of General and Acute beds open in October has increased which is associated with the move towards the opening of additional winter beds • There has also been an increase in the lengths of stay which has been driven by an increase in length of stay for non-elective patients in the month. **Responsive Domain:** • There has been an increase in emergency department attendances as well as ambulance handover times • 12 hour delays have decreased **Well Led Domain:** • The number of staff in contracted posts increased again in October, and there has been a decrease in both bank and agency requests. • Sickness absence levels have increased this month however rolling rates have remained stable. Dr G Findley, Chief Nurse and Deputy Chief Executive, highlighted that the decrease in serious incidents was likely to be due to the introduction of the patient safety incident response framework (PSIRF) therefore consideration was required around how future levels should be reported and this will be discussed with the performance and planning team. Mrs A Stabler, Non-Executive Director, and Mr A Crampsie, Non-Executive Director, have recently attended the NHS England training and acknowledged that further training around the changes was required across the organisation. Mrs M Pavlou, Non-Executive Director and Chair of the People and Organisational Development Committee, highlighted that the improved position around recruitment was discussed at the last meeting however there is further work to do around sickness absence rates. Mrs T Davies, Chief Executive, explained that this was the national picture across the health service due to increased activity and demands on teams however improved messaging would be beneficial to highlight positive productivity. Mrs A Venner, Group Director of People and Organisational Development, reported that the Managing Well and Leading Well programmes were being well attended to support managers and staffing reports were being monitored via the People and Organisational Development Committee to understand drivers however there were opportunities to improve rates further. Following a query from Mrs Stabler in relation to the winter bed base, Mrs J Halliwell, Group Chief Operating Officer, explained that escalation beds have been included within ward areas and following completion of the new operating model estates work, all wards are now situated within their permanent areas therefore this will provide a clearer organisational position on bed base and will be reviewed in relation to staffing. It was	GF

Agenda Item	Discussion and Action Points	Action By
	agreed that this would be reviewed via the Quality Governance Committee. Mrs H Parker, Non-Executive Director, commented that length of stay and discharge rates have improved however felt that further work could be undertaken to improve these further. Mrs J Halliwell, Group Chief Operating Officer, reported that work is in progress and the Trust is working closing with the Local Authority. An increase in domiciliary care and reablement provision within the community is supporting this however Mr N Halford, Medical Director of Operations, explained that the Clinical Strategy Group have been reviewing complex clinical pathways and further work is required. Following a query from Mr Crampsie, in relation to Duty of Candour compliance levels, Dr Findley explained that this was due to the introduction of In-Phase, the new incident reporting system, however is being reviewed within the cycle of business for the Quality Governance Committee. After consideration, it was: **RESOLVED:** to receive the report for assurance, noting the improvements and ongoing challenges in key areas.	GF/ JH
23/248	**NURSE STAFFING UPDATE:** **Monthly Nurse Staffing Exception Report**: Dr G Findley, Chief Nurse and Deputy Chief Executive, presented the report for October 2023 which provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls. She reported that ward staffing levels are now fully recruited to on all acute wards however exceptions have been noted in relation to Ward 23 and Ward 25 due to elevated levels of sickness absence throughout October. There is continued focused work around the recruitment and retention of staff and managing staff attendance. Following discussion, it was: **RESOLVED:** to receive the report for assurance. **Bi-annual Inpatient Safer Nursing Care Staffing Report:** Dr Findley presented the report which provides the Board with continual assurance that the nursing workforce is safe, competent, and compliant with National Institute for Clinical Excellence (NICE), National Quality Board (NQB) and NHS England's Safer Staffing guidelines and standards. Dr Findley reported that individual ward areas have been reviewed and some small adjustments are required that can be completed within	

Agenda Item	Discussion and Action Points	Action By
	budget. Headroom calculations remain at 21% and work to address sickness absence will assist this. She highlighted that some adjustment to the rosters are required to increase night shift cover and the staff nursing care calculations for the Emergency Department and Emergency Admissions Unit requires further detailed work due to the acuity of the patients and the way in which the units are currently running. Dr Findley highlighted to the Board that a business case may need to be developed for consideration by the Senior Management Team to address any remaining gaps once the detailed work has been completed. Following discussion, it was: **RESOLVED:** to receive the report for assurance and note the work being completed to address the remaining gaps.	
23/249	**MATERNITY UPDATE:** **Maternity Integrated Oversight Report:** Mrs J Conroy, Head of Midwifery, presented a summary of the maternity indicators for the Trust for September 2023. She drew attention to the key performance indicators within the Maternity Dashboard and highlighted that there has been an increase in the number of births and an increase in post-partum haemorrhages (PPH) however this is an ongoing trend across the region and significant focussed work is being undertaken to provide a clearer understanding of the reason. There is some focussed work being undertaken in relation to compliance with the essential maternity safety training and discussions are taking place with staff members to ensure this is completed. An Ockenden Assurance Visit took place on 13th September 2023 and positive feedback was received by the review team with support from North Tees Peer Review team. Mrs Conroy highlighted that it was shared that staff demonstrated commitment and were clearly passionate about their roles and the service. There was also multiple areas of good practice which will be shared to benefit other maternity units in the region. The Board congratulated the team and acknowledged the support provided by Mrs A Stabler, Non-Executive Director. Discussion took place around the increase in PPH rates and it was noted that it would be beneficial to show PPH as a proportion of volume in future reports. Following a query from Mrs T Davies, Chief Executive, in relation to system learning and practice, Mrs Conroy reported that the Trust is not being highlighted as an outlier however deep dive work is being undertaken and focus groups are reviewing cases to understand techniques and support learning. Mrs Stabler highlighted that Newcastle	

Agenda Item	Discussion and Action Points	Action By
	have undertaken some learning exercises and felt that it would be beneficial to review this. Following a query from Mr A Crampsie, Non-Executive Director, in relation to training compliance rates, Mrs Conroy confirmed that national targets have been updated therefore a local agreement is in place to ensure 80% compliance by the end of December 2023 with 90% compliance being achieved by February 2024. It was noted that further work was required in some of the staff groups and this is being reviewed to ensure compliance levels are reached. It was agreed that future reports would include an assessment of PPH as a proportion of volume, as well as a trajectory to demonstrate training compliance. After consideration, it was: **RESOLVED:** to receive the report for assurance. Mrs Conroy left the meeting.	GF / JC
23/250	**LEARNING FROM DEATHS SIX MONTHLY REPORT:** Mr N Halford, Medical Director of Operations, presented the report which provides 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 12th October 2023 covering the period from June 2022 to May 2024 and showed that the Trust has a SHMI banding of 'Lower Deaths than Expected'. The Hospital Standardised Mortality Ration (HSMR) for the period August 2022 to July 2023 is 103.7 and shows 'Deaths as Expected'. All deaths continue to be initially scrutinised by the Trust's Medical Examiner office and are scored or referred for further review where appropriate. Mr Halford highlighted that there has been a change in how data is being reported therefore there may be some changes to the scores however this will be monitored and teams are proactively working with the national data teams to manage this. Mrs A Stabler, Non-Executive Director, highlighted that discussions took place in relation to learning from deaths with learning disabilities at the Quality Governance Committee and this is being reviewed due to the national standard not being met however it was noted that the Trust currently has only one specialist Learning Disability nurse within the service. Following discussion, it was: **RESOLVED:** to receive the report for assurance and information.	

Agenda Item	Discussion and Action Points	Action By
23/251	**QE FACILITIES SIX MONTHLY REPORT:** Mr S Harrison, Interim QE Facilities Managing Director, presented the report which provides an update on work over the last six months. He drew attention to some of the key highlights including the work undertaken to improve governance and controls which has resulted in stronger relationships and improved colleague engagement. He also drew attention to some of the achievements within QE Facilities' services including estates and facilities; transport, portering and security; and pharmacy and concluded by highlighting some of future opportunities including national and regional partnership working. The Board thanked Mr Harrison for his work and support. After consideration, it was: **RESOLVED:** to receive the report for assurance and information.	
23/252	**CYCLE OF BUSINESS:** Mrs J Boyle presented the cycle of business which outlines forthcoming items for consideration by the Board. This provides advanced notice and greater visibility in relation to forward planning. The Board are therefore encouraged to review the cycle of business ahead of the next meeting in January 2024 and it was: **RESOLVED:** to receive the cycle of business for 2023/24.	
23/253	**QUESTIONS FROM GOVERNORS IN ATTENDANCE:** There were no questions received from Governors present however a question was received in advance of the meeting from Mr J Bedlington, Public Governor for Central Gateshead, in relation to cyber security risks and Mrs K Mackenzie, Group Director of Finance and Digital, reported that the Trust has an annual certification in place and undertakes an active test of security systems in line with NHS England requirements. The Trust has leads present on the Cyber Associates Network and continues to expand on processes and software. Mr A Moffat, Non-Executive Director and Chair of the Digital Committee, also highlighted that cyber security metrics are being developed within the development of the key performance indicators.	

Agenda Item	Discussion and Action Points	Action By
23/254	**DATE AND TIME OF THE NEXT MEETING:** The next meeting of the Board of Directors will be held at 9:30am on Wednesday 31st January 2024.	
23/255	**CLOSURE OF THE MEETING:** Mrs Marshall declared the meeting closed.	
23/256	**EXCLUSION OF THE PRESS AND PUBLIC:** **RESOLVED:** to exclude the press and public from the remainder of the meeting due to the confidential nature of the business to be discussed	

PUBLIC BOARD ACTION TRACKER

Gateshead Health NHS Foundation Trust

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

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
23/64	29/03/2023	Board Committee Assurance Report	Discussion around proposed rescheduling of committee meetings required – to be discussed at Exec Team	24/05/2023	Exec	May 23 – outcome to be provided July 23 – to be reviewed as part of GGI review. Action to be retained as open until this review concludes. Sept 23 – review is due to conclude in early October. Board discussion planned for October Board Development day. **Nov 23** – POD committee dates to be agreed. Action to remain open until approved.	
23/196	27/09/2023	F&P Committee Assurance Report	Discussions re. implications of validation in relation to elective recovery board self-assessment to take place at future Board Development Day	31/12/2023	JH / JB	Oct 23 – scheduled for the Dec 23 Board development day **Dec 23** – discussed as part of elective recovery presentation at Dec 23 Board development day. **Action recommended for closure.**	
23/199	27/09/2023	HCA pay rates	The Board to be kept informed of progress in the HCA pay rate review via the People and OD Committee update reports	31/12/2023	GF/AV	**Nov 23 –** coversheet enclosed to provide update. Full PID being developed and working group established. Progress report to go to POD Committee in January 2024 and updated position shared with Board. **Jan 24** – discussed at POD Committee in January 24.	

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
23/206	27/09/2023	FTSU Guardian Report	To provide details to Board members re. FTSU training	29/11/2023	GR / AV	**Nov 23 –** details shared at POD Committee however a reminder will be sent to Board members. To remain open until completed	
23/247	29/11/2023	IOR and Leading Indicators	To consider how future rates should be reported following introduction of PSIRF. To be discussed with planning and performance team	31/01/2024	GF	**Jan 24** - in progress. Awaiting information from the regional team as to how incidents will be reported to Boards across the region. In the meantime, all significant incidents are reviewed by the Chief Nurse and Medical Director and reported via reportable issues log.	
23/247	29/11/2023	IOR and Leading Indicators	To review bed base in relation to staffing via the Quality Governance Committee	31/01/2024	GF / JH	Jan 24 - work ongoing and bed base has been agreed internally. **Action recommended for closure.**	
23/249	29/11/2023	Maternity IOR	Future reports to include an assessment of PPH as a proportion of volume, as well as a trajectory to demonstrate training compliance.	31/01/2024	GF / JC	Jan 24 – to be included in reports going forward. **Action recommended for closure.**	

Closed Actions from last meeting

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
23/120	24/05/2023	Learning from Deaths	To include suggested links to litigations and Getting It Right First Time in next iteration of the report	29/11/2023	AB	This has been reviewed - neither claims info or GIRFT data give specific information that link to mortality and are not thought to add anything in terms of interpreting mortality data. Action agreed as closed on this basis.	
23/157		Board Assurance Report - Digital	To discuss with the Digital Committee Chair the most appropriate approach for agreeing the next steps for the Electronic Patient Record development (e.g. Board development session or additional Digital Committee) and report back to Board.	18/10/2023	Kmac	**Sept 23** - Discussion to take place at the October Board Development Day in relation to strategic decision making **Nov 23** – wider strategic discussion held and EPR engagement day scheduled for 13 December. Action agreed as closed on this basis.	
23/158	23/07/2023	CEO update	Mental Health Services overview – to request further clarification re. contractual obligations	27/09/2023	TD	**Sept 23 –** no further information received following request. Nov 23 – GF to pick up with CNTW Chief Nurse during SLA discussion. Action agreed as closed on this basis.	
23/204	27/09/2023	Maternity IOR	To include summary of perinatal mortality review tool reports in next report	29/11/2023	GF	**Nov 23 –** now included in report therefore action agreed for closure	
23/207	27/09/2023	WRES and WDES report	To discuss options around sharing information with the violence and aggression group in relation to bullying and harassment	29/11/2023	GF/GR	**Nov 23 –** staff toolkit developed and will be monitored via the POD Committee and Quality Governance Committee. Action agreed for closure	

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 8

Report Title:	**EPRR annual assurance report 2023 including NHSE Core Standards self-assessment final submission.**			
Name of Meeting:	Trust Board			
Date of Meeting:	31 January 2024			
Author:	David Patterson, Head of Emergency Planning, Response and Response			
Executive Sponsor:	Jo Halliwell, Group Chief Operating Officer			
Report presented by:	Jo Halliwell, Group Chief Operating Officer			
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 2023 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:	Trust Board (Part 2) – November 2023 Strategic EPRR Committee - December 2023 Executive Risk Management Group (ERMG) - January 2024 Northeast North Cumbria (NENC) ICB EPRR team			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• It is a requirement that NHS Providers submit an annual self-assessment statement of assurance against the EPRR core standards to their board. • In June 2023, NHSE outlined to the North East North Cumbria (NENC) Integrated Care Board (ICB) a revised process for the 2023 EPRR Assurance Process. • As a consequence, NHS providers within NENC were asked to submit physical evidence via a national portal that was reviewed by NHSE against newly issued EPRR Assessment Guidelines • An initial internal self-assessment of the EPRR core standards and evidence submission resulted in a self-assessment rating of substantial compliance. • Following the NHSE review of evidence submitted, they recommended an assurance position of non-compliant.			

<table>
<tr><td></td><td colspan="5">Given the significant discrepancy evidenced by the two reviews, a further check and challenge process with the ICB was instigated which has resulted in a final position of 77% - partial compliance.
The final trust position was externally verified by the Local Health Resilience Partnership (LHRP) on 30 November 2023
The trust's annual assurance report for 2023 including the NHSE 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 for 2023 resulting in a final self-assessed position of 77% and partial compliance.
b) Be assured that the differential gap in evidential requirements will form part of the 2024 EPRR development work-plan.
c) endorse the assurance provided within the 2023 Annual Assurance Report and;
d) support the inclusion of the compliance rating in the Trust's annual report for 2023-24.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">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 (identify significant risks and DATIX reference)</td><td colspan="5">Ref 2851 - 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
☒</td></tr>
</table>

Emergency Preparedness, Resilience and Response (EPRR)

Annual Assurance Report 2023

[EPRR Team]
Published: January 2024
Review date: July 2024

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 in preceding 15 months.

This is the first report in this revised format. The timeframe referred to in this report will cover September 2022 to December 2023 following changes to the NHSE Core Standards process alluded to in this report. Moving forward, the Trust Board annual assurance reports will cover a 12-month period.

It should be acknowledged that the period between November 2022 and December 2023 has been dominated by the response and recovery to a series of unprecedented periods of industrial action by several health unions. The activity has naturally meant that focus has been

on the planning, coordination, and wider liaison required to ensure patient safety, and continued service delivery.

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 self-assessment 2023 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 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 'Training and Exercising'.

4. How are we assessed?

The overall EPRR assurance rating is based on the percentage of core standards that trusts can self-assess against. This is explained in more detail below:

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

In previous years, NHS providers have been required to provide a RAG-rating for each applicable standard and comment on the evidence that supported this assessment.

The Trust's previous self-assessment position from 2022 was **83% partial compliance.**

5. What are the changes to NHS Core Standards Assurance Process 2023?

In June 2023, NHSE confirmed to the North East, North Cumbria (NENC) Integrated Care Board (ICBs), and health organisations, a revised process for the 2023-24 EPRR Assurance Process. For the first time, NHS providers within the North East and Yorkshire region were asked to submit physical evidence via a national portal. This was to demonstrate how the Trust complies with the standards from an NHSE viewpoint in support of the trust's self-assessment compliance rating.

NHSE undertook a review of the evidence submitted to understand the self-assessment position. Each core standard was reviewed against new NHSE EPRR Assessment guidelines (issued in June 2023) and rated, along with providing documented reasons for any challenge.

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

The purpose of this change is to support more objective assurance and highlight areas for further work to strengthen arrangements.

As a trust we recognise the core principles of this approach and acknowledge that this is important in light of the recent recommendations from the public enquiries into Manchester Arena and the Grenfell Tower fire.

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 submitted evidence and self-assessment compliance rating, oversight at the EPRR Committee (September 2023) before the submission to NHSE.

In the interests of an open and transparent organisational culture, the Trust has ensured that members of the Executive Management Team, Executive Risk Management Group and the Company Secretary were kept fully appraised.

Following the completion of our initial self-assessment, the Trust's compliance rating (as at 27 September 2023) was assessed as **92% substantial compliance.**

7. What happened with the NHSE Check and Challenge?

The primary evidence was submitted on 29 September 2023. Initial feedback was received from NHSE on 23 October 2023 from the primary evidence review with a number of challenges being raised into a noted variation from the Trust self-assessed rating and that of NHSE reviewers. In line with the timelines, a portfolio of supplementary evidence was submitted on 30 October 2023.

The assessed position provided by NHSE following the check and challenge significantly reduced the overall assessment score and the compliance rating to **non-compliant**.

There was a substantial discrepancy and variation between the Trust's initial self-assessment rating and the NHSE assessment rating – this was consistent with other providers within the North East and Yorkshire region, and on average was a **70% reduction** in compliance.

The Trust worked with the NENC ICB to review the position to provide context, support and leadership.

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

The Trust has accepted a number of recommendations from the check and challenge process and will consider any additional requirements for the 2024 submission as part of the EPRR work programme.

The Trust has also refuted a number of the challenges as it deems that the evidence submitted is sufficient to achieve full compliance. This approach was supported by the ICB and discussed with the Local Health Resilience Partnership (LHRP) chairs who are also in support.

The Trust's final reported self-assessment for 2023 was:

Percentage Compliance	77%
Overall Assessment	Partially 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	Not Applicable
Governance	6	6	0	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	8	3	0	0
Command and control	2	1	1	0	0
Training and exercising	4	1	3	0	0
Response	7	6	1	0	0
Warning and informing	4	4	0	0	0
Cooperation	4	3	1	0	0
Business continuity	10	9	1	0	0
Hazmat/CBRN	12	8	4	0	0
Total	**62**	**48**	**14**	**0**	**0**

Figure 2 – final Trust self-assessment (November 2023)

A final check and challenge session with the Local Health Resilience Partnership (LHRP) was scheduled to take on place on 13 November 2023 but was deferred until 30 November 2023. This was a change and out with of our agreed internal governance and has resulted in a deferral of our final position which was reported through to the January 2024 Trust Board. The final Gateshead self-assessment and assurance was verified by the partnership.

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

As a trust there continues to be a clear ambition and intent to develop and enhance our capabilities and capacity in line with NHSE EPRR Framework. However, the level of audit, scrutiny, and changes in this process have seen an increased demand on the Trust's EPRR Team during a challenging period.

This has not affected the Trust's ability and confidence to respond to an EPRR incident and the statutory position remains unchanged. 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.

An anonymised regional comparison of the **final** self-assessment ratings highlighted below demonstrates that the Trust is amongst the highest achieving final provider self-assessment ratings:

No	Organisation	Initial organisation assessment rating	Initial NHSE Check & Challenge rating	Final NHSE rating	Final provider self-assessment rating	Assurance rating
1		98%	21%	34%	90%	Substantial
2		90%	31%	52%	81%	Partial
3	**Gateshead Health**	**92%**	**15%**	**23%**	**77%**	**Partial**
4		90%	19%	40%	77%	Partial
5		98%	6%	15%	77%	Partial
6		81%	13%	27%	77%	Partial
7		90%	13%	13%	73%	Non-compliant
8		77%	24%	31%	53%	Non-compliant
9		83%	0%	2%	52%	Non-compliant
10		78%	3%	3%	50%	Non-compliant
11		70%	5%	6%	49%	Non-compliant
12		81%	6%	7%	45%	Non-compliant

10. 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 2023, this includes:

- a successful response to (20) periods of **industrial action** maintaining patient safety.
- a response to **severe winter pressures** (2022-23) and an unprecedented level of demand
- **a recognised protocol for debriefing and embedding of organisational learning** acknowledged by NHSE in the core standards check and challenge as being of high quality
- **a recognised robust risk assessment process** acknowledged by NHSE in the core standards check and challenge as being worthy of note as good practice
- a number of **reviewed plans, policies and protocols** undertaken by the EPRR Committee
- implementing a **revised on-call mechanism** in alignment with other regional approaches
- Trust Strategic and Tactical commanders attending **Principles of Health Command** training sessions hosted by NHSE
- procurement of a new **business continuity** software solution and recruitment of a dedicated **Business Continuity Coordinator**
- continued **engagement and development of strengthened relationships** with the NENC ICB

- 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 an up to date EPRR Policy 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 new Group Chief Operating Officer was appointed in October 2023 at Board level who is the designated Accountable Emergency Officer on behalf of the Chief Executive Officer.
- The EPRR committee provides strategic assurance to the Executive Risk Management Group 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.
- The Trust's EPRR function is delivered by a dedicated team, made up of the Head of EPRR and the EPRR & Business Continuity Coordinator (job share role). A service re-design and consolidation of an existing admin assistant vacancy and 2 days from a recent vacated EPRR Coordinator has created a new role full time EPRR Project Support Officer that will provide resilience to the team.
- The EPRR Team have coordinated **24 debriefing programmes** during 2023 on a range of issues from training and exercising feedback and from response, identifying organisational learning.
- The service re-design for the EPRR Team and an internal refresh of the EPRR governance forum is a priority area to implement in early 2024.

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 Risk Register takes account of Local Resilience Forum community risk registers 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

- 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.
- Plans are reflective of national guidance and risk assessments, as well as national planning assumptions and are developed in collaboration with other partners.

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.
- A review undertaken of the on call team implemented in October 2023 has increased resilience across all levels of on-call with a fairer share of participants; align Gateshead Health with other trusts and system partners in consistency of approach and implement a leaner and more manageable on-call framework.

Domain 5 – Training and exercising

- The Trust has a Strategic Training Needs Analysis and exercising programme in place with a clear direction of travel for 2024.
- The participants on the strategic and tactical on-call team continue to undertake NHSE Principles of Health Command training.
- Local exercising to test local risks has continued to take place with teams and services throughout this year.
- In July 2023, an Exercise Blackstart was undertaken to test electricity resilience.

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 business continuity issues including:

    - External IT outage (October 2022)
    - Pre-planned Care Flow downtime (October 2022)
    - Industrial action (20 periods) (November 2022 to December 2023)
    - Adverse Weather (September 2023)
    - External IT system issue (October 2023)
    - Telecoms issue (November 2023)

- Following each issue, a debrief programme was implemented to identify organisational learning.

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 – this has been extensively tested and demonstrated in our response to industrial action during 2022-23

Domain 8 – Co-operation

- The Trust continues to co-operate with partner organisations within the LRF and LHRP, and as part of recognised arrangements including strengthened arrangements with the North East North Cumbria Integrated Care Board (ICB).

Domain 9 – Business Continuity

- The Trust is transitioning 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 2024 (incorporating organisational learning from covid, industrial action and other issues)

Domain 10 – CBRN/HazMat

- A flexible Trust response plan can be illustrated to deal with a CBRN/HazMat incident that is based upon a local/national assessment of threat and risk, with a further consolidation of training and exercising planned in 2024.

11. What are the priority areas for development?

Providing the self-assessment process remains consistent, the Trust has a clearer picture of the expectations and development required for 2024 submission.

Our priority areas in 2024 include:

- A focus on training and exercising across the domains, including at least one live exercise. Spring 2024 currently identified for the first live test.
- Implementation of a business continuity software solution to allow us to provide consistency to alleviate and assist with the day-to-day management of issues; the ability to create, store, manage and distribute Business Continuity Plans; a performance management function and a call cascade with real time reporting and tracking.
- Review of plans, frameworks, and protocols to strengthen our arrangements.
- Implementing a new EPRR governance forum for assessment and coordination of impacts
- Assurance and demonstration of embedding organisational learning to improve our EPRR response.

12. Conclusion and next steps

Although there have been significant challenges within the revised core standards process and acknowledging this major change in expectations and requirements, 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 workplan; indicate a measure of progress, and to identify and embed internal organisational learning and opportunities for improvement.

In summary, the Trust assurance statement for 2023:

- The Trust continues ‘on a journey, making good progress’.
- There is a clear Trust ambition and intent to develop and enhance our EPRR capacities and capability and acknowledgement that it’s a constantly evolving journey and pathway of organisational learning.
- Use the basis of the core standards as a benchmark for prioritisation of the Trust EPRR development work-plan for 2024, measure progress, embed organisational learning and opportunities for improvement.

- As a Trust, commit to work with the NENC ICB and other health providers to identify best/leading practice for each domain that will be shared and discussed collaboratively with the aim of enhancing the threshold of evidence and future compliance.
- An aspiration to achieve substantial compliance for the 2024 self-assessment submission.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 9

Report Title:	**Board Committee Terms of Reference**			
Name of Meeting:	Board of Directors			
Date of Meeting:	31 January 2024			
Author:	Company Secretary			
Executive Sponsor:	Chair of the Board of Directors			
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 Quality Governance Committee, Group Audit Committee and Group Remuneration Committee			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Group Remuneration Committee – November 2023 Group Audit Committee – September 2023 Quality Governance Committee – December 2023			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	Group Remuneration Committee: • This is a new set of terms of reference which incorporate recommendations from an external review. • They also now cover the group role of the Committee. Group Audit Committee: • The terms of reference were reviewed and no changes proposed. Quality Governance Committee: • The terms of reference were amended to reflect the attendance of the Integrated Care Board to observe the Committee. • Other minor amendments to terminology were made, along with updating the frequency and membership to reflect current practice.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is requested to ratify the reviewed / revised terms of reference for the three Committees, noting that they have already been approved by the respective			

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

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	November 2023
Review Frequency	Annually
Review and approval	Remuneration Committee
Adoption and ratification	Board of Directors – January 2024 (TBC)

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 • 3 Non-Executive Directors who chair Board Committees 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.

Committee

Terms of Reference

Group Audit Committee

Constitution and Purpose – The Group Audit Committee (thereafter referred to as the Audit Committee) is a formal committee of the Board with delegated responsibility to conclude upon the adequacy and effective operation of the organisation's overall internal control system including an effective system of integrated governance and risk management.

It provides a form of independent check upon the executive arm of the Board. The Audit Committee is a Group Audit Committee, overseeing the controls, governance and risk environment of Gateshead Health NHS Foundation Trust and QE Facilities.

In this document the use of the term 'Trust' shall mean Gateshead Health NHS Foundation Trust and QE Facilities.

The Committee is authorised by the Gateshead Health NHS Foundation 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	September 2023
Review Frequency	Annually
Review and approval	Group Audit Committee
Adoption and ratification	Board of Directors – January 2024 (TBC)

Membership	The Committee shall be appointed by the Trust Board and shall consist of: • 4 Non-Executive Directors At least one Audit Committee member should have recent and relevant financial experience and this person should chair the Committee. A Non-Executive Director shall be nominated as Deputy Chair for the Committee.
Attendance	The following are also invited and expected to attend all Audit Committee meetings: • Group Director of Finance and Digital • QEF Director of Finance

	• Chief Nurse • Company Secretary • Assistant Director of Finance • A representative of Internal Audit • A representative of External Audit • A representative of the Counter Fraud The Chair of the Trust shall not chair or be a member of the Committee, but can be invited to attend the Committee as required. The Accountable Officer (Chief Executive) should be invited to attend the meeting that considers the draft Annual Governance Statement and the Annual Report and Accounts and should discuss the process for assurance that supports the Governance Statement. All invited attendees, if they cannot attend, should ensure a deputy attends in their absence. Other Executive Directors and Senior Managers may be invited to attend meetings depending upon the issues under discussion.
Meeting frequency and quorum	Meetings shall be held **no less than five times per year** (including the meeting held to review and make recommendations relating to the Annual Report & Accounts) and as required by the national regulatory timetable. Meetings shall be held at such a time that supports the timely flow of assurance and items for escalation to the Gateshead Health NHS Foundation Board of Directors. To be quorate there should be at **least 2 Non-Executive Directors** present. The external and internal auditors shall be afforded the opportunity at least once per year to meet with the Audit Committee without Executive Directors present. Members of the Audit Committee shall meet at least once a year without Executive Directors present. Members of the Audit Committee will meet with the Chief Executive at least once a year.
Meeting organisation	The Committee shall be supported administratively by the Corporate Management Team secretarial body. In accordance with the Trust's Standing Orders, **papers will be circulated to members and attendees six days before the meeting.** Minutes of the Committee's meetings are held by the Corporate Management Team secretarial body and are circulated (alongside the agenda for the following meeting), to members and attendees.

Committee duties and responsibilities

Internal control and risk management	To ensure the provision and maintenance of an effective system of **financial risk identification and associated controls, reporting and governance**. To maintain an **oversight of the Group's general risk management structures, processes and responsibilities**, including the production and issue of any risk and control-related disclosure statements. The Executive Risk Management Group will support the flow of risk management assurance to the Group Audit Committee. To **review processes to ensure appropriate information flows to the Group Audit Committee** from executive management, the Executive Risk Management Group and other board committees in relation to the trust's overall internal control and risk management position. To **review the adequacy of the policies and procedures in respect of all counter-fraud work**. The Committee must satisfy itself that adequate arrangements are in place to counter fraud and consider and agree the Annual Counter Fraud Plan and the results of counter fraud work. To review the **adequacy of the Trust's arrangements by which Trust staff may, in confidence, raise concerns** about possible improprieties in matters of financial reporting and control or any other matters of concern. To review the **adequacy of underlying assurance processes indicating the degree of achievement of corporate objectives** and the effectiveness of the management of principal risks via the Board Assurance Framework. To review the **adequacy of policies and procedures** for ensuring **compliance with relevant regulatory, legal and conduct requirements**.
Financial reporting	The Committee shall **review the Annual Report and Financial Statements** before submission to the Board in order to determine their completeness, objectivity, integrity and accuracy. The review should particularly focus on: • The contents of the Annual Report and Accounts and **Annual Governance Statement** and other year-end disclosures / reporting including the Corporate Governance Statement and self-certifications. • Changes in, and compliance with, the accounting policies and practices and estimation techniques. • Unadjusted mis-statements in the financial statements. • Major judgemental areas. • Significant adjustments resulting from the audit. • Letters of representation. • Explanations for any significant year on year movements. The Committee shall also ensure that the **systems and processes for financial reporting** to the Board, including those of budgetary control, are subject to review as to **completeness and accuracy** of the information

	provided to the Board. This includes seeking assurance that controls and processes are in place to enable the Trust to utilise the outputs of the annual reference cost exercise to identify efficiencies and promote value for money. The Committee shall review the **QE Facilities year-end accounts** in conjunction with the work and opinion of external audit. The Committee shall review the **Charitable Funds accounts** in conjunction with the work and opinion of external audit.
Internal Audit	To **review and approve the approach adopted by Internal Audit and the Internal Audit annual plan**, ensuring that it is consistent with the needs of the organisation. To oversee on an on-going basis the **effective operation of Internal Audit** in respect of: • Adequate resourcing and has appropriate standing within the Trust; • Its co-ordination with External Audit to optimise the use of audit resources; • Meeting relevant internal audit standards; • Providing adequate independence assurances; • Meeting the Public Sector Internal Audit Standards 2017; and • Meeting the internal audit needs of the Trust. To **consider the major findings of internal audits undertaken** and management's response and their implications and monitor progress of the implementation of agreed recommendations. To consider the **provision of the Internal Audit service and the cost** of the service. To conduct an **annual review** of the Internal Audit function, seeking feedback from Committee members / attendees, Internal Audit and other Trust personnel involved in audits during the year
External Audit	The Committee will **agree with the Council of Governors the criteria for appointing, reappointing and removing auditors**. The Audit Committee should make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the External Auditor alongside the remuneration and terms of engagement. The Committee shall review and monitor the external auditors' **independence and objectivity and the effectiveness** of the audit process. The Committee shall **review the work and findings of the External Auditor** appointed by the Governors and consider the implications and management's responses to their work and monitor progress of the implementation of agreed recommendations.

	Consider the performance of the External Auditor and **report at least annually to the Council of Governors on the continued adequacy or otherwise of the appointed auditors**, including recommendations for the tendering of External Audit services. A review of effectiveness will include seeking feedback from Committee members / attendees, External Audit and other Trust personnel involved in the audit during the year. The Audit Committee will **discuss and agree** with the External Auditor, before the audit commences, of **the nature and scope of the audit** as set out in their Annual Plan, and ensuring co-ordination, as appropriate, with other External Auditors in the local health economy. Discuss with the External Auditors of their **evaluation of audit risks** and assessment of the Trust in line with the tendered audit fee and agreement of any additional work and fees. **Review all External Audit reports**, including agreement of the annual audit letter before submission to the Gateshead Health NHS Foundation Trust Board or QE Facilities Board (as appropriate) any work undertaken outside of the annual audit plan, together with the appropriateness of the management responses. **Develop and implement a policy on the engagement of the external auditor to supply non-audit services**, taking into account relevant ethical guidance and National Audit Office requirements regarding the provision of non-audit services by the external audit firm (noting that assurance work on the Quality Report is classified as a non-audit service but excluded from non-audit service cap threshold set by the National Audit Office).
Counter Fraud (CF)	The Committee shall ensure that there is an **effective Counter Fraud function** established by management, which meets the standards of NHS Counter Fraud Authority. This will be achieved by: • The provision of the CF function. • Review and approval of the CF Annual Plan. • Consideration of the major findings of CF work and fraud investigations, management's response and progress of the implementation of agreed recommendations. • Ensuring that the CF function is adequately resourced. • Annual review of the effectiveness of the CF function.
Regulatory and governance	Review on behalf of the Foundation Trust Board of Directors the operation of, and proposed changes to, the **Standing Orders** and **Standing Financial Instructions**, the **Constitution** and the **Scheme of Delegation**. The Committee will make recommendations to the Foundation Trust Board regarding the adoption of proposed amendments. To **review the findings of other significant assurance functions**, both internal and external to the organisation and consider the implications to the governance of the organisation, where the review is not covered by

	another Board Committee. The Committee shall receive and review the **schedules of losses and special payments** and authorise the Chief Executive and Group Director of Finance to approve any write-offs / special payments. The Committee will seek to **satisfy itself that the Board Committees are operating effectively**, seeking and obtaining appropriate levels of assurance and identifying emerging risks from the business transacted. Assurance will be obtained via: • Review of the **Board Assurance Framework** on a bi-annual basis as part of the wider risk management reporting; • Review of the controls and processes for the development and delivery of the **clinical audit programme** (whose content and outputs are monitored by Quality Governance Committee); and • Access to the **Board committee effectiveness reviews** conducted annually, for information and assurance only (noting that they are also presented to the Board of Directors).

Reporting and monitoring	
Sub-groups	The following sub-groups report into the Committee: • Executive Risk Management Group The summary of assurances and escalations document are received by the Committee as part of the flow of assurance through the Trust's governance structure.
Board reporting	An assurance report from the Committee will be presented by the Chair to the next meeting of the Foundation Trust Board of Directors. Where items considered at the Committee pertain to QE Facilities, a separate assurance report will be submitted to the QE Facilities Board of Directors for consideration (with the Non-Executive Director holding a dual role on Group Audit Committee and QE Facilities Board able to facilitate this).
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 Foundation Trust Board of Directors following considered by the Committee. This will also be shared with the QE Facilities Board of Directors.

	The Gateshead Health NHS Foundation Trust Annual Report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

Committee

Terms of Reference

Gateshead Health NHS Foundation Trust

Quality Governance Committee

Constitution and Purpose – The Quality Governance Committee is a formal committee of the Board with delegated responsibility to monitor, review and make recommendations to the Trust Board with regard to all aspects of quality of clinical care; quality and clinical governance systems; clinical risk issues, research & development; and regulatory standards of quality and safety.

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	December 2023
Review Frequency	Annually
Review and approval	Quality Governance Committee
Adoption and ratification	Board of Directors – January 2024 (TBC)

Membership	The Committee shall be appointed by the Trust Board and shall consist of: • 2 Non-Executive Directors – one with clinical / medical expertise and knowledge to act as Committee Chair • Group Medical Director • Group Chief Nurse • Group Chief Operating Officer A Non-Executive Director shall be nominated as Deputy Chair for the Committee.
Attendance	The following will be expected to attend the Committee on a routine basis: • Deputy Chief Nurse • Deputy Director of Corporate Services and Transformation • Head of Quality and Patient Experience • Head of Risk and Patient Safety

	• Head of Midwifery • Senior Representation from the ICB and NECS to observe Executive Directors and senior managers should ensure that a deputy attends in their absence. Other Executive Directors and Senior Managers may be invited to attend meetings depending upon the issues under discussion. Two nominated Governors will be in attendance at the Committee as observers.
Meeting frequency and quorum	Meetings shall be held **bi-monthly.** Additional extraordinary meetings of the Committee can be called by the Chair in accordance with business need. To be quorate there should be at **least 1 Non-Executive Director** and 2 **Executive Directors** present. Members and regular attendees are expected to achieve **75% attendance** annually.
Meeting organisation	The Committee shall be supported administratively by the Corporate Management Team secretarial body. In accordance with the Trust's Standing Orders, **papers will be circulated to members and attendees six days before the meeting** wherever possible, and no later than three clear days before the meeting, save in emergency. Minutes of the Committee's meetings are held by the Corporate Management Team secretarial body and are circulated (alongside the agenda for the following meeting), to members and attendees.

Committee duties and responsibilities	
Strategy, planning and risk	To **seek assurance over the delivery of the corporate objectives** mapped to the Committee for monitoring at the commencement of the financial year. This includes seeking assurance over the Trust's contribution to tackling **health inequalities** and the **contribution to Gateshead system** working to improve health and care outcomes to the local population. To approve and seek assurance over the **delivery of national and local-level strategies** relating to the remit of the Committee. This

	includes: the Allied Health Professional Strategy; Nursing Strategy; Midwifery Strategy; Cancer Strategy; Quality Strategy and Research and Development Strategy. To **review the sections of the Board Assurance Framework (BAF)** mapped to the Committee for oversight and assurance, triangulating the control and assurance assertions on the BAF with the assurances and risks identified during each meeting. To **review the quality / medical–related risks on the Organisational Risk Register**, seeking assurance over the effective management of these risks towards the achievement of their target scores. The Committee will triangulate the risk registers against the assurances and risks emerging from the meeting for completeness.
Safety	The **Leading Indicators Report** will be used to provide an overview of aspects of safety performance (in accordance with the metrics defined in NHS England and Improvement's Single Oversight Report) and enable spotlight reporting on areas of greatest risk. This report includes maternity and neonatal quality and safety indicators and is also reviewed by the Board (resulting in monthly review of maternity metrics). Seek assurance that the Trust has **effective systems for safety**, with particular focus on quality, patient safety, staff safety and wider health & safety requirements. This should also include routine assurance regarding compliance with **safe staffing levels**. Seek assurance over the **robustness of procedures to ensure that adverse incidents and events are detected, openly investigated, with lessons learned being promptly applied** and appropriately disseminated in the best interests of patients, of staff and of the Trust. To seek assurance that the Trust embeds **learning from deaths** and had a robust process in place which complies with mandatory requirements. To seek assurance that the Trust appropriately **responds to requests and requirements from coroners and other regulatory bodies** in respect of patient safety. To gain assurance that the Trust has in place such systems of work and controls that **ensure medicines are effectively managed** and complaint with legislative requirements. To gain assurance that the Trust has in place such systems of work and controls that **ensure medical devices are effectively managed** and complaint with legislative requirements. To gain assurance that the Trust has in place systems of work and

	controls that ensure **infection prevention and control** is effectively managed and compliant with legislative requirements. To gain assurance that **safeguarding** is compliant with national and local requirements such that patients are safe in the Trust's care. On behalf of the Board the Committee will seek assurance on **maternity services** bi-monthly. This report will include: • Serious Incident key themes • Maternity staffing for all relevant professional groups • Clinical outcomes and compliance • Essential training compliance
Patient experience	The **Leading Indicators Report** will be used to provide an overview of aspects of patient experience metrics (in accordance with the metrics defined in NHS England and Improvement's Single Oversight Report) and enable spotlight reporting on areas of greatest risk. Seek assurance that the Trust has **effective systems for delivering a high quality experience** for all its patients and users, with particular focus on **involvement and engagement** for the purposes of learning and making improvement. To provide assurance to Trust Board that there are robust systems for **learning lessons from complaints**, and action is being taken to minimise the risk of occurrence of adverse events. This should include the **sharing of aspects of good practice identified through compliments** and patient feedback. To seek assurance that the Trust is **delivering high quality care for patients with learning disabilities** in accordance with nationally and locally prescribed standards.
Clinical effectiveness, leadership and training	The **Leading Indicators Report** will be used to provide an overview of aspects of clinical effectiveness and outcomes (in accordance with the metrics defined in NHS England and Improvement's Single Oversight Report) and enable spotlight reporting on areas of greatest risk. Seek assurance that the Trust has **effective systems for monitoring clinical outcomes and clinical effectiveness,** with particular focus on ensuring patients receive the best possible outcomes of care across the full range of Trust activities. To seek assurance over the **effective engagement of clinical leads** in the development and delivery of quality improvement initiatives. To review the **clinical audit plan and progress reports** to support the

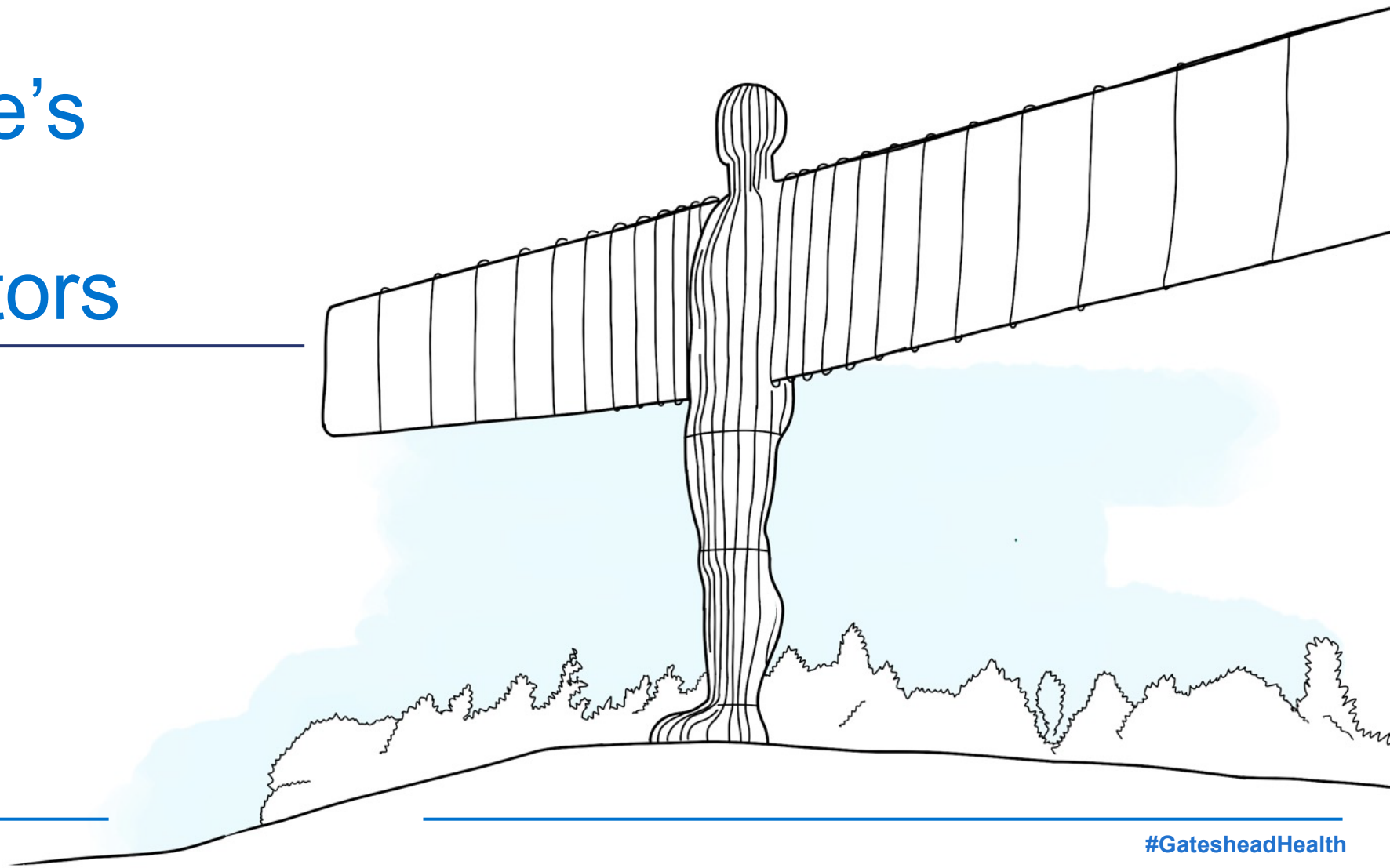
	assurance process regarding effective clinical practice. Through close working with the HR Committee, seek assurance that **statutory and mandatory training requirements** relating to quality of care and clinical practice are being fulfilled.
Regulatory and governance	To monitor, scrutinise and provide assurance to the Trust Board on the Trust's **compliance with core regulatory standards**, including the Care Quality Commission's Fundamental Standards, quality-related elements of NHS England and Improvement metrics and NICE guidance. On behalf of the Board, take a lead role in **seeking assurance that the Trust's annual Quality Report is compliant with regulatory requirements**, reflective of the main achievements and challenges during the year and has been appropriately consulted upon. To triangulate through assurance the **robustness of quality-assurance processes relating to all research undertaken** in the name of the Trust and / or by its staff, in terms of compliance with standards and ethics, and clinical and patient safety improvement processes. To receive an annual assurance report on the compliance with the NHS England and Improvement '**Developing Workforce Safeguards'** requirements. 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 **feedback from NHSI** relating to quality and safety. To review any material **emerging regulatory guidance / requirements** in relation to quality and clinical matters on behalf of the Board.

Reporting and monitoring	
Sub-groups	The following sub-groups report into the Committee: • Mental Health Act Compliance Group • Nursing, Midwifery and AHP Professional Forum • Group Health and Safety Committee

	• Infection, Prevention and Control Committee • Safeguarding Committee • Mortality and Morbidity Steering Group • Safecare, Risk and Patient Safety Council The minutes and summary of assurances and escalations documents are received by the Committee as part of the flow of assurance through the Trust's governance structure. The Committee will receive detailed assurance reports from the Mental Health Act Legislation Committee.
Board reporting	An assurance report from the Committee will be presented by the Chair to the next meeting of the Board of Directors.
Monitoring	Compliance with the terms of reference will be reviewed via an annual self-assessment. This will inform any proposed revisions to the terms of reference and the cycle of business. The outcome of the effectiveness and terms of reference review is presented to the Board of Directors following consideration by the Committee.

NHS
Gateshead Health
NHS Foundation Trust

Chief Executive's Update to the Board of Directors



Trudie Davies, Chief Executive

31 January 2024

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

NHS Gateshead Health NHS Foundation Trust

- Our paediatric department has become the first in the region to be awarded the '**Gold Standard for Autism Acceptance**' from the North East Autism Society. This reflects the work the team have undertaken to tailor care and experience for neurodivergent children.
- In December 2023 we celebrated **80 years of our maternity unit** providing high quality care to families across our community.
- We received a **National Joint Registry (NJR) Quality Data Provider certificate** which recognises our successful completion of a national programme of local data audits. The registry collects high quality orthopaedic data in order to provide evidence to support patient safety, standards in quality of care, and overall value in joint replacement surgery.
- Held an engagement event for clinical colleagues and managers to support us in identifying the most appropriate **electronic patient record** system for the Trust.
- We rebranded and relaunched our charity, which is now called **Gateshead Health Charity**. This signifies our commitment to improving the experience of our patients, visitors and staff by providing resources that go beyond the statutory requirements of the NHS.

Engagement, involvement and visits:

- Charity relaunch
- Meeting with patient and family
- Electronic patient record engagement event

GATESHEAD HEALTH CHARITY

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

NHS Gateshead Health NHS Foundation Trust

- Thank you to all of our colleagues and volunteers who worked very hard over the busy holiday period to provide the highest quality care to our patients, both in the hospital and in the community.
- We experienced a challenging period of **strike action** in December and early January. Whilst there were some unavoidable cancellations of elective appointments, our teams worked very hard to keep our patients safe and prioritise those requiring emergency treatment during this time.
- We welcomed our **new Governors** at the beginning of January.
- We are continuing our commitment to work with our trade unions and colleagues on the implementation of the national **Health Care Assistant regrading** process.
- We are delighted to announce that Karen Parker has been appointed substantively to the **Head of Midwifery** role and commenced in post on 1 January 2024.
- Our **Medical Director**, Andy Beeby, has announced his retirement after nearly 30 years at the Trust and 38 years in the NHS. He will be leaving us in March and we wish him a very happy retirement on behalf of the Board, Council of Governors and all colleagues.
- We have continued our focus on developing a **zero-tolerance culture** and empowering colleagues to challenge inappropriate behaviour.

Engagement, involvement and visits:

- Tea and chat
- Facebook Live
- Light up a Life event
- Vascular access team
- Infection prevention and control team
- Medical Education training event

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

- We are currently engaged in the **annual planning process**. At the time of writing the national planning guidance has not been published, but we are continuing to develop our plans internally, engaging widely on our future priorities. This has included engagement sessions with our Council of Governors, Clinical Strategy Group and Senior Management Team. The principles of being clinically-led and management supported are at the heart of the planning process.
- We have been undertaking some focussed work around **counting and coding** using our clinically-led and management supported principles. This is a key workstream which helps us to accurately represent activity to ensure we are providing safe and high quality care to our patients.
- This year we have been focussed on developing our strategic intent, embedding our clinically-led and management supported methodology, getting the basics right (back to basics), enhancing our governance and ensuring that our culture is aligned with our values. We are seeing this focus translating into key improvements in the domains of performance, quality, people and finance. This includes:
    - Key reductions in our waiting list size, including community-based services – the biggest percentage improvement in the region at present;
    - Increased productivity across a number of metrics, which has a direct impact on our patients;
    - Being the second best performer in the region for diagnostics;
    - Improvements in A&E performance, particularly in relation to ambulance handovers and a significant reduction in 12 hour waits for a bed;
    - Reductions in our vacancy rate from 5.7% to 2.5%; and
    - Being on track to achieve our planned deficit at the end of the financial year.
- We recognise that there is more to do to ensure sustainability in these areas and our planning will be key to this.

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

- In January, we announced our intention to pursue an **alliance** model of working with Newcastle, Northumbria and North Cumbria Foundation Trusts, as a means of improving collaboration and working towards financial and operational sustainability.
- We welcomed partners from Gateshead Council, the Integrated Care Board and the Provider Collaborative to the Trust in December. Our partners joined us in a **festive tour** of the Trust to thank our colleagues for their hard work, see our facilities and hear about some of the work we have been doing.
- We have committed our support to the **Health and Life Sciences Pledge** in the region. This brings together partners from across the wider health and care system with the aim of collectively addressing the region's health and social care challenges. There is an ambition to reduce health inequalities, attract and drive investment and promote economic growth.
- We were delighted to welcome **Newcastle College's performing arts group** who provided some festive cheer to patients on our stroke unit, boosting morale and helping patients to engage in activities during their time in hospital.
- As part of our commitment to addressing **health inequalities** we are undertaking a self-assessment against the health inequalities toolkit which has been developed as part of the North East and North Cumbria multiagency response to tackling health inequalities. The assessment against the toolkit will inform our operational planning.
- We held our first relaunched **Medicine for Members** event in December with an interesting insight into Research and Development, as well as opportunities for members and the public to meet with our Governors.
- We continue our commitment to contribute to the **prevention agenda** for our community through initiatives such as our Alcohol Care Team, Smoking Cessation Team, Refugee and Asylum Seeker Nurse and Homelessness Nurse.

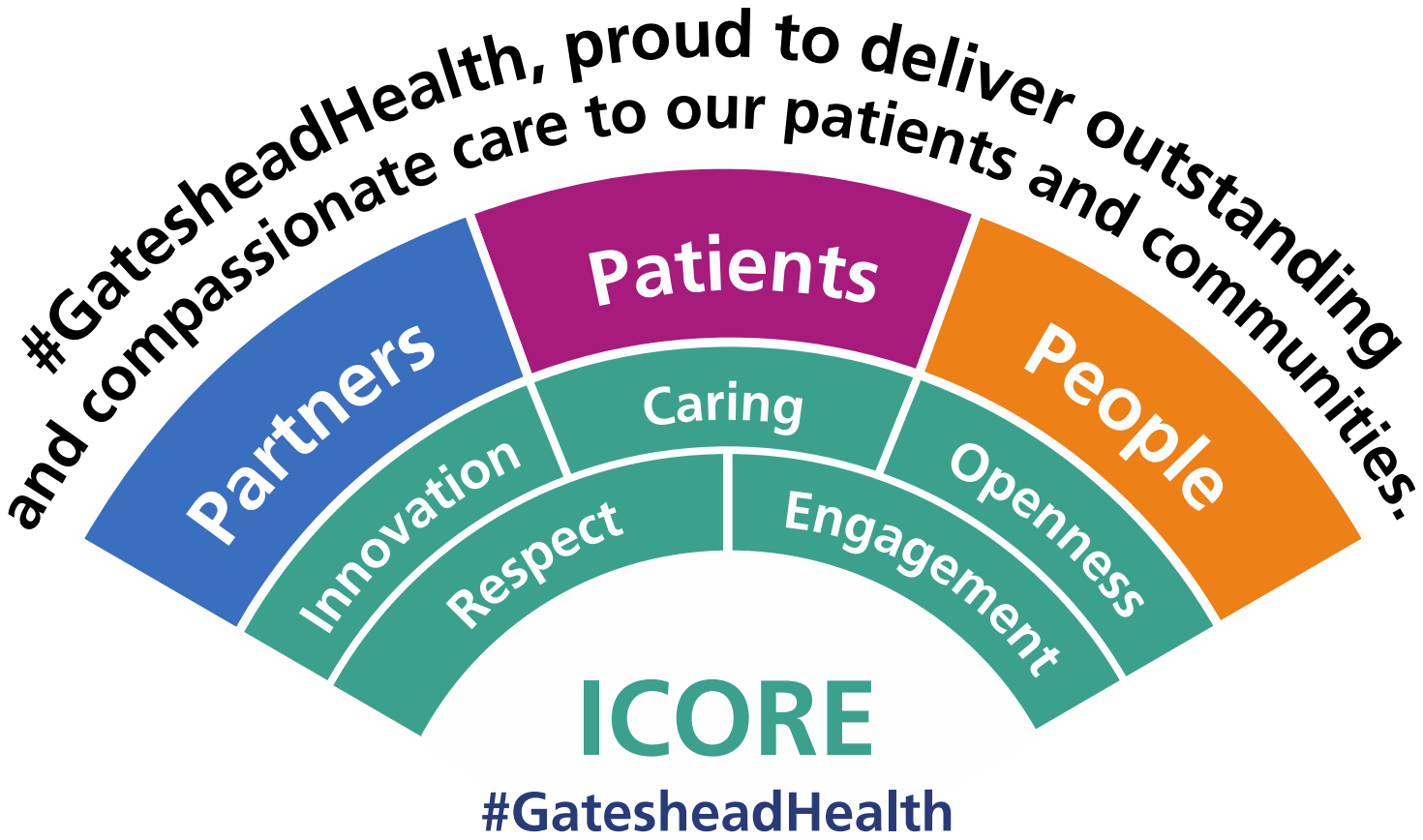
Engagement, involvement and visits:

- Festive tour with partners
- Meetings with Gateshead Council
- Provider Collaborative meetings
- Meetings with provider colleagues in the region

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

- We are making good progress with the **Community Diagnostic Centre (CDC)** at the Metro Centre in partnership with colleagues in Newcastle Hospitals. The CDC will have significant benefits to patients in Gateshead and Newcastle, enabling increased diagnostic capacity for our patients. This links directly with our strategic intent to be a diagnostics centre of choice for patients.
- We are continuing our work to become the **Northern Centre of Excellence for Women's Health**, which is a clear part of our strategy and sustainability plan. We have secured £250k to develop our women's health hub. The first oversight meeting has now been held which included partners from primary care, public health and the voluntary sector, with the aim of identifying the areas that would make the biggest difference to women and girls in Gateshead.

Gateshead Health
NHS Foundation Trust



Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 12i

Report Title:	Organisational Risk Register (ORR)			
Name of Meeting:	Board of Directors			
Date of Meeting:	31st 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 now received in the Executive Team Meeting each week, and at the Executive Risk Management Group meeting every month.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience*	Accompanying Report shows the following and is detailed within this report. Risks on the ORR were comprehensively discussed at previous two ERMG meetings in December and January, and the following updates and movements agreed:			

<table>
<tr><td>

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

</td><td colspan="6">-There were 2 risks added, 1 risk removed, and 3 risks reduced, demonstrating active management of organisational risks as part of risk management framework.

-actions that have been completed in period are shown (shaded) within the risk register on the accompanying report.

-Risks are actively being reviewed and managed as per policy timeframes.
Compliance with risks reviews 89%.
Compliance with actions reviews 100%</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 Board are asked to:

• Review the risks and actions on the attached report and discuss and seek further information relating to risks as appropriate.
• Take assurance over the ongoing management of risks on the ORR.
• Be clearly sited on the top 3 risks for the organisation.
• Note for information, initial findings from internal audit (Audit one) for 2023.</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">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 colspan="2">Well-led
☒</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">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 colspan="2">Not applicable
☒</td></tr>
</table>

Organisational Risk Register

Executive Summary

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

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

Internal Audit of Risk Management and the Board Assurance Framework undertaken in November 2023 initial findings have concluded that Governance, risk management and control arrangements provide a good level of assurance that the risks identified are managed effectively. A high level of compliance with the control framework was found to be taking place.

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

This report covers the period 17th November 2023- 17th January 2024 (extraction date for this report).

Organisational Risk Register – Movements

Following ERMG meetings in December 2023 and January 2024, there have been 2 additions to the ORR, 2 reductions and 1 removal.
There are currently 18 risks on the ORR, nine of which have a current score of 16 agreed by the group as per enclosed report.

New additions:
2 newly added high risks for Digital

- **3313 (Digital)** Risk of breaching legislative requirements due to lack of long term strategic approach to the management and storage of health records [both digital and paper]. This could lead to regulatory and reputational harm. (16)

- **3310 (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)

Reductions in score

Risk reduced from 16 to 12:

- **3255 (CEO)** There is a potential for people to lose trust and confidence in our services as a result of recent reports and incidents (12)

-thematic review and a delivery plan has been developed and shared with ICB

Risk reduced from 20 to 16:

- **3277 (CSS)** Risk of losing MRI provision due to temporary closure of department for essential refurbishment. This will result in reduced capacity and productivity. (16)

-mobile scanner on site
-Negotiating reducing onsite scanner downtime with contractors
-Discussions ongoing to agree an SLA with NUTH

Risks removed- managed locally.

- **2993 (CEO)** Risk of potential non-compliance with current legislation and guidance as a result of policies not being up to date (8)

-removed from ORR.
-Compliance with reviews sits above 90% therefore reducing the likelihood.

Risks closed in period:

0 risks closed in period

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

Finance - 3 significant financial risks on the ORR.
Performance – Risk of delivery of performance targets (collective activity)
Workforce – Continued and prolonged industrial action could lead to harm

1. **Finance:**

- **3127 (Finance)** There is a considerable risk that the trust will not be able to meet the planned trajectory of £12.588m adjusted deficit. (16)

-Overarching financial risk, and with 3 financial risks on the ORR, there is significant emphasis on financial implications as an organisation.

2. **Performance:**

- **3261 (P+P)** There is a risk that the Trust will not achieve zero > 52 week waiters by March 2024. (12)

-There has been a significant increase in waiting times and access to various patient services across the organisation which could result in patient harm and reduced quality.

3. **Workforce:**

- **3095 (POD)** Risk to quality of care and service disruption due to Industrial Action of various trade unions across various sectors affecting staffing levels and potential impact on patient care, safety and quality (16)

-Continued and prolonged industrial action has the potential to cause significant disruption to services, as well as potential harm to staff and service users.

Current compliance with Risk reviews:

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

Risk and action review compliance is currently at 89% and 100% consecutively. This is an improvement on last reporting period.
Actions are assigned to all risks.
Support with reviews continues to be offered by Corporate and Clinical Risk Lead where able.

Recommendations

The Board of Directors are asked to:

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

Organisational Risk Register Report

Reporting Period: 01-Jan-2024 to 17-Jan-2024

Gateshead Health NHS Foundation Trust

Risk Profile (Current/Managed)

Resources - 1

POD 2764 - Risk of not having clearly agreed workforce plans for the next 3, 5 and 10 years. (16)

Staff Safety - 1

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

Wellbeing - 1

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

Business Continuity - 2

IMT 1636 - Malware such as Ransomware Compromising Unpatched Endpoints, Servers and Equipment (10)

ESTFAC 3186 - There is a risk to ongoing business continuity of service provision due to ageing trust estate (12)

Digital - 1

COO 2945 - Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI. (12)

Finance - 3

FIN 3102 - Activity is not deliverved in line with planned trajectories, leading to reduction in income (16)

FIN 3103 - Risk that efficiency requirements are not met. (16)

FIN 3127 - There is a considerable risk that the Trust is unable to meet the financial projections included in its plan. (16)

Information Governance - 1

IMT 3310 - Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure. (16)

No Risks

Effectiveness - 1

MEDIC 2982 - Risk of delayed transfers of care and increased hospital lengths of stay (16)

Experience - 1

CEOL2 3255 - People may lose trust an confidence in our services (12)

Safety - 4

CSS 3277 - Risk of no MRI facility in the hospital (16)

NMQ 3089 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures. (12)

POD 3095 - Risk of Significant, unprecidented service disruption due to industrial action (16)

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

Compliance - 1

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

Information Governance - 1

IMT 3313 - Inability to support legislation and best practice associated with records management (16)

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

Organisational Risk Register Report

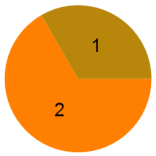
Reporting Period: 01-Jan-2024 to 17-Jan-2024

Gateshead Health NHS Foundation Trust

People & Resources

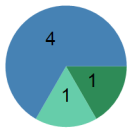
Sub Category

Cause



Quality Outcomes

Sub Category



Cause

Finance & Efficiency

Sub Category

Cause

Regulation & Compliance

Sub Category

No Data Available

Cause

No Data Available

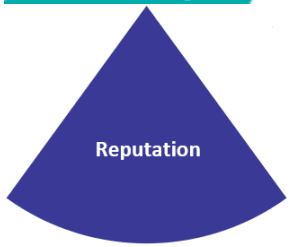
Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
IRR - Initial Risk Rating **TRR** - Target Risk Rating

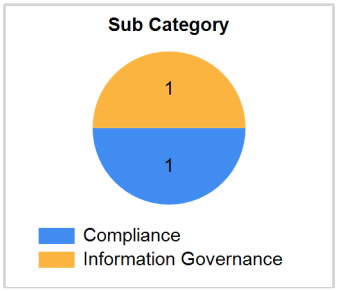
Business Intelligence

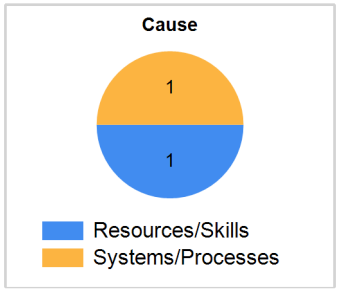
Organisational Risk Register Report

Reporting Period: 01-Jan-2024 to 17-Jan-2024

Gateshead Health NHS Foundation Trust







Organisational Risk Register Report

Reporting Period: 01-Jan-2024 to 17-Jan-2024

Gateshead Health NHS Foundation Trust

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

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

Organisational Risk Register Report

Reporting Period: 01-Jan-2024 to 17-Jan-2024

Gateshead Health NHS Foundation Trust

2764 17/11/2020 Natasha Botto People and OD Human Resources 20/01/2024 BAF ORG HRC QGC SA1.1 Continue to improve our maternity services in line with the wider learning from the Ockenden review, SA1.2 Continuous Quality improvement plan, SA2.2 Growing and developing our workforce	Risk that not having a clearly agreed workforce plans for the next 3, 5 and 10 years as a result of a lack of a robust workforce planning framework and agreed approach could result in a lack of a sustainable workforce model that is fit to meet future service needs.	20	International recruitment team established and well embed within the organisation, providing a regular supply pipeline. Domestic recruitment actively pursued and monitored. Strategy to over recruit to HCSW position. Registered Nurse Degree apprenticeship programme agreed. School and local community supply initiatives in place to attract the Trust's future workforce. Refreshed absence management policy and focused support absence management rolled out across the Trust to ensure we maximise the availability of our current workforce. Local pay arrangements agreed during times of pressure/areas where we struggle to recruit and retain. Consideration given to a strategic workforce planning approach as part of the work that was undertaken with the Whole Systems Partnership. Operational workforce plan submitted as part of the 2023-24 Operating Planning submission. Focus on growing and developing our workforce in the Trust's People Strategy and in the Trust's Strategic Aim 2.2, with associated actions. NHS Long Term Workforce Plan published to set a direction of travel and commit to an ongoing programme of strategic workforce planning. November 2023- AV- Trust Interim Director of Strategy and Planning appointed and working closely to agree an integrated Trustwide approach to planning, including finance and performance	16	Develop systems, processes and comms to support increasing exit interview completion rates across the Trust	Natasha Botto 31/01/2024	8	d/w AV score to remain the same at present, query to reduce at next review following planning round.
					Transfer Window - establish as is position and action required to progress and operationalise	Sarah Neilson 31/01/2024		
					Review current retention offer and scope retention offer moving forward.	Natasha Botto 31/01/2024		
					Work with Director of Strategy, Planning and Partnerships to explore broader approach to planning Trust wide and how we align the workforce planning approach to this	Natasha Botto 28/02/2024		
					Education, learning and Workforce development group to continue work on the implications of the LTWFP and share proposals.	Sarah Neilson 31/03/2024		

Organisational Risk Register Report

Reporting Period: 01-Jan-2024 to 17-Jan-2024

Gateshead Health NHS Foundation Trust

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
2982 06/12/2021 Mark Dale Medical Services Medical Services - Divisional Management 29/01/2024 BAF BU_DIR COO FPC ORG SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans, SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population	Risk of delay in transfer to community due to lack of social care provision and intermediate care beds, due to increased numbers of patients awaiting POC up to 30 patients in medical wards. This delay adds significant pressures to acute bed availability, escalation beds being required and significant risk of problems with flow through hospital impacting A&E breach standards and risk of patients being delayed within ambulances. This could result in patients remaining in hospital when medically optimised creating risk to these patients as well as other patients as bed capacity not able to meet demand. There is also a risk of patients deconditioning, resulting in failed discharge secondary to this. This could lead to increased pressures on nursing teams as well as poor patient experience and quality.	20	Daily meeting with LA to examine capacity in out of hospital system and match with demand for discharges. Target discharges of 40 per week to keep pace with demand. Monitoring of Delayed transfers of care twice weekly meeting Escalation of delays of care to the community BU and social services at twice weekly meetings. Monitoring of Breach levels and times. Monitoring of Ambulance delays. Monitoring increased LOS of medically optimised patients. Escalation of patients requiring social services support raised weekly at Discharge Systems group which includes Social services management and ICB representative. Medically Optimised meeting 2x week, passed to IPC/ICB Pilot on 2 wards re improving discharges.	16	Weekly stranded patient meeting Escalation to system partners	Rachel Thompson 29/01/2024 Joanna Clark (Completed 20/11/2023)	9	Focused work continues to reduce delays Stranded patient meeting in place Daily discusion at 10.30 patient flow meeting Director works across community and medicine

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

Organisational Risk Register Report

Reporting Period: 01-Jan-2024 to 17-Jan-2024

Gateshead Health NHS Foundation Trust

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
3095 26/07/2022 Amanda Venner People and OD Workforce Development 09/02/2024 BU_DIR EPRR ORG HRC QGC SA1.2 Continuous Quality improvement plan, SA2.1 Protect and understand the health and well-being of our staff by looking after our workforce, SA2.2 Growing and developing our workforce	Risk to quality of care and service disruption due to Industrial Action of various trade unions across various sectors affecting staffing levels and potential impact on patient care, safety and quality.	**20**	Industrial action working group established and meeting regularly. Focused planning sessions have taken place to explore the planning, response and recovery elements of industrial action with reasonable worse case scenarios considered. A detailed work plan has been produced with a number of actions, lead officers and timescales. Set up of command and control and coordination (wef 12/12/2022). Local strike committee in place (wef 09/05/2022). Citrep position updated daily during period of IA. Business continuity planning, including an EPRR work place that runs along each period of IA. Command and control structure standards up in the event of IA. Close partnership working and regular local discussions with staff-side and respective trade union representatives as part of the IA Internal Working Group and the Sub-group of the JCC. Cancellation of some elective services to reduce need for junior medical staff. Consideration of utilisation of other staffing sources- consultants and/or specialist nurses and pharmacy support. Review of on call teams.	**16**	Support twice weekly co-ordination cell and fortnightly industrial action Trust wide working group.	Amanda Venner 09/02/2024	**8**	reviewed as part of ERMG - no change. remains dynamic.

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

Organisational Risk Register Report

Reporting Period: 01-Jan-2024 to 17-Jan-2024

Gateshead Health NHS Foundation Trust

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
3102 22/08/2022 Kris MacKenzie Finance Finance 20/01/2024 BU_DIR FPC ORG SA3.2 Achieving financial sustainability	Activity is not delivered in line with planned trajectories, resulting in the Trust having reduced access to core funding.	20	Active and in depth monitoring of activity information underway. Review of business units plans to deliver activity trajectories reviewed as part of monthly oveersight meetings. Activity achievement to be reviewed fortnightly at performance focussed SMT meeting. CRP project in development to strengthen counting and coding. november 2023- access and performance clinic work underway.	16	Timley and detailed reporting information Counting and Coding Review	Jane Fay 31/03/2024 Nick Black 31/03/2024	6	discussed at ERMG. no chane to remain on ORR
3103 22/08/2022 Kris MacKenzie Finance Finance 20/01/2024 BU_DIR COO FPC ORG SA3.2 Achieving financial sustainability	Efficiency requirements are not achieved.	20	Efficiency delivery closely monitored as part of month end reporting. Weekly CRP working group in place to ensure traction, delivery and ongoing engagement. SMT meeting to focus on performance on a fortnightly basis.	16	delivery oversight group and finance focus sessions	Kris MacKenzie 01/02/2024	9	Risk remains, althought there is a fully costed plan to deliver CRP, it has not yet been transacted and the plan is mainly non-recurrent.
3127 17/10/2022 Kris MacKenzie Finance Finance 20/01/2024 BAF BU_DIR FPC ORG SA3.2 Achieving financial sustainability	There is a considerable risk that the trust will not be able to meet the planned trajectory of £12.588m adjusted deficit. Contributory risks include delivery of planned elective activity limiting access to income, delivery of CRP, impact of inflation, realisation of mitigations and cost of ongoing service pressures resulting from unscheduled care activity and further periods of industrial action.	20	Financial performance being managed in line with the financial accountability framework. Accountability for performance part of the divisional oversight meetings discussions.	16	Delivery of financial mitigations inherent in plan Monitoring and modelling of impact of industrial action Comprehensive cost analysis	Jane Fay 31/03/2024 Jane Fay 31/03/2024 Jane Fay 31/03/2024	4	d/w F+P committee and agreed to reduce. formal agreement at ERMG to lower risk to 16. remain on ORR

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

Organisational Risk Register Report

Reporting Period: 01-Jan-2024 to 17-Jan-2024

Gateshead Health NHS Foundation Trust

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
3277 14/08/2023 Phil Davidson Clinical Support & Screening Diagnostics 16/02/2024 BU_DIR COO FPC HSC ORG QGC SA1.2 Continuous Quality improvement plan	Risk of losing MRI provision due to temporary closure of department for essential refurbishment. This will result in reduced capacity and productivity. This could have significant consequences for inpatients requiring an MRI scan, and will increase waiting times for outpatient scans. This could have consequences for a number of patient pathways,including FDS pathways.	20	Recovering scanning capacity from NuTH on the mobile provision at BPCC. Negotiating reducing onsite scanner downtime with contractors. Mobile scanner will be on site for 19 weeks. Tunnel erected by QEF to connect Mobile unit to hospital. full assessment by engineer underway 16/01/2024	16	Finalised plans Identify contractor to complete works Check pad	Anthony Pratt 31/01/2024 Anthony Pratt (Completed 15/12/2023) Phil Davidson (Completed 15/12/2023)	8	Mobile scanner magnets not working, scans cannot be done. Engineer due onsite today to assess. ? Extensive repair required, will be at least 2 days. So we are still at risk of having no MRI scanning capacity (for all patients). risk remains significant
3310 21/11/2023 Dianne Ridsdale Digital Digital Transformation and Assurance 24/12/2023 BAF BU_DIR DIGC ORG SA1.3 Digital where it makes a difference	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.	20	Trust Policies, procedures, guides, materials and tools. Staff training, awareness and communication programmes Internal and external auditing and IG spot check programme	16	Identify and bring resources in to support the services to complete their IARs/DFMs Getting IAOs to take ownership of their information assets	Dianne Ridsdale 31/01/2024 Nick Black 31/01/2024	4	score agreed as 16 following digital risk meeting with CB. added to ORR

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

Organisational Risk Register Report

Reporting Period: 01-Jan-2024 to 17-Jan-2024

Gateshead Health NHS Foundation Trust

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
3313 24/11/2023 Mark Smith Digital Health Records 31/01/2024 BU_DIR DIGC ORG SA1.3 Digital where it makes a difference	Risk of breaching legislative requirements due to lack of long term strategic approach to the management and storage of health records [both digital and paper]. This could lead to regulatory and reputational harm.	20	Action to scope and procure an EPR to support robust record management requirements [Record Lifecycle - creation to destruction]	16	scope and procure an EPR	Mark Smith 31/01/2024	8	replaces risk 1797 as per ERMG. score agreed by K Mac and added to the ORR. actions from closed risk transfered.
					map out current health record sources	Mark Smith 31/03/2024		
					develop FBC for clinical system	Nick Black 30/04/2024		
					implement single document store	Adam Charlton 30/04/2024		
2373 01/08/2018 Laura Farrington People and OD Workforce Development 19/01/2024 BU_DIR HSC ORG QGC HRC SA2.1 Protect and understand the health and well-being of our staff by looking after our workforce	Staff exposure to incidents of violence and aggression from patients and visitors. Risk of harm to staff, risk to staff well-being through challenging behaviour demonstrated by some patients and/or visitors to ECC resulting in injury, increased absence from work, potential effect on recruitment and retention of staff, staff morale and confidence	20	policies in place to support staff training available reporting tools available forums for debrief/discussion and support available	15	Policy review -to include clinical teams, group policy	Lee Taylor 31/01/2024	6	d/w AV- no change to risk

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

Organisational Risk Register Report

Reporting Period: 01-Jan-2024 to 17-Jan-2024

Gateshead Health NHS Foundation Trust

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
2398 28/12/2018 Kate Hewitson Surgical Services Obstetrics 29/02/2024 BAF BU_DIR COO ORG QGC SA1.1 Continue to improve our maternity services in line with the wider learning from the Ockenden review, SA1.2 Continuous Quality improvement plan	There is a risk of delayed treatment due to maternity estate being a separate building resulting in the potential for severe harm to mothers and babies. Rising acuity of maternity patients and more frequent use of CCU, theatre staff and Paediatric teams creates additional likelihood of the need for these teams to attend the maternity department and delays to be incurred.	20	Pre-assessment - Women deemed likely to require critical care after elective procedures have their operation in main theatre to allow swift access to critical care. This only applies to elective patients and not emergency procedures or those in spontaneous labour. Any incidents are investigated to identify potential learning. major haemorrhage protocols in place	15	2861 action re looking into estate options	Kate Hewitson 03/06/2024	5	D/W RP no change.
2945 14/09/2021 Debbie Renwick Chief Operating Officer Planning & Performance 28/01/2024 BU_DIR FPC ORG SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans	Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely business intelligence to deliver and improve services	15	Programme of work established to work on improving access to BI and improve board reporting along with service line access to quality performance and workforce data Project Manager appointed to lead on this work with support from NECS. Programme involves 3 projects Static reporting – Look back - this is what we achieved Live reporting – this is how we are doing now and where we need to intervene to prevent poor performance Forecasting – these are the trends to be able to plan services much more effectively to meet demand the later two points need further development Some BI available in sitreps and excel format	12	• Work with the BU managers looking at what is available and start to build what is needed and get rid of what is not used/helpful	Debbie Renwick 31/01/2024	3	This Risk is currently being re-written. Draft with KM/MM for review (29/12)

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

Organisational Risk Register Report

Reporting Period: 01-Jan-2024 to 17-Jan-2024

Gateshead Health NHS Foundation Trust

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
3089 25/07/2022 Gillian Findley Nursing, Midwifery & Quality Quality Governance 29/02/2024 BAF BU_DIR ORG QGC SA1.2 Continuous Quality improvement plan	Quality - There is a risk of quality failures in patient care (patient safety, patient experience and effectiveness) due to external causes such as delayed discharges and pressures from other Trusts resulting in patient harm, regulatory action, and reputational impact	15	Daily report provided detailing all delayed discharges within the Trust. regular meetings now established with social care. Discharge liaison staff available to support wards and facilitate earlier discharge.	12	implementation of winter plan	Jo Halliwell (Completed 28/12/2023)	6	surge plan is in place and is being managed.
3186 07/02/2023 Steven Harrison QE Facilities Estates 02/02/2024 BU_DIR COO FPC ORG SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans, SA3.2 Achieving financial sustainability	There is a risk to maintaining business continuity of services and recovery plans due to the estate infrastructure, age and backlog maintenance requirements which exceed the Trusts capital allocation.	16	Clinically led estates strategy developed and prioritsied on priority versus affordability	12	commission full estates review as part of Bensham retraction programme	Anthony Pratt 30/04/2024	6	No update - progressing with capital programme in 2023-24 and looking at requirements for 2024-25 programme.
3255 27/06/2023 Gillian Findley Chief Executive Office Chief Executive Office 27/01/2024 BU_DIR ORG QGC	There is a potential for people to lose trust and confidence in our services as a result of recent reports and incidents.	20	ICB have been notified and a risk escalation meeting was enacted. The Trust has included these concerns in a thematic review and a delivery plan has been developed. Plan is for enhanced surveillance to be stood down after next meeting.	12	monitor implementation of thematic review delivery plan	Gillian Findley 30/04/2024	8	risk reviewed and updated
					complete thematic review actions	Gillian Findley (Completed 27/12/2023)		

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

Business Intelligence

Organisational Risk Register Report

Reporting Period: 01-Jan-2024 to 17-Jan-2024

NHS Gateshead Health NHS Foundation Trust

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
3261 05/07/2023 Chief Operating Officer Planning & Performance 01/01/2024 BU_DIR FPC ORG QGC SA1.2 Continuous Quality improvement plan, SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans	There is a risk that the Trust will not achieve zero > 52 week waiters by March 2024. There are a number of services projecting long waiters over planned levels for multiple reasons Industrial Action, capacity deficits, workforce issues. This could result in patients waiting too long for treatment (potential for harm and litigation claims) and potential reputational damage for the Trust.	20	Performance clinics established to support overall delivery plans, recovery actions and future projections. Weekly Access & Performance Meetings: Progressing actions with relevant Service Lines at Risk.	12	work with BUs to explore mutual aid and independent sector supportesidual actions- mutual aid	Debbie Renwick 26/01/2024	8	Weekly A&P meeting managing risk of lost capacity IA IS and mutual aid sought / pooled lists for 'at risk' specialties Current forecasts included in A&P Output files to expedite risks.
					Theatre roadmap aligning capacity and productivity to delivery plan	Debbie Renwick (Completed 29/12/2023)		
3298 24/10/2023 Amanda Venner People and OD Workforce Development 28/01/2024 BU_DIR ORG HRC SA2.1 Protect and understand the health and well-being of our staff by looking after our workforce	There is a risk that promoting an environment that encourages speaking out and creating a psychologically safe culture may lead to increased reports of poor behaviour. This could have a negative impact on staff and require addiitional time and capacity to appropriately address the concerns. This could result in further health and well being concerns and staff absence.	15	Zero-Tolerance Campaign underway, focusing on clarifying expectations and providing training and support for colleagues in identifying and responding to bullying, harassment and discrimination from colleagues, patients or service users. Establishment of a full time, permanent Freedom to Speak Up Guardian and increasing number of FTSU Champions, creating an increasing number of avenues for colleagues to report incidents.	12	Deliver training for managers	Laura Farrington 31/01/2024	6	reworded as d/w AV.
					Review existing Bullying & Harassment policy	Natasha Botto 01/02/2024		
					Create a zero-tolerance campaign	Laura Farrington 29/02/2024		
					EDI strategy to be developed	Amanda Venner 31/03/2024		
					ICS EDI programme to be fully scoped and network chairs supported	Amanda Venner 31/03/2024		
					Embed FTSU Champions within the Organisation	Tracy Healy 01/04/2024		

Organisational Risk Register Report

Reporting Period: 01-Jan-2024 to 17-Jan-2024

Gateshead Health NHS Foundation Trust

Organisational Risk Register (sorted by highest CRR and risk ID) - Current/Managed Risks

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
1636 10/11/2014 Dianne Ridsdale Digital Digital Transformation and Assurance 25/10/2024 BU_DIR DIGC MDMG ORG SA1.3 Digital where it makes a difference	There is a risk of potential exposure to published critical cyber vulnerabilities. Laptops, workstations and medical devices compromised by ransomware or botnets, due to endpoints being susceptible to compromise through the use of obsolete, old, or unpatched operating systems and third party software, including Java. Endpoints often not monitored for patch status. Endpoints compromised more easily through dangerous browser plugins (such as Java, Flash), or unsupported browsers. Servers compromised by ransomware, due to servers susceptible to compromise through the use of obsolete, old, or unpatched operating systems and software. Servers often not monitored for patch status. Due to failure to maintain all Digital assets, including installing Operating system patches, AV patches or other software and hardware updates across the IT estate, including network equipment and medical devices. Resulting in potential harm to patients, data leaks, impacts on service delivery.	15	AV on all end points AV up to date ATP in place site wide NHSD & Microsoft group policy templates Ongoing updates routinely planned as they are released Patching regime Network fully supported and maintained	10	Review trust asset register for EOL hardware/Software	Mark Bell (Completed 25/10/2023)	5	discussed at ERMG- to be reviewed by Digital and potentially removed from ORR
								18

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

Organisational Risk Register Report

Reporting Period: 01-Jan-2024 to 17-Jan-2024

Gateshead Health NHS Foundation Trust

Changes to CRR in Period - Current/Managed Risks

**If a risk has changed CRR multiple times within the period, it will appear more than once*

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note	PRR
3277 14/08/2023 Phil Davidson Clinical Support & Screening Diagnostics 16/02/2024 BU_DIR COO FPC HSC ORG QGC SA1.2 Continuous Quality improvement plan	Risk of no MRI facility in the hospital	20	Recovering scanning capacity from NuTH on the mobile provision at BPCC. Negotiating reducing onsite scanner downtime with contractors. Mobile scanner will be on site for 19 weeks. Tunnel erected by QEF to connect Mobile unit to hospital. full assessment by engineer underway 16/01/2024	16	Finalised plans	Anthony Pratt 31/01/2024	8	Mobile scanner magnets not working, scans cannot be done. Engineer due onsite today to assess. ? Extensive repair required, will be at least 2 days. So we are still at risk of having no MRI scanning capacity (for all patients). risk remains significant	20
					Identify contractor to complete works	Anthony Pratt (Completed 15/12/2023)			
					Check pad	Phil Davidson (Completed 15/12/2023)			
									1

Risks Moved to Managed in Period

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR
							0

Risks Closed in Period

Organisational Risk Register Report

Reporting Period: 01-Jan-2024 to 17-Jan-2024

Gateshead Health NHS Foundation Trust

Risk ID / Date Identified	Risk Description / Risk Name	IRR	Current Controls	CRR	Action	Action Owner / Action Due (Open Actions)	TRR	Closure Details
Handler BU Service Line Next Review Date BAF / Risk Register Objectives								
								0

Risks Added in Period

Risk ID / Date Identified	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note / Date Added to ORR
Handler BU Service Line Next Review Date BAF / Risk Register Objectives								
								0

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

Organisational Risk Register Report

Reporting Period: 01-Jan-2024 to 17-Jan-2024

Gateshead Health NHS Foundation Trust

Risks Removed in Period

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note / Date Removed from ORR
2993 28/01/2022 Kirsty Roberton Chief Executive Office Corporate Services & Transformation 08/02/2024 BAF BU_DIR SA1.2 Continuous Quality improvement plan	Risk of potential non-compliance with current legislation and guidance as a result of policies not being up to date, resulting in potential safety events and legislation and compliance breaches which may result in external scrutiny and reputational harm.	16	Policies in place for all key areas of legislation Overall policy management sat with CS&T Department (gap in leads for this work for a period) Policy system (pandora) maintained to manage and publish policies for staff to access Policy for Policies in place to provide clear direction and requirements for policy management Policies have lead 'author' and lead 'executive' Policy Review Group (PRG) in place (from Jan 22) to streamline process and target current backlog Policies include details of legislation and guidance they relate to, and information as to how compliance is monitored. Febraury 2023- starting to Monitor compliance against policies.	8	Establish process for gaining assurance over policy compliance and embed	Kirsty Roberton 28/02/2024	4	formal agreement at ERMG to reduce to 8 based on likelihood (2). Organisation's current compliance sits above 90%. Removed from ORR. 08-01-2024
								1

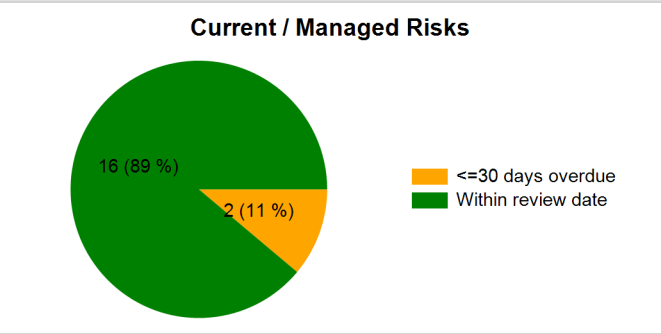
Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
IRR - Initial Risk Rating **TRR** - Target Risk Rating

Organisational Risk Register Report

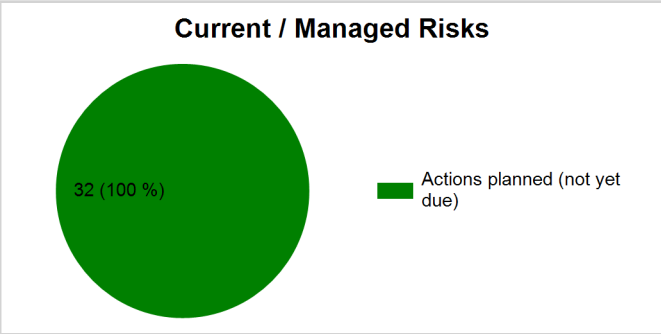
Reporting Period: 01-Jan-2024 to 17-Jan-2024

Gateshead Health NHS Foundation Trust

Risk Review Compliance



Risk Action Compliance



Movements in CRR

				CRR
BU	Service Line	ID	Risk Description	Today
Chief Executive Office	Chief Executive Office	3255	People may lose trust an confidence in our services	12
Chief Operating Officer	Planning & Performance	2945	Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI.	12
		3261	Failure to Deliver Operational Plan of Zero > 52 week waits by March 2024	12
Clinical Support & Screening	Diagnostics	3277	Risk of no MRI facility in the hospital	16
Digital	Digital Transformation and Assurance	3310	Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure.	16
	Health Records	3313	Inability to support legislation and best practice associated with records management	16
Finance	Finance	3102	Activity is not deliverved in line with planned trajectories, leading to reduction in income	16
		3103	Risk that efficiency requirements are not met.	16

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

Organisational Risk Register Report

Reporting Period: 01-Jan-2024 to 17-Jan-2024

Gateshead Health NHS Foundation Trust

Movements in CRR

				CRR
BU	Service Line	ID	Risk Description	Today
Finance	Finance	3127	There is a considerable risk that the Trust is unable to meet the financial projections included in its plan.	16
Medical Services	Medical Services - Divisional Management	2982	Risk of delayed transfers of care and increased hospital lengths of stay	16
Nursing, Midwifery & Quality	Quality Governance	3089	Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures.	12
People and OD	Human Resources	2764	Risk of not having clearly agreed workforce plans for the next 3, 5 and 10 years.	16
	Workforce Development	2373	Exposure to incidents of violence and aggression in ECC	15
		3095	Risk of Significant, unprecidented service disruption due to industrial action	16
		3298	Increase in incivility and disrespectful behaviours being reported	12
QE Facilities	Estates	3186	There is a risk to ongoing business continuity of service provision due to ageing trust estate	12
Surgical Services	Obstetrics	2398	Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings	15

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

Gateshead Health NHS Foundation Trust

Assurance Report Agenda Item: 12i

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Finance and Performance Committee			
Name of Meeting:	Board of Directors			
Date of Meeting:	19 December 2023			
Author:	Mrs K Mackenzie, Group Director of Finance & Digital			
Executive Lead:	Mrs K Mackenzie, Group Director of Finance & Digital			
Report presented by:	Mr M Robson, Chair of Committee			
Matters to be escalated to the Board:	None			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	<u>Sickness Absence:</u> The report was presented in response to a request from committee members informing that over a 12 month rolling period until the end of October 2023, 33.9% relate to anxiety, stress, depression and other psychiatric illness and the volume of staff referred into Occupational Health who require counselling has increased. The Committee noted that the POD Committee are tracking detailed progress on their work plan. <u>Leading Indicators:</u> The report was presented for assurance and discussion. Key areas for attention related to challenge in achievement of the ambulance handovers within 15 minutes. The Committee requested a report for the next meeting on ambulance handovers with an SBAR approach including tactical options and risk mitigation. <u>Paediatric Autism Pathway Validation:</u> The report was presented for information and assurance noting that the Trust had undertaken a validation exercise linked to a review of the longest waiters. Technical reporting changes resulted from the exercise. <u>Month 8 Financial Report:</u> The report was presented informing that the Trust has a revenue deficit of £9.271m which is an adverse variance of £0.108m. The report was received for information and assurance.			

	Internal Audit Reports: The report was presented sharing the outcomes of the recent off payroll payments report audit. The committee noted that the Reverse SLA between the Trust and QE Facilities will go to the QEF Board. Internal Audit Action Monitoring Report: It was agreed to bring an updated version of this report to the next Committee as many of the target dates are at the end of December 2023. Supply Procurement Committee Report: The report was on the recent work of the SPC. In total 10 reports were received with a total value of £1,611,921.66. The report was received for assurance. Capital Steering Group (CSG) Update: The report was presented for information. Standing Financial Instructions: The Committee received the document for consultation and will provide comments ahead of the next committee meeting. The next meeting will receive the proposed final version. Strategic Objectives: The report was presented for information. Organisational Risk Register (ORR): The Committee reviewed the ORR noting there are 8 risks from the BAF and ORR that are reflected in the report. Board Assurance Framework (BAF): The Committee reviewed and updated the BAF. Oversight Meeting Action Plans: For information. Finance and Performance Calendar Dates 2024-25: For information. Finance and Performance Committee Cycle of Business 2023/24 For information.	
Recommended actions for Board	The Board is requested to note the assurances and risks identified by the Committee and be mindful of this when reviewing and discussing related agenda items.	
Trust Strategic Aims that the report relates to: **(Including reference to any specific risk)**	**Aim 1** ☐	We will continuously improve the quality and safety of our services for our patients
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce

	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes
	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead
Financial Implications:	As outlined in the Finance Report paper on the agenda.	
Links to Risks (identify significant risks and DATIX reference)		
People and OD Implications:		

Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒

Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☐	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments
	Obj. 2 ☒	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers
	Obj. 3 ☐	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve

Gateshead Health NHS Foundation Trust

Assurance Report Agenda Item: 12ii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☒
Committee Reporting Assurance:	Quality Governance Committee December 2023			
Name of Meeting:	Trust Board			
Date of Meeting:	December 2023			
Author:	Mrs A Stabler, Non-Executive Director			
Executive Lead:	Dr G Findley, Chief Nurse			
Report presented by:	Mrs A Stabler, Non-Executive Director			
Matters to be escalated to the Board:	For information only: The Committee noted there are a number of areas of non-compliance in the Paediatric Audiology Hearing Service Review but will be seeking assurance from the Committee in the next few months. The Committee also noted there is a regional call on 19 December 2023 that Medical Directors and Chief Nurses are attending due to the high risk of system issues with delayed ambulance handovers.			
Executive Summary:	**Items received for assurance:** **QEF Pharmacy Quality, Safety and Performance Report** The report was presented informing the quality management system consist of two parts in the pharmacy service of dispensary and whole sale service. SPC has been applied to slide 1 of the presentation and there are 2 high risk incidents reported with HR involved. The Committee noted there were 2 serious incidents reported in March 2023. The Systemic Anti-Cancer Therapy (SACT) homecare project went live on 4 December 2023 and the Group will be updated on progress. **Health and Safety Quarterly Update** The report was presented informing there were no Group Health and Safety Committee meetings during July to September 2023 due to unavailability of several key members and there is currently no Health and Safety Manager in post and the Compliance Auditor Apprentice role remains vacant. The Health and Safety Work Plan has not changed since the last quarter due to the absence of the Health and Safety Manager.			

	The Committee requested a clear recovery plan to be developed and presented to the Executive Management Team in January 2024 then they will bring assurance to the Committee in February 2024 with oversight at the QE Facilities Board. **Health Inequalities** The report was presented informing that a project has been established to carry out a gap analysis across the Trust against the Core 20 plus 5 with resources identified from existing budgets to manage this project. **PHSO Review of Cases** The report was presented informing there are currently 6 cases with PHSO with 4 in the category of “current”, 2 “awaiting decision” and another one that has been received this month of awaiting decision. There are 2 significant cases of a patient who arrived into ED with self-harm who was later found deceased and a patient found deceased on his commode with the oxygen disconnected. **Complaints Update** A verbal update was provided informing there are currently 43 open complaints with 18 beyond the 40 day internal deadline and 1 open over the 60 patient deadline with the date of completion of November 2023. The 1 outstanding complaint is a complex case and all others are between the 40 to 60 days and have been escalated. The Committee will receive an update at the next meeting. **Quarterly Learning Update** A verbal update was provided informing that work was ongoing to co-ordinate learning between complaints, incidents and mortality alerts. A Learning Triangulation Meeting has been introduced with the next meeting planned on 28 December 2023 and will be reported to the Trust Learning Panel. **EQIA Update** The report was presented informing there are currently 34 EQIAs of which 8 relate to cost reduction plans (CRPs). The Medical Director and Chief Nurse met with the business units to discuss the long list of CRPs and agreed which ones needed a more in depth EQIA as some clearly had not impact on quality or equality. There are 14 EQIAs that have been closed for information and assurance. **Assurances from Safeguarding Group** The report was presented for information noting the performance data should be presented as an SPC chart going forward. **Leading Indicators** The report was presented informing there is a deterioration in the C.diff rate which is not unexpected as it is a seasonal

	condition and we will breach the absolute number of cases we were given as a tolerance. **Maternity Oversight Report** The report was presented informing that the PPH rate continues to flag as high and are doing significant work on this. We are on track to reach the 90% compliance with new training requirements in most areas by the end of December 2023. The Committee asked for a deep dive in readmissions for the next report. **Assurances from Strategic SafeCare Risk and Safety Council** A verbal update was provided informing due to the timing of the meeting there has not been a SafeCare meeting. An Extra-ordinary meeting was held to discuss terms of reference and the timing of the meetings. **Serious Incidents Report** The report was presented informing during quarter 2 there were 9 serious incidents reported. The closing of the actions for historic incidents is challenging in InPhase, so we have opened Datix to help. The ICB closed 7 serious incidents in quarter 2 and there are currently 15 serious incidents open with plans in place to take a pragmatic approach and a plan for them all to be closed by the end of March 2024. **Falls Update** A verbal update was provided informing that the Trust Falls Prevention Group has been functioning for 14 months and completed pieces of work such as “think yellow”. The most frequently reported incidents are falls therefore we have refreshed the terms of reference, membership and the policy. The Committee agreed to remove this update from the cycle of business as significant progress has been made and further updates this will be reported into the SafeCare Council. **Safer Staffing Report** The report was presented informing that the two areas to flag are Ward 11 and Ward 22 who have 4 staff on maternity leave with staff in post that are undertaking training. The staffing report includes red flags and we are trying to correlate sickness. When the Head of Nursing – Workforce is in post they will triangulate issues and areas of harm to improve the report. **Feedback from Risk Escalation Meetings** A verbal update was provided informing that the formal process has been ongoing for some time and there has been no further meetings as no further concerns have arisen.

<table>
<tr><td></td><td colspan="6">ICB Update
A verbal update was provided informing that there is currently a restructure across the Organisation and the consultation process closed on 15 December 2023. The final structures will be published on 5 January 2024 with the new structure live on 1 April 2024.

Items received by the Committee for information:
• Mental Health Act Compliance Minutes – August 2023
• Research and Development Annual Report
• Palliative Care 6 Month Update
• Objectives Delivery Report
• Cycle of Business</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="6">Board are asked to note the work of the Committee and the assurances received and note the areas of risk identified but note the actions in place to resolve.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to: (Including reference to any specific risk)</td><td>Aim 1
☒</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>Financial Implications:</td><td colspan="6">None to Note</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">ORR Risks, 2879 – Maternity, 2779 CQC Compliance/ Improvement, 2868 – Further wave of Covid, 2880</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">Gaps in workforce in nursing, midwifery and mental health.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td colspan="2">Safe
☒</td></tr>
<tr><td rowspan="3">Trust Diversity & Inclusion Objective that the report relates to</td><td>Obj.1
☐</td><td colspan="5">The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments</td></tr>
<tr><td>Obj. 2
☒</td><td colspan="5">All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers</td></tr>
<tr><td>Obj. 3
☐</td><td colspan="5">Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve</td></tr>
</table>

Gateshead Health NHS Foundation Trust

Assurance Report

Agenda Item: 12iii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Digital Committee			
Name of Meeting:	Board of Directors			
Date of Meeting:	Wednesday 8th November 2023			
Author:	Miss C Bright, Head of Digital Assurance and Transformation			
Executive Lead:	Mrs K Mackenzie, Group Director of Finance & Digital			
Report presented by:	Mr A Moffat, Chair of Committee			
Matters to be escalated to the Board:	None			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	The meeting of the Digital Committee followed a revised format, which was well received by the members. <u>Introducing the Patient Engagement Portal (PEP)</u> An overview of the PEP solution and the progress being made against its deployment in Gateshead was presented for assurance. The committee heard how the Trust is the first to go-live with enhanced PEP functionality (correspondence and supporting information). Centrally funded for 2 years; it is anticipated that future significant savings would enable PEP to be self-funding. <u>Organisational Strategic Objectives – Digital</u> Report presented for assurance. Associated risk identified given the interdependencies with the EPR development. <u>Digital Delivery Plan</u> The committee were provided with an overview of current position of the digital programme for assurance. 3 items (GP switch to MESH, ICCP and Optica, and the Medical Photography pilot) have been completed over the last reporting period. 3 projects are reporting a level of risk: Outpatient Transfer of Care Solution, Nervecentre Paediatric Sepsis upgrade and Paediatric Digitisation. 2 projects reporting as high risk - Office 365 and File Fast app – and committee received assurance on the			

	mitigation plans put in place to ensure the risks are managed. The committee heard about ongoing work to enhance the controls that exist. <u>Digital Maturity Assessment</u> The committee were presented with the outcome of the national DMA and benchmarking exercise including a gap analysis which will help to inform the Trust's strategy delivery plan and EPR specification moving forward. <u>Integrated Electronic Patient Record procurement</u> The committee received an update for information and assurance relating to the EPR system development. The committee heard about planning for the supplier event that was scheduled for the 15/12/23. The committee heard about the levels of clinical engagement and managerial support incorporated into the day. <u>System Exploitation Framework</u> The committee were provided with a presentation outlining the framework by which the key system exploitation plans will be developed. The framework is split into nine areas - data, training, continuity and change control, clinical safety, supplier management, policies and procedures, and user support. The framework has been approved at DDAG and DTG. <u>Organisational Risk Register</u> The committee were presented with the digital risks on the ORR. They were advised that there had been a review of the historic items within the organisational risk register; as a result some risks had been closed and replaced by two new risks to reflect the current position with regards to access management and cyber threat. <u>Data Breaches Reported to ICO</u> This represents a new item on the agenda having been identified by the digital team as a potential reporting gap. The committee were advised that there have been four data security incidents reported to the ICO within the current financial year with no further action required from the Trust. <u>Digital Service Key Performance Indicators</u> The committee were presented with the first cycle of the new reporting format receiving assurance regarding the performance levels of the services associated actions to mitigate risks.

<table>
<tr><td></td><td colspan="6">Committee noted that Trust performance against Information Asset Register maintenance compliance remains an issue.

<u>Regulatory and Governance</u>
Internal audit actions presented for assurance.</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="6">The Board is requested to note the assurances and risks identified by the Committee and be mindful of this when reviewing and discussing related agenda items.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:
(Including reference to any specific risk)</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>Financial Implications:</td><td colspan="6">None to note</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">There are no significant risks on Datix relating to the business conducted at this meeting.</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">Each active project has an associated stakeholder analysis and staffing impact assessment.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td colspan="2">Safe
☒</td></tr>
<tr><td rowspan="3">Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)</td><td>Obj.1
☐</td><td colspan="5">The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments</td></tr>
<tr><td>Obj. 2
☒</td><td colspan="5">All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers</td></tr>
<tr><td>Obj. 3
☐</td><td colspan="5">Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve</td></tr>
</table>

Gateshead Health NHS Foundation Trust

Assurance Report Agenda Item: 12iv

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	People and OD Committee			
Name of Meeting:	Trust Board			
Date of Meeting:	15 January 2024			
Author:	Amanda Venner, Director of People & OD			
Executive Lead:	Amanda Venner, Director of People & OD			
Report presented by:	Maggie Pavlou, Non-Executive Director			
Matters to be escalated to the Board:	• Due to changes at NHSE/I our ADQM report will not be released to us at the normal point of the year and therefore Committee have agreed a different sign off route, providing delegated authority to the Executive Team to sign this off. • MHPS Case Review. • Limited assurance internal audit report. • Healthcare Support Worker Rebanding.			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	**Items received for assurance:** **Executive Director POD Summary Report:** The report was presented informing the vacancy rate indicator has moved to above the trajectory remaining below the 5% target at 2.5% and the sickness levels are decreasing. The Freedom to Speak Up reporting has increased dramatically since the introduction of a new Guardian and there was a 'rally' organised by Unison around the Healthcare Support Worker rebanding in December 2023 which we managed to work with Unison to call off at the last minute. The Committee also noted that the 2023 Annual Staff Survey has now closed with a final completion rate of 49% for Trust, 17% for Bank and 59% for QE Facilities, giving a group response rate of 50%. **Cross Referral form Audit Committee** The counterfraud disciplinary cases were discussed and assurance provided that the decisions to not pursue the two cases where the employees had left the organisation were appropriate. Existing process strengthened and robust escalation process in place.			

Vaccination Programme Update Report:
The report was presented informing there is a Jabbathon planned on 26 January and 23 February 2024 to increase the vaccination uptake and the Committee asked for a plan to be brought to the next meeting from the Vaccination Commitee.

It was also noted that there is a low uptake in ethnic groups and the Communications on the vaccination campaign had lost momentum as there appeared to be a lack of clinical engagement. It was agreed for the rates to be escalated to Senior Management Team and for an Executive Lead to be identified to oversee.

Freedom to Speak Up Report Q3:
The report was presented informing there are 4 members of the Trust Board who are outstanding to complete the training. Q1 and Q2 had both 7 cases raised which within that period in Q3 there were 18 cases raised. It was noted a business case has been started for an overview of data collection and will allow anonymous reporting.

The Committee agreed the report is not informing if there is a problem or not, the concern of the role of the Freedom to Speak Up Guardian and what we are looking at. It was mentioned it would be helpful to see in the report set out in a heat map format, identifying of areas of concern so consideration could be given around how this intelligence is then shared with both Operational Directors Clinical Heads of Service.

Anti-Racism Charter:
The charter was presented with the accompanying action plan.

Historic Pre-Employment Checks:
The report was presented informing that 80% of files have been checked and gaps were continuing to be closed. The current risk relates to timescales for competition and being able to start securing any ID documentation required. The Committee noted that the project is currently forecast to extend beyond the agreed31 January 2024 timescale.

Healthcare Support Worker Rebanding:
The report was presented informing this is a high priority area which carries a risk of strike action and potential pay claims. The project plan is supported by the Deputy Director of Transformation and there is a meeting planned for 16 January 2024 with Staff Side which focuses on Healthcare Assistants but the scope could broadened for other areas. The implementation plan is the end of March 2024 but processing will take a number of months after that date with the costs picked up in the next financial year.

	MHPS Case Review: The report was presented following a request for MHPS cases that have taken place across the organisation to be reviewed. The report reviewed all cases that have taken place in the past 8 years. It was found that although the process is difficult to adhere, in terms of the challenging 4 week timescales, the process is robust. The Committee asked for an additional report with recommendations and conclusions to circulate to the Committee via email for approval then to Trust Board this month. **Internal Audit Reports:** **Senior Medical Staff Job Planning (GHE 2023-24/07):** The report was presented confirming that limited assurance had been received on this audit with detail within the pack and the cover sheet includes the action list. The majority of issues identified were known to the team and actions were already underway to progress these, with clinical engagement and communication collectively on this across the wider teams being key. The Committee asked following the lack of assurance for a summary report to go through the task and finish group, Executive Management Group, Audit Committee and this Committee. **Outstanding & Upcoming Audit Actions Progress:** The report was presented informing the Internal Audit 2023/24 audit plan had limited assurance on Senior Medical Staff Job Planning and have internal monitoring processes for this. There are a further 10 actions in total dating back to 2020-21. 6 of these actions relate to the Heathroster system which has moved not the corporate nursing portfolio. Since the point of writing this report, the 3 Internal Audit actions have been completed and 1 outstanding relating to Covid risk assessment. **People and OD Organisational Risk Register:** The report was presented informing there are 4 risks on the risk register. Risk 2764 was discussed at the Executive Risk Management Group with a view to lower the score as the position has improved and Risk 2373 has recently moved into People and OD with some work underway linking to zero tolerance work. **Items received by the Committee for information:** • Cycle of Business • Leading Indicators • People & OD Additional Metrics • Industrial Action Update

Recommended actions for Board	Note main assurances against the strategic People and OD themes detailed and key associated risks.				
Trust Strategic Aims that the report relates to: (Including reference to any specific risk)	**Aim 1** ☐	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Financial Implications:	Potential costs related to the Healthcare Support workers regrading.				
Links to Risks (identify significant risks and DATIX reference)	ORR Risks, 3095 risk to quality of care, 2764 risk of not having a clearly agreed workforce plans and 3272 historic checks.				
People and OD Implications:	As set out				
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)	**Obj.1** ☒	The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments			
	Obj. 2 ☐	All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers			
	Obj. 3 ☒	Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve			

Gateshead Health NHS Foundation Trust

Assurance Report

Agenda Item: 12v

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Audit Committee Assurance Report from Meeting held on 5 December 2023			
Name of Meeting:	Audit Committee			
Date of Meeting:	5 December 2023			
Author:	Mrs K Mackenzie, Group Director of Finance and Digital			
Executive Lead:	Mrs K Mackenzie, Group Director of Finance and Digital			
Report presented by:	Mr A Moffat, Non – Executive Director			
Matters to be escalated to the Board of Directors:	It was agreed that committee would escalate: • Limited assurance audit reports with incomplete or no management responses • Recommendations exceeding revised target implementation dates with no management updates • Revision of target dates for implementation of actions			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	**Executive Risk Management Group update** Paper presented for assurance. Discussion took place pertaining to risks on ORR and an update on training relating to inphase implementation was received. **Reference Costs** Item deferred as submission not yet taken place due to the portal not yet being open. **Accounts and Reporting Timetable** Presented for information this paper shared the provisional dates for accounts and reporting for financial year 2023/24 which have been announced by DHSC. Little change on previous years. Committee noted key dates. **Charitable Funds Accounts** Audit findings report was presented with findings that the accounts are maintained robustly and there are no items to raise. Accounts recommended for approval to Board of Trustees.			

	QE Facilities Accounts Update presented on the draft accounts, noting the auditors are going through testing and confident they will meet the deadline for the Extra Ordinary Audit taking place on the 12th. There were some issues advised around Mazars capacity and absence from committee. **Internal Audit** Report presented for assurance. Internal Audit noted that there are two reports included at draft where management responses haven't been received in a timely manner. Similar there are recommendations which are overdue for which four have had a target date revised since the last committee and two with no responses received. The report contained a final output of limited assurance into the reverse SLA arrangements between the Trust and QEF. Decision taken to escalate concerns to Board and to the CEO. **External Audit** The report proposes that the Audit committee recommends to the Council of Governors that the 24-month extension on the current external contract is taken and that the Group should market test the service during 2025/2026 with a view to awarding a contract for the service in March 2026. Committee has agreed to recommend for approval. **Counter Fraud** The committee received an overview of the work plan proposed for 23/24. Noted service is facing the same challenges as internal audit. **Schedule Of Losses and Special Payments** Committee received and approved the paper presented. **Proposed Schedule for future meetings for 2024/2025** Proposed dates have now been issued. **Board Committee Escalations Summary** Report received for discussion and consultation. Comments provided to Trust Secretary for action and reflection.
Recommended actions for the Board of Directors	The Board is requested to take assurance from the work of the Committee and note the assurances, actions and decisions of the Committee in framing related items on the Board agenda.

<table>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:
(Including reference to any specific risk)</td><td>Aim 1
☒</td><td>We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☐</td><td>We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td>We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td>We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td>We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Financial Implications:</td><td colspan="2">None to note</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="2">There are no significant risks on Datix relating to the business conducted at this meeting.</td></tr>
<tr><td>People and OD Implications:</td><td colspan="2">None to note.</td></tr>
<tr><td>Links to CQC KLOE</td><td colspan="2"><table><tr><td>Caring
☐</td><td>Responsive
☐</td><td>Well-led
☒</td><td>Effective
☐</td><td>Safe
☒</td></tr></table></td></tr>
<tr><td rowspan="3">Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)</td><td>Obj.1
☐</td><td>The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments</td></tr>
<tr><td>Obj. 2
☐</td><td>All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers</td></tr>
<tr><td>Obj. 3
☐</td><td>Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve</td></tr>
</table>

Gateshead Health NHS Foundation Trust

Assurance Report

Agenda Item: 12v

Purpose of Report	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Committee Reporting Assurance:	Audit Committee Assurance Report from Meeting held on 12 December 2023			
Name of Meeting:	Audit Committee			
Date of Meeting:	12 December 2023			
Author:	Mrs K Mackenzie, Group Director of Finance and Digital			
Executive Lead:	Mrs K Mackenzie, Group Director of Finance and Digital			
Report presented by:	Mr A Moffat, Non – Executive Director			
Matters to be escalated to the Board of Directors:	None			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	**QEF Annual Accounts – External Audit** Paper presented providing audit opinion on the draft accounts of QEF for the financial year 2022/23. Additional verbale update was presented by Mazars advising that the majority of testing has been completed. A small extrapolated error was identified. Audit Committee agreed to recommend submission of the accounts to QEF Board on the understanding that there were no material changes to the paper presented.			
Recommended actions for the Board of Directors	The Board is requested to take assurance from the work of the Committee and note the assurances, actions and decisions of the Committee in framing related items on the Board agenda.			
Trust Strategic Aims that the report relates to: (Including reference to any specific risk)	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients		
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce		
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources		
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes		
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead		
Financial Implications:	None to note			

<table>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">There are no significant risks on Datix relating to the business conducted at this meeting.</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">None to note.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☐</td><td>Responsive
☐</td><td>Well-led
☒</td><td>Effective
☐</td><td colspan="2">Safe
☒</td></tr>
<tr><td rowspan="3">Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)</td><td>Obj.1
☐</td><td colspan="5">The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments</td></tr>
<tr><td>Obj. 2
☐</td><td colspan="5">All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers</td></tr>
<tr><td>Obj. 3
☐</td><td colspan="5">Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve</td></tr>
</table>

Gateshead Health NHS Foundation Trust

Assurance Report

Agenda Item: 12v

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee Reporting Assurance:	Group Remuneration Committee			
Name of Meeting:	Board of Directors			
Date of Meeting:	29 November 2023 and 9 January 2024			
Author:	Mr M Robson, Chair of the Group Remuneration Committee			
Executive Lead:	Mrs T Davies, Group Chief Executive			
Report presented by:	Mr M Robson, Chair of the Group Remuneration Committee			
Matters to be escalated to the Board:	None			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	Key decisions and assurances received: • For good governance the Committee formally confirmed recent Executive-level appointments (delegated authority had been granted). • Assurance is provided that the NHS England's recommendations regarding Very Senior Manager pay for 2023/24 were duly considered for each applicable post. • The Committee approved revised role descriptions for Executive positions to reflect group responsibilities, strengthening the governance arrangements in place. • The Committee was assured that succession planning / talent management is being progressed for Executive posts. • The Committee approved a new set of terms of reference and cycle of business, which will support the Committee to deliver its key role in relation to remuneration and appointment in line with the requirements of the Code of Governance. In January 2024 the Committee ratified new terms of reference for the QE Facilities' Remuneration Committee. • Given the announcement of the retirement of the Medical Director, the Committee received assurance over the future plans for this post. • With regards to QE Facilities the Committee reviewed a proposal to amend the composition of its Board – this will be considered further by the Group Board in Part 2.			

<table>
<tr><td>Recommended actions for Board</td><td colspan="6">The Board is requested to note the assurances and decisions of the Committee.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to: (Including reference to any specific risk)</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>Financial Implications:</td><td colspan="6">Remuneration decisions on current and future posts by their nature have financial implications</td></tr>
<tr><td>Links to Risks (identify significant risks and risk reference)</td><td colspan="6">-</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">People and OD professional advice provided to the Committee by the Group Executive Director of People and OD</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☐</td><td>Responsive
☐</td><td>Well-led
☒</td><td>Effective
☐</td><td colspan="2">Safe
☐</td></tr>
<tr><td rowspan="3">Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)</td><td>Obj.1
☒</td><td colspan="5">The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments</td></tr>
<tr><td>Obj. 2
☐</td><td colspan="5">All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers</td></tr>
<tr><td>Obj. 3
☒</td><td colspan="5">Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve</td></tr>
</table>

Gateshead Health NHS Foundation Trust

Assurance Report Agenda Item: 12vii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
Committee/Group/Board Reporting Assurance:	QE Facilities' Board of Directors			
Date of Meeting:	January 2024			
Author:	Maggie Pavlou, Chair of QEF Board			
Executive Lead:	Steven Harrison, QEF Managing Director			
Report presented by:	Maggie Pavlou, Chair of QEF Board			
Matters to be escalated to the Group Board:	The Board noted two matters considered worthy of escalation to the Group Board namely: 1. Quality Governance Committee concerns in relation to assurance on Health and Safety which are currently being addressed through development of an improvement plan. 2. Implications of an upcoming increase in the Real Living Wage			
Executive Summary: ***(outline assurances and gaps including mitigating actions)***	The following key issues were considered during the meeting: • Financial Performance – Business profit for month slightly adverse to budget however profit is forecasted to meet year-end target. • QEF budget 2024/25 Principles were outlined and agreed subject to alignment with recently commenced Trust planning work. • SFI's and Scheme of Delegation Revised set of 'rules' (as per Deloitte recommendation) were presented and it was recommended that these be approved and passed to Group Board for approval. • Real Living Wage The financial impact of continuing to retain the business's Living Wage accreditation was noted (an additional £504k above 23/24 costs). It was agreed to defer any decisions/recommendations until after the NHS pay award offer (not likely to be received before May 2024) • Annual Accounts			

<table>
<tr><td></td><td colspan="6">Mazars representative gave an overview of the accounts (and process). The Board approved the signing of the accounts (delegated to the Managing Director). The Board expressed its disappointment in the delay caused by external auditor resourcing.</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="6">The Board is requested to note the assurances and risks identified by the QEF Board and be mindful of this when reviewing and discussing related agenda items.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to: (Including reference to any specific risk)</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>Financial Implications:</td><td colspan="6">• Business profit for month slightly adverse to budget however profit is forecasted to meet year-end target.
• Potential cost increases associated with increase in Living Wage (£504k)
• Budget outlined forecasted position on revenue and profit for 2024/25 (subject to further review)</td></tr>
<tr><td>Links to Risks (identify significant risks and risk register reference)</td><td colspan="6">Potential cost increases associated with increase in Living Wage (£504k) – to be added to risk register</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">Impact of decisions in relation to Living Wage on (lower paid) staff.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring ☒</td><td>Responsive ☒</td><td>Well-led ☒</td><td>Effective ☒</td><td colspan="2">Safe ☒</td></tr>
<tr><td rowspan="3">Trust Diversity & Inclusion Objective that the report relates to: (including reference to any specific implications and actions)</td><td>Obj.1 ☒</td><td colspan="5">The Trust promotes a culture of inclusion where employees have the opportunity to work in a supportive and positive environment and find a healthy balance between working life and personal commitments</td></tr>
<tr><td>Obj. 2 ☒</td><td colspan="5">All patients receive high quality care through streamlined accessible services with a focus on improving knowledge and capacity to support communication barriers</td></tr>
<tr><td>Obj. 3 ☒</td><td colspan="5">Leaders within the Trust are informed and knowledgeable about the impact of business decisions on a diverse workforce and the differing needs of the communities we serve</td></tr>
</table>

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 13

Report Title:	**Consolidated Finance Report – Part One**			
Name of Meeting:	Trust Board			
Date of Meeting:	31st January 2024			
Author:	Mrs Jane Fay, Deputy Director of Finance			
Executive Sponsor:	Mrs Kris Mackenzie, Group Director of Finance & Digital			
Report presented by:	Mrs Kris Mackenzie, Group Director of Finance & Digital			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	The purpose of this paper is to provide assurance against corporate objectives and address financial risks			
Proposed level of assurance – to be completed by paper sponsor:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Not applicable			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity, and inclusion*	The Trust has an approved 2023-24 planned deficit of **£12.588m.** As of December 23, the Trust has reported an actual deficit of **£10.244m** after adjustments for donated assets and gain & losses of asset disposal. This is an adverse variance of **£0.224m** from its year-to-date target for reasons detailed in the body of this report. As of December 23, the Trust is forecasting achievement of its planned deficit totalling **£12.588m.** The Trust has an approved 2023-2024 capital programme totalling **£29.792m.** However following changes to schemes funded from external and charitable funds the Trust is reporting against an updated internal plan of **£26.662m** As of December 2023, the Trust has reported actual capital spend totalling £7.035m, and a reported under-spend of £14.357m against the year-to-date target, for the reasons detailed in the body of this report.			

	As of December 2023, the Trust is forecasting capital spend totalling £25.087m and a £1.575m underspend.				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper.*	The recommendation to Board is to receive the report, discuss the potential implications and record partial assurance for the achievement of the 2023-2024 planned deficit as a direct consequence of the reported year to date position and financial risks. To note the summary of performance as of December 2023 (Month 9) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds).				
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:	Achieving financial sustainability				
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)	3127 Overall risk of not meeting financial plan, with contributing risks relating to activity (3102), efficiency (3103) and cost of delivery of New Operating Model (3128).				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

1. Introduction

1.1 The purpose of this report is to provide a summary of financial performance as of 31st December 2023 (month 9) for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds).

1.2 Reporting for December is against the Trusts 2023-2024 financial plan which reports an adjusted annual deficit of £12.588m inclusive of the achievement of a £15.900m cost reduction target and achievement of elective recovery funding income (ERF) totalling £2.654m.

2 Income and Expenditure

2.1 The Trust has reported a deficit of £10.438m for the period April 23 to December 23 and £10.244m after the adjustment for donated assets, gains / loss on disposal of assets.

2.2 This is an adverse variance of £0.224m against the Trusts financial plan as detailed on the Trust Statement of Comprehensive Income (SOCI) as presented in Table 1.

2.3 For the month of December 23 the Trust has reported actual income of £32.224m and total year to date income of £283.302m. This is an adverse variance of £0.364m against the Trusts financial plan. The year-to-date variance comprises of less income than planned for variable income streams included in the scope of the national elective recovery fund initiative totalling £1.310m, and the impact of unachieved CRP £0.676m, offset by national funding to cover industrial action pressures of £1.754m.

2.4 For the month of December 23 the Trust has reported actual operating expenditure of £32.909m and total year to date operating expenditure of £291.220m. This is an adverse variance of £4.186m against the Trusts internal financial plan. The year-to-date variance comprises of an overspend on pay budgets totalling £4.202m and non-pay budgets totalling £0.343m offset by the impact of an overachievement of CRP totalling £0.359m across pay and non-pay budgets.

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

2.6 The Trust is reporting achievement of its planned deficit totalling £12.588m deficit.

STATEMENT OF COMPREHENSIVE INCOME

December 23-24	NHSE APRIL - MARCH 24 FINAL PLAN					VARIANCE		
	Annual Plan	Plan In Month	Actual In Month	Plan to Date	Actual to Date	Variance (Actual - Plan)	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	(341,576)	(27,121)	(29,397)	(256,597)	(257,314)	(717)	1,559	(2,276)
Income From Local Authority Care Contracts	(314)	1	2	(208)	(238)	(30)	(30)	0
Private Patient Revenue	(735)	(61)	(67)	(551)	(574)	(23)	(17)	(6)
Injury Cost Recovery	(500)	(42)	(53)	(375)	(364)	11	23	(12)
Other non-NHS clinical revenue	(153)	(13)	(12)	(115)	(108)	7	5	1
Total Operating Income From Patient Care activities	**(343,278)**	**(27,235)**	**(29,527)**	**(257,847)**	**(258,599)**	**(752)**	**1,540**	**(2,292)**
Other Operating Income								
Education and Training Income	(11,331)	(941)	(953)	(8,508)	(8,472)	36	47	**(12)**
R&D Income	(979)	(93)	(94)	(794)	(802)	(8)	(7)	**(1)**
Funding outside of System Envelope	0	0	0	0	0	0	0	-
Other Income	(20,361)	(1,435)	(1,650)	(15,669)	(15,379)	290	506	**(216)**
Donations & Grants Received	(229)	(19)	0	(172)	(50)	122	103	**19**
Cost Improvement Programme - Income	(978)	(1,227)		(676)	0	676	(552)	**1,227**
Total Other Operating Income	**(33,878)**	**(3,715)**	**(2,697)**	**(25,819)**	**(24,703)**	**1,116**	**98**	**1,018**
Total Operating Income	**(377,156)**	**(30,950)**	**(32,224)**	**(283,666)**	**(283,302)**	**364**	**1,638**	**(1,274)**
Operating Expenses								
Employee Expenses - Substantive	253,584	20,185	20,654	186,010	182,286	(3,724)	(3,397)	**(327)**
Employee Expenses - Bank	503	48	631	401	6,433	6,031	5,449	**583**
Employee Expenses - Agency	1,978	290	204	1,485	3,333	1,848	1,934	**(86)**
Employee Expenses - Other	1,288	236	101	1,004	1,050	46	181	**(135)**
Cost Improvement Programme - Pay	647	728		2,757	0	(2,757)	(2,825)	**68**
Total Employee Expenses	**258,000**	**21,486**	**21,589**	**191,657**	**193,102**	**1,445**	**1,341**	**103**
Purchase of Healthcare - NHS bodies	8,445	746	731	6,237	6,142	(96)	(81)	**(15)**
Purchase of Healthcare - Non NHS bodies	4,061	343	276	3,152	2,904	(249)	(182)	**(67)**
Purchase of Social Care	0	0	0	0	0	0	0	-
NED's	187	16	15	140	124	(16)	(15)	**(1)**
Supplies & Services - Clinical	36,206	3,235	3,335	27,086	29,354	2,268	2,167	**100**
Supplies & Services - General	3,158	265	292	2,335	1,628	(707)	(734)	**27**
Drugs	23,152	1,892	1,732	17,534	17,145	(389)	(229)	**(160)**
Research & Development expenses	11	0	5	11	34	23	18	**5**
Education & Training expenses	1,889	166	167	1,369	1,480	111	111	**0**
Consultancy costs	797	235	235	686	654	(32)	(32)	**0**
Establishment expenses	4,266	315	329	3,243	3,334	91	77	**14**
Premises	19,533	1,675	1,702	14,536	14,997	460	434	**27**
Transport	1,885	154	146	1,424	1,262	(162)	(154)	**(8)**
Clinical Negligence	7,933	696	689	5,852	5,606	(246)	(239)	**(7)**
Operating Leases	107	14	94	64	352	288	208	**80**
Other Operating expenses	8,657	337	541	4,564	5,551	987	783	**204**
Cost Improvement Programme - Non Pay	(4,071)	(456)	0	(2,398)	0	2,398	1,942	**456**
Reserves	0	(0)	0	(0)	0	0	0	**0**
Operating Expenses included in EBITDA	**374,217**	**31,119**	**31,877**	**277,492**	**283,667**	**6,175**	**5,417**	**758**
Depreciation & Amortisation - Purchased / Constructed	7,088	305	720	5,411	5,154	(258)	(673)	**415**
Depreciation & Amortisation - Donated / Granted	290	24	4	221	194	(26)	(7)	**(20)**
Depreciation & Amortisation - Finance Leases	5,112	426	278	3,834	2,579	(1,255)	(1,107)	**(148)**
Impairment & Revaluation	100	8	30	75	(375)	(450)	(472)	**22**
Operating Expenses excluded from EBITDA	**12,590**	**763**	**1,032**	**9,541**	**7,552**	**(1,989)**	**(2,258)**	**269**
Total Operating Expenses	**386,800**	**31,882**	**32,909**	**287,033**	**291,220**	**4,186**	**3,159**	**1,027**
(Profit)/Loss from Operations	**9,644**	**932**	**685**	**3,367**	**7,918**	**4,550**	**4,797**	**(247)**
Non Operating								
Non-Operating Income								
Finance Income	(2,224)	(215)	(180)	(1,580)	(1,783)	(203)	(238)	**35**
Total Non-Operating Income	**(2,224)**	**(215)**	**(180)**	**(1,580)**	**(1,783)**	**(203)**	**(238)**	**35**
Non-Operating Expenses								
Finance Costs	483	40	57	363	565	202	185	**17**
Gains / (Losses) on Disposal of Assets	0	0	0	0	0	0	0	**0**
PDC dividend expense	3,885	324	324	2,914	2,914	1	1	**0**
Total Finance Costs (for non-financial activities)	**4,368**	**364**	**381**	**3,276**	**3,479**	**203**	**185**	**17**
Other Non-Operating Expenses								
Misc. Other Non-Operating expenses	0	0	0	0	0	0	0	
Total Non-Operating Expenses	**4,368**	**364**	**381**	**3,276**	**3,479**	**203**	**185**	**17**
(Surplus) / Deficit Before Tax	**11,788**	**1,081**	**887**	**5,064**	**9,614**	**4,550**	**4,744**	**(194)**
Corporation Tax	914	81	92	593	825	232	222	**11**
(Surplus) / Deficit After Tax	**12,702**	**1,162**	**978**	**5,657**	**10,439**	**4,782**	**4,966**	**(184)**
Balancing Adjustment to NHSE Plan		**(295)**		4,453		(4,453)	(4,748)	295
(Surplus) / Deficit After Tax from Continuing Operations	**12,702**	**867**	**978**	**10,110**	**10,438**	**328**	**218**	**111**
Remove capital donations / grants I&E impact	(114)	(10)	(4)	(90)	(194)	(104)	(110)	6
Adjusted Financial Performance (Surplus) / Deficit	**12,588**	**857**	**973**	**10,020**	**10,244**	**224**	**108**	**116**

Table 1: Trust Statement of Comprehensive Income

3 Cost Reduction Programme (CRP)

3.1 Included in the Trusts 2023-24 financial plans is an annual CRP requirement of £15.900m of which the Trust achieved £10.319m as of December 23 and £11.498m for the financial year. This equates to 72.3% of the annual target.

Business Unit	23-24 Annual Target £000	23-24 YTD Target £000	23-24 YTD Achieved £000	23-24 YTD Variance £000	23-24 Annual Achieved £000	23-24 Annual Variance £000	23-24 Annual Achieved %
Chief Executive	(0.012)	(0.008)	0.000	(0.008)	0.000	(0.012)	0.0%
Chief Operating Officer	(0.111)	(0.072)	(0.010)	(0.063)	(0.010)	(0.102)	8.6%
Clinical Support & Screening	(3.479)	(2.261)	(2.719)	0.458	(2.790)	(0.689)	80.2%
Community	(1.211)	(0.788)	(0.697)	(0.090)	(0.723)	(0.488)	59.7%
Director Of Nursing	(0.186)	(0.121)	(0.322)	0.200	(0.322)	0.135	172.8%
Estates & Facilities	(0.195)	(0.127)	0.000	(0.127)	0.000	(0.195)	0.0%
Finance & Information	(0.566)	(0.368)	(0.476)	0.108	(0.532)	(0.034)	94.0%
Medical Director	(0.025)	(0.017)	(0.055)	0.039	(0.055)	0.030	221.6%
Medicine & Elderly	(3.129)	(2.033)	0.000	(2.033)	0.000	(3.129)	0.0%
People & Organisational Development	(0.202)	(0.131)	(0.165)	0.034	(0.165)	(0.038)	81.4%
Surgical Services	(3.284)	(2.134)	(2.030)	(0.104)	(2.099)	(1.185)	63.9%
Corporate Cost Reduction	(3.500)	(2.577)	(3.846)	1.269	(4.803)	1.303	137.2%
Total	**(15.900)**	**(10.636)**	**(10.319)**	**(0.317)**	**(11.498)**	**(4.402)**	**72.3%**

Table 2:2023-24 Cost Reduction Performance

4 Cash and Working Balances

4.1 Group cash as of 1st April 23 totalled £49.335m. The cash position as at the end of December totals £34.479m and is a reduction of £3.892m from the balance as at the end of November, this cash balance is equivalent to an estimated 33.47 day's operating costs (37.25 days November).

4.2 The liquidity metric has deteriorated by 1.80 days against November to -3.20 days, this is 7.74 days below plan (+4.54 days). This is due to a £7.716m decrease in working capital balance against plan and an increase of £15.802m in operating costs net of depreciation.

4.3 The balance sheet is presented in Table 3.

Statement of Position - December 2023

	2023/2024 November 2023 Group £000's	2023/2024 December 2023 Group £000's	Movement from Prior Month £000's	2023/2024 December 2023 QEF £000's	2023/2024 December 2023 FT £000's
Assets					
Non-Current Assets					
Investments	80	80	0	80	16,824
Property, Plant and Equipment, Net	144,073	144,834	761	1,190	143,644
Right of Use Assets	11,710	11,710	0	0	11,710
Trade and Other Receivables, Net	1,915	1,927	13	814	1,113
Finance Lease - Intragroup				41,326	0
Trade and Other Receivables - Intragroup Loan	0	0	0		7,403
Total Non Current Assets	157,777	158,551	774	43,409	180,694
Current Assets					
Inventories	5,029	5,044	14	2,853	2,191
Trade and Other Receivables - NHS	6,552	8,365	1,813	1,314	7,051
Trade and Other Receivables - Non NHS	5,235	6,310	1,075	995	5,315
Trade and Other Receivables - Intragroup				8,433	133
Trade and Other Receivables - Other	0	0	0		0
Prepayments	6,537	6,294	(243)	513	5,781
Cash and Cash Equivalents	38,371	34,479	(3,892)	8,011	26,468
Other Financial Assets - PDC Dividend	0	0	0		0
Accrued Income	1,610	1,732	122	1,214	517
Finance Lease - Intragroup				183	0
Trade and Other Receivables - Intragroup Loan					1,080
Total Current Assets	63,334	62,223	(1,111)	23,516	48,537
Liabilities					
Current Liabilites					
Deferred Income	9,900	8,543	(1,358)	81	8,462
Provisions	2,774	2,750	(24)	579	2,171
Current Tax Payables	5,075	4,980	(94)	430	4,550
Trade and Other Payables - NHS	2,019	2,190	171	0	2,190
Trade and Other Payables -Intragroup				133	8,433
Trade and Other Payables - Other	8,965	8,539	(426)	3,185	5,353
Lease Liabilities	4,101	4,110	9	0	4,110
Trade and Other Payables - Capital	0	0	0	0	0
Other Financial Liabilities - Accruals	29,870	32,006	2,136	9,819	22,187
Other Financial Liabilities - Borrowings FTFF	499	499	0	0	499
Other Financial Liabilities - PDC Dividend	648	971	324	0	971
Other Financial Liabilities - Intragroup Borrowings	0	0		1,080	0
Finance Lease - Intragroup	0	0		0	183
Total Current Liabilities	63,851	64,589	738	15,308	59,110
NET CURRENT ASSETS (LIABILITIES)	(517)	(2,365)	(1,848)	8,207	(10,573)
Non-Current Liabilities					
Deferred Income	2,015	2,015	0	1,719	296
Provisions	2,332	2,236	(96)	0	2,236
Trade and Other Payables - Other	-	0	0	0	0
Lease Liabilities	7,959	7,959	0	0	7,959
Other Financial Liabilities - Accruals	0	0	0	0	0
Other Financial Liabilities - Intragroup Borrowings	0	0	0	7,403	0
Other Financial Liabilities - Borrowings FTFF	12,012	12,012	0	0	12,012
Finance Lease - Intragroup				0	41,326
Total Non-Current Liabilities	24,317	24,221	(96)	9,122	63,828
TOTAL ASSETS EMPLOYED	**132,942**	**131,964**	(978)	**42,495**	**106,294**
Tax Payers' and Others' Equity					
PDC	149,767	149,767	0	0	149,767
Taxpayers Equity	0	0	0	0	0
Share Capital	0	0	0	16,824	0
Retained Earnings (Accumulated Losses)	(26,719)	(27,697)	(978)	25,671	(53,368)
Other Reserves	0	0	0	0	0
Revaluation Reserve	9,795	9,795	0	0	9,795
Misc Reserve	99	99	0	0	99
TOTAL TAXPAYERS EQUITY	132,942	131,964	(978)	42,495	106,294
TOTAL ASSETS EMPLOYED	**132,942**	**131,964**	(978)	**42,495**	**106,294**

Table 3 – Statement of Position

5 Capital

5.1 The Trusts 23-24 CDEL limit had been set at £9.469m.

5.2 As part of 2023-24 planning the Trust Board approved the Trust to spend £1.000m in excess of the original CDEL value totalling £10.649m. The projections are that the Trust will fully utilise the internal funding available along with the PDC and charitable funds to support capital in this year.

Kris Mackenzie, Group Director of Finance & Digital
January 2024

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 14

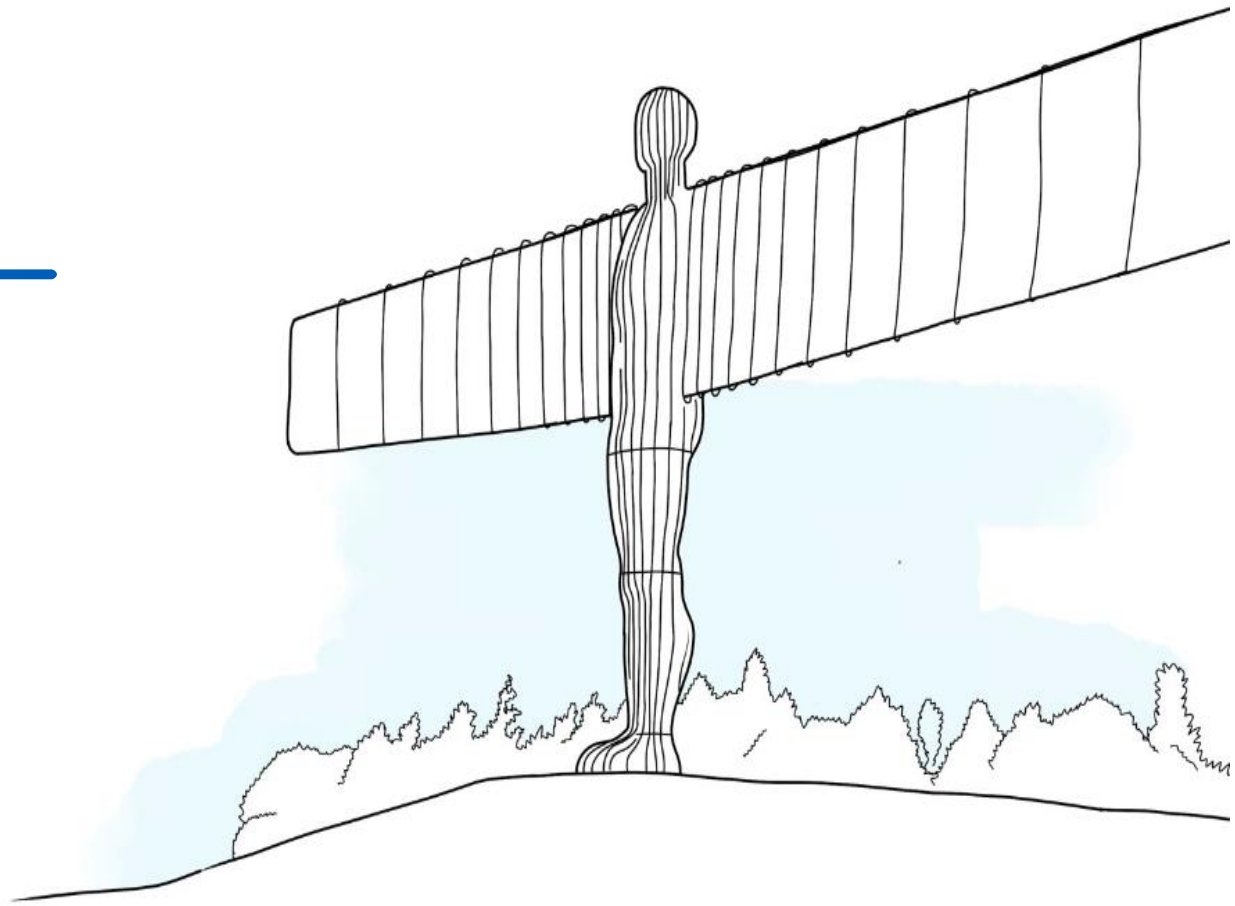
Report Title:	Combined Leading Indicators & Elective Recovery Report			
Name of Meeting:	Trust Board			
Date of Meeting:	31st January 2024			
Author:	Deborah Renwick			
Executive Sponsor:	Kris Mackenzie			
Report presented by:	Kris Mackenzie /Jo Halliwell			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☐	**Information:** ☒
	This report presents progress, risk and assurance in relation to the Trusts Leading Indicators and Elective Recovery for the reporting period of December.			
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*	Not applicable (SMT retrospectively)			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal*	**Leading Indicator Summary:** **Will continually improve the quality and safety of our services for our patients:** Risks are emerging within Quality and Safety Domains: • C.Difficile rates are now above upper control levels and total 26 cases in December, above the total annual stretch allowance of 21. • Harm rates from falls area also an outlier. However, progress against the CQC action plan remains stable. Further deep dives are investigations are underway to understand the reasons for the increase in falls and gain assurance. **We will improve productivity and efficiency of our operational services** • Whist 7 DTA's in December represents a deterioration from zero DTAs in November, this is still a huge improvement in the			

• *Equality, diversity and inclusion*	reduction of patients wating for a bed, in December last year 536 patients waited longer than 12 hours for bed. • The supporting break through objective, and national focus area of minimising ambulance handover delays is also performing well. • 52 week waiters continue to improve. **We will be a great organisation with a highly engaged workforce** • Metric unchanged: staff survey results are embargoed. • Group sickness absence rated deteriorated from 5.6% to 6% • Vacancy rates remain static at 2.5% **We will achieve financial sustainability:** • CRP below planned levels in month £1.7m, adverse variance YTD of £323k. • Pay spend over planned levels in month £859k, adverse variance YTD of £6.7m • Non pay spend over planned levels in month by £740k, adverse variance YTD of £3.1m **Elective Recovery Summary:** **Elective and diagnostic activity** continue to over-perform, whilst new outpatients and follow-up outpatients are below required levels: A new and revised Outpatient transformation plan will support delivery and assurance in these areas. **Year end DM01** performance: our current forecast is changed to underachieve; projected performance is now forecast at 94.9% • MRI capacity reduction is the main driver with contributory risks in stability of echo workforce and audiology workforce plans recovery plans. Continued delivery oversight at Access & Performance to support mitigating current capacity and workforce risks to deliver within target remains a key priority over the coming months. Significant improvements have been made in reducing our **RTT long waiters:** Forecasting zero > 65 weeks at year end and continued focus and close management of service line specific risks surrounding projected 52 week waiters and year end position. The Trust was the only provider in NENC to achieve **90% of RTT patients waiting over 12 weeks validated by 31st December**. This position is being maintained into January. Cancer continues to perform well across faster diagnosis, 31 day treatments and reducing our long waiters – Specific tumour group issues undertake deep dives reporting into Access and Performance meetings and commissioned workstreams are tasked to undertake

<table>
<tr><td></td><td colspan="5">improvement work. Issues remain within our challenged shared pathways, where collaborative discussions are underway to resolve issues. Partnership working and balancing tumour specific performance within the Trust and within the Alliance remains a priority.</td></tr>
<tr><td>Recommended actions for this meeting:
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">• Improving the productivity and efficiency of our operational services
• Improving the quality and safety of our services for our patients
• Being a great organisation with a highly engaged workforce
• Achieving financial sustainability</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">• Elective activity: 3102 (Positive)
• Cancer: 1784 Long waiters: (Positive)
• RTT 52 week waiters: 3261 (Positive)
• DM01 MRI Scanner: 3277 (Same)
• Waiting List/Validation/DQ: 2689 (Positive)</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>

NHS
Gateshead Health
NHS Foundation Trust

Leading Indicators & Elective Recovery Combined Report



December Report

THIS PACK IS BEST VIEWED ON SCREEN IN SLIDESHOW MODE

Gateshead Health NHS Foundation Trust

Leading Indicators

THIS PACK IS BEST VIEWED ON SCREEN IN SLIDESHOW MODE

Leading Indicators Heatmap: December 2023

Gateshead Health NHS Foundation Trust

Achieving

Not Achieving

Deteriorating

Improving

0

CQC Action Plan ⟷

1

C.Difficile ↓

Cost Reduction ↓

Harm rate from falls ↓

Length of Stay ↓

Staff Engagement ⟷

Trolley waits ↓

Time to a bed ↓

7

RTT 52 week waits ⟷

1

Heatmap Key

Achieving plan, Trajectory, and target, although demonstrating a deteriorating position **Standards to watch and intervene**	Achieving plan and maintaining or improving performance **Standards to maintain**
Not achieving plan, trajectory, Target - deteriorating position **Standards to prioritise and focus on**	Not achieving plan, trajectory or target but demonstrating an improving position **Standards to support**

Domains: Linked to indicators

- Safety
- Provision of Care
- Effective & Responsive
- Workforce
- Finance

Arrows signify movement from quadrant to quadrant in month

Gateshead Health NHS Foundation Trust

Leading Indicator Summary

Metrics not achieving and also deteriorating: 6 metrics moved into this quadrant in month, 1 stayed the same.

Quality & Safety (Appendices pg 26 – 30)
C. Difficile rates deteriorated in month to 26 from 21 in November. The Trust is now above the annual allowance of 23 cases. Actions include careful monitoring of antibiotic prescribing & 10 point action plan and new audit assistant appointment to support focused work.
Harm Rates from falls are now at 4.48 per 1,000 bed days - the first month this metric is above the upper control limits. Further deep dives are being sought to better understand the position. Lenth of Stay increased from 4.78 days to 4.85 days in December the increase is driven by an increase in elective lengths of stay from 2.1 days to 2.8 days. Industrial action and prioritising elective work for higher risk patients (P2s) changes the acuity and case-mix in elective care. Non-elective length of stay slightly improved from 5.1 days to 5.08 days: supported by targeted work in the winter plans and improvement work in expediting discharges across challenged pathways.

Effective & Responsive (Appendices pg 20 – 25)
There were 7 12-hr DTA's (trolley waits) in December and 10 % of our patients waited less than an hour for a bed. Whist seven DTA's represents a deterioration from zero DTAs in November, this is still a huge improvement in the reduction of patients wating for a bed, in December last year 536 patients waited longer than 12 hours for bed. Seven DTA's in December contributes to 97 long waits to date.
Collaborative working within our clinical teams has also made a real difference in handover delays and improving patient care. High volumes of ambulance conveyances totalled 2,042 in December of which 46.1% were handed over within 15mins and 50% between 15-30mins. The Trust remains a strong performer within NENC against ambulance handover and clearance times with lower than average times, supporting crews to get back out on the road sooner to attend other emergency calls much quicker.

Productivity & Efficiency – Finance (Appendices pg 33 – 34)
Cost Reduction savings were below planned levels of £1.7m, and an adverse variance of £323k from plan.
Pay spend was over planned levels by £859k in month with a M9 adverse variance from plan of £6.7m
Non pay spend was over planned levels by £740k in month with a M9 adverse variance from plan of £3.1m

Workforce (Appendices pg 31– 32)
Our staff engagement score remains the same. Staff survey results are currently embargoed.
Our Trust sickness absence rates deteriorated from 5.9% to 6.0%

Gateshead Health NHS Foundation Trust

Leading Indicator Summary

Below trajectory – and improving: 2 metrics stayed within this quadrant, but are improving.

Effective & Responsive – Elective Care (Appendices pg 20 – 25)
The number of RTT waiters > 52 weeks improved to143 patients waiting at the end of December, representing a 46% improvement rate from 263 patients waiting in November. There still remains some delivery risk surrounding our current 112 projected 52 week waiters at year end. These waiters are being carefully managed at the weekly meetings, with developing plans including: reallocating direct clinical care activities, maximising productivity initiatives and utilising mutual aid and lastly utilising the independent sector. Targeted focus on elective recovery via weekly Access & Performance meetings is supporting improvements across the suite of recovery measures including 10% reduction in waiting list, and the Trust was the only in the region to comply with the ask to have 90% of the waiting list validated by 31 December.

Above trajectory – but deteriorating: 1 metric stayed the same within this quadrant.

Quality & Safety (Appendices pg 26 – 31)
On balance the CQC action plan remain in this quadrant with no over-due actions, 13 are on track for achievement, 7 actions were completed with a risks of non-achievement moving from 4 to 5 actions. Plans are in place to manage the risk.

- HMSR slightly deteriorated from 104 to 105 – but remains with control/expected levels.
- SHMI slightly deteriorated from 0.90 to 0.93 – but remains below 1 and within control/expected levels

Summary
- Quality and safety measures relating to harm from falls and C.Difficile infection rates will require focus for improvement from current position.
- Focus on Cost Reduction Plans remain an area of high priority – improvements to the over-all plan and planned deficit levels are being made.
- Elective care has seen some huge improvements in month – represented in the elective recovery section, risks remain surrounding known and future impact of IA and reducing our waiting lists.

NHS
Gateshead Health
NHS Foundation Trust

Elective Recovery

THIS PACK IS BEST VIEWED ON SCREEN IN SLIDESHOW MODE

Priorities: Elective Recovery & Transformation

Gateshead Health NHS Foundation Trust

Recovering activity/service levels to pre-covid and better, reducing waiting times and back-log of patients waiting by transforming clinical pathways & services to ensure resilience and sustainability.

Waiting List Management:

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

System Resources:

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

Back to Basics:

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

Productivity:

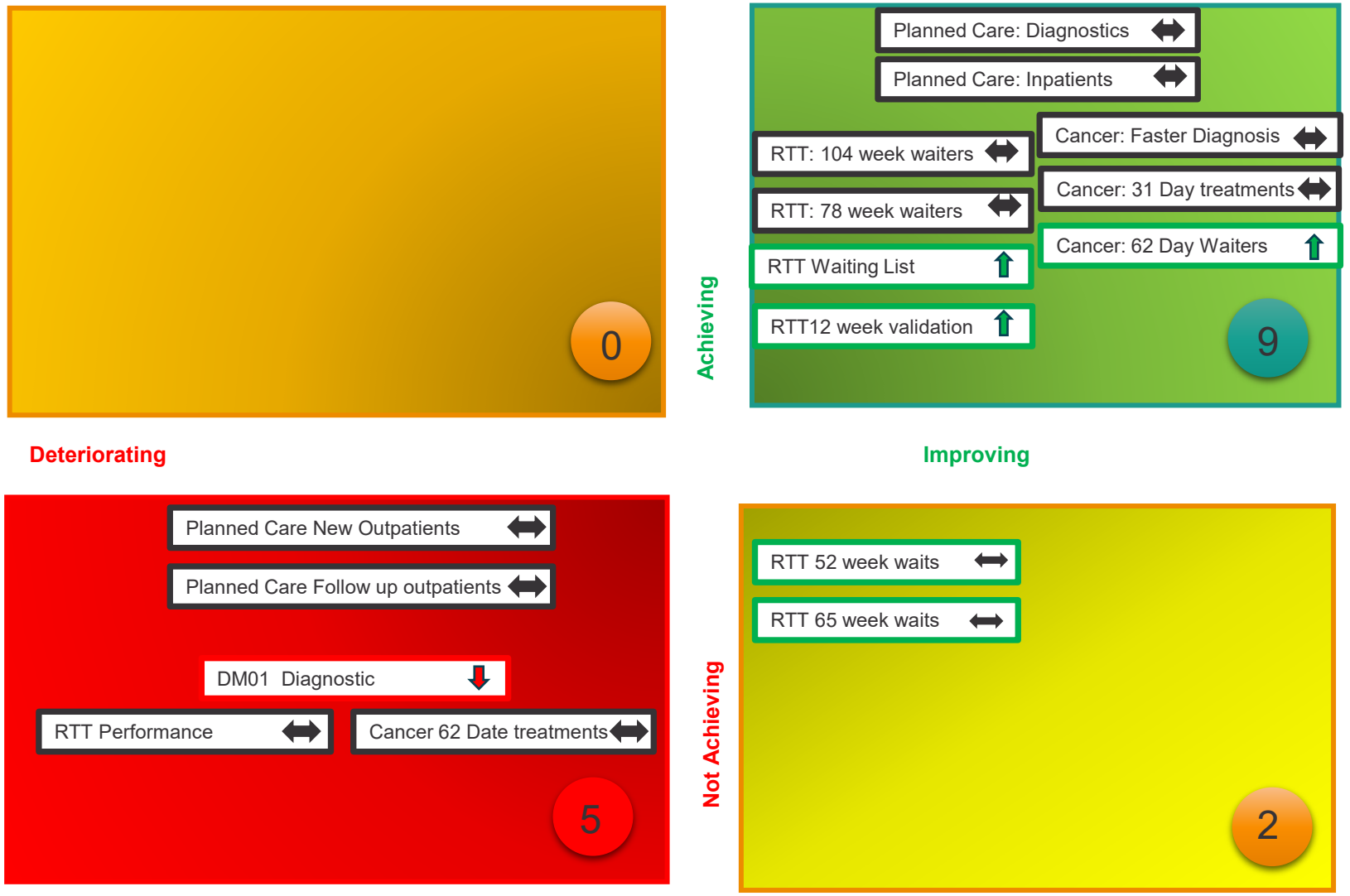
- Reducing unnecessary follow-up outpatient activity and converting activity to areas which add value to patient care
- Theatre productivity to ensure effective & efficient use of theatre resources

Transforming Clinical Pathways:

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

Elective Recovery Heatmap: December 2023

Gateshead Health NHS Foundation Trust



Heatmap Key

Achieving plan, Trajectory, and target, although demonstrating a deteriorating position **Standards to watch and intervene**	Achieving plan and maintaining or improving performance **Standards to maintain**
Not achieving plan, trajectory, Target - deteriorating position **Standards to prioritise and focus on**	Not achieving plan, trajectory or target but demonstrating an improving position **Standards to support**

Heatmap Narrative

Gateshead Health NHS Foundation Trust

Not Achieving – and Deteriorating

Planned Care Outpatient First Appointments and Follow Up Appointments
Activity relating to first and follow-up outpatients are behind planned levels. To date we are below new outpatient activity levels by -2,059 (5%) and we have seen 6,010 more outpatient follow-up patients than plan (14%). A Full outpatient transformation programme is being developed. Waits to first outpatient appointments being reviewed in weekly Access and Performance Clinics and we are reinstating partial booking. Undertaking clinical triage and reviewing prevention of referrals within A&G booking systems, whilst reviewing of Patient Initiated Follow Up (PIFU) to extend and/or evidence benefits. Current PIFU levels are below plan at 3.7%.

RTT waits within 18 weeks.
Trust is achieving 67% against the RTT standard, a deteriorating position from last month at 68%. Validating the WL at 12 weeks has affected removals from both over 18 weeks and under 18 weeks – which will impact on the standards.

DM01 Performance deteriorated from last month's validated position of 94.1% to 91.4% in December, which is both below planned recovery trajectory level and below 95% target, driven primarily by lost MRI scanner capacity. Improvements were seen however across endoscopy and barium. The deterioration in lost MRI capacity places the current year end recovery trajectory at risk. The revised recovery plan is being actively managed and monitored at Access and Performance to mitigate and improve the risk. The Trust still remains No.2 performing Trust in NENC.

CWT : 62 day Referral to Treatments
Cancer performance below expected in Q3 with lower levels of cancer treatments. This is currently being reviewed in TSG's and reporting back into Access & Performance. There has also been an increase in urological referrals and lost capacity with some managed services - which has impacted on treatment levels leading to longer waits. Challenges with multi provider pathways and reliance on other providers to deliver key pathway elements. A revision of the cancer improvement workstreams reporting into Access and Performance are underway to support focus pieces of work in on the areas of greatest risk.

Not Achieving - but Improving

RTT: 52 weeks waits
Position is improving steadily with a continued focus on achieving zero position by the end of the financial year. Current forecasts place 112 patients at risk, however plans to mitigate against specialty level risks include: additional internal sessions, realignment of direct clinical care in the job plans, technical and clinical validation of the waiting list, and use of mutual aid and utilising Independent Sector options.

RTT: 65 weeks waits
Continued focus through the weekly Access and Performance meetings with pathways forecasting and early interventions to prevent extended waits. Despite IA, we are confident that robust plans are in place to ensure there are no over 65 week waiters at the end of March.

Elective Recovery Narrative

Gateshead Health NHS Foundation Trust

Achieving & Improving:

Planned Care Activity:

The theatres efficiency work from the GIRFT reviews and the implementation of the Theatres Road Map has resulted in an increase in theatres activity. The total number of elective cases undertaken in theatres continues to improve the year to date variance 686 (103.5%) combined elective inpatients. Diagnostic activity also continues with a positive cumulative variance of 836 (1.7%) diagnostics tests

Waiting List Management:

Long waiting patients continue to be reviewed in the weekly Access & Performance meeting as well as validation. Additional activity, recent validation work and Access Policy application review has all contributed to the RTT PTL being at its lowest all year and is now circa July 22 levels. There are no 104, 78 and 65 week waiters forecast for year end and plans are in place manage the risk in 52 week current PTL projections.

Cancer Standards:

Whilst there are capacity and booking risks in the early parts of our pathways in some tumour specific groups, the Trust continues to perform well against the faster diagnosis standards, 31 day treatments and reducing out back of long waiters. The Trust remains a strong performer in NENC and continues to benchmark well within these measures.

Summary

- There are some positive indicators linked to the framework of the weekly Access and Performance meetings with clear focus on the month end and forecasted year end positions.
- Validation has had a very positive impact on most performance measures, being the only one Trust in the ICS to achieve 90% validated for patients waiting 12 weeks.
- Despite a drop in month diagnostic performance continues to remain in top 2 Trusts in NENC, there is risk surrounding the year end position re: MRI capacity.
- Improvements in theatre productivity continue to linked to the programmes in place. The year end zero 52 week position will be influenced by risks surrounding IA and our ability to collaborate and source alternative treatment options for patients outside of Gateshead Health.

Demand & Activity

Gateshead Health NHS Foundation Trust

Demand

- 6% above planned levels in December
- 3% above plan year to date

Activity Summary in Month – December

Activity is 104% over planned activity levels or 106% of revised (2% adjusted) plan.

Electives inpatients & diagnostics are overdelivering, supporting an overall cumulative year to date improvement, whilst new outpatients below planned levels, and follow-up outpatients continue to be behind on planned reduction levels.

Year to Date

- Positive variance of 10,241 against plan (4%)
- Positive variance of 14,944 against revised plan (6%)
- Driven by : Daycase and diagnostics and more Follow-up Outpatients than planned levels.

Activity Risks

- Revised adjustment of 2% still identifies a cumulative M9 deficit against:
  - Inpatients: 239 (-11%)
  - New OP: 2,049 (-5%)
  - FU OP: 15,283 (16%)
  - IA: Cancelled activity is circa 0.6% of overall plan

MMR Referrals Plan	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend	M1-M9
Demand Plan	4,185	4,743	4,442	3,628	3,816	4,141	4,014	3,983	4,128	4,214	4,068	4,277	3,225		35,866
Referrals Received	3,225	4,063	3,856	4,560	3,814	4,349	4,657	4,179	4,012	4,056	4,373	4,259	3,424		37,123
Variance	-960	-680	-586	932	-2	208	643	196	-116	-158	305	-18	199		1,257

Activity Summary All POD's	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend	M1-M9
Total Plan	25,249	28,683	26,180	29,244	29,117	30,631	27,859	31,665	28,364	29,954	30,922	28,940	25419		237,452
Restated Plan (2% adjusted)					28,535	30,019	27,302	31,032	27,797	29,355	30,304	28,362	24911		232,706
Actuals	27,355	30,911	28,358	31,432	28,955	30,687	32,072	29,990	31,075	29,604	32,367	32,144	26,316		246,894
Variance Plan	2,106	2,228	2,178	2,188	-162	56	4,213	-1,675	2,711	-350	1,445	3,204	897		9,442
Variance Restated Plan					420	668	4,770	-1,042	3,278	249	2,063	3,782	1,405		14,188
Industrial Action Cancellations					353	107	153	172	239	161	100	-	157		1,442

POD Variance	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend	M1-M9
Inpatients	-64	4	-77	-109	-56	-76	-91	-82	-29	-12	28	5	27		-286
Daycase	48	-137	-15	-15	-364	16	474	-199	231	-33	122	181	41		469
New Outpatients	-52	-129	75	-447	-717	-328	23	-858	295	-686	-286	-126	-412		-3,095
Follow-up Outpatients	1,723	1,984	2,091	2,619	1,302	727	3,432	174	2,053	730	1,467	2,798	903		13,586
Diagnostics	450	507	104	140	-327	-283	375	-710	161	-350	17	346	338		-433

POD Variance Adjusted Plans (-2%)	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend	M1-M9
Inpatients	-64	4	-77	-109	-51	-70	-85	-76	-24	-7	33	10	31		-239
Daycase	48	-137	-15	-15	-313	68	521	-144	278	18	174	280	232		1,114
New Outpatients	-52	-129	75	-447	-604	-210	140	-734	402	-568	-161	-4	-310		-2,049
Follow-up Outpatients	1,723	1,984	2,091	2,619	1,572	1,017	3,677	471	2,317	1,010	1029	3,058	1,132		15,283
Diagnostics	450	507	104	140	-186	-138	515	-561	303	-208	163	484	463		835

Transformation

Gateshead Health NHS Foundation Trust

Transformation Metrics	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend	RAG
PIFU (5%)	1.9%	2.5%	3.4%	3.6%	3.1%	3.5%	3.4%	3.3%	3.1%	3.2%	3.6%	3.8%	3.7%		
Digital Outpatients (25%)	26.8%	25.8%	24.5%	25.6%	22.0%	23.8%	23.4%	24.5%	24.4%	22.5%	23.0%	23.1%	23.6%		
Advice & Guidance (A&G - 16%)	7.6%	7.3%	8.2%	9.3%	7.4%	7.6%	8.4%	8.6%	6.6%	9.8%	7.6%	7.3%	7.9%		
Appointment Slot Issues (ASI's) 2WW's	49.5%	12.1%	35.9%	33.4%	43.2%	27.8%	18.3%	27.8%	19.8%	22.5%	16.8%	9.5%			
DNA Rates (6%)	8.9%	7.6%	7.8%	7.8%	6.9%	7.8%	7.6%	7.6%	7.2%	7.4%	8.1%	7.5%	8.6%		
Theatre Utilisation Funded Capacity (85%)	80.20%	84.70%	81.30%	77.90%	69.9%	78.6%	75.4%	70.9%	68.4%	81.6%	90.9%	92.4%	80.9%		
Theatre Utilisation of sessions ran (85%)	81.60%	81.60%	84.80%	81.10%	81.0%	83.2%	81.6%	81.9%	82.2%	82.1%	81.8%	83.1%	81.5%		
Daycase Rates (85%)	91.9%	91.1%	91.0%	91.8%	91.3%	91.9%	92.7%	92.0%	92.0%	90.8%	89.9%	90.4%	90.0%		

All of the schemes identified as transformational in this matrix will be referenced as part of one of the Delivery Oversight Group schemes or will be transferred under the new Innovation approach

DM01 Diagnostic Performance - Actual

Gateshead Health NHS Foundation Trust

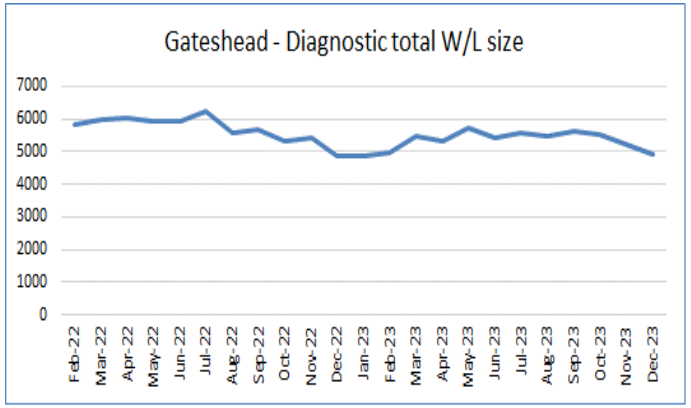
Validated Latest Month: Nov 91.4%

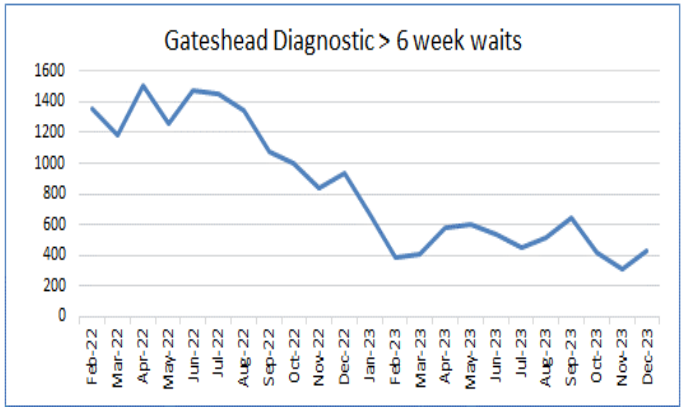
Last Month's waits: **Nov: 94.1%**

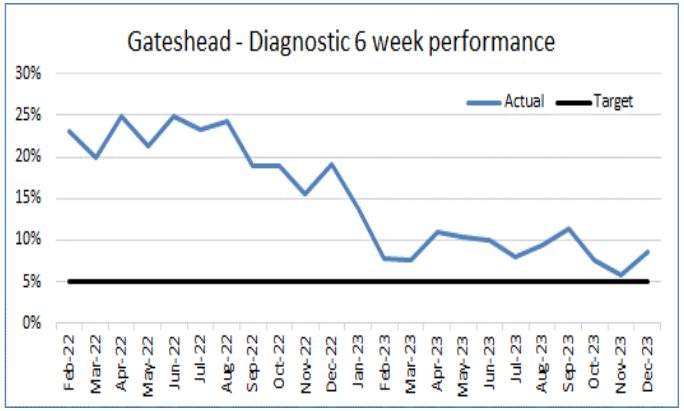
Current performance: **Dec: 91.4%**

Year end: **94.9%**

Monthly Diagnostic Activity | Dec 23	Activity during month			Number of Patients Waiting at Month End			Diagnostic Performance (% of patients waiting > 6wks)	Diagnostic Performance (% of patients waiting < 6wks)
GATESHEAD HEALTH NHS FOUNDATION TRUST	Waiting list	Planned	Unscheduled	< 6 week waiters	> 6 week waiters	*Total Waiting List*		
Test Type: Total	**6513**	**676**	**870**	**4489**	**424**	**4913**	**8.6%**	91.4%
Test Type: Magnetic Resonance Imaging	679	72	29	553	44	597	7.4%	92.6%
Test Type: Computed Tomography	1476	212	800	405	8	413	1.9%	98.1%
Test Type: Non-obstetric ultrasound	2111	184	38	1488	30	1518	2.0%	98.0%
Test Type: DEXA scan	329	23	0	431	9	440	2.0%	98.0%
Test Type: Cardiology - echocardiography	371	114	3	570	62	632	9.8%	90.2%
Test Type: Urodynamics - pressures and flows	15	16		26	1	27	3.7%	96.3%
Test Type: Audiology - Audiology Assessments	906	0	0	282	228	510	44.7%	55.3%
Test Type: Barium Enema	30	13	0	47	12	59	20.3%	79.7%
Test Type: Gastroscopy	220	25	0	222	11	233	4.7%	95.3%
Test Type: Colonoscopy	197	17	0	262	14	276	5.1%	94.9%
Test Type: Flexi sigmoidoscopy	55	0	0	73	1	74	1.4%	98.6%
Test Type: Cystoscopy	124	0	0	130	4	134	3.0%	97.0%
Test Type: Endoscopy (Total)	**596**	**42**	**0**	**687**	**30**	**717**	**4.2%**	**95.8%**







DM01 Diagnostic Performance & Forecast

Gateshead Health NHS Foundation Trust

DM01 Forecasts as of 20/12/23

		ACTUAL				FORECASTS				Actual	Variance - Forcast to actual
		Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Dec-23	Dec-23
Barium Enema	Waiters	106	111	97	85	80	70	50	40	59	-21
	>6wks	42	55	37	19	20	11	5	2	12	-8
	Performance	60.4%	50.5%	61.9%	77.6%	75.0%	85.0%	90.0%	95.0%	79.7%	4.66%
CT	Waiters	406	405	446	455	440	400	400	400	413	-27
	>6wks	5	6	1	3	4	2	3	3	8	4
	Performance	98.8%	98.5%	99.8%	99.4%	99.0%	99.5%	99.3%	99.2%	98.1%	-0.92%
MRI	Waiters	340	417	453	557	700	800	900	1,000	597	-103
	>6wks	2	5	1	4	108	130	160	180	44	-64
	Performance	99.4%	98.8%	99.8%	99.3%	84.6%	83.8%	82.2%	82.0%	92.6%	8.06%
Non-obstetric ultrasound	Waiters	2,070	2,162	2,030	1,798	2,300	2,100	2,000	2,000	1,518	-782
	>6wks	54	130	31	8	8	14	12	11	30	22
	Performance	97.4%	94.0%	98.5%	99.6%	99.6%	99.4%	99.4%	99.5%	98.0%	-1.61%
Audiology	Waiters	647	641	625	569	497	403	292	202	510	13
	>6wks	288	348	267	206	204	141	39	9	228	24
	Performance	55.5%	45.7%	57.3%	63.8%	59.0%	65.0%	86.6%	95.5%	55.3%	-3.71%
Colonoscopy	Waiters	332	308	335	270	350	350	350	350	276	-74
	>6wks	32	24	16	8	25	21	18	18	14	-11
	Performance	90.4%	92.2%	95.2%	97.0%	93.0%	94.0%	95.0%	95.0%	94.9%	1.93%
Flexisigmoidoscopy	Waiters	100	97	89	86	90	80	80	80	74	-16
	>6wks	21	10	3	3	11	6	4	4	1	-10
	Performance	79.0%	89.7%	96.6%	96.5%	88.0%	93.0%	95.0%	95.0%	98.6%	10.65%
Gastroscopy	Waiters	231	244	254	211	230	220	210	200	233	3
	>6wks	21	13	9	12	16	13	11	10	11	-5
	Performance	90.9%	94.7%	96.5%	94.3%	93.0%	94.0%	95.0%	95.0%	95.3%	2.28%
Cystoscopy	Waiters	146	139	86	99	140	140	150	150	134	-6
	>6wks	8	14	2	-	8	8	8	8	4	-4
	Performance	94.5%	89.9%	97.7%	100.0%	94.0%	94.5%	95.0%	95.0%	97.0%	3.01%
Dexa	Waiters	447	466	511	486	440	430	420	400	440	-
	>6wks	5	5	20	17	7	2	8	5	9	2
	Performance	98.9%	98.9%	96.1%	96.5%	98.5%	99.5%	98.2%	98.7%	98.0%	-0.50%
Urodynamics	Waiters	24	25	21	12	30	20	30	15	27	-3
	>6wks	1	2	-	-	2	1	2	1	1	-1
	Performance	95.8%	92.0%	100.0%	100.0%	95.0%	95.0%	95.0%	95.0%	96.3%	1.30%
Echocardiography	Waiters	643	594	559	605	600	600	600	600	632	32
	>6wks	33	28	29	28	30	30	30	30	62	32
	Performance	94.9%	95.3%	94.8%	95.4%	95.0%	95.0%	95.0%	95.0%	90.2%	-4.81%
Trust Totals	Waiters	5,492	5,609	5,506	5,233	5,897	5,613	5,482	5,437	4,913	-984
	>6wks	512	640	416	308	443	378	297	280	424	-19
	Performance	90.7%	88.6%	92.4%	94.1%	92.5%	93.3%	94.6%	94.9%	91.4%	-1.12%

In month performance deteriorated in December to 91.4% from 94.1%.
Modalities achieving 95% on DM01 include: CT, non obstetric ultrasound, and aggregate endoscopy modalities.

Modalities below 95% but performing better than planned performance levels include Barium Enema, MRI.

Modalities below 95% and below planned trajectory levels include Audiology, Colonoscopy, Echocardiology.

Access & performance meetings continue to manage risks in echocardiology re: workforce models alongside recruitment and sickness absence issues in audiology.

The main modality risk affecting year end performance position is MRI. The year end forecast has now deteriorated from 95% to below target at 94.9%.

The building work to support a Second MRI scanner has resulted in at 20% loss off MRI capacity. Mitigating actions are reviewed weekly in Access & Performance to support managing risks and delays. The current action plan forecasts this modality to achieve DM01 in July 2024.

Recovering performance sooner in this area remains a key priority.

Year end: **94.9%**

Cancer Performance

NHS Gateshead Health NHS Foundation Trust

Current Performance Positions

Cancer Performance Summary	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend
2 week Waits	83.3%	79.8%	82.3%	82.7%	75.4%	75.2%	75.8%	76.8%	78.5%	76.7%	80.4%	83.4%	83.6%	
28 Day Faster Diagnosis (75%)	76.0%	75.3%	77.3%	76.2%	72.0%	69.3%	78.0%	77.0%	78.4%	77.7%	81.8%	83.2%	77.3%	
31 Day Diagnosis to Treatment (96%)	100.0%	99.2%	99.3%	97.2%	100.0%	99.3%	100.0%	100.0%	100.0%	98.9%	97.3%	96.5%	97.9%	
Cancer 31 day subsequent drugs compliance	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.2%	
Cancer 31 day subsequent surgery compliance	100.0%	95.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.2%	100.0%	100.0%	100.0%	100.0%	
62 Day Referral to Treatment (85%)	61.7%	56.5%	60.4%	66.9%	66.7%	68.6%	68.6%	69.6%	74.0%	64.7%	54.5%	54.5%	46.7%	
62 Day Referral to Treatment Screening	91.4%	88.5%	91.5%	93.9%	93.2%	92.7%	85.2%	78.1%	84.2%	85.9%	75.5%	82.4%	91.9%	
62 Day Referral to Treatment Upgraded	0.0%	0.0%	40.0%	0.0%	50.0%	50.0%	42.9%	0.0%	0.0%	60.0%	84.2%	79.3%	86.4%	

Cancer Performance Summary	Combined Metrics From October 2023	Oct-23	Nov-23	Dec-23	Year end Risk
28 Day FDS		77.4%	77.6%	80.5%	
31 Day		100%	97.5%	97.5%	
62 Day Combined		67.9%	67.0%	63.3%	

Cancer Recovery &Transformation Metrics

Cancer	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend	Year end Risk
> 62 Day waiters plan (2ww classic pathway)					65	61	64	69	67	70	60	55	59		
> 62 Day waiters actual (2ww classic pathway)	58	64	62	41	64	68	52	59	43	55	58	69	39		
Variance					-1	7	-12	-10	-24	-15	-2	14	-20		
Backlog > 104 days (2ww classic pathway)	11	12	9	7	11	11	9	6	9	11	5	13	5		
(Revised methodology Apr-23) Now only inc. Prostate / Colorectal	11%	18%	17%	14%	6%	17%	13%	46%	17%	12%					
CQUIN 04 Timed Diagnostic Pathways (35-55%)	37%	37%			23%			18%							
Referrals with Faecal Immunochemical Test (FIT)					78.40%	86.10%	85.90%	87.90%	90.80%	89.50%					

Performance Risk Summary:

Faster Diagnosis (75% - 85% in 2025/26)

Last Month's waits: Nov **77.6%**

This Month: Dec **80.5%**

Year End: **>75%**

New 31 Day Treatment Standard (96%)

Last Month's waits: Nov 97.5%

This Month: Dec **97.5%**

Year End: **>96%**

New 62 Day Treatment Standard (70%-85%)

Last Month's waits: Nov **67%**

This Month: Dec **63.3%**

Year End: **<70%**

Over 62 day waits against plan

Last Month's waits: Nov **69**

This Month: Dec **39**

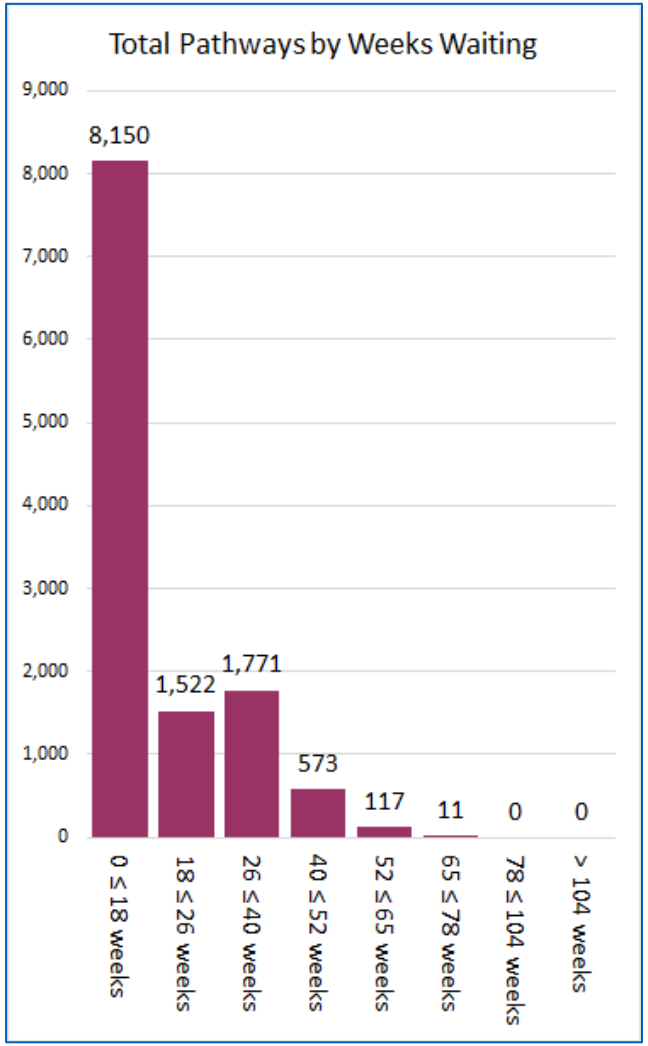
Yearend: **<=55**

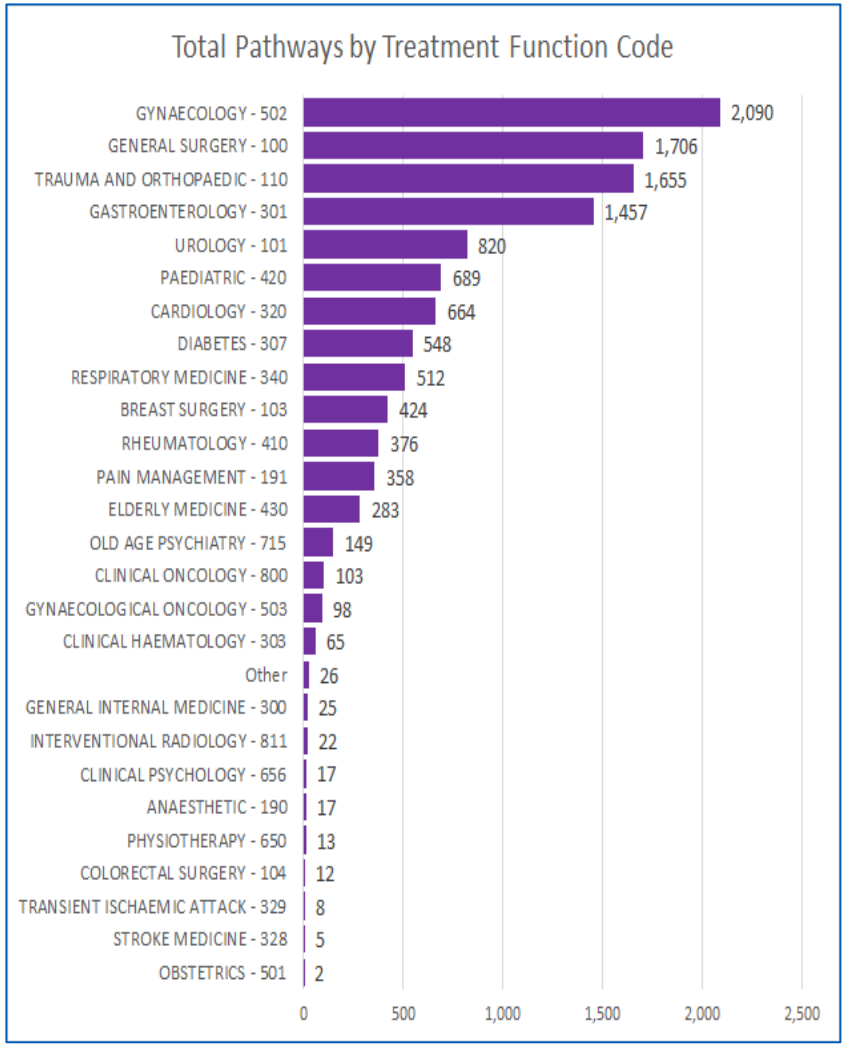
RTT Waiting List Summary

Gateshead Health NHS Foundation Trust

RTT Waiting List Breakdown current snap-shot view

(Waiting list up to and including 21 January 2024)





Waiting List Plan

Last Month's waits: **13,277**

Current waits: **12,144**

Year-end **<14,020**

Over 104week waiters (zero)

Last Month's waits: **Zero**

Current waits: **Zero**

Yearend: **Zero**

Over 78week waiters (zero)

Last Month's waits: **Zero**

Current waits: **Zero**

Yearend: Zero

Over 65week waiters (zero)

Last Month's November waits: **48**

Current waits**: 11**

Year end: Zero

Over 52week waiters (minimise)

Last Month's waits: **208**

Current waits: **128**

Year end: Zero:

Outpatient Position – GP referrals

Gateshead Health NHS Foundation Trust

5. Medway Data only

Average waiting time by specialty in weeks

Specialty	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Cardiology	11.6	12.9	14.0	15.1	15.1	16.6	19.9	21.0	22.7	22.7	22.9	21.6
Clinical Haematology	3.4	2.6	3.1	3.9	4.0	2.6	3.0	2.9	4.8	2.8	2.9	1.9
Diabetic Medicine	7.4	6.3	3.9	10.1	9.9	7.1	6.6	19.6	11.4	9.4	9.0	8.4
Gastroenterology	16.9	17.1	17.1	18.2	18.7	20.1	21.3	22.2	23.1	23.3	24.6	24.9
General Surgery	7.9	7.2	6.4	7.9	8.0	7.4	8.0	7.6	7.0	7.0	8.4	6.6
Geriatric Medicine	12.0	13.1	17.9	12.4	17.3	13.3	14.1	15.5	16.3	16.0	16.9	14.4
Gynaecological Oncology	4.9				17.0	2.3	3.8		2.9		1.9	
Gynaecology	14.0	16.4	18.0	20.1	21.1	23.1	23.2	23.6	26.7	26.8	27.9	25.9
Obstetrics	2.6	2.1	4.0	3.7	3.7	3.7	3.4	3.3	3.4	3.3	3.9	3.4
Paediatrics	12.1	11.5	10.1	10.6	12.4	12.9	10.6	13.0	14.0	13.9	14.7	13.3
Pain Management	48.4	51.0	52.6	25.9	52.1	52.0	61.5	59.2	56.6	50.3	41.9	41.9
Respiratory Medicine	22.2	11.1	10.1	8.9	9.7	13.7	13.7	14.1	15.4	17.1	16.1	11.3
Rheumatology	7.9	7.1	4.1	4.6	3.3	5.3	11.1	11.1	8.1	9.5	17.8	20.4
Trauma & Orthopaedics	8.1	8.7	6.1	6.6	6.9	6.7	5.6	7.1	7.9	6.3	6.6	4.1
Urology	12.9	8.8	10.0	11.5	16.1	15.5	15.4	16.4	16.0	15.4	15.1	15.6

Pressures: December 2023

Extremely High Priority/ Risk > 20 weeks

- Cardiology 21.6
- Gastroenterology 24.9
- Gynaecology 25.9
- Pain 41.9* (exc. MSK)
- Rheumatology 20.4

High Priority/Risk 12-20 weeks

- Geriatric Medicine 14.4
- Paediatrics 13.3
- Urology 15.6

Medium Priority 6-12 weeks

- Diabetic Medicine 8.4
- Respiratory Medicine 11.3
- General Surgery 6.6

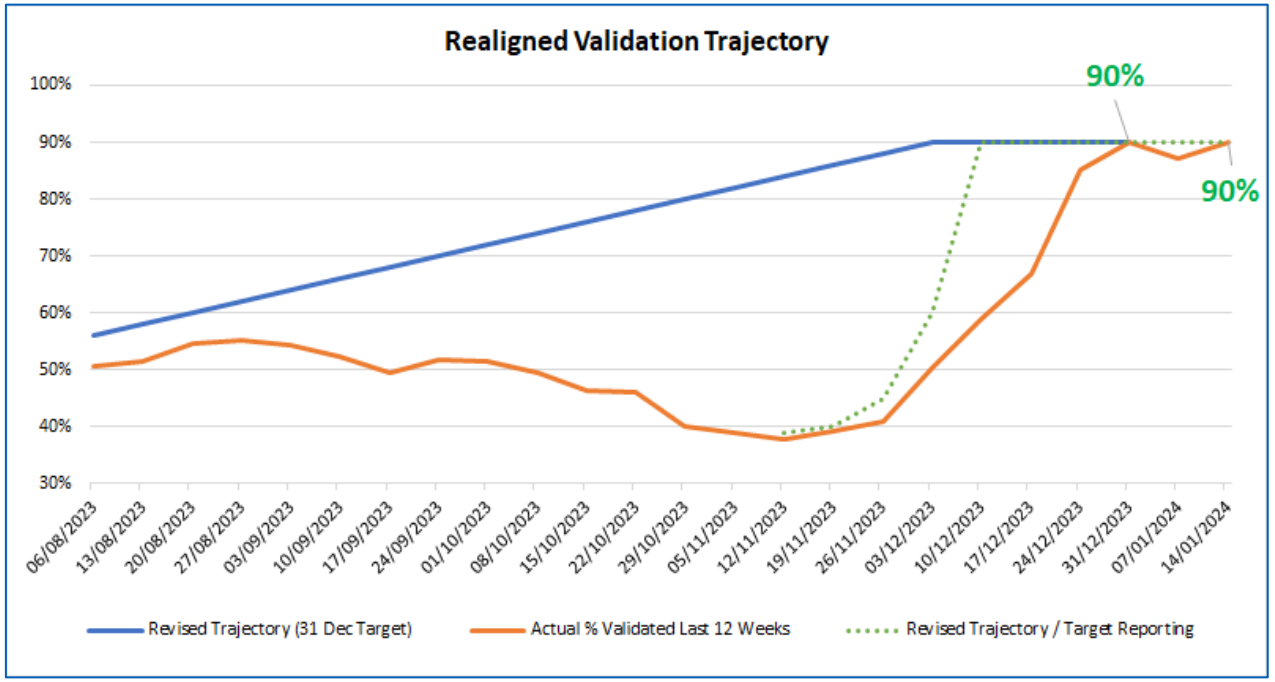
Within Expected <6 weeks

Clinical Haematology 1.9
Obstetrics 3.4
T&O 4.1

RTT Assurances: Validation

Gateshead Health NHS Foundation Trust

RTT: Validation 90% of patients waiting > 12 weeks – 31st December 2023



RTT Validation: 90% by end of December* revised trajectory

Validation Recovery – December 2023: Assurances

- The Trust achieved the ask to have 90% of patents validated who are waiting more than 12 weeks.
- Gateshead Health was the only Trust in NENC to achieve this ask.
- Performance leads have shared our successful processes with NENC colleagues in support of system wide improvements.
- Sustaining our validated position remains a priority and features in 2024/25 Operational Plans.
- The waiting list has reduced by 10 % since targeted validation
- Waiting List managers are actively reviewing learning from validation and linking with training.

- There is a medium-term plan to review validation models going forward & options appraise the best for the Trust.

NHS
Gateshead Health
NHS Foundation Trust

Leading Indicator Appendices

With agreement and approval from the Committee:

Plans going forward would be to streamline this report and upload this section (LI appendices pages 19-34) into the reading room.

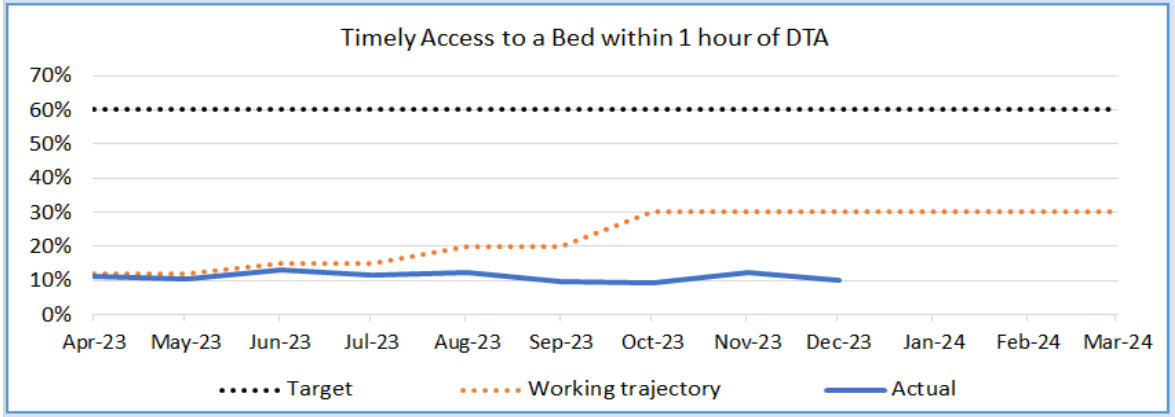
NHS
Gateshead Health
NHS Foundation Trust

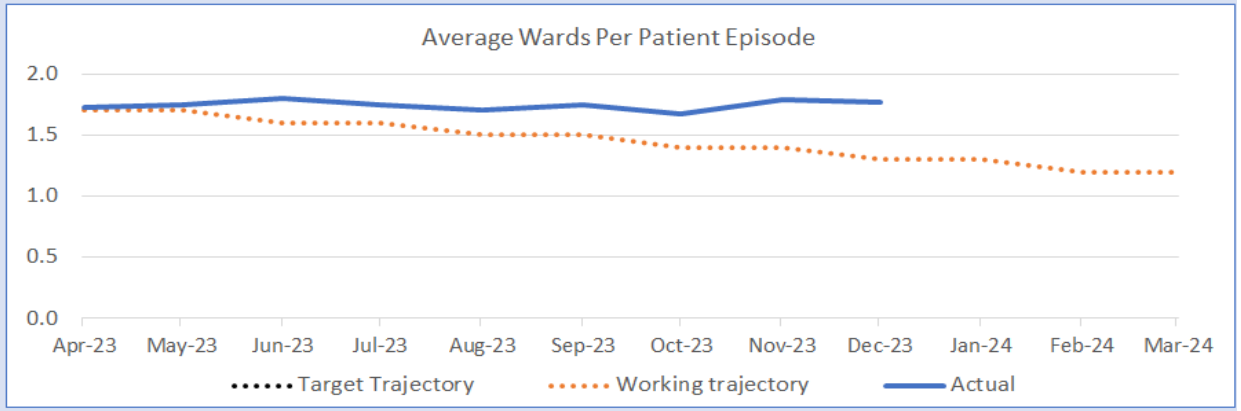
We will improve productivity and efficiency of our operational services

We will improve productivity and efficiency of our operational services

	Status		
LI: Increase the percentage of patients waiting less than 1 hour for a bed from the decision to admit	LI	Director:	Joanna Clark
BO: Reduce the average number of ward per patient episode	BO	Ops Lead:	Mark Dale
BO: Patients moving to the right bed (this measure is currently not available as under development)	BO	Oversight:	Unscheduled Care Programme

NOTE: The indicators in this template "Patients moving to the right bed" and "Reduce the average number of ward moves per patient" are new metrics. Futher work will be undertaken on them to make them as meaningful as possible.





Indicator	Leading Indicator	Period	Target	Target Type	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend
Timely Access to a Bed within an Hour of DTA	LI	Dec-23	>60%	Loc	8.92%	7.49%	9.58%	11.01%	10.49%	12.92%	11.61%	12.22%	9.51%	9.11%	12.25%	10.03%	
Reduction in the average number of wards per patient episode	BO	Dec-23	TBA	Loc	1.74	1.77	1.81	1.73	1.75	1.80	1.75	1.76	1.75	1.67	1.79	1.77	
Patients Moving to the Right Bed	BO		TBA	Loc	(this measure is currently not available as under development)												

Risks: Risk of delayed transfers from the Emergency Department leading to an overcrowded department, extended waits within the ED, poor patient outcomes, poor patient and staff experience.

Risk Mitigation: Unscheduled care programme of work incorporating operational efficiencies, effectiveness and patient flow focus across the place with an emphasis on discharge processes, admission avoidance and attendance alternatives. Formal review of the form and function of the patient flow resource for the organisation. Development of a Task and Finish Group linked to the delivery of a Hospital at Night / Deteriorating Patient Response Model. Relaunch of the Criteria to Reside initiative to improve visibility of our bed occupancy linked to patients with No Reason to Reside.

Causal Factors: Patients remaining in the bed base with no criteria to reside. Reducing bed availability for acute admissions. Temporary reduction in base ward beds due to the final stages of the NOM programme delivery. Digital solution and consistency of reporting linked to the criteria to reside information data set. Further work needed on the BO metrics.

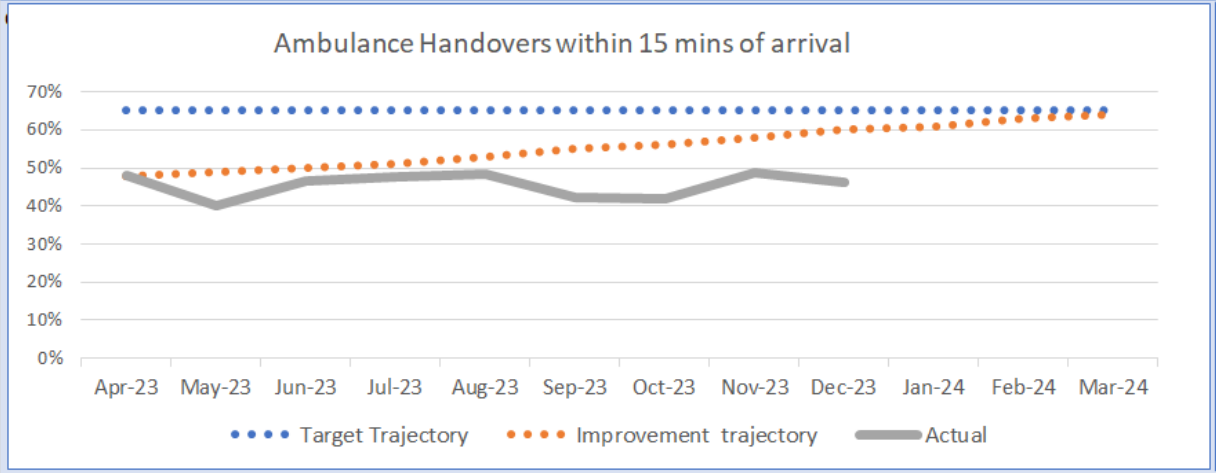
Actions being taken: Completion of the NOM programme in late November. Formal review of the patient flow form and function with amended information flows. Programme to relaunched and engage the organisation in criteria to reside. Review of the BO metrics as part of the leading indicators to link to operational actions.

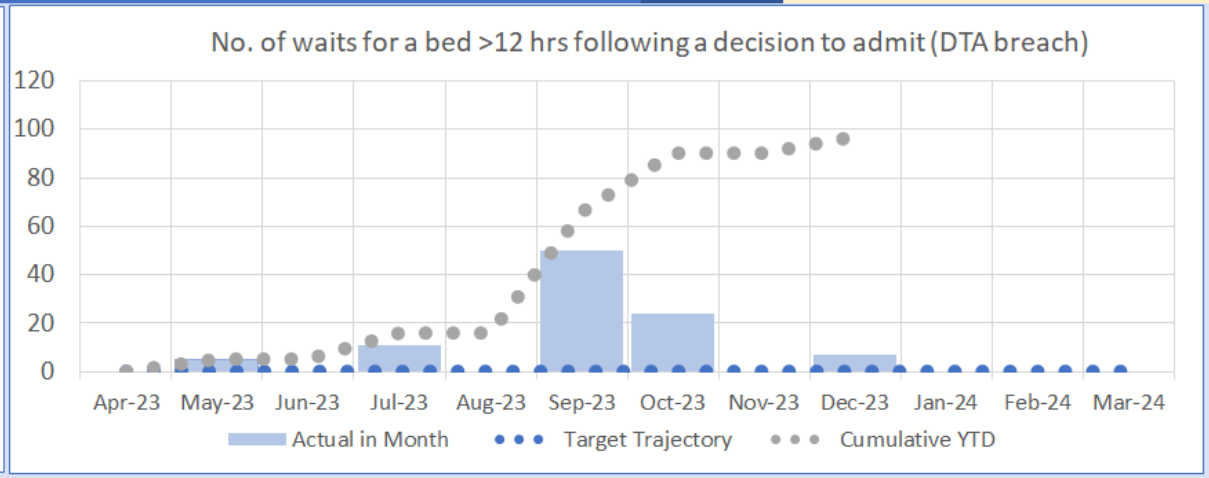
New patient flow meeting format being piloted, which includes increased actions to improve flow and monitoring of 1 hour DTA to bed. Stranded patient meetings also restarted to reduce length of stay.
Weekend discharge service in place to increase discharges on Saturday and Sundays

Winter ward opened 05/11/23 and move away from medically optimised wards which slow flow

We will improve productivity and efficiency of our operational services

	Status		
LI: Reduce the number of waits for a bed >12 hrs following a decision to admit (DTA breach)	LI	Director:	Joanna Clark
BO: Increase in the % of ambulance handovers within 15 minutes	BO	Ops Lead:	Mark Dale
		Oversight:	Unscheduled Care Programme





Indicator	Leading Indicator	Period	Target	Target Type	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend
Ambulance Handovers within 15 mins from arrival	BO	Dec-23	65%	Nat.	39.5%	48.6%	48.0%	48.0%	40.3%	46.6%	47.8%	48.3%	42.4%	41.7%	48.9%	46.1%	
Waits for a bed >12 hrs following a decision to admit (DTA breach)	LI	Dec-23	Zero	Nat.	320	40	80	0	5	0	11	0	50	24	0	7	

Risks:
Risk of delayed transfers from the Emergency Department leading to an overcrowded department, extended waits within the ED, poor patient outcomes, poor patient and staff experience. Risk of ambulance handover delays resulting in an undifferentiated risk in the community due to unavailability of resources to respond, poor patient outcomes and poor patient and staff experience.

Risk Mitigation:
Unscheduled care programme of work incorporating operational efficiencies, effectiveness and patient flow focus across the place.

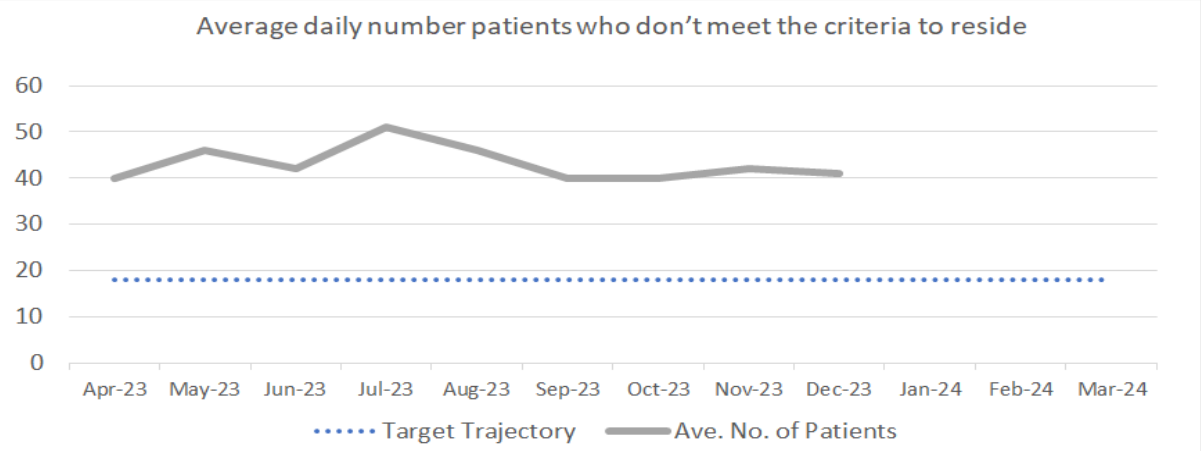
Causal Factors: Estates work is continuing resulting in a temporary decant of wards 'Clustering' of ambulance arrivals making handover difficult at peak times due to environmental constraints within the department. Decision to place in patients within the Same Day Emergency Care environment – reducing SDEC capacity and increasing delays within the Emergency Department.

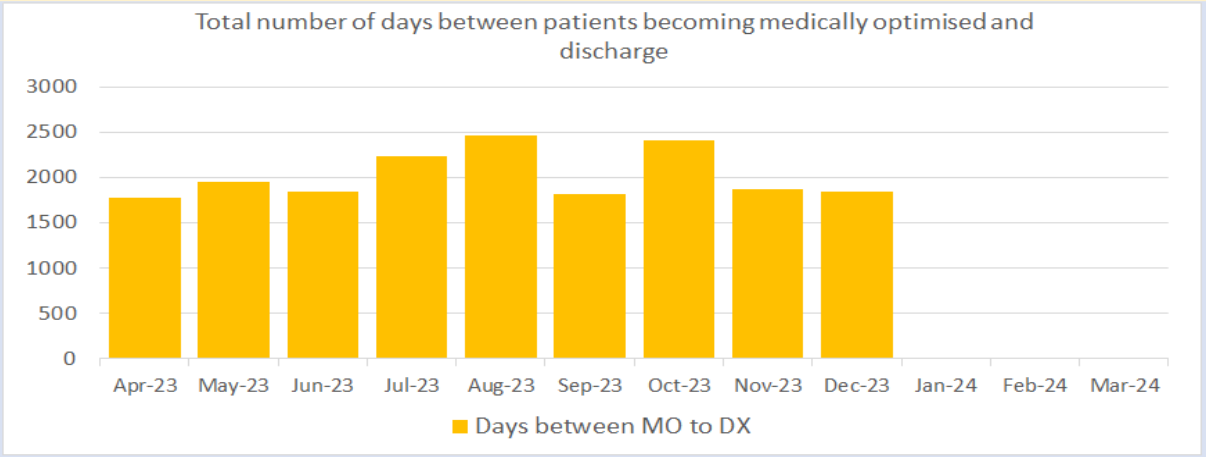
Actions being taken:
Completion of the NOM programme . Review of the ambulance conveyances and identification of 'peak' clustering periods. Meeting with NEAS set up to review conveyance levels and timings. Internal ED action plan progressing to reduce delays. Review of the impact of SDEC being used as additional inpatient capacity. Weekly meeting chaired by the COO in place, alongside an action plan to improve performance.

We will improve productivity and efficiency of our operational services

	Status		
BO: Reduction in the time (days) between patients becoming medically optimised and discharge	BO	Director:	Joanna Clark
BO: Reduce the average number of patients that are in acute beds and who are fit for discharge (do not meet criteria to reside)	BO	Ops Lead:	Gareth Johnson
		Oversight:	Transformation Board

NOTE: The Trust is currently reviewing management of these patients to reflect NHSE terminology of "criteria to reside". Our intention is to reduce patients in acute beds who no longer meet the criteria to reside so this indicator will be subject to change.





Indicator	Leading Indicator	Period	Target	Target Type	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend
Average daily number patients who don't meet the criteria to reside	BO	Dec-23	≤18	Loc.	53	51	43	40	46	42	51	46	40	40	42	41	
Total days between patients becoming MO and discharged	BO	Dec-23	Monitor	Loc.	2259	2391	2798	1783	1952	1851	2236	2467	1818	2407	1877	1851	

Risks: The Trust has an improvement trajectory of no more than 18 patients who are MOFD. There are risks of long waits in ED, cancellation of planned procedures and the risk of opening additional beds with associated staffing implications & patient risk management. Patients remaining within hospital beds longer than necessary for treatment have increased risk of deconditioning and hospital acquired infection.

Risk Mitigation: Risks are managed dynamically through two routes: Operationally this involves daily liaison with social care to identify services outside hospital and increased capacity on surge days for trusted assessment. Strategically this involves working with Commissioners and colleagues at "Place" to ensure that the correct step up step down capacity is in place to facilitate discharge. System partners are working with providers of care outside Gateshead to determine whether discharges to these areas can be expedited.

Causal Factors: There has been a recent increase in LOS of patients over 21 days many of whom remain clinically ongoing. Despite winter pressures the average number of patients daily who do not meet the criteria to reside has remained static and the work on reducing time between MO and discharge continues. Out of area patients awaiting discharge on pathways 1-3 remain high. There remains challenges with patients being discharged to Sunderland.

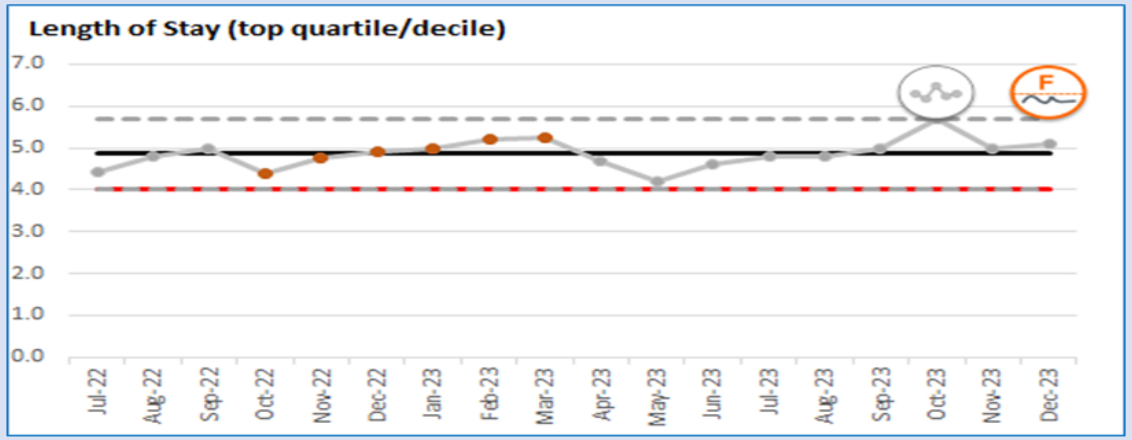
Actions being taken: Daily review of patients on list of patients who are medically optimised. Daily allocation of patients to appropriate out of hospital placements. Strategic planning with social care to identify and appropriately and commission system capacity to reduce pathway 1-3 delays.

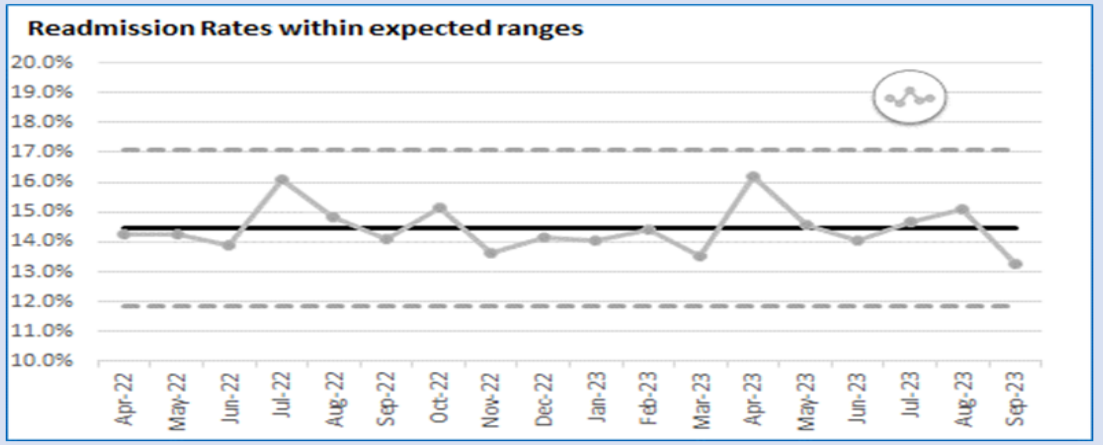
A weekly stranded patient review led by the Chief Matrons has been introduced to further ensure that patients are not remaining in hospital unnecessarily in addition to daily ward review processes.

Virtual Ward staff are coming in to support patients out of back of house beds.

We will improve productivity and efficiency of our operational services

	Status		
LI: Reduction in overall Trust length of stay to the top quartile (<4)	LI	Director:	Neil Halford
BO: Readmission rates within the expected range	BO	Ops Lead:	
		Oversight:	Unscheduled Care Transformation





Indicator	Leading Indicator	Period	Target	Target Type	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend
Trust overall length of stay	LI	Dec-23	Top Quartile <4	Loc.	4.98	5.19	5.23	4.68	4.26	4.44	4.5	4.56	4.73	5.52	4.78	4.85	
Elective (exc. DC)		Dec-23	Monitor	Loc.	4.44	4.7	3.09	4.26	2.52	2.66	3.91	2.48	3.75	3.25	2.17	2.8	
Non Elective		Dec-23	Monitor	Loc.	5.04	5.24	5.45	4.72	4.43	4.6	4.55	4.66	4.83	5.79	5.1	5.08	
Readmission Rates	BO	Sep-23	Monitor	Loc.	14.2%	14.1%	14.4%	13.5%	16.2%	14.6%	14.0%	14.7%	15.1%	13.3%			

Risks

Prolonged stays in hospital are deconditioning patients, especially for those who are frail or elderly, and can provide patients with a poorer care experience, therefore there is a focus on patients being discharged from hospital without unnecessary delay.

Artificially high readmission rates due to all SDEC attendances being captured as NEL Admissions.

Risk Mitigation

Length of stay – Being managed and monitored by Business Unit and Service Line. Forms part of Unscheduled Care Transformation Programme.

Re-admissions - Being managed and monitored by Business Unit and Service Line. Forms part of Unscheduled Care Transformation Programme.

Causal Factors:

Length of stay – Influenced by factors external to the Trust with respect to discharge. Improve discharges to earlier in the day and improving transfer of care. Getting people to the right place first time. Keeping the system flowing well.

Re-admissions - Data capture of SDEC return patients as NEL admissions inflates re-admission rate. Digital capacity to implement change to Type 5 is limited - Risk of deferring.

Actions being taken:

Length of stay – Work closely and into the system wide winter plan. Identify priorities within clinical pathways to allow timely and appropriate resource allocation (outputs from CSG). Further development of frailty at the front door to reduce admissions, embedded use of the virtual ward, criteria led discharge, red and green days, development of the discharge lounge and better use of digital enablers.

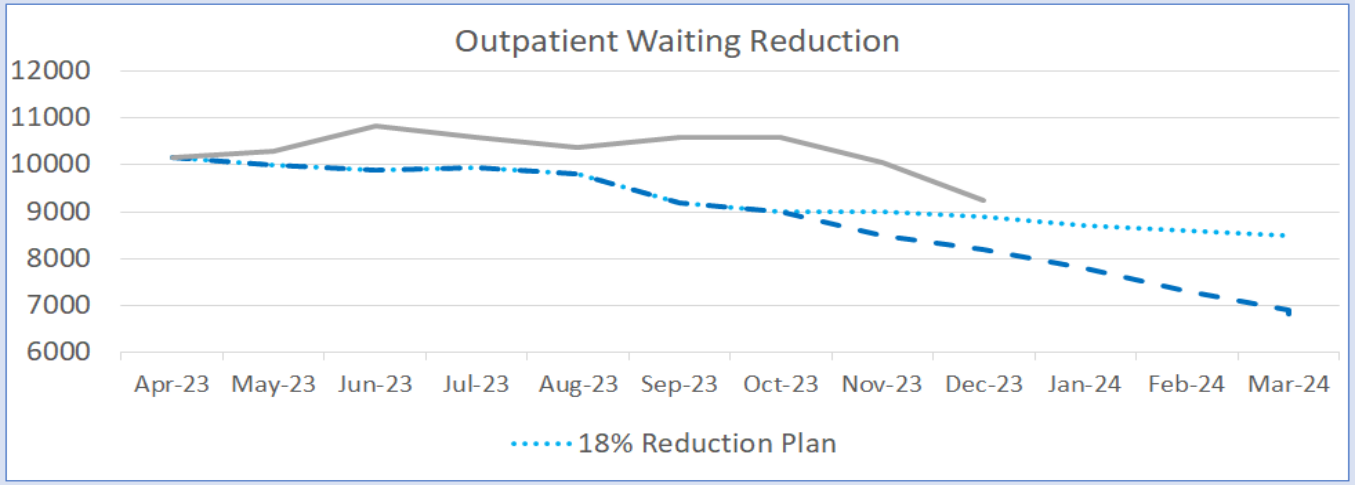
Re-admissions - Remodel SDEC Follow-ups, deduct from NEL to determine real rate, and continue to monitor. Develop integrated flow across the integrated care model.

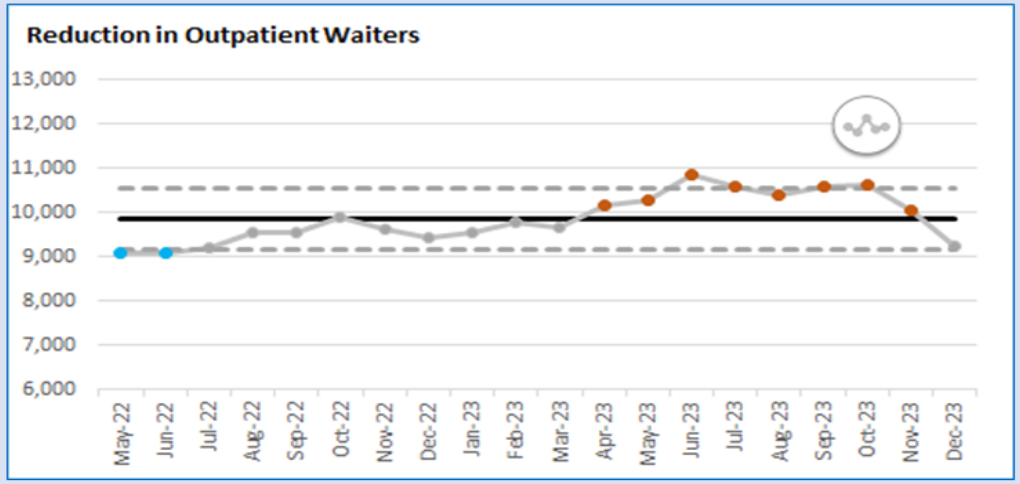
We will improve productivity and efficiency of our operational services

BO: A reduction in the RTT PTL outpatient waiting list

Status: BO

Director: Amy Muldoon / Mike Graham
Ops Lead: Ross Peddie / Jason Crawford
Oversight: Elective Care Programme





Indicator	Leading Indicator	Period	Target	Target Type	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend
No of outpatient on the RTT waiting list	BO	Dec-23	7,500	Loc.	9558	9784	9643	10146	10283	10835	10584	10387	10580	10601	10044	9249	

Risks: Referrals are above pre covid levels. Capacity planning difficult without up-to-date job plans. Forecast waits above planned levels: reputational risk. Risk of ability to achieve target of Zero 52w by year end.

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

Causal Factors:
Elective activity below plan- IA and Staffing issues impacting position due to cancellation of elective activity. Whilst significant success has been achieved with the recent validation exercise, there is not a dedicated resource in place to fulfil this function on an ongoing basis.

Actions being taken: Productivity opportunity by implementation pilot of partial booking. Activity plans discussed weekly through Access and Performance meeting, and divisional meetings. Scoping opportunities for additional activity through additional clinics. Review of OP clinic templates in progress to understand any potential opportunities. Potential of clinical triage of referrals to manage demand- scoping in the SBU presently. Outpatients Transformation programme to look at further opportunities in draft. Job plan reviews underway. Scoping independent sector for potential additional capacity.

Scoping potential 'super clinics' for Surgical specialties where there is a long wait for 1st Outpatient appointment as well as targeted clinic validation for referrals

Targeted validation work is in progress across all specialties., with validating all patients over 10 weeks currently on the PTL (adm and non adm) taking place.

NHS
Gateshead Health
NHS Foundation Trust

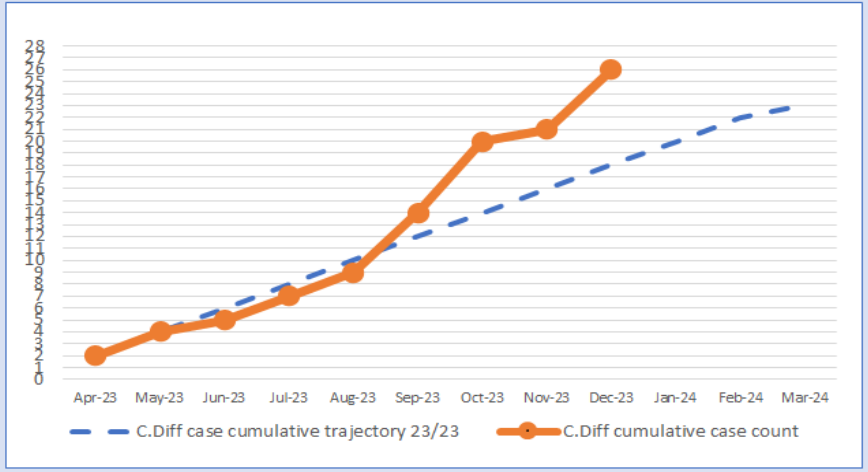
We will continually improve the quality and safety of our services for our patients

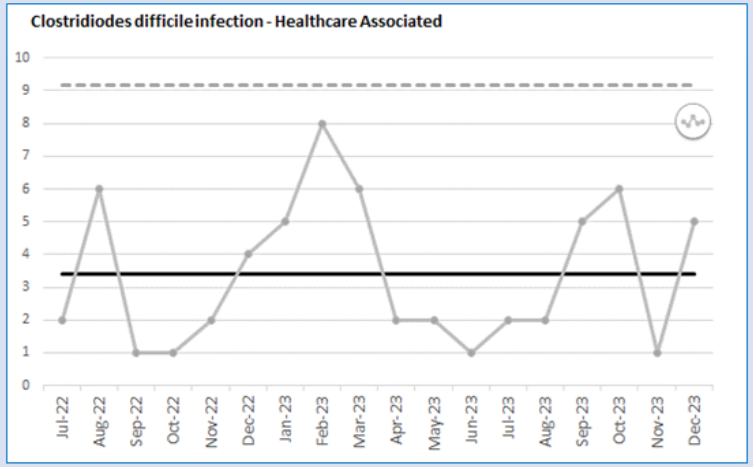
NHS Gateshead Health NHS Foundation Trust

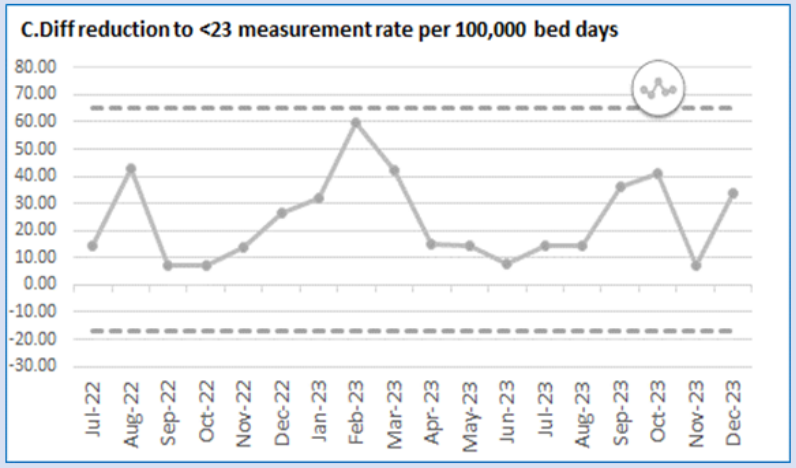
We will continually improve the quality and safety of our services for our patients

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

Status		
LI	Director:	Gill Findley
	Ops Lead:	Gareth Armstrong
	Oversight:	QGC







C Difficile	C.Diff Reduction target of <23 actual incidents for 2023/24											
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Healthcare Associated	2	2	1	2	2	5	6	1	5			
Total YTD (target no more than 23 in the year)	2	4	5	7	9	14	20	21	26			
Community Associated	2	0	0	0	2	2	0	0	1			

Risks: Risk of patients getting c diff and experiencing poor outcomes, extended stays and potential death. Reputational risk of not hitting national targets. Due to the severely decreased threshold for 23/24, there is a risk that the threshold is not met/exceeded.

Risk Mitigation: Education for front line staff. Good hand hygiene monitored by matrons monthly. New RAG rated cleaning process implemented for environment where c-diff has occurred. Increased surveillance by the IPC team regarding CDI patients. Sporicidal wipes placed in all clinical areas for enhanced equipment cleaning. New posters planned for display across the organisation. All Healthcare Associated Infections are investigated, and any learning shared with the relevant business units.

Causal Factors: High levels of C Diff currently circulating in the community. More virulent strain of C-diff identified by UKHSA. High level of antibiotic prescribing in some areas. High bed occupancy rate. De-escalation of IV to oral antibiotics.
Increase of bays in some parts of the organisation to above recommended levels i.e. 6 beds in a bay on scheme 3. Hand hygiene and bare below the elbow compliance on clinical areas. Sharing of contaminated equipment.

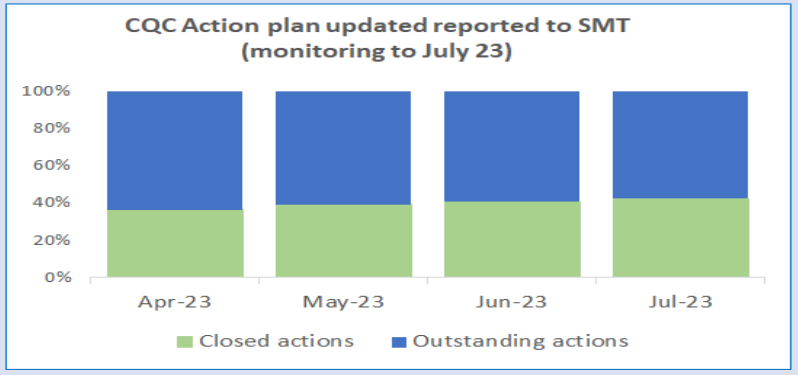
Actions being taken: Careful monitoring of antibiotic prescribing. Increased work on improving hand hygiene. Introduction of faecal transplanting for some patients. A 10 point action plan has been developed by the IPC team and the consultant microbiologists. This reflects the regional strategy for Clostridioides difficile reduction rate across our ICB. The 10 actions covered within the plan have been discussed and approved at the IPCC and are as follows; education, information campaign, hand hygiene drive, digital record keeping, thematic review and feedback, antimicrobial stewardship, diagnostic stewardship, prevent onward spread, cleaning and disinfection and prevent recurrent cases through enhancing treatment.

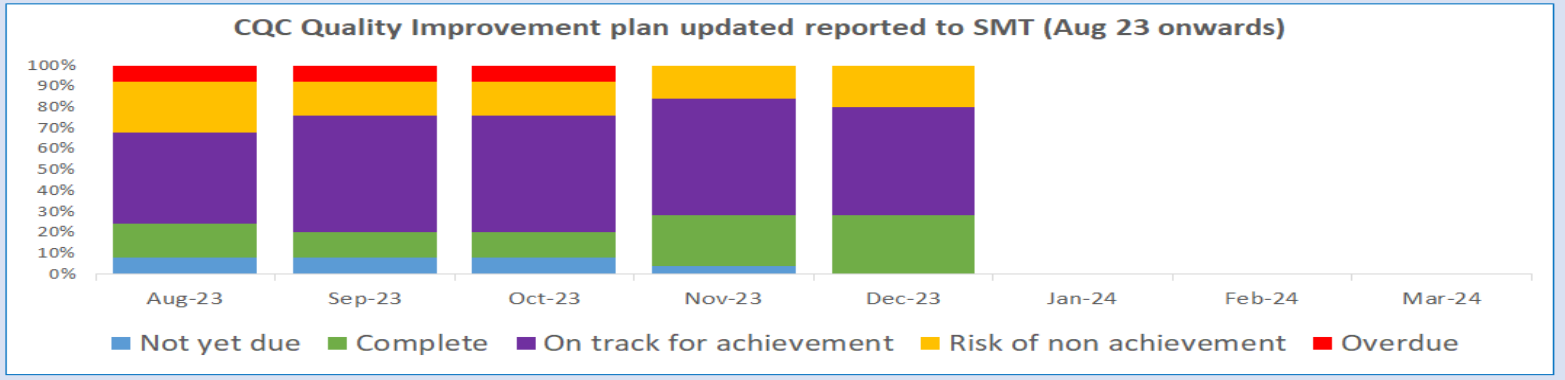
Poster campaign regarding bare below the elbow, new role of IPC audit assistant to focus on hand hygiene and bare below the elbow compliance, helping to collate areas in need of greater education. Independent audit of equipment cleanliness.

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

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

Status		
LI	Director:	Gill Findlay
	Ops Lead:	Andrew Rayner / Lindsay Grieves
	Oversight:	SMT





	CQC Action Plan updated reported to SMT											
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Total number of actions	154	151	158	158	Old monitoring to July 23 - replaced from Aug 23 onwards, see below.							
Outstanding actions	98	92	94	91								
Closed actions	56	59	64	67								

	CQC Quality Improvement Plan updated reported to SMT											
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Total Actions	New monitoring from Aug 23 onwards				25	25	25	25	25	25	25	25
Overdue					2	2	2	0	0			
Risk of non achievement					6	4	4	4	5			
On track for achievement					11	14	14	14	13			
Not yet due					2	2	2	1	0			
Complete					4	3	3	6	7			

Risks:
Non-compliance with CQC regulations. Risk of harm to patients if regulations not followed. Reputational damage if CQC visit and we are in breach of licence.

Risk Mitigation:
CQC compliance officer in post. Regular reporting to SMT. Actions clearly allocated to identified leads with clear timescales.

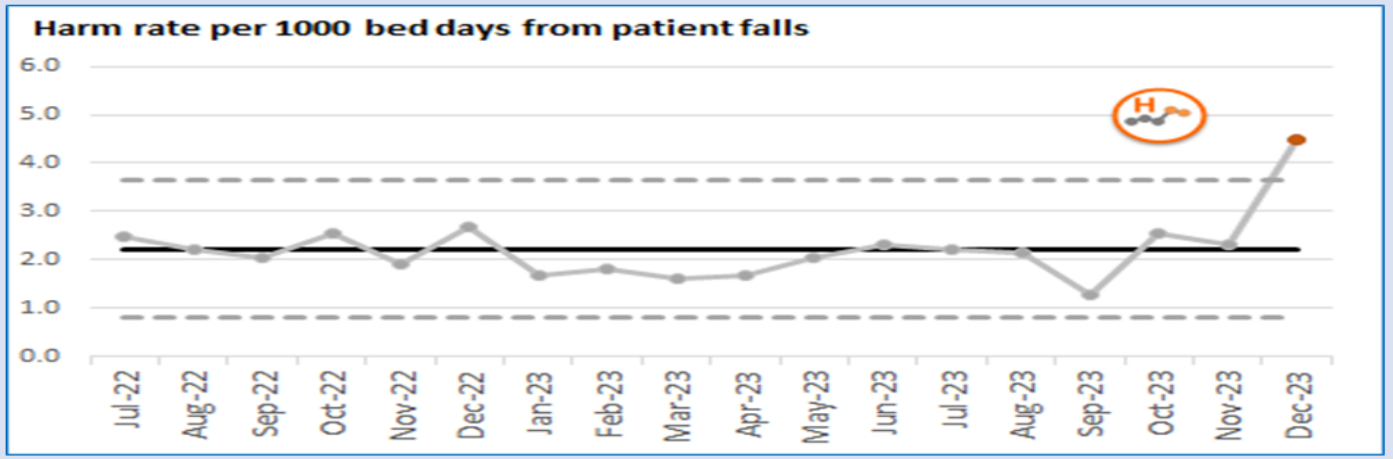
Causal Factors:
Changes to CQC regulations and requirements.

Actions being taken:
Continuous monitoring of the Quality Improvement Plan and regular meetings with action owners will take place.
Bi-monthly updates on the plan will be taken to SMT to monitor progress and escalate any issues when necessary.
Note: 1 outstanding action remains on the 2019 CQC action plan. This action is currently rated as amber and is in relation to staff appraisals rates with a focus on Surgery where the initial issue was raised.

NHS Gateshead Health NHS Foundation Trust

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

	Status		
LI: Reduction in the harm rate per 1,000 bed days from patient falls	LI	Director:	Gill Findlay
		Ops Lead:	Shelley Dyson / Louise Lodge
		Oversight:	Quality Governance Committee



	Monthly harm from falls											
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Harm rate per 1,000 bed days from patient falls	1.67	2.13	2.31	2.21	2.13	1.27	2.54	2.37	4.48			
Improvement Trajectory	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA			

Risks: Inpatient falls continue to be a leading patient safety event reported in the Trust. These can vary from no harm to severe harm, and whilst the majority reported are no harm/low harm, we still have a number where patients sustain fractured neck of femurs or sustain significant head injuries from falling.

Risk Mitigation: Falls reviews and learning responses are managed at a ward level but overseen by the patient safety lead for that area. All falls learning responses are reviewed at learning panels, and the Trust also supports wider improvement initiatives via a Trust Falls Prevention Group/workstream. This supports the new PSIRF (patient safety incident response framework) which replaces the SIF (serious incident framework). This allows Trusts to focus on prevention work/quality improvement initiatives by investigating themes instead of every individual fall (that invariably generates no new learning). Falls are a leading quality Metrix, reported monthly and reviewed and action planned at ward level. Competency based assessment training for registered and HCSW staff is available and supported.

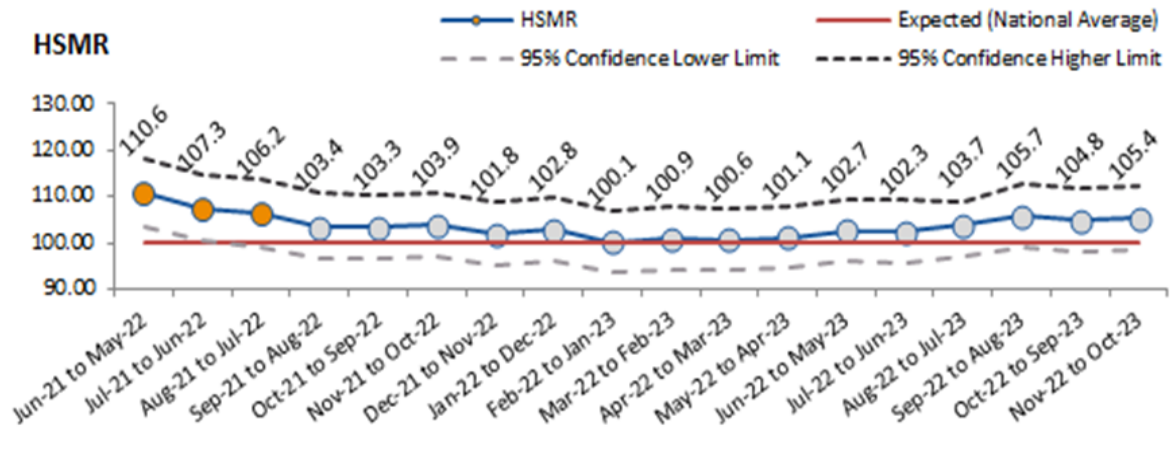
Causal Factors: No inpatient falls provision to support with training, education, and expertise.

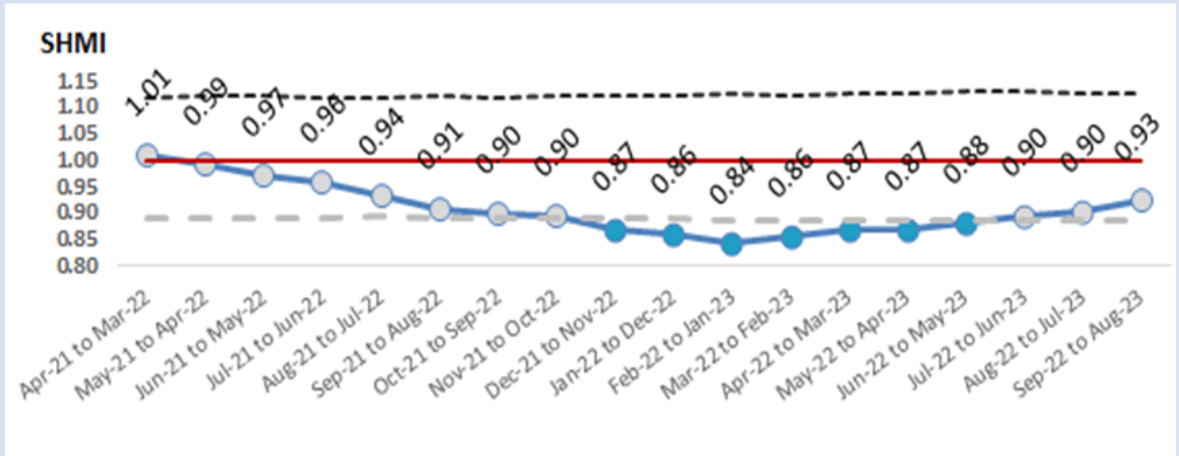
December saw a significant increase in the rate of harm falls per 1000 bed days. Initial analysis indicates that this may be attributable to an increase in patients falling multiple times within the month. Further investigation may be required to identify if these were patients susceptible to falling and the use of risk assessments to capture this. It can also be acknowledged that reporting onto the new Trust incident reporting system is strong and staff confidence in using the system may have increased reporting of incidents overall.

Actions being taken: Review of how we monitor falls and learn from incidents. Introduction of 'Avoiding Falls Level of Observation Assessment Tool (AFLOAT)', the aim was to reduce specific falls risk, improve patient safety and improve patient outcomes and experience. Audits of compliance will now be commenced. Further investigations to understand the sudden increase in incidents.

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

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





Indicator	Leading Indicator	Period	Target	Target Type	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Trend
Summary Hospital Mortaility Indicator (SHMI) (rolling 12 months)	BO	Aug-23	≤1	Nat.	0.84	0.86	0.87	0.87	0.88	0.9	0.9	0.93			
Hospital Standard Mortality Ratio (HSMR) (rolling 12 months)	BO	Sep-23	`	Nat.	100.1	100.9	100.6	101.1	102.7	102.3	103.7	105.7	104.8	105.4	

Risks: Both the HSMR and SHMI are quality benchmarking metrics, that monitor Trust performance in relation to mortality against statistical expectation calculated from national datasets. The HSMR is showing deaths 'As Expected' with a score of 105.4 against the national average figure of 100. The SHMI recently returned to As 'Expected' deaths with the latest figure of 0.93. A likely explanation for the recent reduction in the SHMI score is the inclusion of SDEC activity within the inpatient dataset from Sep-21. Observed deaths will remain the same, however the increased volume of activity will result in higher expected deaths being calculated by the model. Once SDEC activity moves to Type 5 A&E activity (Planned early 2024-25) then the SHMI score is likely to increase at that point.

Risk Mitigation: Cases scoring more than Hogan 1 are subject to a review at Mortality Council, a proportion of these cases are also patient safety incidents and would go through the Trusts Patient Safety Learning Panel. Since the inception of the Medical Examiner Service in September 2020, all deaths are reviewed and cases may be escalated for additional investigations i.e., Mortality Council, patient safety investigation. Mortality review data for the last 12 months demonstrates that 99.8% of deaths reviewed were 'Definitely not preventable' with 96.6% of cases reviewed identified as 'Good practice'.

Casual Factors: Reviewing of deaths of under 65 with a serious mental illness diagnosis. Outstanding ward level reviews in Medicine and Surgical BU's. challenges of representation at Mortality Council meetings. Cancellation of Mortality Council due to industrial action increases the backlog of cases to review.

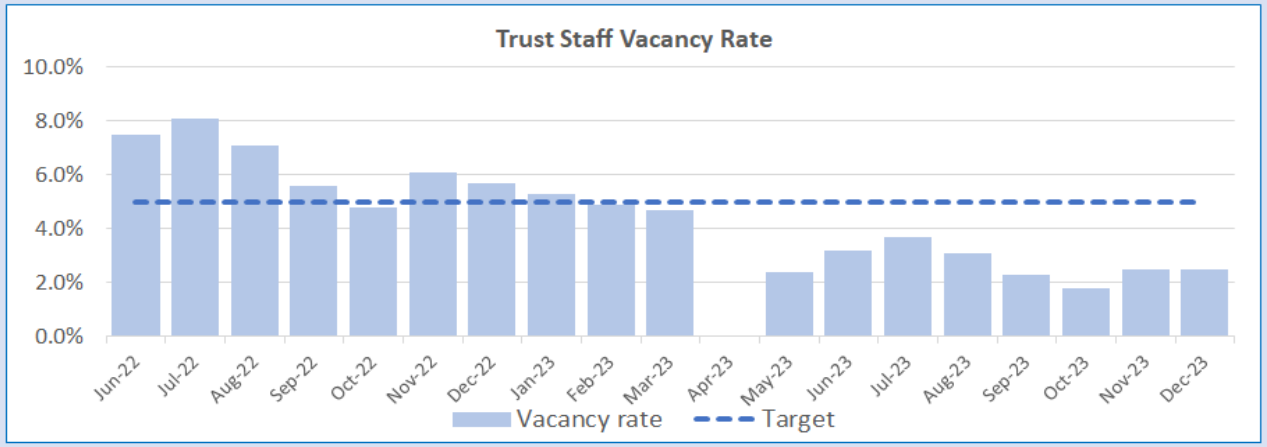
Actions being taken: The process for reviewing deaths were patients had a serious mental illness diagnosis. The process is embedded for those over 65, however the process to review under 65s relies on input from CNTW. The process has now been agreed with CNTW, they will review the backlog of cases and present at the Mortality Council in the next couple of months and do these when they arise going forward.
Several further Mortality Councils have been scheduled and existing meetings extended to attempt to resolve the backlog of cases. The attendance at the Council by clinicians has increased over the last couple of months, reducing issues around quoracy. A governor has joined the meeting to provide input from the patient perspective.
Some of the backlog are cases that rely on other processes such serious incident and complaints investigations – these cases will be scheduled on completion of these investigations.

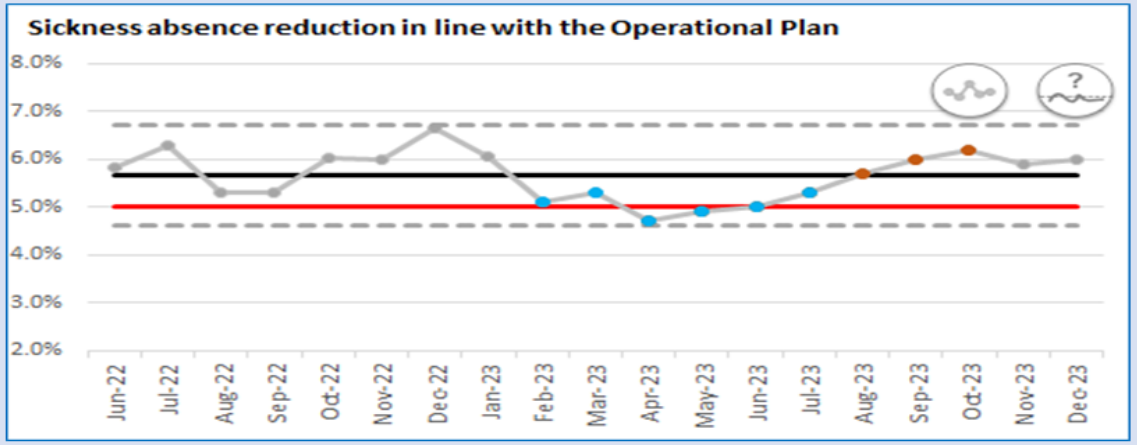
NHS
Gateshead Health
NHS Foundation Trust

We will be a great organisation with a highly engaged workforce

We will be a great organisation with a highly engaged workforce

	Status		
LI: Maintain a target score of 6.9 in Trust Staff Survey for engagement	LI	Director:	Amanda Venner
BO: Reduce the vacancy rate in line with the Operational Plan to below 5%	BO	Ops Lead:	Natasha Botto
BO: Reduce the sickness absence rate in line with the Operational Plan to below 5%	BO	Oversight:	P&OD Committee





Indicator	Leading Indicator	Period	Target	Target Type	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend
Trust Staff Survey rate - Engagement score	LI	Q1	SS: 6.9	Loc.	6.47			6.77			5.92			from staff survey			
Group Staff Vacancy rates	BO	Dec-23	≤5%	Loc.	5.3%	4.9%	4.7%	Not Available	2.6%	3.4%	3.7%	3.1%	2.3%	1.8%	2.5%	2.5%	
Group Sickness Absence	BO	Dec-23	≤5%	Loc.	6.1%	5.1%	5.30%	5.0%	4.9%	5.0%	5.3%	5.7%	6.0%	6.2%	5.9%	6.0%	

Risks: Engagement Score: Low levels of engagement with both Annual and Pulse Survey Results, bringing validity of measure into question. Annual Engagement score has been declining since 2018 and 2022 saw this steady for the second year at 6.9. **Vacancy Rates:** Vacancies add pressure to the group and our ability to provide a safe and high quality service. **Absence rates:** Absence adds pressure to the group and our ability to provide a safe and high quality service.

Mitigation of Risk; Engagement Score: A revised focus on increasing engagement, particularly clinical engagement, reducing vacancy and absence rates to improve staffing levels, which is cited as a key area of concern for colleagues. **Vacancy Rates:** Continued monitoring of group vacancy rates at a granular level. **Absence rates:** Robust system of absence management introduced – new policy in place >12 months. Absence management training package available. Focused work including monthly case reviews, target setting and sickness clinics.

Causal Factors:
Engagement Score: Individuals across the organisation experiencing 'survey fatigue' or feeling that their feedback is not acted upon. **Vacancy Rates:** Local & national qualified staff shortages. **Absence rates:** Volume of individuals triggering and continuing to trigger the absence management policy. Pockets of strong engagement, but not universal.

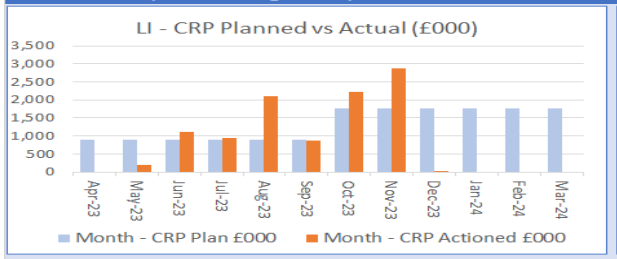
Actions beign taken: Engagement Score: Plans in place to encourage engagement, as well diversify engagement measurement tools to gain a more rounded picture. Likely this will involve a more targeted focus on the 3 elements of the Engagement Score i.e. Motivation, Involvement and Advocacy. Comms via the CEO messaging around the importance of completing staff survey and tangible Trust Wide actions that have been taken as a result of this. **Vacancy Rates:** POD strategies including focusing on retention, absence management, health & wellbeing, international recruitment. Consideration of the NHS long term plan and implications at a local level. Begin to develop robust workforce planning processes across the organisation considering skills requirements and utilisation of new roles e.g. RDNA programme. **Absence rates:** Continue with monthly case management approach of all long term absence cases. Business Units provided with monthly short term absence reports highlighting all employees who have triggered short term absence procedure. Ongoing training and development being explored internally to support managers. Recruited recent vacancies within the POD team and on appointment anticipate again seeing the benefit of specialist support being involved from an early stage in the absence process.

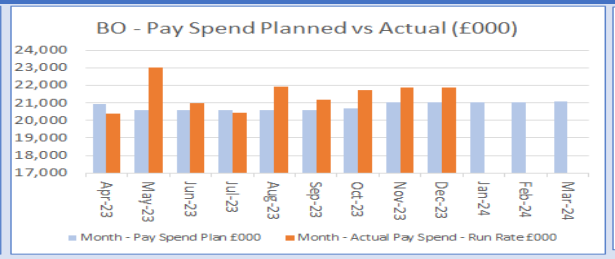
Gateshead Health NHS Foundation Trust

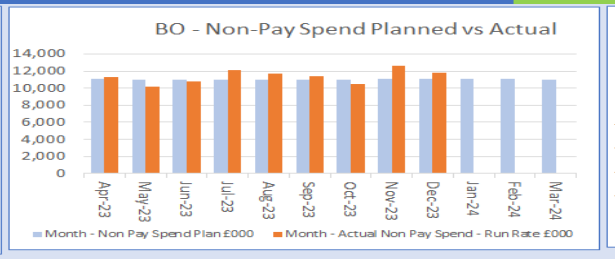
We will achieve financial sustainability

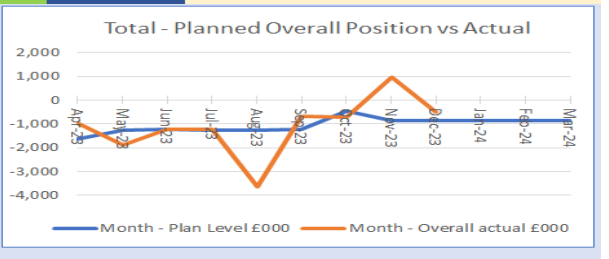
We will achieve financial sustainability

	Status		
LI: CRP actioned to achive £15.9m reductions	LI	Director:	Kris Mckenzie
BO: Pay spend no greater than £250m	BO	Ops Lead:	Jane Faye
BO: Non-pay spend no greater than than £132.5m	BO		
BO: Overall position against plan deficit of £12.58m	BO	Oversight:	Finance & Performance Committee









	Leading Indicator	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	YTD
Month - CRP Plan £000	LI	897	897	897	897	897	897	1,753	1,753	1,753				10,641
Month - CRP Actioned £000		0	191	1,116	949	2,096	861	2,231	2871	3				10,318
Month - Variance £000		-897	-706	219	52	1,199	-36	478	1,118	-1,750				-323
YTD - CRP Plan £000		897	1,794	2,691	3,588	4,485	5,382	7,135	8,888	10,641				
YTD - CRP Actioned £000		0	191	1,307	2,256	4,352	5,213	7,444	10,315	10,318				
YTD - Variance £000		-897	-1,603	-1,384	-1,332	-133	-169	309	1,427	-323				
Month - Pay Spend Plan £000	BO	20,953	20,593	20,593	20,593	20,593	20,593	20,677	21,037	21,037				186,669
Month - Actual Pay Spend - Run Rate £000		20,379	23,002	20,994	20,451	21,913	21,154	21,724	21,896	21,896				193,409
Month - Variance £000		-574	2,409	401	-142	1,320	561	1,047	859	859				6,740
YTD - Pay Spend Plan £000		20,953	41,546	62,139	82,732	103,325	123,918	144,595	165,632	186,669				
YTD - Actual Pay Spend - Run Rate £000		20,379	43,381	64,375	84,826	106,739	127,893	149,617	171,513	193,409				
YTD - Variance £000		-574	1,835	2,236	2,094	3,414	3,975	5,022	5,881	6,740				
Month - Non Pay Spend Plan £000	BO	11,051	11,025	11,025	11,025	11,025	11,025	11,027	11,053	11,053				99,309
Month - Actual Non Pay Spend - Run Rate £000		11,311	10,203	10,823	12,152	11,681	11,388	10,505	12,568	11793				102,425
Month - Variance £000		260	-822	-202	1,127	656	363	-522	1,515	740				3,116
YTD - Non Pay Spend Plan £000		11,051	22,076	33,101	44,126	55,151	66,176	77,203	88,256	99,309				
YTD - Actual Non Pay Spend - Run Rate £000		11,311	21,514	32,337	44,489	56,170	67,559	78,064	90,632	102,425				
YTD - Variance £000		260	-562	-764	363	1,019	1,383	861	2,376	3,116				
		Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
Month - Plan Level £000	Overall position against plan	-1,628	-1,242	-1,240	-1,242	-1,242	-1,239	-472	-858	-857				-10,020
Month - Overall actual £000		-954	-1866	-1211	-1216	-3625	-666	-710	978	-502				-9,772
Month - Variance £000		674	-624	29	26	-2,383	573	-238	1,836	355				248
YTD - - Plan Level £000		-1,628	-2,870	-4,110	-5,352	-6,594	-7,833	-8,305	-9,163	-10,020				
YTD - Overall actual £000		-954	-2,820	-4,031	-5,247	-8,872	-9,538	-10,248	-9,270	-9,772				
YTD - Variance £000		674	50	79	105	-2,278	-1,705	-1,943	-107	248				

Risks: Overspend against delegated budgets.
Non-achievement of recurrent cost reduction programme.
Non-achievement of activity trajectories and income targets.

Risk mitigation: Performance monitoring and identified support in accordance with Trusts accountability programme.
Performance monitoring as part of monthly oversight meetings. Weekly activity performance dashboards and introduction of new financial controls limiting discretionary spend, authorisation of waiting list payments and use of agency staff.

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

Action being taken: Investment in admission avoidance and discharge schemes from external funding to support urgent & emergency care and virtual wards. Implementation of new operating model ward configuration. Deep dive into Medicine Business Unit and production of financial recovery plan. Finance workstream delivery oversight groups which includes back to basics and enhanced financial controls including minimising discretionary spend, criteria for the approval of waiting lists and use of agency staff. Investment in international nurse recruitment to fill substantive vacancies. Deep dive into senior medical funded establishments, job plans and actual payments. Coding & Counting review and elective care transformation programme. Regional discussions to secure non-recurrent funding to support pressures associated with industrial action.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 15i

Report Title:	**Maternity Integrated Oversight Report – November and December 2023**			
Name of Meeting:	Trust Board			
Date of Meeting:	31st January 2024			
Author:	Ms Karen Parker, Lead Midwife for Risk and Patient Safety/Head of Midwifery and Ms Kate Hewitson, Service Line Manager			
Executive Sponsor:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	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 months of November and December 2023			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	This paper has been considered by the departmental Safecare and Surgical Business Unit Safecare			
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 November 2023, we had 150 births, 0 serious incidents (SI's), 0 HSIB cases and 1 perinatal loss. • In December, we had 179 births, 0 serious incidents (SI's), 0 HSIB cases and 1 perinatal loss. • Our PPH rate (>1.5 L blood loss after birth) continues to flag on SPC but has settled to the previous level of around 12/month. This is in line with regional and national trends. Focussed departmental audits and QI work continues alongside regional sharing. • 3rd and 4th degree tears are flagged as low on SPC. The service is considering reducing the target to align to regional and national reported data. • An update is provided on maternal readmissions following a high SPC flag in October 2023. Cases are within target since then. • The December 2023 birth rate is 17% higher than December 2022.			

	Mortality and morbidity rates • 2 perinatal losses during November and December 2023 • 0 HSIB cases • 0 Serious Incidents **Compliance with Maternity Incentive Scheme and Saving Babies Lives Care Bundle** • The service will be reporting full compliance with the MIS (separate report) • The service will be reporting compliance at the required target with SBLCB in order to meet MIS requirements (report to follow in January IOR following LMNS assurance meeting)	
	The Board is asked to review the detail provided within this report for assurance.	
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead
Trust corporate objectives that the report relates to:		

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 November 2023

Maternity IOR contents

- Maternity Dashboard 2023/24:
    - November 2023 data

- Exception reports:
    - Maternity dashboard exceptions
        - PPH>1500ml
        - 3rd & 4th degree tears

- Items for information:

    - Perinatal Quality Surveillance minimum dataset
    - Incidents
        - No SIs reported in November 2023
        - No HSIB cases reported in November 2023
    - Perinatal Mortality and Morbidity
        - 1 perinatal loss in November 2023
    - Transitional care/Term admissions – Q2 summary & pneumothorax review

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Births	Nov 23	150	-			149	112	186
Spontaneous vaginal deliveries	Nov 23	84	-			77	52	102
Assited births	Nov 23	66	-			72	47	98
Induction of Labour	Nov 23	64.00%	-			64.94%	44.60%	85.28%
Maternity Readmissions	Nov 23	0	-			3	-2	8
Neonatal Readmissions	Nov 23	6	-			5	-3	12
Smoking at time of booking	Nov 23	9.14%	15.00%		?	10.85%	5.77%	15.93%
Smoking at time of delivery	Nov 23	10.74%	6.00%		?	9.94%	4.03%	15.85%
In area CO at booking	Nov 23	89.53%	90.00%		?	82.14%	71.31%	92.98%
In area CO at 36 weeks	Nov 23	83.80%	80.00%		?	80.05%	69.02%	91.08%
Admitted directly to NNU (SCBU) (>37 weeks)	Nov 23	6	4		?	5	-4	14
Percentage Admitted directly to NNU (SCBU) (>37 weeks)	Nov 23	4.29%	6.00%		?	3.61%	-2.70%	9.92%
Preterm birth rate <=36+6 weeks at birth	Nov 23	6.04%	6.00%		?	5.64%	1.11%	10.16%
Continuity of Carer: Percentage placed on pathway (29 w	Nov 23	17.33%	-			18.25%	11.41%	25.08%
Continuity of Carer: Percentage from BAME backgrounds	Nov 23	34.62%	-			29.20%	1.22%	57.18%
Spontaneous Vaginal Births (%)	Nov 23	56.38%	-			51.65%	35.87%	67.42%
Induction Rate	Nov 23	42.67%	-			44.21%	31.10%	57.31%
Instrumental Delivery Rate	Nov 23	14.00%	-			11.85%	3.23%	20.47%
Elective C Section Rate	Nov 23	14.77%	-			18.28%	8.93%	27.64%
Emergency C Section Rate	Nov 23	14.77%	-			18.01%	7.18%	28.84%
C Section Rate	Nov 23	29.53%	-			36.29%	22.44%	50.15%
3rd or 4th degree tear (Total) Precentage	Nov 23	1.33%	5.00%		P	1.59%	-1.76%	4.94%
Massive PPH >=1.5L (All births)	Nov 23	11	2	H	?	8	-1	17
Breastfeeding: Percentage of Initiated Breasfeeding	Nov 23	71.81%	66.20%		?	69.21%	48.09%	90.32%
Breastfeeding: Breasfeeding at Discharge (Transfer to Co	Nov 23	48.99%	56.20%		?	51.60%	38.70%	64.50%

Maternity

NHS
Gateshead Health
NHS Foundation Trust

Safe

Responsive

Maternity Dashboard 2023/24

Maternity Dashboard 2023/24

Maternity

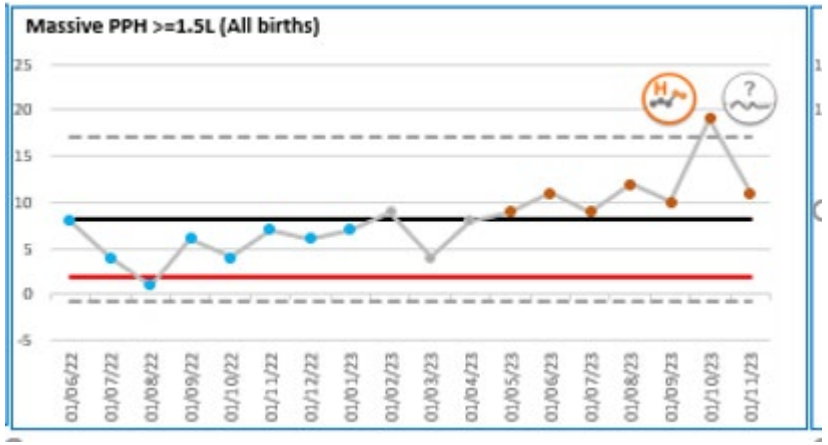
NHS

Gateshead Health

NHS Foundation Trust

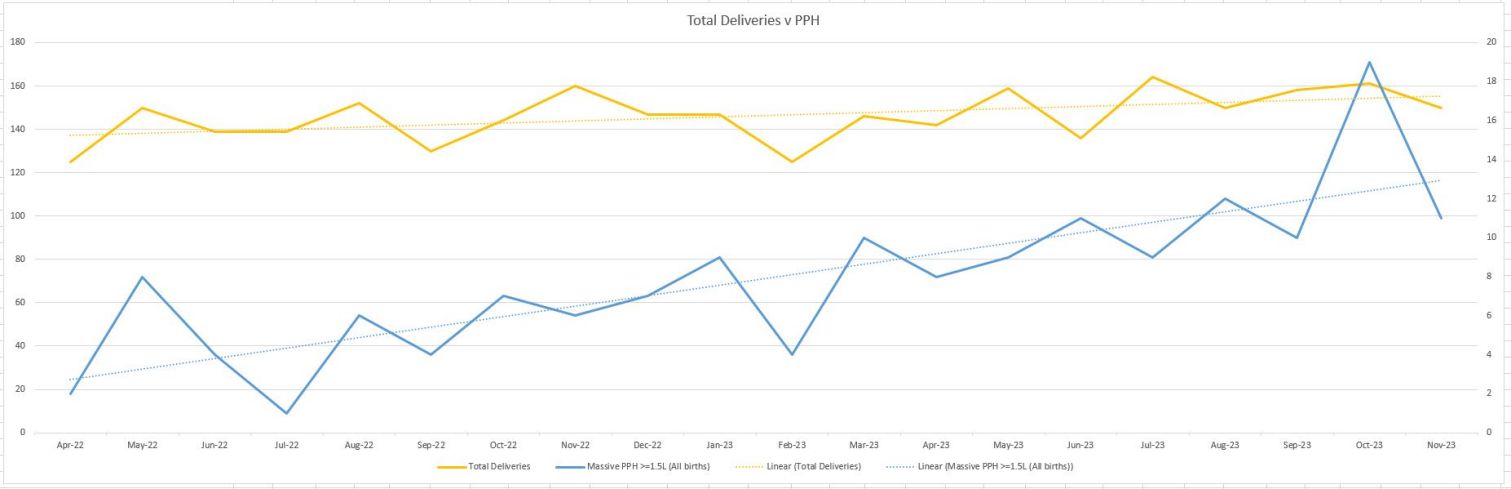
Safe

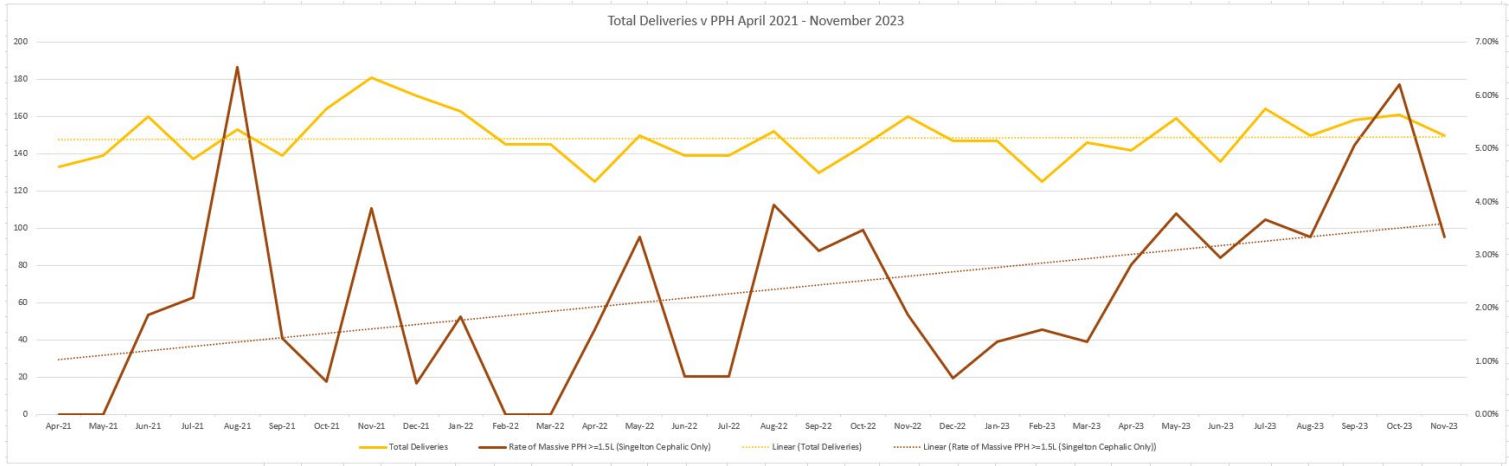
Responsive



- **Background**
  - Changes to measurement of blood loss from November 2022 – MBL not EBL (measured not estimated)
  - Anticipated increase in PPH as more accurate
- **Assessment**
  - Sustained increase in PPH observed even after change in measuring process – reduction observed in November data
- **Actions**
  - Moderate harm case review completed to understand organisational impact of massive PPH – movement of staff, separate building, transfer of patients to ITU, risk register updated
  - Thematic review of PPHs completed to understand risk factors, acuity, antenatal optimisation and management – increased incidence with instrumental deliveries – deep dive being performed
  - NENC review of PPH underway led by intrapartum specialist group – similar theme seen across region
- **Recommendations**
  - Graduated drapes now in routine use to enable measurement of blood loss during procedure to identify/act on PPH sooner
  - Skills drill to be completed in maternity with wider teams (theatre, critical care, porters, switchboard)
  - Share learning internally & at NENC maternity patient safety learning network & intrapartum group
  - Engage with LMNS-wide action/learning on PPH

PPH





Maternity

NHS
Gateshead Health
NHS Foundation Trust

Safe

Responsive

The service has commenced a deep dive into PPH rates.

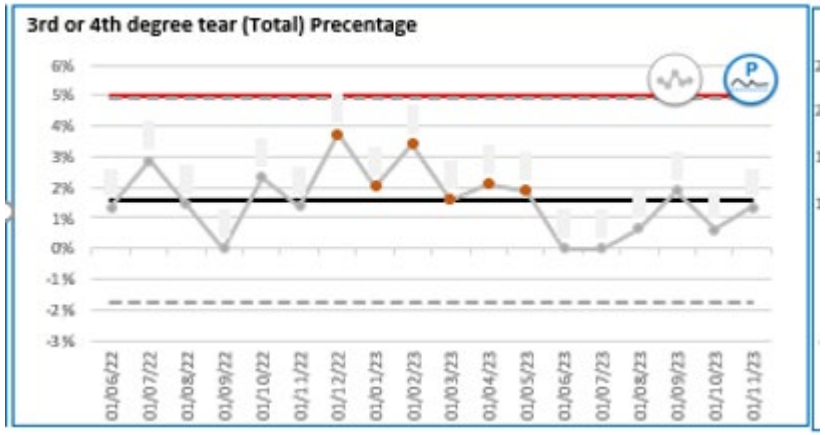
Themes:

- 11/31 PPHs reviewed were of 1500ml-1700ml – this may be a reflection of more accurate measuring to reach the 1500ml threshold
- No common themes around individuals or staff grades assisting births
- Well managed emergencies
- Increase in both operative and assisted vaginal births in line with increase in PPH rates observed (but PPH increase is at higher rate)

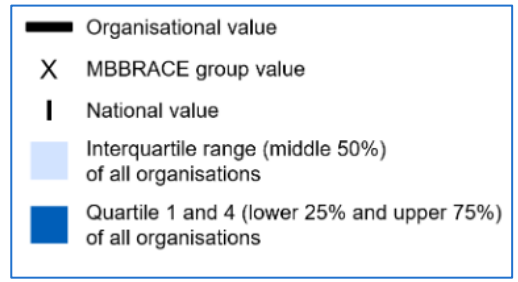
Maternity Dashboard 2023/24

Maternity

NHS Gateshead Health NHS Foundation Trust



National maternity dashboard – October 2023 data:



- **Background**
  - 3rd & 4th degree tears have flagged as low SPC for 6 months
- **Assessment**
  - Data from the National Maternity Dashboard suggests national/MBBRACE group average of 25-29/1000 births
  - Previous Trust target was raised to 5% around 5 years ago in response to increase in incidence/interventions
- **Actions**
  - Question received from last IOR – are we under-reporting/missing perineal trauma in light of continued low rates?
  - Review of incident reports – no themes/trends of readmissions with perineal concerns/missed trauma
- **Recommendations**
  - Audit to include readmissions, gynae & colo-rectal referrals related to perineal trauma in childbirth, 6 week follow up reports, legal cases
  - Review of Gateshead target – possible reduction
  - Review regional (NENC) dashboard when available to ensure accurate target setting & benchmarking – in line with NENC Trusts (regional dashboard on next slide)

Responsive

Safe

NENC regional maternity dashboard

Gateshead Health NHS Foundation Trust

Regional Maternity Measures Report - Comparison Table by Trust

NHS England

Comparison View - this table will allow you to compare up to ten measures and eight Trusts. Select Region (All) and then Select ICB (All) then select the trusts you want to compare

Select Region: North East and Yorkshire
ICB: North East and North Cumbria
Select Organisation: All
Select Measure: All
Reset Filter

Measure	Latest Period	Unit of Measurement	Trust										
			City Hospitals Sunderland NHS Foundation Trust	County Durham and Darlington NHS Foundation Trust	Gateshead Health NHS Foundation Trust	North Cumbria Integrated Care NHS Foundation Trust	North Tees and Hartlepool NHS Foundation Trust	Northumberland, Tyne and Wea..	Northumbria Healthcare NHS Foundation Trust	South Tees Hospitals NHS Foundation Trust	South Tyneside and Sunderland NHS Foundation Trust	South Tyneside NHS Foundation Trust	The Newcastle Upon Tyne Hospitals NHS Foundation Trust
3rd/4th degree tears	3 months to August 2023	Rate per 1,000		14.0	.	.	.		.	26.0	14.0		18.0
Administration of magnesium sulphate	2020/21	Percentage		44.4%		70.0%	.%		76.1%	88.3%	86.7%		100.0%
Administration of Steroids	2020/21	Percentage		86.4%		90.6%	.%		90.9%	94.0%	95.2%		96.3%
Apgar Score < 7	3 months to August 2023	Rate per 1,000		13.0	23.0	24.0	.		19.0	15.0	38.0		23.0
Baby Friendly Accreditation - Maternity	November 2023	Percentage		0.0%	0.0%	0.0%	0.0%		0.0%	0.0%	0.0%		0.0%
Baby Friendly Accreditation - Neonatal	November 2023	Percentage		0.0%	0.0%	0.0%	0.0%		0.0%	0.0%	0.0%		100.0%
Births in women aged Over 40	August 2023	Percentage		2.5%	4.8%	4.4%	2.5%		3.8%	4.1%	3.2%		3.6%
Births in women aged under 18	August 2023	Percentage		1.2%	2.4%	2.2%	2.5%		1.9%	1.4%	1.6%		0.9%
Booking < 70 days gestation	August 2023	Percentage		66.3%	68.9%	70.0%	58.8%		72.9%	61.3%	66.7%		63.4%
Booking within 10 weeks for women with complex social factors	August 2023	Percentage		50.0%	80.0%	50.0%	55.6%		73.3%	37.5%	60.0%		54.5%

Well Led

Safe

Gateshead Health NHS Foundation Trust

CQC Maternity Rating February 2023	Overall	Safe	Effective	Caring	Well-led	Responsive
	Good	Good			Good	
Maternity Safety Support Programme – Not applicable						
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)					**94%**	
Score from specialty trainees in Obstetrics & Gynaecology of clinical supervision out of hours (Reported annually)					**97.5%**	

2. Saving Babies Lives v3 compliance Q2 2022/23 71% compliance	Maternity Incentive Scheme Q2 2023/24 Updated November 2023	
Element 1:	Safety Action 1 (PMRT):	Safety Action 6 (SBL Care Bundle):
Element 2:	Safety Action 2 (MSDS):	Safety Action 7 (MVP):
Element 3:	Safety Action 3 (ATAIN):	Safety Action 8 (Core Competency Framework):
Element 4:	Safety Action 4 (Clinical Workforce Planning):	Safety Action 9 (Trust Board Oversight):
Element 5:	Safety Action 5 (Midwifery Workforce):	Safety Action 10 (HSIB & ENS):
Element 6:		

2023		Jan	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec
Number of perinatal losses		1	1	0	0	1	2	0	0	0	0	1	
Number of HSIB cases		0	0	0	0	0	0	0	0	0	0	0	
Number of incidents logged as moderate harm or above		0	0	0	0	1	3	1	2	1	0	0	
Minimum obstetric safe staffing on labour ward		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Minimum midwifery safe staffing including labour ward (average fill rates)	Day shift	146%	151.3%	150.10%	135.30%	161%	156.10%	155.20%	Staffing establishment alignments under review with nursing workforce lead			113.6%	
	Night shift	104.60%	101.40%	102.30%	107.90%	108.10%	104.10%	101.70%				102.2%	
	CHP PD*	20.7	21.4	20.8	21.6	20.6	21.2	20.6				19.5	
Service user feedback	FFT "Overall how was your experience of our service" – total score for *very good* and *good* responses	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
	Complaints	1	1	1	0	0	1	0	1	3	2	0	
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	0	0	
Coroner Reg 28 made directly to Trust		0	0	0	0	0	0	0	0	0	0	0	

Training data and trajectory

Effective

Safe

Gateshead Health NHS Foundation Trust

The following two slides show current & predicted essential maternity safety training compliance as updated on 22/12/2023

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

Actions:

- Essential training compliance to be moved to financial year reporting (April-April) in line with other NENC Trusts to accommodate standardised TNA syllabus in line with Core Competency Framework v2
- GHNT engagement/leadership of NENC training faculty developing 2024/25 regional TNA - may require additional time for some staffing groups to achieve minimum requirements for essential training as mandated by CCFv2

*update letter received October 2023 - 80% compliance at the end of the previously specified 12-month MIS reporting period (December 2022 to December 2023) will be accepted, provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period.

Training data and trajectory

Updated 22/12/23

Gateshead Health NHS Foundation Trust

Emergency training day (Day 1)					
Staff group	**CCFv1 compliant**	**CCFv2 compliant**	**Booked by December**	**Total compliance 22 December 2023**	**Target to achieve 100% compliance**
Obstetric Consultants	25%	67%	No further training dates	92%	1 booked for March 2024
Obstetric Doctors	New staff rotation	100%	No further training dates	100%	
Midwives		93%	No further training dates	93%	2 booked for Jan 2024 1 booked for Feb 2024 6 to book
Anaesthetic Consultants	60%	13%	No further training dates	100%	
Anaesthetic Doctors	44%	56%	No further training dates	100%	
HCA/MSW	17%	78%	No further training dates	95%	3 booked for Jan 2024 1 to book

Fetal wellbeing/surveillance training day (Day 2)

Staff group	CCFv1 compliant	CCFv2 compliant	Booked by December	Total compliance 22 December 2023	Target to achieve 100% compliance
Obstetric Consultants	42%	58%	No further training dates	100%	
Obstetric Doctors	New staff rotation	91%	No further training dates	91%	2 booked Jan 2024
Midwives	27%	63%	No further training dates	90%	7 booked Jan 2024 5 to book

Newborn Life Support training (inc in Day 1)

Staff group	CCFv1 compliant	CCFv2 compliant	Booked by December	Total compliance 22 December 2023	Target to achieve 100% compliance
Paediatric Doctors (all grades on obstetric rota)	New staff rotation Cons 100% with previous year	85%	No further training dates	96%	1 to book
Midwives	8%	92%	No further training dates	100%	
Neonatal Nurses	No change with CCFv2	94%	No further training dates	94%	1 to book
Anaesthetic Doctors	*N/A	44%	No further training dates	56%	
Obstetric Doctors	*N/A	67%	No further training dates	88%	
HCA/MSW	*N/A	80%	No further training dates	80%	

*training not mandated in this staffing group in CCFv1 requirements

MMAT training day (Day 3) plus e-learning modules						
Staff group	**CCFv1 compliant**	**CCFv2 compliant**	**Booked by December**	**Total projected compliance by December**	**E-learning**	**Non-compliant**
Obstetric Consultants	*N/A	75%	No further training dates	75% *new requirement for CCFv2	100%	3 remaining Consultants booked for 5/1/24
Obstetric Doctors	New staff rotation	100%	No further training dates	100%	100%	
Midwives	8%	90%	No further training dates	98%	91%	3 booked for 2024
Anaesthetic Consultants	*N/A				100%	
Anaesthetic Doctors	*N/A				100%	
HCA/MSW	19%	72%	No further training dates	91%*	58% *new requirement for CCFv2	3 booked for 5/1/2024

ATAIN- Avoiding term admissions to SCBU

Q2 2023/24 Total births	Births >37 weeks	Total term admissions	Reason for admission
475	454	21	Respiratory distress syndrome (RDS) *Pneumothorax Sepsis Hypoglycaemia Meconium
Q2 2023/24 Total births	**Babies receiving TC**		**Reason for TC**
475	55		Small for gestational age Babies of diabetic mother Preterm

In Q2 55 babies avoided SCBU admission through TC

21 Term infants admitted to SCBU

Item No	Link to ATAIN admission criteria	Learning	Action
1	Hypoglycaemia, poor feeding	Only 1/3 babies receiving feed within 1st hour of life	Identify named MSW to support with golden hour each shift/elective LSCS list, identify vulnerable neonates at safety huddles
2	Observations	Only 1/2 babies receiving observations within 1st hour of life	
3	Hypothermia, hypoglycaemia, poor feeding	Poor uptake of golden hour during nights shifts & babies born by LSCS	
4	n/a	Review governance process for MDT review & sharing of leanring from ATAIN reviews	Additional risk management midwife capacity included in review team, named neontatal team & obstetric consultant leads, fetal monitoring lead midwife/consultant to review all cases involving CTG/FHR monitoring
	n/a	MDT leads in place	Job/role descriptions needed for neonatal & obstetric leads
5	Reasons for caesarean sections	The Trust needs to better understand it's data related to caesarean sections	Audit of Caesarean sections based on Robson Criteria
6	Dates for 2024 meetings tbc		Dates tbc around obstetric & neonatal clinical commitments & circulated

ATAIN- Avoiding term admissions to SCBU *neonatal pneumothoraces

- On 23 November 2023, the maternity & neonatal safety teams identified a potential increase in reported neonatal pneumothorax cases & an urgent MDT meeting was convened to identify any immediate learning/actions

- Summary:
  - Neonatal pneumothorax cases – 8 cases reported in 2023 (2 in 2020, 1 in 2021, 0 in 2022)
  - No clear themes identified – changing patient demographic (term, caesarean section, no steroids, diabetes) – potential to utilise CPAP too quickly & some term babies could be managed using high flow oxygen
  - Field safety notice (FSN) issued regarding pressure settings on CPAP machines – “red herring” as FSN issued in September 2022 therefore not related to current increase in cases, however learning for patient safety team/engineering re cascade of FSNs

- Actions:
  - 3 year retrospective review of all neonatal pneumothorax cases (obstetric & neonatal) – completed & discussed at departmental risk & Safecare meetings
  - Team training to be developed for high flow oxygen management as alternative to CPAP depending on clinical scenario
  - Review of FSN & service/calibration of CPAP machines – current software/consumable set-up not affected by FSN but calibration completed to ensure staff confidence in equipment
  - Routine maintenance/calibration of resuscitaires completed – safety message to remind staff to check pressure delivered at daily equipment check & prior to each use, & document pressures delivered at any resuscitation – included on NLS training sessions
  - Patient safety team review of process for managing/disseminating safety alerts/FSNs
  - Medical engineering team to develop process for fortnightly review of MHRA safety notices & utilise generic email address to avoid single person point of contact for suppliers
  - Message to all teams re using high flow oxygen as first line for term babies & for Consultant discussion prior to commencing CPAP

Gateshead Health NHS Foundation Trust

Maternity Integrated Oversight Report

Maternity data from December 2023

Maternity IOR contents

- Maternity Dashboard 2023/24:
    - December 2023 data

- Exception reports:
    - Maternity dashboard exceptions
        - PPH update
        - Smoking at time of delivery (SATOD)
        - Maternal readmission update

- Items for information:
    - Perinatal Quality Surveillance minimum dataset
    - Incidents
        - No SIs reported in December 2023
        - No HSIB cases reported in December 2023
    - Perinatal Mortality and Morbidity
        - 1 perinatal loss in December 2023
    - Saving Babies Lives Care Bundle – update deferred

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Births	Dec 23	179	-			150	111	190
Spontaneous vaginal deliveries	Dec 23	86	-			77	53	101
Assited births	Dec 23	93	-			73	47	100
Induction of Labour	Dec 23	70	-			65	45	84
Maternity Readmissions	Dec 23	1	-			3	-2	8
Neonatal Readmissions	Dec 23	9	-			5	-3	13
Smoking at time of booking	Dec 23	4.66%	15.00%	L	?	10.46%	4.74%	16.18%
Smoking at time of delivery	Dec 23	9.77%	6.00%		?	9.81%	4.13%	15.50%
In area CO at booking	Dec 23	95.83%	90.00%	H	?	83.74%	72.62%	94.87%
In area CO at 36 weeks	Dec 23	85.93%	80.00%		?	81.06%	70.08%	92.04%
Admitted directly to NNU (SCBU) (>37 weeks)	Dec 23	8	4		?	5	-3	14
Percentage Admitted directly to NNU (SCBU) (>37 we	Dec 23	4.82%	6.00%		?	3.72%	-2.46%	9.90%
Preterm birth rate <=36+6 weeks at birth	Dec 23	7.82%	6.00%		?	5.63%	1.61%	9.66%
Continuity of Carer: Percentage placed on pathway (2	Dec 23	24.26%	-			18.59%	11.48%	25.71%
Continuity of Carer: Percentage from BAME backgrou	Dec 23	39.29%	-			29.53%	2.31%	56.75%
Spontaneous Vaginal Births (%)	Dec 23	48.04%	-			51.54%	36.16%	66.92%
Induction Rate	Dec 23	40.23%	-			43.63%	30.98%	56.27%
Instrumental Delivery Rate	Dec 23	17.24%	-			11.73%	4.17%	19.29%
Elective C Section Rate	Dec 23	17.32%	-			18.48%	9.17%	27.79%
Emergency C Section Rate	Dec 23	17.88%	-			18.09%	7.30%	28.87%
C Section Rate	Dec 23	35.20%	-			36.57%	21.91%	51.22%
3rd or 4th degree tear (Total) Precentage	Dec 23	0.00%	5.00%		P	1.52%	-1.80%	4.83%
Massive PPH >=1.5L (All births)	Dec 23	12	2	H	?	8	0	17
Breastfeeding: Percentage of Initiated Breasfeeding	Dec 23	70.11%	66.20%		?	68.90%	48.02%	89.78%
Breastfeeding: Breasfeeding at Discharge (Transfer to	Dec 23	53.07%	56.20%		?	51.92%	39.02%	64.82%

Safe

Responsive

Maternity

NHS

Gateshead Health

NHS Foundation Trust

Maternity Dashboard 2023/24

Maternity

NHS
Gateshead Health
NHS Foundation Trust

Safe

Responsive

Birth rates

Whilst not yet flagging on SPC, the service has noted an increase month-on-month of births, with a 17% increase in December 2023 compared to births in December 2022.

This is likely to due to drift from neighbouring units in response to CQC reports and birth centre closures.

Whilst a positive finding that Gateshead is increasing the provider of choice for maternity care for local families, it is creating additional pressure on the service.

The service is currently undergoing a Birthrate+ midwifery staffing assessment which will include this rise in births in the assessment of safe staffing levels for midwives. This report is anticipated to be complete in March 2024. The service also needs to review staffing levels for Obstetric and Anaesthetic staff, as well as theatre cover.

The service has continued to monitor activity and acuity via acuity tool reporting and sitrep reporting to the region.

The bi-annual staffing report including acuity will be presented to QGC in February 2024.

Maternity Dashboard 2023/24

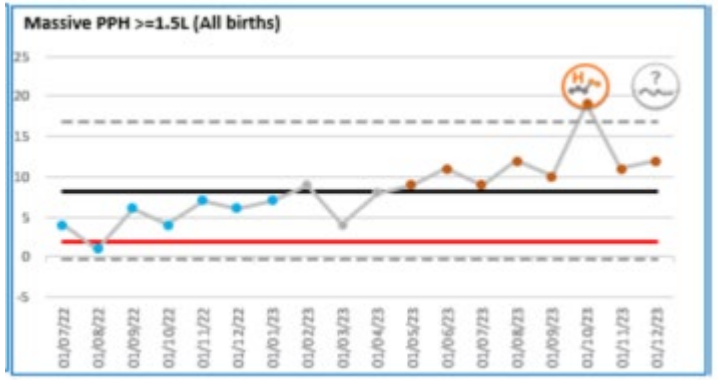
Maternity

NHS

Gateshead Health
NHS Foundation Trust

Safe

Responsive



- **Background**
  - PPH high for >12 months in line with regional/national picture & following change in practice to MBL from EBL#
  - Audits performed with action from Trust board for further information
  - October 2023 saw spike in cases at 19
- **Assessment**
  - October spike has settled to previous months level
  - Q2 audit performed with additional metrics requested
  - Link to RCOG Consultant attendance audit for PPH
  - Increased in operative deliveries (vaginal & LSCS)
  - No themes around individual operators or grades

Microsoft
werPoint Presentat

- **Actions**
  - Continue to audit quarterly
  - Earlier anticipation of delivery/PPH – have drugs ready for immediate use
- **Recommendations**
  - Consider implementation of Badger PPH prevention proforma – not currently fit for purpose, regional discussions on pre=populated management plans (Digital group)
  - Contemporaneous blood measurement – no surprises at completion
  - Skills drills, measurement drills, COPE research trial ongoing

Maternity Dashboard 2023/24

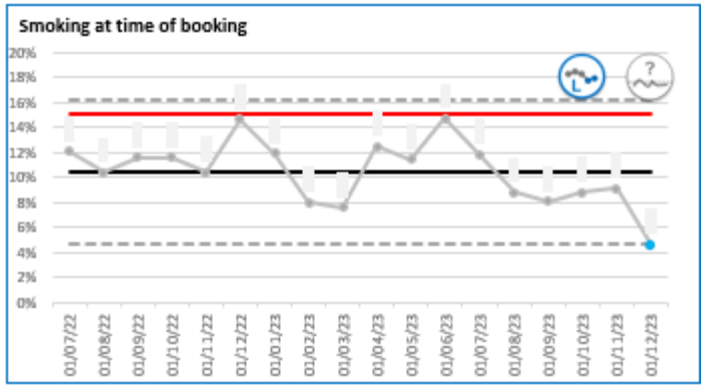
Maternity

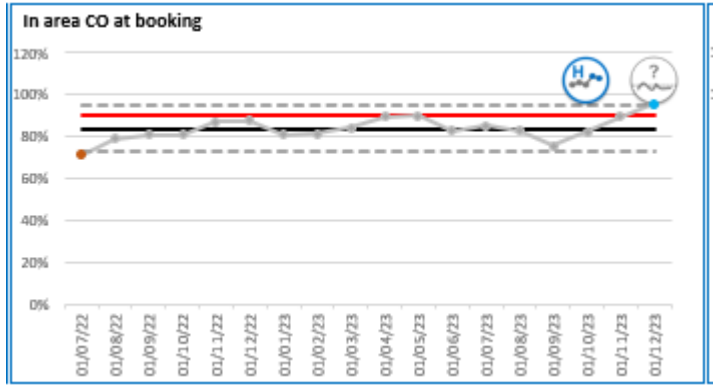
NHS

Gateshead Health
NHS Foundation Trust

Safe

Responsive





- **Background**
  - Element of Saving Babies Lives Care Bundle – reducing smoking in pregnancy
- **Assessment**
  - Lowest rate of SATOD – well below target
  - Complemented by Alice Wiseman DOPH at Festive Trust walkabout
  - CO target at booking of 90% & 36 weeks of 80% reached for MIS compliance
- **Actions**
  - Staff thanked for work to achieve targets
  - Share at Safecare
- **Recommendations**
  - Continue to monitor all smoking in pregnancy metrics associated with MIS & SBLCB
  - Q3 audit in progress to include CO reading at every contact for smokers baseline data

Maternity Dashboard 2023/24: Maternal readmission update

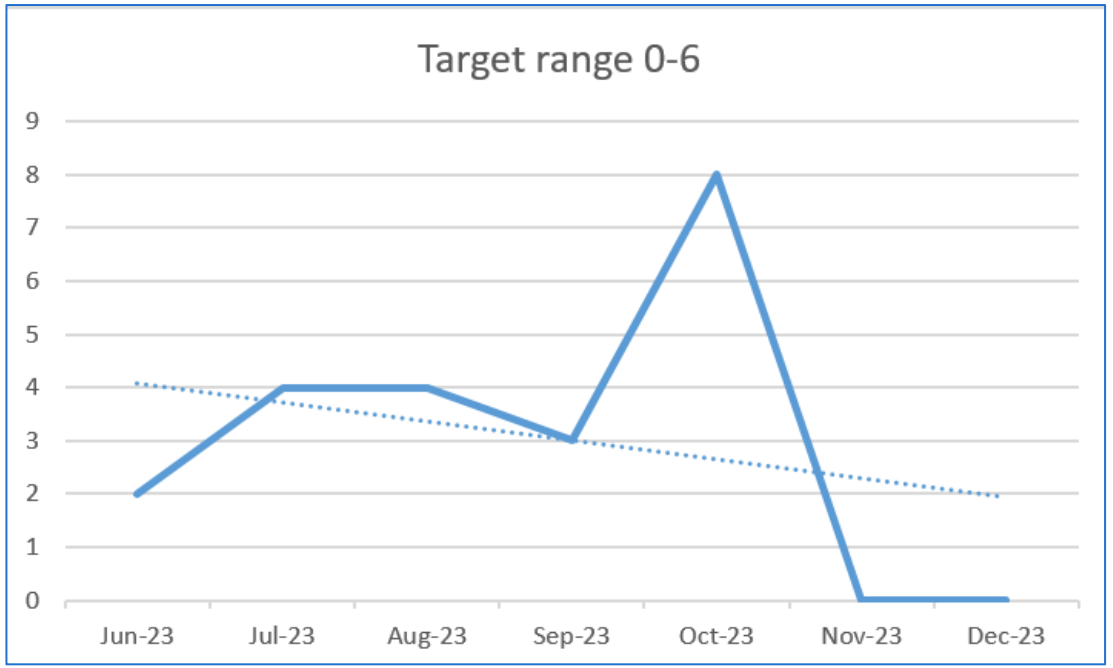
Maternity

NHS Gateshead Health NHS Foundation Trust

Safe

Responsive

Month	Target range 0-6
June 2023	2
July 2023	4
August 2023	4
September 2023	3
October 2023	8
November 2023	0
December 2023	0



- **Background**
  - Maternal readmissions flagged on SPC as high & reported in October 2023 IOR
  - Action to bring update back in IOR
- **Assessment**
  - Maternal readmissions not flagged as high since October 2023
- **Actions**
  - Audit completed March-May 2023
  - Actions in place following audit including pain relief bundle, sepsis teaching, UNICEF training
- **Recommendations**
  - Audit inclusion on annual audit planner – repeat end of Q4 2023/24
  - Continue InPhase reporting & individual case reviews

Well Led

Safe

Gateshead Health NHS Foundation Trust

CQC Maternity Rating February 2023	Overall	Safe	Effective	Caring	Well-led	Responsive
	Good	Good			Good	
Maternity Safety Support Programme – Not applicable						
Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)					**94%**	
Score from specialty trainees in Obstetrics & Gynaecology of clinical supervision out of hours (Reported annually)					**97.5%**	

2. Saving Babies Lives v3 compliance Q2 2022/23 71% compliance	**Maternity Incentive Scheme Q2 2023/24 Updated November 2023**	
Element 1:	Safety Action 1 (PMRT):	Safety Action 6 (SBL Care Bundle):
Element 2:	Safety Action 2 (MSDS):	Safety Action 7 (MVP):
Element 3:	Safety Action 3 (ATAIN):	Safety Action 8 (Core Competency Framework):
Element 4:	Safety Action 4 (Clinical Workforce Planning):	Safety Action 9 (Trust Board Oversight):
Element 5:	Safety Action 5 (Midwifery Workforce):	Safety Action 10 (HSIB & ENS):
Element 6:		

2023		Jan	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec
Number of perinatal losses		1	1	0	0	1	2	0	0	0	0	1	1
Number of HSIB cases		0	0	0	0	0	0	0	0	0	0	0	0
Number of incidents logged as moderate harm or above		0	0	0	0	1	3	1	2	1	0	0	0
Minimum obstetric safe staffing on labour ward		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Minimum midwifery safe staffing including labour ward (average fill rates)	Day shift	146%	151.3%	150.10%	135.30%	161%	156.10%	155.20%	Staffing establishment alignments under review with nursing workforce lead			113.6%	
	Night shift	104.60%	101.40%	102.30%	107.90%	108.10%	104.10%	101.70%				102.2%	
	CHP PD*	20.7	21.4	20.8	21.6	20.6	21.2	20.6				19.5	
Service user feedback	FFT “Overall how was your experience of our service” – total score for *very good* and *good* responses	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	Complaints	1	1	1	0	0	1	0	1	3	2	0	0
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	0	0	0
Coroner Reg 28 made directly to Trust		0	0	0	0	0	0	0	0	0	0	0	0

Q3 Saving Babies Lives v3 Implementation

- Update due in this IOR report - deferred until next IOR as LMNS validation meeting taking place 18/1/2024
- On track to meet target compliance required for Maternity Incentive Scheme – quarterly LMNS review meetings
- Full compliance with SBLCBv2 required by 31 March 2024

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 15ii

Report Title:	**Maternity Incentive Scheme (MIS) Assurance Framework** January 2024 – FINAL compliance report			
Name of Meeting:	Trust Board of Directors			
Date of Meeting:	31 January 2024			
Author:	Karen Parker – Head of Midwifery Kate Hewitson – Service Line Manager			
Executive Sponsor:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Karen Parker – 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 evidence held to meet full compliance with the Maternity Incentive Scheme Year 5 ten safety standards			
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*	Safecare/Risk and Safety Council 25/1/2024 Quality Governance Committee 30/1/2024			
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 reporting full compliance with the ten safety actions for Year 5 of the Maternity Incentive Scheme. Achieving full compliance will result in a rebate of at least 10% of the Trust maternity contribution to the Clinical Negligence Scheme for Trusts (CNST). This is ring-fenced for maternity safety. Trusts must submit their completed Board declaration form to NHS Resolution by **12 noon on 1 February 2024***			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	Member of the Trust board are asked to review the detail provided within this report for assurance.			

Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☒	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:					
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)	3253 – risk to be closed as requirements met				
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

January 2024 – FINAL compliance report

Karen Parker – Head of Midwifery
Kate Hewitson – Service Line Manager

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 16

Report Title:	**Nursing Staffing Exception Report**			
Name of Meeting:	Meeting of the Board of Directors			
Date of Meeting:	31st January 2024			
Author:	Andrew Rayner, Deputy Chief Nurse Laura Edgar, Head of Nursing Workforce			
Executive Sponsor:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHP's			
Report presented by:	Andrew Rayner, Deputy Chief Nurse			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	This report is to provide assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *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 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 2023. December has demonstrated areas with staffing challenges relating to vacancies and short term sickness absence alongside ward movements to accommodate maintenance across the Trust. Within December we continued to experience periods of increased patient activity with surge pressure resulting in escalation areas. This has impacted on staffing resource. There is continued focused work around the recruitment and retention of staff and managing staff attendance. Wards where staffing fell below 75% of the funded establishment are shown within the paper. Detailed context and actions taken to mitigate risk are documented. A staffing escalation protocol is now in			

<table>
<tr><td></td><td colspan="5">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:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The Board are asked to:
receive the report for assurance
note the work being undertaken to address the shortfalls in staffing</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5"></td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☐</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">There were 8 staffing incidences raised via datix throughout the trust during the month of December of which there were no moderate harm incident identified.</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

Gateshead Health NHS Foundation trust
Nursing and Midwifery Staffing Exception Report
December 2023

1. Introduction

This report details the staffing exceptions for Gateshead Health NHS Foundation Trust during the month of December 2023. 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 2023

Day	Day	Night	Night
Average fill rate - registered nurses/midwives (%)	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
90.0%	**126.4%**	**101.1%**	**108.7%**

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

Exceptions:

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

Safer Nursing Care Tool (SNCT) data collection is completed bi-annually in January and July each year. Patient acuity and dependency data is triangulated with key performance indicators and professional judgement templates in line with the Developing Workforce Safeguards and Safe Staffing Recommendations (NHSi 2018).

Contextual information and actions taken

Ward 11 Winter escalation continued throughout December to experience higher than trust target levels of sickness absence in both workforce groups. There were three staffing incidents raised via the reporting system to highlight concern over staffing levels during December. There was one red flags raised via the SafeCare system, which was escalated to the senior nurse and documented within the on call resilience bulletin. They also had a prolonged period of escalated beds during December.
Ward 28 Ortho elective ward had a 5 day period of closure within December due to no elective activity, which has reduced the registered staffing levels throughout the month.

The exceptions to report for December are as below:

December 2023	
Registered Nurse Days	**%**
Ward 11 Winter Escalation	71.7%
Ward 28 Ortho Elective	71.1%
Registered Nurse Nights	**%**
Ward 28 Ortho Elective	63.2%
Healthcare Support Worker Days	**%**
N/a	
Healthcare Support Worker Nights	**%**
N/a	

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 8.0. This compares well when benchmarked with other peer-reviewed hospitals.

4. Monitoring Nurse Staffing via Incident Reporting system

The Trust has an escalation process in place for addressing staffing shortages with identified actions to be taken. Further discussion is to take place to scope the potential for identifying thresholds that trigger when a staffing related incident should be submitted to provide reporting consistency. In addition to this the ongoing work to triangulate fill rates and care hours against reported staffing and patient safety incidents, has highlighted that the subcategories available to the reporter within the incident reporting system requires review to streamline and enable an increased understanding of the causes of the shortages, e.g., short notice sickness, staff moves or inability to fill the rota.

A report of staffing concern related incidents is generated monthly and discussed at the Nursing Professional Forum. There were 8 staffing incidents raised via the incident reporting system. From these incidences, none of which related to the two areas highlighted in the staffing exception report.

5. Nursing Red Flags

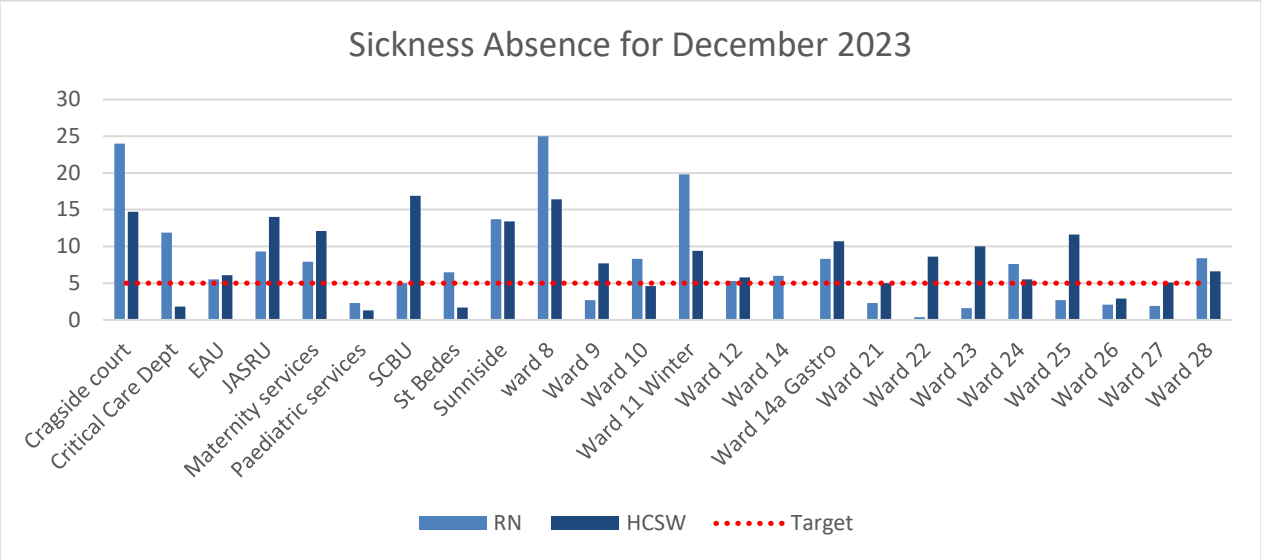
The National Institute for Health and Care Excellence (NICE) guideline for Safe Staffing for nursing in adult inpatient wards in acute hospitals (2014) recommend the use of nursing Red Flag reporting. A Nursing red flag can be raised directly as a result of rostering practice/shortfall in staffing or by the nurse in charge if they identify a shortfall in staffing requirements resulting in basic patient care not able to be delivered. Throughout the month of December there were 5 nursing red flags reported. Of those 5 Red flags, one of those raised is highlighted in this paper as an area where planned staffing levels fell below 75%.

Date	Shift type	Ward	Flag Type	Narrative
04/12/23 08:15	Early	Ward 12	Shortfall in RN time	Escalated and staff sickness
20/12/23 20:04	Late	Ward 11 Winter escalation	Temporary staffing	Escalated staffing as only 2 HCA's for late shift and X1 patient needing 1-1 enhanced care due to suicidal ideation. Escalated to senior nurse however no staff available to send.
23/12/2023 12:03	Early	Ward 12	Shortfall in RN time	Sent qualified member of staff to ward 23 as requested by senior nurse. Left with x3 RN and x2 HCSW as had to send 1 HCSW home due to being covid +ve. Ward became unsafe due to x2 patients requiring 1-1 care. Escalated this to the senior nurse.
24/12/2023 12:41	Day	SRT	Shortfall in RN time	Only 1 clinical and 1 senior nurse on today- ward 8 only have two qualified- priority given to clinical as holding cardiac arrest bleeps.
27/12/23	Early	JASRU	Vital signs not assessed or recorded	No narrative given.

Of the above recorded red flags, one is captured on the on-call resilience bulletin. Staff redeployments were initiated to support the above areas when possible.

6. Attendance of Nursing workforce

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



7. Governance

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

8. Conclusion

This paper provides an exception report for nursing and midwifery staffing in December 2023 and provides assurance of ongoing work to triangulate workforce metrics against staffing and care hours.

9. Recommendations

The Board is asked to receive this report for assurance.

Dr Gill Findley
Chief Nurse and Professional Lead for Midwifery and AHP's

Appendix 1- Table 3: Ward by Ward staffing December 2023

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Cragside Court	80.3%	120.0%	90.4%	184.1%	303	5.6	9.1	14.8
Critical Care Dept	81.2%	127.0%	90.2%	92.2%	240	30.3	6.4	36.7
Emergency Care Centre - EAU	83.1%	141.8%	80.0%	136.3%	1422	5.7	4.8	10.4
JASRU	87.9%	92.1%	102.8%	135.9%	609	3.3	4.5	7.8
Maternity Unit	103.2%	144.6%	106.8%	90.7%	707	11.8	4.8	16.6
Paediatrics	149.4%	114.3%	118.0%		38	75.5	18.8	94.3
Special Care Baby Unit	90.1%	109.4%	108.1%	87.3%	145	12.1	4.2	16.3
St. Bedes	89.0%	102.9%	100.0%	95.8%	294	5.0	4.1	9.1
Sunniside Unit	80.8%	121.5%	92.5%	104.9%	286	5.2	4.3	9.5
Ward 08	75.4%	142.1%	103.5%	99.9%	606	3.0	3.8	6.8
Ward 09	95.5%	142.4%	101.8%	99.5%	822	2.6	2.8	5.4
Ward 10	88.0%	131.6%	103.9%	119.2%	721	2.8	3.2	6.0
Ward 11 Winter Escalation	71.7%	83.9%	102.1%	123.7%	764	2.7	3.0	5.7

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Ward 12	87.0%	107.2%	102.9%	100.2%	782	2.5	2.8	5.3
Ward 14 Medicine	93.8%	143.2%	124.4%	113.6%	755	3.0	3.4	6.4
Ward 14a Gastro	89.2%	108.7%	104.8%	106.9%	776	2.6	2.9	5.5
Ward 21 T&O	90.0%	174.0%	138.6%	88.8%	816	2.9	4.0	6.9
Ward 22	79.1%	117.9%	109.0%	99.2%	890	2.3	3.5	5.8
Ward 23	106.0%	139.5%	101.9%	92.6%	713	2.9	4.0	6.9
Ward 24	85.0%	118.9%	101.6%	100.1%	902	2.4	3.5	5.8
Ward 25	104.4%	117.0%	140.2%	75.9%	941	2.9	3.0	5.9
Ward 26	79.0%	132.2%	137.7%	124.8%	719	3.2	4.3	7.5
Ward 27	91.5%	126.9%	146.9%	108.6%	829	3.1	3.5	6.6
Ward 28	71.1%	97.4%	63.2%	98.6%	178	6.0	6.5	12.5
QUEEN ELIZABETH HOSPITAL - RR7EN	**90.0%**	**126.4%**	**101.1%**	**108.7%**	**15258**	4.2	3.8	8.0

Meeting:	Trust Board
Chair:	Alison Marshall
Financial year:	2023/24

	Lead	Type of item	Public/Private	May-23	June 23 (year end only)	Jul-23	Sep-23	Nov-23	Jan-24	Mar-24
Standing Items			Part 1 & Part 2							
Apologies	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√	√	√
Declaration of interests	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√	√	√
Minutes	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Action log	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Matters arising	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Chair's Report	Chair	Standing Item	Part 1					√	√	√
Chief Executive's Update Report	Chief Executive	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Cycle of Business	Company Secretary	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Patient & Staff Story	Company Secretary	Standing Item	Part 1	√		√	√	√	√	√
Questions from Governors	Chair	Standing Item	Part 1	√		√	√	√	√	√
Items for Decision			Part 1 & Part 2							
Annual Declarations of Interest	Company Secretary	Item for Decision	Part 1							√
Approval of new Strategic Objectives	Deputy Director of Corporate Services & Transformation	Item for Decision	Part 1	√						
Board Assurance Framework - quarterly updates	Company Secretary	Item for Assurance	Part 1			√		√		
Board Assurance Framework - approval of closing and opening position	Company Secretary	Item for Decision	Part 1							√
Standing Financial Instructions, Delegation of Powers, Constitution and Standing Orders - annual review	Company Secretary / Group Director of Finance	Item for Decision	Part 1				√		√	
Calendar of Board Meetings	Company Secretary	Item for Decision	Part 1					√		
Winter Plan	Chief Operating Officer	Item for Decision	Part 1				√			
Board Committee Annual Reviews of Effectiveness and Terms of Reference Update	Company Secretary	Item for Decision	Part 1	√						
CQC Statement of Purpose and Registration	Chief Nurse	Item for Decision	Part 1						Deferred	√
Items for Assurance			Part 1 & Part 2							
Board Committee Assurance Reports	Committee Chairs	Item for Assurance	Part 1	√		√	√	√	√	√
Trust Strategic Objectives - quarterly updates	Director of Strategy, Planning and Partnerships	Item for Assurance	Part 1			√		√		√
Board Assurance Framework - quarterly updates	Company Secretary	Item for Assurance	Part 1			√		√		
Organisational Risk Register	Chief Nurse	Item for Assurance	Part 1	√		√	√	√	√	√
Annual Staff Survey Results	Exec Director of People & OD	Item for Assurance	Part 1							√
Finance Report	Group Director of Finance	Item for Assurance	Part 1	√		√	√	√	√	√
Integrated Oversight Report	Chief Operating Officer	Item for Assurance	Part 1	√		√	√	√	√	√
Maternity Integrated Oversight Report	Chief Nurse	Item for Assurance	Part 1	√		√	√	√	√	√
Nurse Staffing Exception Report	Chief Nurse	Item for Assurance	Part 1	√		√	√	√	√	√
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	√				√		
SIRO Report & Digital Update	Group Director of Finance	Item for Assurance	Part 1	√						
EPRR Core Standards Self-Assessment Report	Chief Operating Officer	Item for Assurance	Part 1					√	√	
CNST Maternity Compliance Report	Chief Nurse	Item for Assurance	Part 1						√	
Green Plan (formally Sustainable Development Management Plan)	QEF Managing Director	Item for Assurance	Part 1					Annually F&P		
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				√			√
Quality Accounts Priorities 6 monthly update	Chief Nurse	Item for Assurance	Part 1					QGC		
Items for Information			Part 1 & Part 2							
Register of Official Seal	Company Secretary	Item for Information	Part 1				√			

Ad Hoc Items (i.e. items emerging during the year)			Part 1 & Part 2							
Staff survey results action plan update	Exec Director of People & OD	Item for Assurance	Part 1				√			
Thematic review updates	Chief Executive	Item for Assurance	Part 1					√		