Gateshead Health
NHS Foundation Trust

Board of Directors (Part 1 – Public)

A meeting of the Board of Directors (Part 1 – Public) will be held at 09:30am on 24 September 2024, in Room 3, Education Centre, Queen Elizabeth Hospital / via Microsoft Teams

AGENDA

No	Start time	Item	Purpose	Lead	Paper / Verbal
1.	09:30	Welcome	Information	Chair	Verbal
2.	09:33	Declarations of interest	Information	Chair	Verbal
3.	09:34	Apologies for absence	Information	Chair	Verbal
4.	09:35	Minutes of the last meeting held on 31 July 2024	Decision	Chair	Paper
5.	09:40	Action log and matters arising	Assurance / decision	Chair	Paper
6.	09:45	Patient and Staff Story – Endoscopy	Assurance	Alyson Duncan, Service Line Manager	Presentation
ITEMS FOR DECISION					
7.	10:00	Winter Plan 2024/25	Decision	Group Chief Operating Officer	Paper
8.	10:10	Terms of Reference – Audit Committee and Gateshead Health Leadership Group	Decision	Company Secretary	Paper
9.	10:15	National Pay Award	Decision	Group Director of Finance & Digital	Paper
10.	10:20	QE Facilities Pay Award	Decision	QE Facilities Managing Director	Paper
11.	10:25	QE Facilities – Chair and Non-Executive Director Appointment	Decision	Chair	Paper
ITEMS FOR ASSURANCE					
12.	10:35	Chair's Report	Assurance	Chair	Paper
13.	10:45	Chief Executive's Report	Assurance	Chief Executive	Paper
14.	10:55	Organisational Structure – Clinical Leadership	Assurance	Medical Director	Verbal
15.	11:05	Governance Reports:			
		i) Organisational Risk Register	Assurance	Chief Nurse	Paper
16.	11:10	Assurance from Board Committees:			
		i) Finance and Performance Committee – August and September	Assurance	Chair of the Committee	Paper
		ii) Quality Governance Committee – August 2024	Assurance	Chair of the Committee	Paper
		iii) People and Organisational Development Committee – September 2024	Assurance	Chair of the Committee	Paper
		iv) Group Audit Committee – September 2024	Assurance	Chair of the Committee	Paper

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No	Start time	Item	Purpose	Lead	Paper / Verbal
		v) Group Remuneration Committee	Assurance	Chair of the Committee	Paper
17.	11:30	Board Walkabout Feedback	Assurance	Chief Nurse	Paper
18.	11:40	Finance Report	Assurance	Group Director of Finance and Digital	Paper
19.	11:50	Leading Indicators 2024/25 report	Assurance	Group Director of Finance and Digital	Paper
20.	12:00	Freedom to Speak Up Guardian Report	Assurance	Freedom to Speak Up Guardian	Paper
21.	12:10	WRES and WDES Report	Assurance	Group Director of People & Organisational Development	Paper
22.	12:20	Maternity Integrated Oversight Report	Assurance	Head of Midwifery	Paper
23.	12:30	Nurse Staffing Exception Report	Assurance	Chief Nurse	Paper
ITEMS FOR INFORMATION / MEETING GOVERNANCE					
24.	12:40	Provider Collaborative Managing Director's Report	Information	Chief Executive	Paper
25.	12:45	Register of Official Seal	Information	Company Secretary	Paper
26.	12.50	Care Quality Commission Statement of Purpose	Information	Chief Nurse	Paper
27.	12:55	Cycle of Business	Information	Company Secretary	Paper
28.	13:00	Questions from Governors in Attendance	Discussion	Chair	Verbal
29.	13:10	Any Other Business	Discussion	Chair	Verbal
30.	13:15	Date and Time of Next Meeting – 09:30am on Wednesday 27th November 2024	Information	Chair	Verbal

Exclusion of the Press and Public
To resolve to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed

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Board of Directors (Part 1 – Public)

Minutes of a meeting of the Board of Directors (Part 1) held at 9.30am on Wednesday 31st July 2024 in Room 3, Education Centre, Queen Elizabeth Hospital and via MS Teams.

Name	Position
Members present	
Mrs Alison Marshall	Chair
Mr Adam Crampsie	Non-Executive Director
Mrs Trudie Davies	Group Chief Executive
Mr Gavin Evans	Managing Director for QE Facilities
Dr Gill Findley	Deputy Chief Executive / Chief Nurse
Mr Neil Halford	Medical Director of Strategic Relations
Mrs Joanne Halliwell	Group Chief Operating Officer
Mr Martin Hedley	Non-Executive Director / Senior Independent Director
Dr Carmen Howey	Group Medical Director
Mrs Kris Mackenzie	Group Director of Finance and Digital
Mrs Hilary Parker	Non-Executive Director
Mrs Maggie Pavlou	Deputy Chair / Non-Executive Director
Mr Mike Robson	Non-Executive Director
Mrs Anna Stabler	Non-Executive Director
Mrs Amanda Venner	Group Director of People & Organisational Development
Attendees present	
Ms Denise Bell	Emergency Department Unit Manager (24/07/06)
Mrs Jennifer Boyle	Company Secretary
Ms Nicola Bruce	Interim Director of Strategy, Planning and Performance (24/07/12)
Mr Alex Diggles	Service Line Manager (24/07/06)
Ms Fiona Drummond	Matron (24/07/06)
Ms Tracey Jeffery	Emergency Department Unit Manager (24/07/06)
Mrs Karen Parker	Head of Midwifery (24/07/21)
Ms Diane Waites	Corporate Services Assistant
Governors and Observers	
Ms Helen Adams	Staff Governor
Mr Michael Loome	Public Governor – Central Gateshead
One member of the public	
Apologies	
Mr Andrew Moffat	Non-Executive Director

Agenda Item No		Action Owner
24/07/01	**Chair's Business:** The meeting being quorate, Mrs A Marshall, Chair, declared the meeting open at 9.30 am and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. She welcomed those present including the Trust's Governors and welcomed Dr Carmen Howey to her first Board meeting as Group Medical Director	

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	and Mr Neil Halford to his new role as Medical Director of Strategic Relations. She highlighted that there were a number of items on the agenda for this meeting and asked presenters to take reports as read.	
24/07/02	**Declarations of Interest:** Mrs Marshall requested that Board members present report any revisions to their declared interests or any additional declaration of interest in any of the items on the agenda.	
24/07/03	**Apologies for Absence:** Apologies were received from Mr A Moffat.	
24/07/04	**Minutes of the Previous Meeting:** The minutes of the meeting of the Board of Directors held on Wednesday 5th June 2024 were approved as a correct record.	
24/07/05	**Matters Arising from the Minutes:** The Board reviewed the action tracker as below: • Action 24/03/07 re. to undertake a review of the Articles of Association in line with the approved QE Facilities SFIs. Item on the agenda and also approved by QEF Board therefore action agreed for closure. • Action 24/06/12 re. discussion to take place around stretch target in relation to sickness absence. Detailed presentation on managing absence was taken to People and Organisational Development Committee in July 2024 and work underway noted with further actions agreed. An update is due back to Committee in September 2024. Action agreed for closure. • Action 24/06/13 re. development of an outline strategic intent for maternity to come back to Board for full discussion. A Board session has been diarised for August 2024 therefore action was agreed for closure. • Action 24/06/13 re. further realignment work of maternity and midwifery posts and funding to take place prior to development of business case. A meeting took place on 30 July 2024 and information from this will be shared within the Maternity Integrated Oversight Report. Action agreed for closure.	

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	• Action 24/06/14 relating to the bi-annual inpatient safer nursing care staffing report and need for discussions to take place to agree outputs and further work around the calculations relating to the emergency department. It was highlighted that this exercise will be repeated and reported back via the Quality Governance Committee and its assurance report to Board. Dr G Findley, Chief Nurse and Deputy Chief Executive, reported that a review of emergency department staffing has been completed and discussed with the business unit however there is further work to do to understand the longer term needs (as per the paper "operating in times of pressure" to be discussed on today's agenda). It was felt that this action should remain open due to further discussions required. • Action 24/06/16 re. review of information flows and format of the QE Facilities six monthly report to Board. Mr G Evans, QE Facilities Managing Director reported that a review of the format will be undertaken following comments received and next report due at Board in November 2024 therefore action agreed for closure. The Board reviewed the actions closed at the last meeting which ensures actions have been closed in line with expectations and the agreements made at the previous Board meeting. No further requirements were highlighted.	
24/07/06	**Patient Story – Emergency Department achievements** The Board welcomed Mr Alex Diggles, Service Line Manager, Ms Fiona Drummond, Matron, Ms Tracey Jeffrey and Ms Denise Bell, Emergency Department (ED) Unit Managers who provided a presentation on the achievements within the department particularly around ambulance handover times. Mr Diggles explained that data was reviewed within areas of demand and discussions with clinical and operational colleagues across the Trust took place to support performance improvement including a weekly meeting chaired by the Group Chief Operating Officer. Funding was also utilised from the Integrated Care Board to support additional staffing. This has resulted in an upward trajectory of handovers completed within 15 minutes from c.60% to c.70% in the last 12 months and the latest average handover time for week ending 2nd June 2024 was 14:01 minutes with the Trust being the second best in the region. The department continues to ensure positive patient / staff experience and improved patient safety position and a regional task and finish group has been set up to improve compliance in non-ED areas where learning can be shared across the wider organisation and beyond.	

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	Mrs Marshall thanked the team for attending the Board and sharing their positive story for patients and the community. Following a query from Mrs A Stabler, Non-Executive Director, in relation to learnings and sustainability of the improvements over the winter period, Mr Diggles explained that ensuring that the right staff are in the right place at the right time continues to be a challenge however future planning is being addressed and sufficient equipment is now in place with additional trolleys being supplied following approval via the Charitable Funds Committee. Mrs T Davies, Group Chief Executive, thanked the team for their work and focus on patients and safety and felt that the methodology around the significant improvements made was transformational and could be used to support further transformational and collaborative work, particularly around the 4 hour target. Mr Diggles explained that the focus on risk reduction for patients is also being developed around the 4-hour standard and the Trust's Improvement Team are supporting with this to provide process mapping data. Ms Drummond highlighted that the team are committed to improving patient safety and further continuous improvement work. Following a query from Mr A Crampsie, Non-Executive Director, relating to staff welfare working within highly pressurised areas, Ms Drummond explained that good staff support was available within the team. The Board thanked those involved and the staff for their work and dedication and acknowledged the significant achievement. Mr Diggles, Ms Drummond, Ms Jeffrey and Ms Bell left the meeting.	
24/07/07	**QE Facilities Articles of Association:** Mr G Evans, QE Facilities Managing Director, presented the revised QE Facilities Articles of Association. Mr Evans reported that a number of independent reviews have taken place including the review by Deloitte in relation to QE Facilities governance arrangements and recommended changes have been implemented. These mainly relate to relevant modernisations and gender-neutral terminology however a further update will be required around the appointment of the new independent Non-Executive Director. The document has also been approved by the QE Facilities Board. After consideration, it was: **RESOLVED:** to approve the revised QE Facilities Articles of Association.	
24/07/08	**Finance and Performance Committee Terms of Reference:**	

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	Mrs J Boyle, Company Secretary, presented the revised Finance and Performance Committee Terms of Reference for ratification by the Board. Mrs Boyle reported that the terms of reference have been reviewed and approved by the Finance and Performance Committee. The Committee requested a number of changes, which have been included on the attached version. She explained that this is an interim update to bring the terms of reference in line with agreed changes to membership, attendance and remit however a further full review and update of the terms of reference will be required once the Tier 2 Groups within the governance structure are embedded, enabling the streamlining of reporting to the Tier 1 Board Committees. After consideration, it was: **RESOLVED:** to ratify the revised terms of reference on the recommendation of the Finance and Performance Committee, noting that this is an interim update, with a full review to follow.	
24/07/09	**Organisational Structure Consultation Outcome:** Dr G Findley, Deputy Chief Executive and Chief Nurse, provided a summary of the outcome of the formal consultation on the governance and structural review outcome which requires the Board to approve the proposed structure and governance changes. Dr Findley reminded the Board that the structural changes were previously agreed in principle pending the outcome of the consultation exercise and highlighted that 43 responses were received which were mainly from the community division and the main professional group that responded was the Allied Health Professionals (AHPs). It was noted that these were the groups most affected by the changes and further detail had been requested on how some of the new arrangements would work such as the new cancer service line and the move of AHPs from community to clinical support and screening. It was therefore felt important to retain a focus on community going forward as respondents were concerned about being merged with acute services. It is therefore recommended that the changes are implemented as planned and Dr Findley drew attention to the additional actions as below: • Delay the appointment of the Director of Strategy and Communication for up to 6 months	

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	• Review the managerial support to the division on Medicine and Community to determine whether there is sufficient managerial support within the division • Ensure that community services are well represented at all levels of the governance structure • Children's therapies including children's community nursing and bladder and bowel to stay within the community service line • Urgently consult on and agree the clinical (medical) leadership arrangements including the line management of the Associate medical Directors in the divisions • Change the title of the Head of Midwifery to Associate Director of Midwifery • Clarify the contents of each of the service lines and the management arrangements • Add the alliance structures such as the Committees in Common • Record a session explaining the changes to be circulated widely Mrs A Stabler, Non-Executive Director, highlighted her support to the changes and acknowledged the work that had been completed however queried when the appointment of the Director of Strategy and Communication will be reviewed as the initial six month period will be nearly complete. Mrs T Davies, Group Chief Executive, explained that this will be due to take place in August 2024 to determine if it is appropriate to commence recruitment at this time. Dr C Howey, Group Medical Director, reported that the agreement of the clinical leadership arrangements will need to take place as a priority and a timeline and expectations around this will be agreed. It was agreed that a further update on the clinical leadership elements would be provided at the next Board meeting in September 2024. Mrs Marshall highlighted that the new Gateshead Health Leadership Group is being launched this week therefore queried whether any changes to the Board Tier One Committees will be implemented. Dr Findley explained that the Tier Two committees were now up and running and meetings with the Chairs of the Board Tier One Committees will be taking place to determine how the governance arrangements around assurance reports, etc. will be managed. Following further discussion, it was: **RESOLVED:** to note the content of the report and to approve the implementation of the proposed structure.	GF / CH
24/07/10	**Chair's Report:**	

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	Mrs A Marshall, Chair, gave an update to the Board on some current issues, events and engagement work taking place across the organisation. She began her report with the sad news of the loss of a valued colleague. Alison Clark, a receptionist in outpatients, sadly passed away at the beginning of June. On behalf of the Board, Mrs Marshall expressed her deepest condolences to Alison's family, friends and colleagues. The Board recently appointed Maggie Pavlou as Deputy Chair from 1 July 2024 to 30 June 2027 and Martin Hedley has been appointed as Senior Independent Director from 1 July 2024 to 30 June 2026. Mrs Marshall thanked Mr Mike Robson for his excellent commitment and contributions to the roles over the last five years. Assurance is provided that the annual fit and proper persons return has been completed and submitted to the NHS England Regional Director on 26 June 2024 ahead of the deadline of 30 June and Mrs Marshall confirmed to the Board that all Board Members have been tested and concluded as being fit and proper in line with the Framework. The Council of Governors held an informal private meeting to further discuss the results of the Council of Governors' effectiveness survey (which was largely positive). The opportunity to meet informally was welcomed. Mrs Marshall highlighted that the preparation for the forthcoming Governor elections has commenced. Mrs Marshall drew attention to the Star of the Month nominations and congratulated the winners noting that the winner for June has not yet been announced. Following discussion, it was: **RESOLVED:** to receive the report for assurance.	
24/07/11	**Chief Executive's Report:** Mrs T Davies, Chief Executive, gave an update to the Board on current issues which have aligned to the Trust's Strategic Aims. She 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* – she highlighted that the gynae-oncology team have won an award and have been recognised as one of the best training units in the country. The Trust has also been recognised as one of the best in the region following the results of the National Cancer Patient Experience Survey and the quality of services particularly around diabetes in children.	

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	In relation to Strategic Aim 2: *we will be a great organisation with a highly engaged workforce* – the Trust's internationally-educated nurses all passed their OSCEs (Observed Structural Clinical Examinations) and Mrs Davies congratulated them on their achievement. In relation to Strategic Aim 4: w*e will be an effective partner and be ambitious in our commitment to improving health outcomes* – Mrs Davies highlighted that an event with Gateshead partners hosted by Gateshead Council took place recently and was an excellent opportunity to engage with partners to develop a collective ambition particularly around maternity. In relation to Strategic Aim 5: *we will develop and expand our services within and beyond Gateshead* – Mrs Davies provided an update on the Community Diagnostic Centre and highlighted that the Community Services contract has been extended for two years. Following a query from Mr A Crampsie, Non-Executive Director, around the potential impact of the change in government, Mrs Davies explained that this will be discussed further at the Alliance meeting this week and Mrs J Halliwell, Group Chief Operating Officer explained that a national call is taking place tomorrow however it is anticipated it will include expectations around efficiency and recovery work. It was felt that it would be beneficial for the Board to discuss and work through plans at a future development session. After further discussion, it was: **RESOLVED:** to receive the report for assurance.	Cycle of business
24/07/12	**Great North Healthcare Alliance Progress Report:** Ms N Bruce, Interim Director of Strategy, Planning and Performance, provided an update on the ongoing work of the Great North Healthcare Alliance. She reported that specific areas of focus for Alliance working have been agreed and a Collaboration Agreement has been signed by each of the four organisations which underpins meetings of the Alliance Steering Group Committees in Common to govern the Alliance work plan. Mrs A Marshall currently Chairs this group and two meetings have now taken place. Areas of work have been identified in relation to paediatrics, urgent and emergency care, urology, obstetrics and gynae-oncology. Work is also taking place around learnings and opportunities in relation to the organisations' subsidiaries and a work plan is being developed to include collective opportunities and risks.	

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	Following a query from Mr M Robson, Non-Executive Director, in relation to the progression of the Non-Executive Director group, Mrs Marshall agreed to follow this up with the chairs of the Alliance partners. Mr N Halford, Medical Director of Strategic Relations, highlighted that good conversations are taking place around the alignment of a clinical strategy across the organisations which will include longer-term plans. Mrs K Mackenzie, Group Director of Finance and Digital, also explained that executive level work continues to take place including the development of a digital strategy. Following a query from Mr A Crampsie, Non-Executive Director, in relation to timescales and actions, Mrs Bruce explained that this will be discussed in more detail at the Committees in Common meeting however any changes to services would require formal consultation. Mrs Marshall highlighted that it is planned to bring the Alliance work plan to the next Board meeting which should provide further clarification. Following consideration, it was: **RESOLVED:** to receive the report for assurance and to note progress being made. Ms Bruce left the meeting.	AM Cycle of business
24/07/13	**Integrated Care Board Quality Strategy:** Dr G Findley, Deputy Chief Executive and Chief Nurse, presented the Quality Strategy which has been developed by the Integrated Care Board (ICB) and provides the opportunity for comments to be received prior to its launch in September 2024. It is noted that the strategy aligns well with the Trust's Quality Strategy and does not contradict any of the work we have underway in this area. Mrs T Davies, Group Chief Executive, highlighted that this supports further collaborative working across the system and opportunities to discuss shared services. Mr N Halford, Medical Director of Strategic Relations, explained that a lot of work needs to be undertaken to ensure shared dialogue and focus continues across the system. Mrs H Parker, Non-Executive Director, felt that the strategy was high level however Mrs Davies explained that this enables appropriate linkage to the Trust's strategic intent. After further discussion, it was: **RESOLVED:** to receive the report for assurance and note its content.	

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24/07/14	**Response to NHS England letter on maintaining quality in pressurised services:** Dr G Findley, Deputy Chief Executive and Chief Nurse, presented the Trust's response to the NHS England letter to review the quality of care provided during times of pressure. The paper aims to provide assurance about the care being provided within the Trust. Dr Findley reported that in response to the letter, visits took place to the areas where care may be provided out with the core beds and which are in alignment with agreed internal escalation protocols and assurance has been provided that there are suitable arrangements in place. She reported that further work is required in relation to the use of the ambulance handover corridor however staff are aware that these areas are only to be used in times of extreme pressure as directed by the full capacity protocol or by the strategic / tactical on call manager and it is the ambition of the organisation to have sufficient flow across the system that the need to invoke the Full Capacity Plan is rendered redundant. An example of this was heard earlier by the Emergency Department Team around improvements to ambulance handover times and further improvement work is planned. Mrs J Halliwell, Group Chief Operating Officer, confirmed that risk assessments are undertaken when using these areas however high bed occupancy rates are recorded across the region. Work continues between the Trust and Local Authority and a winter planning session will be taking place across the system next week. Dr C Howey, Group Medical Director, explained that there a number of challenges however key areas of focus have been identified and further clinical engagement work will be taking place. Mr M Robson, Non-Executive Director, reported that detailed discussions took place at the Finance and Performance Committee and as highlighted in the assurance report, a deep dive exercise has been requested in relation to the delivery of urgent care objectives and this will be reviewed on a monthly basis. Mrs T Davies, Group Chief Executive, felt that it was important to recognise that the escalation protocols are not expected to be undertaken on a long-term basis however are implemented to ensure patient safety and are fully risk assessed. Further improvement work will be taking place within the organisation however key conversations are required across the system. Dr Findley highlighted that it had been beneficial to meet with the staff and quality metrics were valued by senior members. Mr N Halford, Medical Director for Strategic Relations, explained that discussions had taken place with clinicians following the Channel 4 Dispatches programme and reassured the Board that this was	

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	not recognised practice within the organisation and would not be tolerated. Mrs Marshall highlighted the value of the Board walkabouts in meeting and discussing issues with staff and patients and will continue going forwards. After consideration, it was: **RESOLVED:** to receive the report for assurance and note its content.	
24/07/15	**Paediatric Audiology Services – Care Quality Commission assurance:** Dr G Findley, Deputy Chief Executive and Chief Nurse, presented the report in response to a letter received by the Care Quality Commission (CQC) around assurances the Trust has in relation to the safety, quality and accessibility of children's hearing services. Dr Findley highlighted that the letter was not received via the usual route therefore the required deadline of 30th June 2024 has been missed however this has been explained to the CQC and a report will be submitted as soon as possible after the Board meeting. A gap analysis against the Improving Quality in Physiological Services (IQIPS) standards has now been completed and the Trust is 67.5% compliant however in order to achieve a greater compliance level there would need to be significant investment in staffing and estates. Dr Findley reported that discussions have taken place with the Executive Team and it is therefore recommended that the Trust continues to strive to achieve the standards, where that is possible, within the constraints of the estate and qualified staff that are available within the service. This is a similar position to regional colleagues and the Trust is continuing to engage with the regional and national incident management programmes led by the Integrated Care Board and NHS England. The Quality Governance Committee have already received an internal action plan and this will continue to be monitored. A look back exercise has also been recommended and will be reported back via the Committee. Mrs T Davies, Group Chief Operating Officer, also reported that this has been discussed via the Alliance work and a working group has been set up. Following discussion, it was: **RESOLVED:** to note the contents of the report for information and note that progress will be monitored at the Safecare Steering Group. Any lack of progress will be escalated to Quality Governance Committee.	

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24/07/16	**Governance Reports:** **Board Assurance Framework Quarterly Update:** Mrs J Boyle, Company Secretary, presented the current Board Assurance Framework (BAF) position and reminded the Board that the summary risks, current scores and target scores were reviewed as part of the Board development session in June 2024 and has been updated to reflect the agreed wording and scores for each risk. The BAF for 2024/25 has now been reviewed by each Board committee and updates agreed at each committee meeting are shown in red text to enable the changes to the BAF to be tracked. At present no summary risks have reduced in score, but Mrs Boyle explained that this is to be expected given that the opening scores for the year were only set by the Board in June 2024. Further work will be undertaken with the Executive leads to determine timescales and ensure appropriate assurances are provided in reducing any gaps in controls. Mr A Crampsie, Non-Executive Director, commented that discussions around the BAF at the Board Committees have improved. After consideration, it was: **RESOLVED:** to receive the report for assurance. **Organisational Risk Register (ORR):** Dr G Findley, Deputy Chief Executive and Chief Nurse, presented the updated ORR to the Board which shows the risk profile of the ORR, including a full register, and provides details of reviewed compliance and risk movements. This report covers the period 23rd May 2024 to 19th July 2024. Dr Findley highlighted that there are currently 19 risks on the ORR which includes five new risks, no escalated risks, no reduced risks and two closed risks during June and July 2024. The new risks relate to medical staffing, cyber security and Freedom of Information and Subject Access Request performance. The top three risks agreed at the last Executive Risk Management Group relate to the financial plan, medical staffing and robustness of business continuity plans. There has been some reduction in compliance around risk and action reviews and Mrs A Stabler, Non-Executive Director, highlighted that this will be discussed in more detail at the next Audit Committee as part of the regular risk reports from Executive Risk Management Group. After consideration, it was: **RESOLVED:** to receive the report for assurance.	

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24/07/17	**Assurance from Board Committees:** The Board reviewed the Committee escalation and assurance reports which provide improved processes to identify areas of concern and ongoing monitoring of assurances. **Finance and Performance Committee:** Mr M Robson, Committee Chair, provided a brief verbal overview to accompany the narrative reports following the June 2024 meeting and drew attention to the most recent meeting which took place on 30th July 2024. Mr Robson highlighted that there was one issue identified as requiring alert to the Board which relates to medical staffing and the level of overspend particularly within the Medicine Business Unit however this is being monitored by the Executive Management Team and the People and Organisational Development Committee. There are some areas subject to ongoing monitoring which includes: • the underlying risk relating to the revised financial plan and delivery of cost reduction plans. The funding arrangements for the national pay award is also currently unknown. • The Committee discussed the continued impact on sickness absence however acknowledged the link across all of the Tier One Committees. • As mentioned earlier in the meeting, a deep dive exercise has been requested around delivery of urgent care objectives and this will be reviewed on a monthly basis. • The Committee received a further update on the paediatric autism pathway and GP shared care remains an issue and is also being picked up by the Quality Governance Committee. Positive assurance was provided to the Committee in relation to the capital programme and funding in relation to cancer services and elective recovery. A verbal update was also provided on the community services contract and a programme of work was presented at the last meeting which will continue to be monitored and progress reported. Mr Robson reported that the Committee discussed the risk relating to medical staffing which is also included on the Organisational Risk Register. **Quality Governance Committee:** Mrs A Stabler, Committee Chair, provided a brief verbal overview to accompany the narrative report following the June meeting. She reported that there was one issue identified as requiring escalation to the Board for further action which relates to shared care contracts and	

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	an options paper is being developed for the Integrated Care Board and a representative will be attending the next meeting. She noted that complaints had been escalated to the Board in error in June and an apology was formally noted. There are some areas subject to ongoing monitoring which includes: • Paediatric audiology as mentioned earlier in the meeting • Assurance around Inphase low and no harm incidents was provided to the Committee and a solution in place. • An agreed plan of assurance was also discussed at the Committee in relation to falls with harm • The Committee was provided with information on plans in place to manage disruption due to the junior doctors strike and this went well. Mrs Stabler reported that there were no changes on the risk register however a risk score on the Board Assurance Framework around the Quality Improvement Plan has been reduced. Mrs M Pavlou, Non-Executive Director, drew attention to the referrals to the People and Organisational Development Committee and felt that this may cause some issues in relation to limited space on Committee agendas and it was agreed that this would be changed to refer to the Executive Lead for consideration around whether any issues should be escalated to the Committee. Mrs J Boyle, Company Secretary, will update the assurance report template and develop the process. Following a query from Mrs Marshall in relation to Inphase, Dr G Findley, Deputy Chief Executive and Chief Nurse, explained that a lot of work has been undertaken to improve the incident reporting system by the Digital Team and Chief Clinical Information Officer. Following a further query from Mrs H Parker, Non-Executive Director, in relation to reporting of Freedom to Speak Up incidents, Dr Findley explained that an additional module has been added to improve reporting mechanisms and anonymous reporting can also be recorded. **Digital Committee:** Mr M Hedley, Non-Executive Director, on behalf of the Committee Chair, provided a brief verbal overview to accompany the narrative report following the May 2024 meeting. He reported that there were two issues identified as requiring escalation to the Board for further action relating to information asset owners and Freedom of Information and Subject Access request performance. Mrs K Mackenzie, Group Director of Finance and Digital, highlighted that the work around information asset owners continues to be a challenge however the Information Governance Team is now fully recruited so improvements should be seen going forwards. There has also been a change to governance processes in relation to Freedom of Information and Subject Access requests with a new meeting in place to oversee	JB

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	this, chaired by the Senior Information Risk Owner (SIRO). Following a query from Mrs Stabler in relation to capacity to respond to requests due to potential financial penalties, Mrs Mackenzie reported that the Executive team are sighted on all requests and timescales are set for responses. A dedicated site with frequently asked questions is also available for owners to refer to. Mr Hedley reported that there were no advisory issues however the Committee has received positive assurance around the progress of the Electronic Patient Record project and a draft outline business case is being developed. Improvements around internal audit actions has also been acknowledged. There were no new risks at the time of the meeting however it has been noted that the risk relating to cyber vulnerability has now been added to the Organisational Risk Register and has been escalated due to the recent national issues. **People and Organisational Development Committee:** Mrs M Pavlou, Committee Chair, provided a brief verbal overview to accompany the narrative report following the July 2024 meeting. She reported that there were no issues requiring escalation to the Board however there are some areas subject to ongoing monitoring which includes: • External audit findings in relation to contracts not being consistently maintained on employee personal records however the Committee have been informed that a plan is in place to rectify the issue and mitigate the risk and a further report will be brought to the Committee in September 2024. • Further deterioration has been reported in relation to sickness absence however improvement work is ongoing and a dedicated focus on sickness should have an impact in the coming months • The Committee was not fully assured over the overall vision and direction of travel of work on equality, diversity and inclusion however a time out session is planned to focus on this. • Work continues on the historic pre-employment identification document checks and a further update will be reported to the Committee at the next meeting. Following a query from Mrs Stabler in relation to suggested disciplinary action, Mrs A Venner, Group Director of People and Organisational Development, explained that all other routes have been exhausted and is a management requirement. The Committee received good assurance and in relation to the oversight of the Freedom to Speak Up Guardian activity however training may need to be delayed to enable staff to concentrate on clinical work. Mrs H Parker, Non-Executive Director, queried whether referrals made to Freedom to Speak Up Champions would be included in reports, and Mrs	

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	Venner explained that this is included in new governance processes and included as part of the Board cycle of business. **Audit Committee:** Mrs H Parker, Non-Executive Director, on behalf of the Committee Chair, provided a brief verbal overview to accompany the narrative report following the June 2024 meeting. She reported that there were no issues requiring escalation to the Board however there are some areas subject to ongoing monitoring which includes the low level of returns in relation to conflicts of interest and gifts and hospitality declarations and the Committee further promotional and education work is required to increase compliance during 2024/25. Mrs J Boyle, Company Secretary, explained that a request is distributed to all senior staff however it has been suggested that the process is revised so that this is operationally managed. Dr C Howey, Group Medical Director, suggested that this could be linked to staff appraisals and Mrs Pavlou felt that this could be picked up by the People and Organisational Development Committee. Mrs K Mackenzie explained that this was also a counter fraud risk in relation to procurement and any gifts and hospitality that is offered and refused should also be declared. Mrs Boyle reported that these factors are being looked at as well as ways to increase awareness. Mrs Parker highlighted that a new risk has been added to the risk register in relation to the acceptance by the Committee that there is no auditable process in place to evidence compliance with Standing Financial Instructions for electronic supplier quotes under £10k however it was noted that mitigations will be put in place around staff training. Mrs Mackenzie highlighted that this risk is relatively low as processes are already in place. Mrs Marshall thanked the Committee Chairs for their reports. After consideration, it was: **RESOLVED**: to receive the reports for assurance	
24/07/18	**Board Walkabout Feedback:** Dr G Findley, Deputy Chief Executive and Chief Nurse, presented the report which provides an overview of observations and reflections from Board walkabouts, supporting triangulation with other sources of information and assurance. She explained that this is a new report however over time, will enable key themes and trends to be identified, as well as any material actions from visits. The current report covers two visits with Domestic services covering Ward 8, Ward 1 and Ward 2 on 2nd April 2024; and Breast screening on 16th July 2024.	

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NHS Foundation Trust

Agenda Item No		Action Owner
	Dr Findley highlighted that the issues identified during the domestic services visit in relation to further visits to the areas where the full capacity protocol could have been enacted have been detailed in the separate paper on today's agenda (Item 14). A suggestion following the visit to breast screening around the Board's reflections on the use of artificial intelligence (AI) has been suggested to take place via the Digital Committee. Mrs K Mackenzie, Group Director of Finance and Digital, felt that it was important to establish how AI is currently being used and Mrs T Davies, Group Chief Executive, felt that this was already being picked up via digital transformation workstreams. Mr N Halford, Medical Director of Strategic Relations, commented that this should be considered in areas that adds benefits to the patient journey and outcome and has been an area of discussion with newly appointed clinicians. Mr A Crampsie, Non-Executive Director, suggested that it may be useful for the walkabouts to be triangulated with forward plans and taking into consideration discussions at Board and Committee level. Dr Findley explained that this may result in some areas not being included on visits if they haven't been subject to a Board / committee discussion, however she will consider this in future planning. Following discussion, it was: **RESOLVED**: to receive the report for assurance	
24/07/19	**Finance Report:** Mrs K Mackenzie, Group Director of Finance and Digital, provided the Board with a summary of financial performance for April to June 2024 (Month 3) for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds). Mrs Mackenzie highlighted some of the key points and reported that the Trust had approved a planned deficit of £12.650m for 2024/25 and at June 2024, the Trust has reported an actual deficit of £7.431m. She explained that this is mainly due to pressures relating to industrial action and plans are being worked through via the cost reduction plan. It should also be noted that there is also an unknown impact in relation to the national pay ward. Mrs Mackenzie reported that the Trust has reported net capital spend totalling £4.999m as of June 2024 which is £0.304m less than planned. There has been a deterioration in the cash balance however this has been predicted and will be balanced. After consideration, it was:	

Agenda Item No		Action Owner
	RESOLVED: to receive Month 3 financial position and note partial assurance for the achievement of the forecast 2024/25 planned deficit as a direct consequence of the reported year to date position and financial risks.	
24/07/20	**Leading Indicators 2024/25 Report:** Mrs J Halliwell, Group Chief Operating Officer, presented the progress, risks and assurance in relation to the Trust's Strategic Objectives for Month 3 2024/25. She highlighted that report is presented for the first time in its new format which has been developed to provide focussed and streamlined information. Further work is being undertaken around the narrative aspect of the report. Mrs Halliwell drew attention to the executive summary and following key areas: Strategic Aim 1: *We will continuously improve the quality and safety of our services for our patients* – there has been raised incidents of falls during this period and targeted analysis work is being undertaken. Strategic Aim 2: *We will be a great organisation with a highly engaged workforce* – there has been a slight increase in the internal sickness absence rate however training and development against the new absence management policy commenced in June 2024. Strategic Aim 3: *we will enhance our productivity and efficiency to make the best use of our resources* – there has been a change in data collection in relation to length of stay therefore baseline figures will need to be reset. Further work is required around planned care particularly in relation to the 52 week wait target however the organisation is seeing more patients overall therefore treatment lists are reducing. Strategic Aim 4: *we will be an effective partner and be ambitious in our commitment to improving health outcomes* – one of the biggest challenges relates to the reduction in waits for gynaecology outpatients however strong performance is reported in relation to increasing the number of digital devices repurposed to the local community. Mrs Halliwell also highlighted that progress in relation to the constitutional standards is included within the report and provides a focussed dashboard to highlight progress against these standards. Mrs A Stabler, Non-Executive Director, provided positive feedback on the new format of the report and wished to thank the team for their work around this. She raised a query in relation to the increase in the number of patients with no criteria to reside and questioned whether the opening of the new Sister Winifred Laver Promoting Independence Centre would have an impact on this. Mrs Halliwell explained that a full multi-	

Agenda Item No		Action Owner
	disciplinary team reviews the criteria for admission however discussions are taking place with the social care team in terms of maximising the unit in relation to escalation processes. Mr A Crampsie, Non-Executive Director, raised a query in relation to the paediatric autism pathway and Mrs Halliwell explained that detailed discussions have taken place at the Finance and Performance Committee and further assurances have been requested in relation to delivery models. Dr C Howey, Group Medical Director, highlighted that a further meeting will be taking place in August to discuss Integrated Care Board funding which had enabled some new appointments to be secured. Mrs Davies highlighted that Executive Directors had reviewed risk registers and collectively agreed the Executive Leads for key strategic risks / areas: Mrs Halliwell will be leading on the 4 hour Emergency Department target; Dr Howey will be leading on medical staffing function and spend; Mrs Venner will be leading on staff attendance; Dr Findley will be leading on falls and complaints; and Mrs Mackenzie will be leading on cost reduction delivery. It is therefore anticipated that this will provide significant improvements in relation to the organisation's leading indicators. Following consideration, it was: **RESOLVED:** to receive the report for assurance and note the key areas of improvement and challenge.	
24/07/21	**Maternity Integrated Oversight Report:** Ms K Parker, Head of Midwifery, presented a summary of the maternity indicators for the Trust for June 2024. She drew attention to the key performance indicators within the Maternity Dashboard and highlighted that there has been a reduction in induction of labour rates for June 2024 and is in line with the overall reduced birth rate and increased caesarean rates. This will continue to be monitored to inform workforce planning. Other positive highlights include the work that has been undertaken around the digital inclusion agenda and Ms Parker explained that this is being supported by the Hope Foundation who have been providing training around the direct referral process at no extra cost to the Trust. There has been a dip in compliance around the Ockenden recommendations however this should be addressed in July due to a number of action plans being monitored via the Local Maternity Services Board.	

Agenda Item No		Action Owner
	Following discussion, it was: **RESOLVED:** to receive the report for assurance. Ms Parker left the meeting.	
24/07/22	**Nurse Staffing Exception Report:** Dr G Findley, Chief Nurse and Deputy Chief Executive, presented the report for June 2024 which provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls. Dr Findley highlighted that the Trust has continued to experience periods of increased patient activity during June 2024 with surge pressure resulting in escalation areas. This has impacted on staffing resource in addition to sickness absence and enhanced care requirements. Focused work therefore continues around the recruitment and retention of staff and managing staff attendance. Mr A Crampsie, Non-Executive Director, suggested that it may be useful to highlight any decreases in red ratings and increases in green ratings against the previous month and this will be considered for future reports. Following discussion, it was: **RESOLVED:** to receive the report for information and assurance.	GF
24/07/23	**Cycle of Business 2024/25:** Mrs J Boyle presented the cycle of business for 2024/25 which outlines forthcoming items for consideration by the Board. This provides advanced notice and greater visibility in relation to forward planning. After consideration, it was: **RESOLVED:** to review and approve the cycle of business for the forthcoming financial year 2024/25.	
24/07/24	**Questions from Governors in Attendance:** No questions were raised from Governors in attendance.	
24/07/25	**Any Other Business:**	

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Agenda Item No		Action Owner
	National Pay Award Mrs A Venner, Group Director of People and Organisational Development, confirmed that the government has accepted the recommendations of the independent Pay Review Bodies in full during the Chancellor's speech with effect from 1st April 2024. This includes a 5.5% consolidated uplift for all Agenda for Change staff on NHS terms and conditions, a 6% uplift for medical staff and a 5% uplift for very senior managers. An offer in relation to junior doctors is currently being considered. A full breakdown of the actual and percentage increases across all staff groups is currently awaited therefore the timing of the pay award implemented is unknown. Mrs T Davies, Group Chief Executive, commented on an article by the Health Service Journal in relation to a report on very senior managers and current difficulties in recruiting to these posts and felt that it was important to review this whilst considering strategic models. Mrs Venner will look into this further and report back. Mrs M Pavlou, Deputy Chair, wanted to thank those involved in the work around the national cyber attack and was reassured by the Trust's response.	AV
24/07/26	**Date and Time of Next Meeting:** The next meeting of the Board of Directors will be held at 9.30am on Wednesday 31st July 2024.	
Exclusion of the Press and Public: Resolved to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed.		

PUBLIC BOARD ACTION TRACKER

Gateshead Health NHS Foundation Trust

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

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
24/06/14	05/06/2024	Bi-annual inpatient safer nursing care staffing report	Discussion to take place to agree outputs and further work around the calculations relating to emergency department therefore exercise will be repeated and reported back via the Quality Governance Committee and its assurance report to Board	~~31/07/2024~~ 25/09/2024	GF	Review of ED staffing has been completed and discussed with the business unit. There is further work to understand the longer term needs within ED (as per the paper "operating in times of pressure" to be discussed on the July Board agenda). To remain open due to further discussions required. **Sept 24** - Several meetings have now been held to discuss staffing. New model agreed from EAU, which releases some funding. Business case for ED now being developed. **Action recommended to close**	
24/07/09	31/07/2024	Organisational Structure Consultation Outcome	A further update on the clinical leadership elements would be provided at the next Board meeting in September 2024	25/09/2024	GF / CH	**Sept 24** - Survey to members of the clinical strategy group has been circulated. Results are pending. This will inform future developments with clinical leadership.	
24/07/11	31/07/2024	Chief Executive's Report	To discuss potential impact of change in government direction and expectations around efficiency and recovery work. To work through plans at future Board Development Session	25/09/2024	TD / AM/JB		

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
24/07/12	31/07/2024	Great North Healthcare Alliance Progress Report	To bring the Alliance work plan to the next Board meeting To follow up on the progress made in developing connections between Non-Executive Directors across the Alliance	25/09/2024	AM / TD		
24/07/17	31/07/2024	Board Committee Assurance	To develop process around assurance report template for referrals to other Committees	25/09/2024	JB	12/08 – template has been amended to enable cross-referral to Executive leads rather than directly to Board committees. **Action recommended for closure.**	
24/07/21	31/07/2024	Nurse Staffing Exception Report	To consider highlighting any decreases and increases against previous month figures for future reports	25/09/2024	GF	Sept 24 - Trend analysis is now included within the report – **Action recommended for closure**	
24/07/25	31/07/2024	Any Other Business	National Pay Award – to assess the impact of a the HSJ article on very senior manager recruitment and brief the Board on key implications	25/09/2024	AV		

Closed Actions from last meeting

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
24/03/07	27/03/2024	QEF SFIs and Scheme of Delegation	To undertaken a review of the Articles of Association in line with the approved SFIs	~~05/06/2024~~ 31/07/2024	GE	A review has taken place and will be presented at the QEF Board prior to ratification at Trust Board **July 24** – item on the agenda and also approved by QEF Board – **action agreed for closure**	
24/06/12	05/06/2024	Leading Indicators 2024/25	To discuss stretch target in relation to sickness absence with POD leads and to address via POD Committee	31/07/2024	AV	Detailed presentation on managing absence taken to POD Committee on 09.07.24. Work underway noted and further actions agreed. An update is due back to Committee in September 2024. **Action agreed for closure.**	
24/06/13	05/06/2024	Maternity IOR	To develop an outline strategic intent for maternity and bring this back to Board for a full discussion.	31/07/2024	EMT / JB	June 24 – seeking to schedule a Board development discussion in August on this. **July 24** – a session has been diarised for August. **Action agreed for closure**.	
24/06/13	05/06/2024	Maternity and Midwifery Staffing Report	Further realignment work of posts and funding to take place prior to development of business case. To keep Board informed on developments	31/07/2024	GF	Meeting scheduled for 30/07/2024. Information from the meeting will be shared in the maternity IOR that comes to each board meeting. **Action agreed for closure.**	
24/06/16	05/06/2024	QEF 6 monthly report	To review information flows and format of the report to Trust Board	31/07/2024	GE	**July 24** – reviewing format in line with comments made. Next report due at Board in November 2024 therefore **action recommended for closure.**	

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Report Cover Sheet Agenda Item: 7

Report Title:	**Draft Winter Plan 2024/25 – Strategic Overview Assurance Report**			
Name of Meeting:	Trust Board			
Date of Meeting:	24 September 2024			
Author:	David Patterson Head of Emergency Preparedness, Resilience and Response			
Executive Sponsor:	Joanne Halliwell, Group Chief Operating Officer			
Report presented by:	Joanne Halliwell, Chief Group Operating Officer			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	This report seeks the endorsement of the Trust Board for the Winter Plan 2024-25 – Strategic Overview.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Executive Management Team, Operations Oversight Group Gateshead Health Winter Operational Group			
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*	Winter 2024-25 is expected to be challenging and complex due to • a necessity to maintain patient flow and respond to periods of surge and demand maintaining clinical safety • expected influenza surges alongside other respiratory viruses • a need to maintain elective activity • the financial context of the organisation and the inability to secure additional funding to support our winter response. These factors will impact the Trust's ability to deliver a high-quality service over the winter months. Robust planning, mitigation and forecasting has taken place in order to reduce these impacts and to ensure our patients continue to have a positive patient experience and receive safe, compassionate and effective care.			

<table>
<tr><td></td><td colspan="5">The requirements for meeting the challenges of winter are dynamic and iterative and a supporting Operational Trust Winter Plan will be produced to provide specific guidance, information and instructions for teams to operationally respond during the winter period.

A system governance structure incorporating strategic oversight and operational management/response at system and trust level has been agreed and implemented.

The Winter Plan 2024-25 – Strategic Overview is attached as Appendix 1 to this report.</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 Trust Board are asked to review the Winter Plan Strategic Overview and to confirm that it provides assurance to support the work of the Trust during the Winter period 2024-25 noting the risks identified.</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">Strategic aim one: We will continuously improve the quality and safety of our services for our patients

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

Strategic aim four: We will be an effective partner and be ambitious in our commitment to improving health outcomes</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 are several risks that are factors to the successful delivery of the winter plan that may impact the trust concurrently. This includes:

<u>Organisational / locally managed trust risks</u>

• Ref 4591 - Disruption to services due to GP collective action, including withdrawal from shared care agreements.</td></tr>
</table>

<table>
<tr><td></td><td colspan="3">

- Ref 2464 - Risk of not being able to deliver services within budget due to unfunded increase in bed base and delay in transfers of care to Local Authority
- Ref 2432 - Risk of quality of care due to industrial action
- Ref 4554 - Cyber security vulnerabilities
- Ref 2498 - Risk that there will be further waves of covid-19 across the trust
- Ref 2545 -Delay in transfer due to lack of social care provision
- Ref 4589 - Risk that services may be overwhelmed by civil unrest.

<u>National / system risks</u>

- Industrial action across various public sectors
- Negative impacts on population health of seasonal illness and cold weather
- Disruption to Adult Social Care through staff unavailability and demand exceeding capacity
- Ambulance service pressure necessitating an amended handover model
- Outbreaks of infectious disease
- Agency caps with staffing frameworks reducing availability of workforce
- Increases in the cost of living.
- Supply chain issues.
- New government leadership that could cause changes to NHS structure.

The detail of the likelihood and consequence of any impacts will be a dynamic process and will be captured on the organisation and local risk registers and will be continually monitored throughout the winter period.

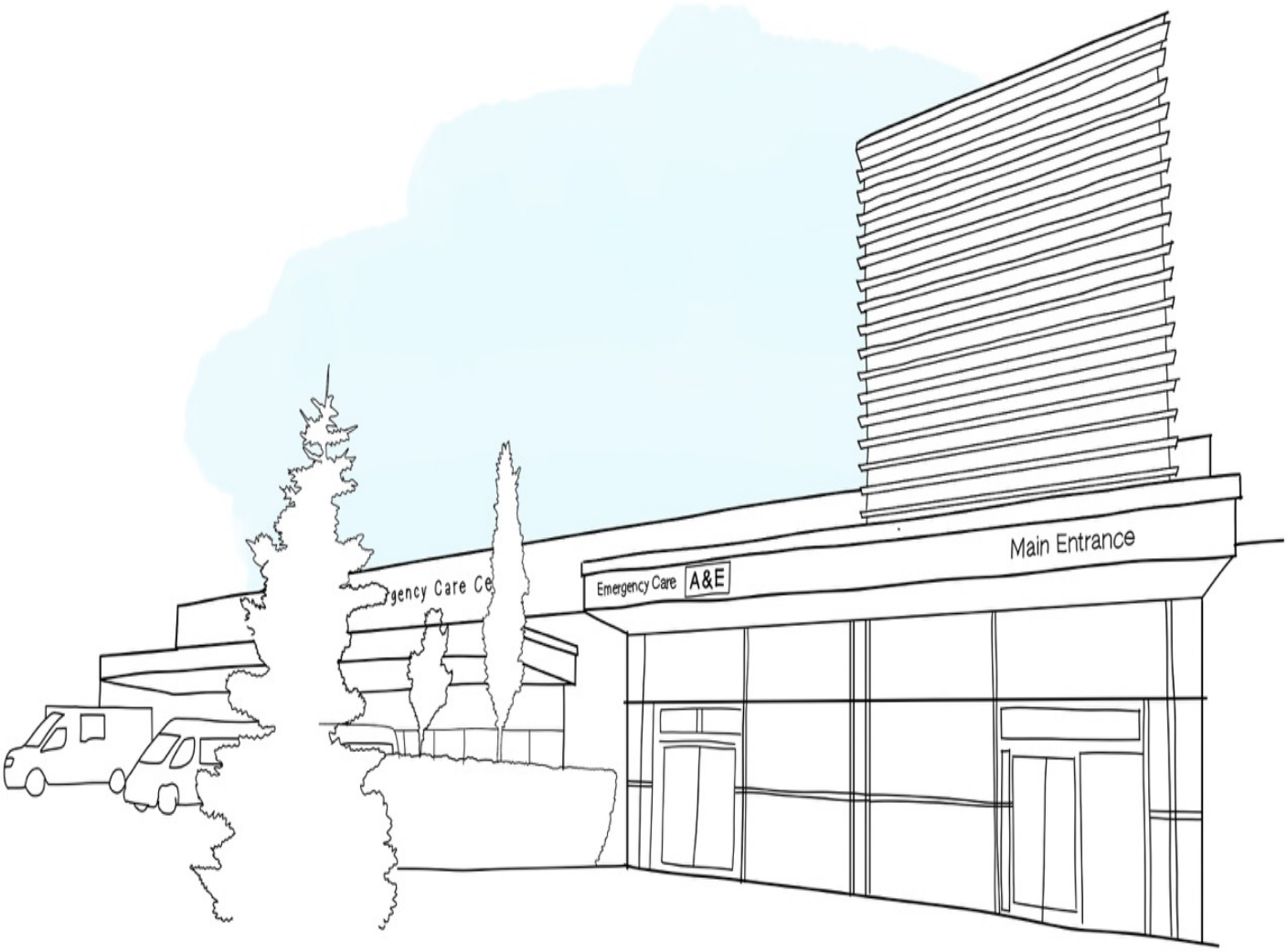
</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td>Yes
☐</td><td>No
☐</td><td>Not applicable
☒</td></tr>
</table>

Gateshead Health
NHS Foundation Trust

Winter Plan 2024 -2025

A strategic overview

September 2024



Contents

1. Introduction & Overview

Historically, winter impacts on the Gateshead population served by the Trust, our local communities and the NHS are well known:

- Increased Emergency Department attendances and associated treatments due to slips, trips and falls due to winter weather conditions.
- Increased incidences of respiratory viral infections
- Increase in Norovirus and similar gastrointestinal conditions.
- Increased emergency admissions due to deterioration of chronic health problems particularly with vulnerable patients
- Increased staff absences due to sickness
- Potential transport difficulties due to adverse weather impacts

For the purposes of this document - Winter 2024-25 covers the period from **Sunday 3 November 2024 to Sunday 6 April 2025.**

The cumulative impacts of the factors above are expected to be particularly challenging to the maintenance of clinical quality and safety. The Trust's ability to deliver a high-quality service may be impacted and, in some instances, our organisational and clinical risk profile will increase.

Robust planning, mitigation and forecasting are in place in order to reduce impacts and to ensure our patients continue to have a positive patient experience and receive safe, compassionate and effective care.

The Trust has continued to evolve the robustness of our plans and has taken a number of steps to improve overall resilience over the last 6 months going into the winter period. This has included:

- An annual review of all related policies and procedures, incident response and the on-call framework to deliver the NHS England (NHSE) Emergency Preparedness, Resilience and Response (EPRR) core standards and strengthening our response.
- A revised bed escalation protocol and robust ambulance handover to prevent delays on arrival.
- A new standard operational procedure for medical boarders - this is currently undergoing further review led by the Clinical Head of Service for Medicine.
- Incorporation of the lessons learned from business continuity and Industrial Action responses into future plans.
- A revised governance framework for outbreak response that includes the implementation of a new outbreak policy
- A review of the Trust Operational Pressures Escalation Level (OPEL) escalation procedures, implementation of the Gateshead Escalation Level (GEL) protocol and multi-agency response arrangements in alignment with the national Framework and System Coordination Centre documentation

This strategic overview was presented to the Gateshead Health NHS Foundation Trust Board on 24 September 2024.

2. Aim and Objectives

The aim of this plan is to provide a strategic overview and assurance for winter planning arrangements at Gateshead Health NHS Foundation Trust.

The following objectives have been identified to deliver our overall aim:

- To identify and embed organisational learning from previous winter periods
- To maintain patient flow and ensure minimal impact to delivery of the elective programme.
- To identify and manage risks to enhance patient safety and experience.
- To achieve high levels of immunity within our staff against vaccine preventable diseases
- To provide appropriate staffing and resources to respond to surge and demand.
- To enable a robust governance process with our system partner organisations across the Gateshead Place Based System
- To utilise national guidance and best practice

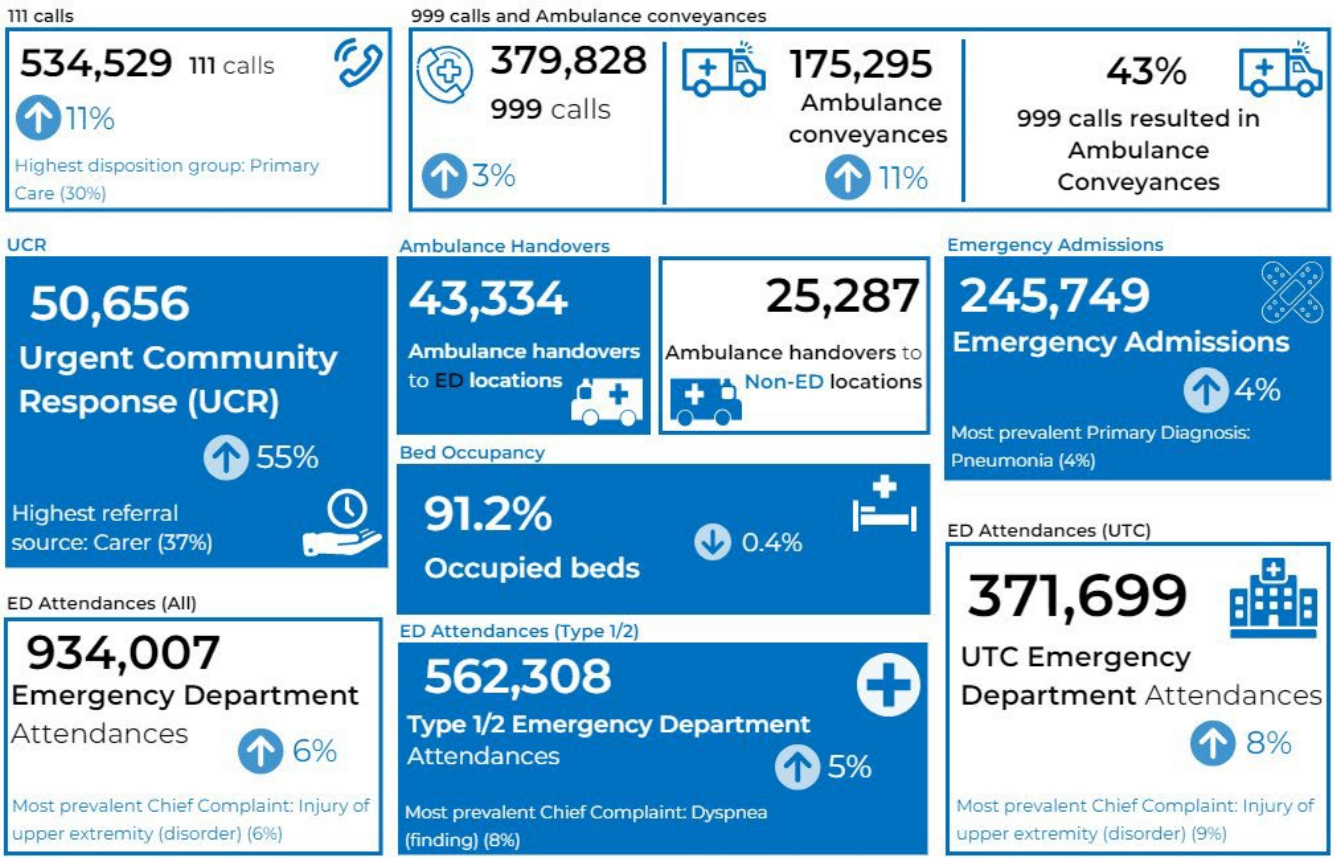
3. Review of Winter 2023-24

Although at times challenging, Winter 2023-24 was well managed by Gateshead Health and system partners. The key features were:

- Robust management of seasonal winter respiratory infections
- Management of industrial action within the medical workforce sector
- Ongoing managed staffing pressures linked to seasonal absences.
- Staffing challenges remained locally and nationally in health and social care.
- Levels of performance remained consistent through the winter period.

Winter pressures were experienced across the Northeast and in particular in some neighbouring Trusts. Consequently, there was an unknown (and therefore unplanned) impact on increased activity in Gateshead which led to patients in ambulances being diverted to us and impacting on our ability to respond.

The below provides an illustrated overview of the NENC ICB Winter Campaign 23/24 - 1st September to 31st March:



The debrief programme took place in two stages with a number of key recommendations which need to be considered in the context of the 2024-25 winter planning.

System debrief findings.

A system debrief programme took place in April 2024 with recommendations for consideration that included:

System strategic actions

Ref	Recommendations	Lead / s
1	Implement a mechanism to evaluate the Gateshead System winter schemes (internally and externally) and the ensure that the cost / benefits are explicit.	Gateshead System Winter Board
2	Enable stronger collaboration across the Gateshead System for winter 2024-25 with a collective system responsibility	Gateshead System Winter Board
3	Ensure early winter planning and a robust governance structure for 2024-25	All system partners
4	Work with partners to improve vaccination rates amongst health and social care provider staff	All system partners
5	Monitor the consequences of the cost-of-living crisis that may see an increase in the respiratory conditions due to poor home environments	Gateshead System Winter Board
6	Work with Voluntary, Community and Social Enterprise (VCSE) partners to develop the Gateshead System Winter Plan for 2024-25	Gateshead System Winter Board
7	Use the identified learning from 2023-24 to implement an ARI hub model for winter 2024-25	Gateshead System Winter Board

Organisational debrief findings.

A Gateshead Health organisational debrief programme took place in May 2024 with recommendations for consideration that included:

Ref	Recommendations
1	Early commencement of winter planning and allocated funding
2	The revision of the winter recruitment strategy and earlier timescales (specifically linked to the inclusion of a winter ward)
3	A review of escalation with very clear stages based on trigger points and decision-making structures.
4	An increase in the uptake of both flu and covid vaccinations across the workforce

5	More focus on hospital avoidance and scope potential increase of resources for front of house – frailty and COTE
6	Early identification and utilisation of the Sister Winifred Laver Centre provision
7	Work with social care partners to ensure there is a greater provision of rehab beds
8	Continue with the winter governance process

A full overview of the debrief findings reports are available on request.

4. National guidance, good practice and local approach

Our approach to winter planning 2024-25 has been developed in conjunction with the following national guidance and good practice:

Winter 2024-25

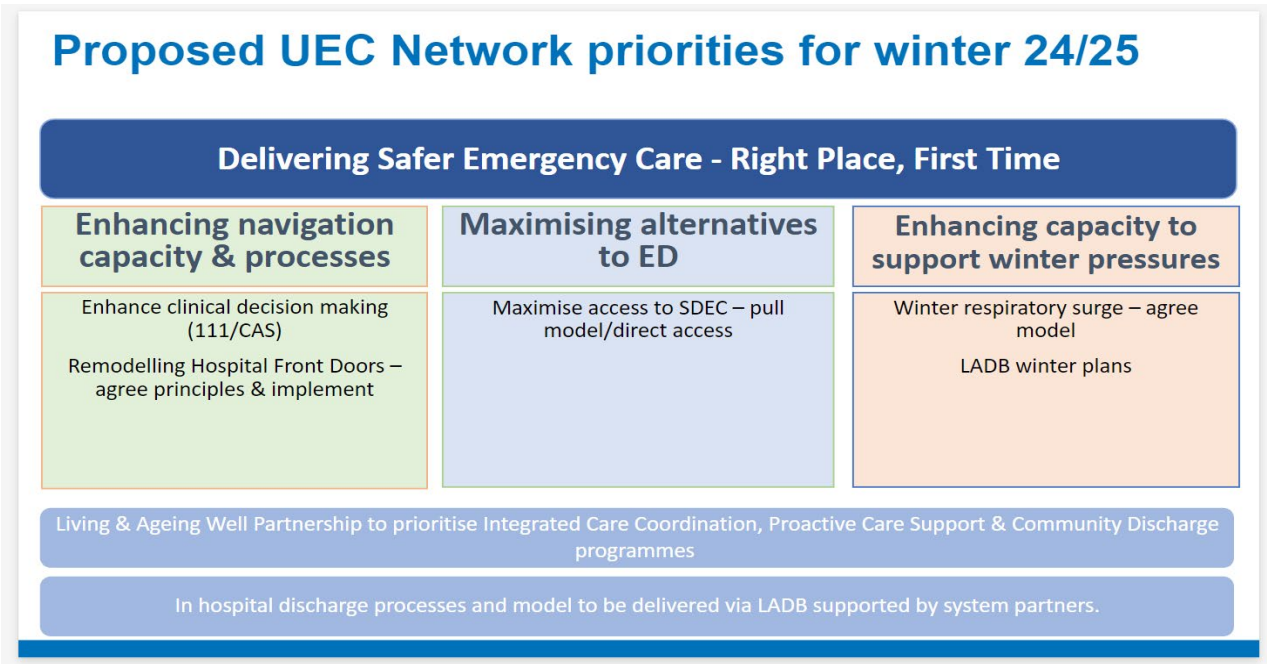
National discussions have outlined three key considerations for winter planning 2024-25, that include:

- Ensuring connectivity and communication
- Maintaining elective activity
- Robust measurement of any winter initiatives

This has been factored into our planning approach.

Urgent Emergency Care Network Priorities for winter 2024-25

Locally within the Urgent Emergency Care (UEC) network the three Winter Priorities agreed within the North East and North Cumbria Integrated Care Board (ICB) area in August 2024 include:



Adverse Weather Health Plan

The UK Health and Security Agency (UKHSA) Adverse Weather and Health Plan aims to protect individuals and communities from the health effects of adverse weather and to build community resilience. The Plan outlines key areas where the public sector, independent sector, voluntary sector, health and social care organisations and local communities can work together to maintain and improve integrated arrangements for planning and response to deliver the best outcomes possible during adverse weather.

https://www.gov.uk/government/publications/adverse-weather-and-health-plan

A national UKHSA Cold Weather Preparedness Programme for winter 2024/25 will take place during September 2024. The session will update stakeholders on changes of the Adverse Weather and Health Plan (AWHP) and signpost users to new material; provide an update of latest revised Cold Health Guidance and Cold Health Alert systems and discuss the latest weather forecast for winter 2024/2025. This will be incorporated into our internal planning for 2024-25.

5. Approach to Winter 2024-25

The national and local planning requirements for meeting the challenges of winter are a dynamic and on-going process.

The focus for our operational teams for winter 2024-25 is to sustain and minimise disruption to patient services throughout times of seasonal surge and demand within our existing operating policies, protocols and frameworks.

The following sections provides some highlights of our corporate approach to Winter:

Vaccination campaign planning

The national Joint Committee of Vaccines and Immunisations (JCVI) have provided guidance to advise there is no evidence or need to routinely vaccinate health care workers for covid-19 this autumn. This advice has been carefully clinically considered within the trust and the recommendations from the IP&C team will be reviewed by our internal Winter group and ratified through our Clinical Strategy Group.

There is no recommendation to vaccinate health care workers for Respiratory Syncytial Virus (RSV).

Therefore, this year's campaign will focus on providing flu vaccinations only.

Learning lessons from last year's winter debrief there is a strong focus on improving last year's figures with an aim to achieve an internal target of an 80% flu vaccination uptake (set by the internal Vaccine Committee) of Trust front line healthcare workers that includes the following highlights:

- The Vaccine Committee (including a wide range of representatives from across the Trust) is currently meeting on a monthly basis to consider the plans and review the identified lessons from the 2023-24 campaign for the vaccination campaign for 2024-25
- The Flu vaccination campaign commences 7 October 2024 until January 2025.
- Staff can continue to inform the Trust they've received the Flu vaccine elsewhere
- A jabathon will take place week commencing 7 October 2024 that will held in Occupational Health. Senior Nurses will also join the Jabathon and offer vaccination to staff in their workplace.
- Drop in clinics will be available every Tuesday and Thursday afternoon in the Occupational Health and Wellbeing Department until December.

- There will be flu champions identified within each ward and department to promote uptake of vaccination. They will be individuals nominated by the Peer vaccinators on the ward to help promote the flu vaccine to their colleagues
- Peer vaccinators to be used within the Trust and in the Community. They will be trained to vaccinate their colleagues.
- A communications plan will be implemented by the Communications Team, (commencing 4 weeks preceding the campaign/delivery)
- Level of uptake will be shared with all staff via Gateshead Health Weekly/Screensavers/Flu page to encourage competition between wards and departments.
- Business Units/Service Lines will be informed of their current level of uptake and senior teams asked to engage/encourage/communicate key messages on a weekly basis
- Planning is reliant on a consistent supply of relevant vaccines to meet planned demand
- Drop-in vaccination clinics will be held on a number of dates during the campaign at Bensham Hospital, Blaydon Urgent Care Centre and the Community Diagnostic Centre (CDC)

All staff working in clinical areas should be vaccinated against flu in a timely manner and this is a key focus of our communications and vaccination campaign.

The POD Steering Group have full oversight of the flu vaccination campaign, with Executive sponsorship from the Group Director for People and Organisational Development.

To enhance the visibility of our vaccination compliance this will be operationally tracked through the internal Trust Winter Group.

Infection, Prevention and Control (IP&C)

During the winter months there is an increase in seasonally related infectious diseases which can lead to higher incidence rates of infections such as respiratory viruses and Norovirus. These viruses thrive in the hospital environment, particularly in the context of high bed occupancy rates and excess patient and staff movement throughout the organisation. They result in an increase in morbidity and mortality rates in patients as well as increasing length of stay.

It is important therefore, that the organisation identify and isolate infectious patients in a timely manner, subject to a clinical risk assessment. Transmission of infections is particularly likely to occur when patients are nursed in close proximity (i.e. corridors in ED or 5-6 bed bays) therefore, every effort should be made to avoid such circumstances wherever possible. Patient movement between beds and wards should also be limited as far as possible to prevent unnecessary spread of infection between wards. This guidance is explicit within our operational planning guidance.

Where a recommendation is made to close or restrict access to beds this will be discussed with the DipC and Group Chief Operating Officer / Strategic On Call lead as part of an organisational risk assessment.

Daily reporting

A daily Sit Rep is sent from IP&C to the Patient Flow Team to provide an overview of any closed beds for IPC reasons, infectious patients and any declared outbreaks.

In the event that these measures impact on patient flow, surge and demand and availability of beds, an IP&C MDT Organisational Risk Assessment SBAR is completed by Patient Flow in conjunction with IP&C leads. This should be escalated to Group Chief Operating Officer and DipC within working hours

and to the Strategic On-Call out of hours, at weekends and during bank holiday periods, for executive oversight, discussion and decision on next steps.

Testing

There is a provisional testing plan for winter incorporating patients for suspected infectious respiratory viruses (Influenza A, Influenza B, RSV and Covid-19), Viral Polymerase Chain Reaction (PCR) swab tests and Point of Care (POC) laminae tests. The final configuration and clinical recommendation re testing with be proposed by the IP&C team based on national guidance and intelligence.

A final decision on approach will be made in October 2024 by the DiPC and IP&C Committee.

Further information and guidance

Written external information/guidance is available for staff an can be found at: NHS England » National infection prevention and control manual (NIPCM) for England

Other supporting internal IPC policies can also be found within the policy suite on staff-zone: https://nhs.sharepoint.com/sites/RR7_StaffZone/SitePages/Infection-Prevention-Control.aspx

Workforce Planning

Nursing

Planning

There are robust planning frameworks in place to ensure safe staffing levels are maintained. These are overseen by the Chief Nurse, Deputy Chief Nurse and Chief Matrons. In the event of staff being required to move locations to maintain safe staffing levels, this will be in line with the OP96 Nursing and Midwifery Staffing Policy.

Decision Making and Escalation

With reference to: NQB Safe Sustainable and Productive staffing guidance and Developing Workforce Safeguards guidance.

When implementing escalation plans, decisions regarding skill mix and nurse ratios will be taken in conjunction with an assessment of patient acuity and dependency, professional judgement, and the environment of care. Oversight of elective skill mix (if we are making a conscious decision to go outside safer staffing rations, this needs oversight from Corporate Nursing and must have Chief Nurse or Deputy Chief Nurse authorisation before implementing.

A robust risk assessment must be undertaken and documented on divisional risk registers, Organisational Risk Register if it is anticipated that staffing levels will be significantly lower than recommended.

Medical

To ensure the delivery of safe, high-quality care, medical staff, both senior and junior will be redeployed (where possible) to support any escalation areas when required. If the need for additional resource is identified the escalation/approval process will be followed.

6. Governance

Gateshead Health has co-operated and collaborated in its winter planning with system partners via the Regional Chief Operating Officer Group (COO Group) and Urgent and Emergency Care (UEC) Network the Integrated Care System (ICS), Local A&E Delivery Boards (LAEDB), Gateshead Care System Board, Integrated Care Partnership (ICP) and the Integrated Care Board (ICB).

To manage winter pressures the Trust works with health and care partners in Gateshead through the Gateshead System Board and Gateshead System Winter Operational Group. Internally the Gateshead Health Winter Operational Group oversees the tactical and operational responsibility for the monitoring, management and delivery of winter plans for Gateshead Health.

The following provides an overview of the boards and groups:

Gateshead System Board

The Winter Board has strategic oversight of planning, assurance and the delivery of winter plans for the Gateshead System equalising risk wherever possible across the system. The Board oversees any financial allocations received ahead of winter and makes decisions about how this will be best utilised across the system. Post financial investment this group will be provided with oversight as to the benefits analysis and may choose to change the investment profile dynamically to best effect.

Responsibilities
The Board brings together system programme leads and organisational winter leads to have strategic oversight of winter schemes and winter planning.

The purpose of the Winter Board is to have strategic oversight and monitoring of the combined impact of all our programmes and winter schemes across the Gateshead place.

The Board is responsible for all aspects of winter planning, including;

- Demand and Capacity planning
- Oversight of winter schemes
- Oversight of Urgent & Emergency Care Assurance Framework

The Board oversees the submission of system assurance in line with the ICB Board Assurance Framework and any associated action plans required to manage any gaps over winter.

The Board is responsible for oversight and allocation of capacity monies through a distributed governance function and if schemes are not able to deliver according to plans, the funding is redistributed.

Values and principles:
The Board works within the collective values and principles as outlined within all partnership and organisational principles.

Governance and reporting:
The Winter Board is accountable to and provides assurance to the ICB and Place partnership committees. Members attend as decision makers within their organisations and with the Place partnerships.

The Gateshead System Board is chaired by the Director of Delivery Newcastle and Gateshead - NENC ICB.

Gateshead System Winter Operational Group

The Winter Operational Group has tactical and operational responsibility for the monitoring, management and delivery of winter plans for the Gateshead System equalising risk wherever possible across the system. The group oversees all key influencing factors, such as Covid-19, flu, RSV and activity levels and act as a team across Gateshead place to ensure actions and resources are optimised and safety is maintained.

Responsibilities
The group brings together system partners to monitor and respond to key indicators over the winter period.

The purpose of the group is to take tactical and operational responsibility for monitoring the combined impact of all our programmes and winter schemes and seeking to resolve issues where they arise.

The group is responsible for all aspects of winter delivery, including;

- Measurement and monitoring
- Acting together to ensure quality is maintained and risk is understood
- Escalation according to agreed frameworks

The group is responsible for shared delivery of additional actions if schemes are not able to deliver according to plans.

The group is responsible for ensuring all partners are informed and aware of issues and emerging risks

Values and principles:
The group works within the collective values and principles as outlined within all partnership and organisational principles.

Governance and reporting:
The Winter group is accountable to the ICB and Place partnership committees and individual organisational structures. Members attend as decision makers within their organisations and with the Place partnerships.

The Gateshead System Winter Operational Group is chaired by the Group Chief Operating Officer at Gateshead Health NHS Foundation Trust. It has been agreed to use the trust's AAA reporting format.

Gateshead Health Winter Operational Group

Internally, the Gateshead Health Winter Operational Group has tactical and operational responsibility for the monitoring, management and delivery of winter plans for Gateshead Health. The group oversees all key influencing factors, such as Covid-19, Flu, RSV and activity levels and act as a team to ensure actions and resources are optimised and safety is maintained

Responsibilities
The group brings together operational leaders from across the Trust to monitor and respond to key indicators over the winter period taking collective ownership for the delivery of the agreed Winter Plan.

The purpose of the Winter group is to take tactical and operational responsibility for monitoring and acting upon the combined impact of all our winter schemes and seeking to resolve issues. It will work in alignment to the System Winter Operational and Strategic Groups, identifying and escalating issues which require system support for resolution

The group is responsible for all aspects of winter delivery, including;

- Measurement and monitoring
- Acting together to ensure quality is maintained and risk is understood.
- Escalation according to agreed frameworks

The group is responsible for action and have responsibility for shared delivery of additional actions if schemes are not able to deliver according to plans.

The group is responsible for ensuring all partners are informed and aware of issues and risks

Values and principles:
The group works within the iCore values of the Trust using these principles to drive collegiate and collective delivery of the plan.

Governance and reporting:
The Winter group is accountable to the Trust Executives and Trust Board via the Gateshead Health Leadership Group. Members attend as decision makers for their Division / Team or specialist area of expertise.

The Gateshead Health Winter Operational Group is chaired by the Director of Operations for Medicine and Community within Gateshead Health NHS Foundation Trust. It has been agreed to use the trust's AAA reporting format.

7. Roles and Responsibilities

To enable the winter plan to work effectively staff must be clear about their roles and responsibilities in delivery of the plan. Outlined below are the identified roles and responsibilities of the Trust Board and Executive Management Team who are instrumental in supporting delivery of this strategic winter plan:

Trust Board
The role of the Trust Board is to ensure that the winter plan is produced and is fit for purpose to meet expected patient demand.

Chief Executive
The role of the Chief Executive is to ensure that there are robust winter planning arrangements in place, that there is delegated responsibility to an Executive Director for the delivery and monitoring of the plan and to ensure adequate resources are made available to implement it.

Group Chief Operating Officer
The Group Chief Operating Officer (COO) has delegated responsibility from the Chief Executive for the development, implementation and monitoring of effectiveness of the plan, alongside being the Accountable Emergency Officer (AEO). In addition, the Chief Operating Officer has the responsibility of bringing to the attention of the Chief Executive and other Executive Directors aspects of the plan that require input from support service directorates.

The Group Chief Operating Officer has shared responsibility, along with the Group Medical Director and the Group Chief Nurse, through the Executive triumvirate to ensure that the quality of care and patient safety is maintained during times of increased patient activity and acuity throughout the winter period.

The Group Chief Operating Officer is also responsible for the development of appropriate communication mechanisms in collaboration with ICS partners and the local COO network specifically

relating to winter management and escalation and will liaise with the Trust Communication lead as appropriate.

Group Medical Director

The Group Medical Director has shared responsibility with the Chief Nurse and Group Chief Operating Officer of ensuring the quality of care and patient safety and clinical outcomes is maintained during times of increased patient activity and acuity during the winter period.

The Group Medical Director will ensure that when quality and safety risks occur, they are quantified and escalated appropriately, and that mitigating actions are identified, implemented and monitored. The medical director is responsible for ensuring clinical outcomes are maintained.

The Group Medical Director will continue to provide visible, professional, leadership to medical colleagues, most specifically at times of increased pressure. The Group Medical Director will play a major role in liaising with the ICB, Social Services and GPs and will provide leadership and support during any staff vaccination programmes.

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

The Group Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals and Deputy Chief Executive has shared responsibility with the Group Medical Director and Group Chief Operating Officer to ensure the quality of care and patient safety is maintained at times of increased patient activity and acuity during the winter period. The Chief Nurse must ensure that quality and safety risks are quantified and escalated appropriately and ensure that mitigating actions are identified, implemented and monitored. The chief nurse will be responsible for the monitoring of safe staffing in line with the safer nursing tool kit recommendations and escalate to CEO and COO when issues arise.

As the Group Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals will continue to provide visible professional leadership to Nursing, Midwifery and AHP colleagues, most specifically at times of increased pressure, and provide leadership and support as Director for Infection Prevention and Control during outbreaks and planned staff vaccination programmes.

Group Director of Finance and Digital

The Group Director of Finance and Digital will ensure that there are adequate finance/resources are made available for the discharge of Gateshead Health's winter planning responsibilities and consider the need for a contingency budget if required in the context of the organisational overarching financial position.

Group Director of People & OD

The Group Director of People & OD will ensure there are adequate workforce arrangements specifically made available for the discharge of Gateshead Health's winter planning responsibilities. The Group Director of People and Organisational Development will provide executive sponsorship for the vaccination campaign.

Managing Director QEF

The Managing Director for QEF will ensure that arrangements are in place to monitor the temperature of clinical areas and take action to ensure safe temperatures are maintained; timely repairs are made and contingency plans put in place to address winter issues; access to the hospital is clear and safe in the event of snow and ice and the site is adequately gritted and that QEF support the actions to manage winter pressures and surges in activity and ensure adequate provision of transport, portering and domestic resources to support the delivery of operational services whilst also embedding a robust health and safety culture.

8. Risk management

The winter of 2024-25 will require Gateshead Health to operate against a backdrop of existing pressures and associated risks.

There are several **risks** that are factors to the successful delivery of the winter plan that may impact the trust concurrently. This includes:

Organisational / locally managed trust risks

Ref	Risk	Management	Rating
4591	Disruption to services due to GP collective action, including withdrawal from shared care agreements.	Organisational	20
2464	Risk of not being able to deliver services within budget due to unfunded increase in bed base and delay in transfers of care to Local Authority	Locally managed within Medicine Division	20
2432	Risk of quality of care due to industrial action	Organisational	16
4554	Cyber security vulnerabilities	Organisational	15
2498	Risk that there will be further waves of covid-19 across the trust	Locally managed within the Medical Directorate	9
2545	Delay in transfer due to lack of social care provision	Organisational	8
4589	Risk that services may be overwhelmed by civil unrest.	Locally managed within Nursing, Midwifery and Quality directorate	6

National / system risks

- Industrial action across various public sectors
- Negative impacts on population health of seasonal illness and cold weather
- Disruption to Adult Social Care through staff unavailability and demand exceeding capacity
- Ambulance service pressure necessitating an amended handover model
- Outbreaks of infectious disease
- Agency caps with staffing frameworks reducing availability of workforce
- Increases in the cost of living.
- Supply chain issues.
- New government leadership that could cause changes to NHS structure.

The detail of the likelihood and consequence of any impacts will be a dynamic process and will be captured on the organisation and local risk registers and will be continually monitored throughout the winter period.

9. Communications

Gateshead Health are part of the regional communications network, which leads the #HeretoHelp campaign. This encourages people to take responsibility to protect themselves, each other and their communities and focusing on messages around our recovery, flu vaccinations, surge plans and staying well over winter.

The campaign includes shared content which can be used across multiple channels, region-wide media and advertising buy which enables us to amplify messages but also localise options where the Trust need to.

The Gateshead Health Strategic Overview and Operational Winter Plan will be cascaded through the staff newsletter. Information will be added to the intranet and any urgent 'all staff' internal communications will be determined by the executive team or strategic on call and disseminated via appropriate channels.

10. Financial Plan

The financial model for winter 2024-25 will be provided within the financial framework of the organisation. The financial context of the Trust will be considered as part of our operational response.

11. Conclusion

In conclusion, Gateshead Health has identified that Winter 2024-25 is expected to be challenging and anticipate the need to respond to unprecedented demand for services.

Our winter planning has allowed the Trust to forecast pressures, to provide mitigation and to assure our patients that they will continue to receive safe and effective care. A strong governance framework at Trust, local and place level is in place to collaboratively manage the impact of winter across multiple providers and sectors.

This will focus on the following areas:

- In winter 2023-24, there was a reduction in the number of outbreaks and therefore a reduction in the amount of associated bed closures. To mitigate within the weather planning for 2024-25, there will be a reduction in the required time for covid-19 isolation period that will align this with the influenza isolation period that will alleviate staff absence and anticipated bed closures.
- The seasonal winter weather within 2023-24 had been warmer with less prolonged cold weather periods on comparison from previous years. To mitigate within planning for 2024-25, a review of our adverse weather arrangements will take place in line with national requirements.
- The predicted spike in-patient admissions and staff absences related to influenza did not evolve in 2023-24. To mitigate within planning for 2024-25, the vaccination campaign will focus on influenza.
- The Sister Winifred Laver Centre is fully operational and a project to review the early identification, review of criteria for admission and utilisation of the provision will be undertaken at a system level
- There is a full establishment of nurse staffing and therefore vacancy rates are low

The plan will continue to evolve dynamically to organisational and clinical risk. Formal evaluation will take place in April 2025 and will be fed back into the relevant elements of the organisation and system planning to inform future changes and plan developments / delivery.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 8

Report Title:	**Terms of Reference**			
Name of Meeting:	Board of Directors			
Date of Meeting:	24 September 2024			
Author:	Company Secretary			
Executive Sponsor:	Chair of the Committee / Chair of the Group Executive Leads			
Report presented by:	Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To ratify the revised terms of reference for Group Audit Committee and Gateshead Health Leadership Group			
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*	Gateshead Health Leadership Group – August 2024 Group Audit Committee – September 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*	Group Audit Committee (Appendix 1) • The terms of reference were reviewed as part of the annual review of effectiveness. • Several minor amendments are proposed to update terminology and reporting arrangements in accordance with the new governance structure, as well as to reflect items which the Audit Committee is already in practice reviewing. • In addition some changes are proposed to bring the terms of reference in line with good practice outlined in the latest HFMA Audit Committee Handbook (such as pragmatic wording around quorum and the inclusion of the review of a comprehensive litigation register). • The Group Audit Committee recommends the revised terms of reference to the Board for ratification. Gateshead Health Leadership Group (GHLG) (Appendix 2): • This is an important new addition to the			

<table>
<tr><td></td><td colspan="6">governance structure and is imperative to embedding the principles of clinically-led and management supported.
• The GHLG indirectly reports to the Board via the Board Committees and via influencing the content of other reports considered by the Board (such as the Chief Executive's reports).
• It is therefore appropriate for the Board of Directors to be the ratification body for the GHLG terms of reference.
• The GHLG recommends the terms of reference to the Board for ratification.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">The Board is requested to ratify the Group Audit Committee and GHLG terms of reference on the recommendation of the Committee and Group.</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">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.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☐</td><td>Responsive
☐</td><td>Well-led
☒</td><td>Effective
☐</td><td colspan="2">Safe
☐</td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="6">-</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>

Appendix 1

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 2024
Review Frequency	Annually
Review and approval	Group Audit Committee – September 2024
Adoption and ratification	Gateshead Health NHS Foundation Trust Board – January 2024

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 Committee reserves the right to pragmatically invite other Non-Executive Directors (excluding the Chair) to attend for a single meeting in order to achieve quoracy if the lack of quoracy is short term / short notice. 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. • Receiving a copy of the completed Counter Fraud Functional Standard Return (CFFSR) for awareness and to demonstrate consistency with counter fraud updates from throughout the year. • 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 reports outlining identified instances of non-compliance with these core documents, providing assurance over any corrective actions taken. 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. On an annual basis the Committee shall receive and review a comprehensive **litigation register**, detailing cases and claims from across all subject areas (including for example patient / quality, people and health and safety). The Committee will seek to **satisfy itself that the Tier 1 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 **Tier 1 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 (via the Gateshead Health Leadership 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.

Appendix 2

Terms of Reference

Gateshead Health NHS Foundation Trust

Gateshead Health Leadership Group

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

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

The GHLG is accountable to the Board of Directors.

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

Date Adopted / Reviewed	September 2024
Review Frequency	Annually
Review and approval	Gateshead Health Leadership Group – August 2024
Adoption and ratification	Board of Directors

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

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

	To be quorate there should be **at least 6 members present**, including: • **At least 3 Executive Directors** - one must be either the Chief Nurse, Medical Director or Chief Operating Officer (i.e. clinical – to ensure the principles of clinically-led are in place). • **At least 1 clinical divisional member** must be present Members and regular attendees are expected to achieve **60% attendance** annually.
Meeting organisation	The Group shall be supported administratively by the Corporate Office, who shall record the minutes and circulate meeting dates, agendas and papers to members and attendees. A decision log will be maintained and used by members and attendees to communicate the key outputs of the meetings to departments and teams. 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.

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

	and that the plan is coherent and consistent across all elements (performance, workforce and finance). In accordance with the Scheme of Delegation GHLG has delegated responsibility for the **approval of in-year changes to the capital spending plan where this equates to less than £1m.** In addition, the GHLG will receive assurance reports showing **in-year monitoring of spend against the approved capital plan**, including the risk of scheme under or over spends (as outlined in the Standing Financial Instructions para 32.4.2). The GHLG will, via the relevant Tier 1 Board Committee make **clear recommendations to the Board on key strategic decisions** which are reserved for the Board under the Scheme of Delegation. The GHLG will review **emerging strategic opportunities, risks and threats** which are brought to its attention by members / attendees or those groups which report directly into it (for example through receiving feedback from attendance at external meetings). As part of this role, the GHLG will seek to ensure that effective arrangements are in place to manage key partnerships and stakeholder engagement. The GHLG will receive for assurance an **exception report detailing agency expenditure above the published price cap** which has been approved in accordance with the Scheme of Delegation. The GHLG will review and approve / reject **business cases** recommended to it by those groups which report directly into it (in accordance with the delegations outlined in the Scheme of Delegation – i.e. revenue and capital business cases less than £1m). The GHLG will **approve / reject all tenders to bid for services** prior to submission (in accordance with the Scheme of Delegation Section 7).
Risk	Identification and agreement of **emerging reportable issues** which requiring reporting to the Board (as part of the reportable issues log) or to external regulators. The GHLG will review the **Organisational Risk Register (ORR)** at every meeting for completeness and accuracy, based on assurance and risks discussed and / or identified through its agenda. The GHLG will review the **Board Assurance Framework (BAF)** on a monthly basis, taking collective responsibility for the timely completion of actions to address identified gaps. GHLG will make recommendations to the Tier 1 Board Committees regarding proposed changes to scores for the summary risks.

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

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

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

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 9

Report Title:	**National Pay Award**			
Name of Meeting:	Trust Board			
Date of Meeting:	24 September 2024			
Author:	Mrs Kris Mackenzie, Group Director of Finance & Digital			
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:** ☐
	Enter purpose here			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	n/a			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	Following a prolonged period of industrial action driven by pay disputes the Government have committed to accepting the NHS Pay Review Body (PRB) recommendations on pay for 2024/25. These are: • Uplifting all pay points for Agenda for Change (AfC0 staff by 5.5% on a consolidated basis, with effect from 1 April 2024. • Adding intermediate pay points at bands 8a and above • Working with the NHS Staff Council to take forward the PRB's recommendations on AfC pay structures. This excludes those employees not employed on AfC terms and conditions. Currently it is not possible to quantify the cost to the organisation and there is no clarity on the formula being applied to determine levels of funding being allocated. Therefore, it is not possible to assess or quantify the overall financial consequences, although noted is the			

	statement that the intention is for the pay award to be cost neutral. The recommendation is for Board to approve the implementation of the pay award, noting that it is nationally mandated and will be automatically applied to the salaries of AfC employees in October pay, backdated to 1 April 2024. It is proposed that once the financial impact is quantified a paper will be brought back to Board.				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The recommendation is to support the acceptance and implementation of the nationally mandated pay award.				
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust strategic objectives that the report relates to:	Achieving financial sustainability				
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):					
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 10

Report Title:	**QEF Pay Award 2024/25**			
Name of Meeting:	Trust Board			
Date of Meeting:	24th October 2024			
Author:	Philip Glasgow			
Executive Sponsor:	Gavin Evans			
Report presented by:	Gavin Evans			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To provide a summary of the recently announced Agenda for Change national pay award and to gain approval from the Board for the 2024/25 QE Facilities Staff Pay Award.			
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*	QE Facilities Board 19th October 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*	Bearing in mind the QE Facilities commitment to the Real Living Wage and noting the potential impact on the level of turnover within our lowest paid staff groups the Board is asked to support the recommendation that QE Facilities: 1. Implement the national Agenda for Change pay award of 5.5% for all staff groups regardless of terms and conditions with the exception of those on the National Living Wage. 2. Implement a pay award of 7.7% for those staff on QE Facilities terms and conditions currently on the national living wage to ensure an hourly pay rate of £12. All proposals are to be backdated to 1st April 2024.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is to agree to the QEF Board recommendation for Option 3. To implement the 5.5% uplift for all QE Facilities staff on either Agenda for Change or QE Facilities terms and conditions but provide an enhanced uplift of 7.7% for those QE Facilities terms and conditions staff on the national minimum wage to			

<table>
<tr><td></td><td colspan="5">ensure a minimum salary of £12 / hr in line with the Real Living Wage.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1 ☐</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2 ☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3 ☐</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4 ☐</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5 ☐</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust strategic objectives that the report relates to:</td><td colspan="5">Strategic theme 1 - Being well managed & financially sound.
Strategic theme 3 - Business growth.
Strategic theme 4 - Being a Good Employer.</td></tr>
<tr><td>Links to CQC Key Lines of Enquiry (KLOE):</td><td>Caring ☐</td><td>Responsive ☒</td><td>Well-led ☒</td><td>Effective ☐</td><td>Safe ☐</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):</td><td colspan="5">- Employee Relation issues should pay scales between AFC and QEF contracts become misaligned.
- Fair and Equal pay position for roles if pay increases are not aligned
- Failure to implement the salary uplift across all staff groups would lead to those staff on the lesser QE
- Facilities terms and conditions being disincentivised.
- Failure to maintain the commitment to the Real Living Wage may increase the turnover of staff in the lowest paid staff groups due to competition in the local area</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>

QEF Board

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 10

Date of Meeting	19 September 2024, 14:00, Spire House			
Report Title:	QEF Pay Award Report 2024/25			
Purpose of Report:	To provide a summary of the recently announced Agenda for Change national pay award and to gain approval from the Board for the 2024/25 QE Facilities Staff Pay Award.			
	Decision: X	**Discussion:**	**Assurance:**	**Information:**
Corporate Objectives report relates to: **(Including reference to any specific risk)**	Strategic theme 1 - Being well managed & financially sound. Strategic theme 3 - Business growth. Strategic theme 4 - Being a Good Employer.			
Proposed level of assurance	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Recommendations: (Action required by Board of Directors)	Bearing in mind the Organisations previous commitment to the Real Living Wage and noting the potential impact on the level of turnover within our lowest paid staff groups the Board is asked to support the recommendation to the Group Board that QE Facilities: 1. Implement the national Agenda for Change pay award of 5.5% for all staff groups regardless of terms and conditions with the exception of those on the National Living Wage. 2. Implement a pay award of 7.7% for those staff on QE Facilities terms and conditions currently on the national living wage to ensure an hourly pay rate of £12. With all proposals to be backdated to 1st April 2024.			
Financial Implications Report Highlights & Summary	The QEF personnel contracts are split across Agenda For Change (AFC) contracts and QEF contracts. The current AFC pay review has been accepted by the NHS Staff Council and as such is expected to be paid as part of the October payroll (5.5% 2024-25 increase). The Real Living Wage (RLW) increased to £12 per hour from 1st April 2024. Previous reports considered by QEF board agreed that if the lowest AFC pay band was above RLW then the QEF minimum salary for non apprentice staff, would also be increased to £12 per hour. As part of the budget setting exercise for 2024/25 a 5% uplift of the pay budget was included to allow for the 2.1% pay award as detailed in national guidance whilst also making allowance for the commitment to remain a Real Living Wage Employer.			

	As a result the unfunded pressure of mirroring the Agenda for Change pay award for all staff, as in previous years, whilst ensuring all staff are, as a minimum, paid the Real Living Wage would be £0.515m. This unfunded pressure would be expect to be partially met by the Group through an increase of the Unitary Payment with the remainder to be found from increases to external to the Group contracts.
Risk Management Implications:	• Employee Relation issues should pay scales between AFC and QEF contracts become misaligned. • Fair and Equal pay position for roles if pay increases are not aligned
Human Resource Implications:	• Failure to implement the salary uplift across all staff groups would lead to those staff on the lesser QE Facilities terms and conditions being disincentivised. • Failure to maintain the commitment to the Real Living Wage may increase the turnover of staff in the lowest paid staff groups due to competition in the local area.
Equality and Diversity Implications:	• Not in this report
Author:	Mr Philip Glasgow, Finance Director
Presented by:	Mr Philip Glasgow, Finance Director

Introduction

On the 29th July 2024 the government announced that it would implement a 5.5% consolidated uplift for all Agenda for Change staff on NHS terms and conditions with effect from the 1st of April 2024.

It is the role of the QE Facilities Board to review the and agree the proposed annual pay award for staff to enable a recommendation to be made to the Group Board in line with the Standing Financial Instructions as detailed in the Scheme of Delegation (7.1.5 & 7.1.6).

Background

On the 29th July 2024 the government announced that it would implement a 5.5% consolidated uplift for all Agenda for Change staff on NHS terms and conditions with effect from the 1st of April 2024.

QE Facilities employs staff on both Agenda for Change NHS terms and conditions, those that TUPE'd in to the organisation on inception, and QE Facilities terms and conditions for those that have subsequently joined the organisation.

Previously in order to maintain parity between the 2 staff groups the national Agenda for Change pay award has been mirrored for all staff, including the non-consolidated payment made in 2023/24.

As of the 31st August 2024 QE Facilities employed 285WTE on the national living wage of £11.44. Due to statutory requirements this group of staff have already received a pay award of 2.6% to reflect the increase in the national living to £11.44 on the 1st April 2024 exceeding the Real Living Wage of £11.15 / hr being paid in 2023 / 24 by QE Facilities as a minimum.

Accredited as a Real Living Wage employer with the Real Living Wage Foundation QE Facilities has given its commitment to ensure that all staff are paid the UK Real Living Wage as a minimum which, as of 1st April 2024, is set as £12.00/hr for all non-apprentice staff. In order to maintain this commitment QE Facilities will need to enact a further pay rise of 5% for those staff on the national living wage meaning that this staff group would receive an overall pay rise of 7.6% in 2024/25.

Due to the delay in the announcement of the Agenda for Change pay award we have been unable to meet this commitment until now as to do so would have meant QE Facilities terms and condition staff would have leap frogged those Agenda for Change staff on Band 2. Following the national pay award Staff on Band 2 will be paid an hourly rate of £12.08/hr allowing the Real Living Wage to be paid to QE Facilities terms and conditions staff without conflict.

Financial Impact

As part of the budget setting process for 2024/25 an allowance was made within the QE Facilities pay budget to support a 5% pay award for all staff. This was based on the national guidance suggesting a 2.1% pay award with additional pressure built in to the fund Living Wage commitments.

Following the announcement of the national Agenda for Change pay award the following options have been considered for implementation:

Option 1

To implement the 5.5% uplift for all Agenda for Change terms and conditions employees with no uplift for those staff on QE Facilities terms and conditions.

Staff Costs (2023/24)	Budgeted Staff Costs Based on a Pay Award of 5% (2024/25)	Pay Award of 5.5% (2024/25) for AFC Staff only & Retain National Living Wage	Additional Pressure
£ 25,077,590.94	£ 25,919,418.87	£ 25,507,516.74	-£ 411,902.13

Option 2

To implement the 5.5% uplift for all QE Facilities staff on either Agenda for Change or QE Facilities terms and conditions but withdraw our commitment to remain a Real Living Wage employer.

Staff Costs (2023/24)	Budgeted Staff Costs Based on a Pay Award of 5% (2024/25)	Staff Costs Including a Pay Award of 5.5% (2024/25)	Additional Pressure
£ 25,077,590.94	£ 25,919,418.87	£ 26,295,393.79	£ 375,974.92

Option 3

To implement the 5.5% uplift for all QE Facilities staff on either Agenda for Change or QE Facilities terms and conditions but provide an enhanced uplift of 7.7% for those QE Facilities terms and conditions staff on the national minimum wage to ensure a minimum salary of £12 / hr in line with the Real Living Wage.

Staff Costs (2023/24)	Budgeted Staff Costs Based on a Pay Award of 5% (2024/25)	Staff Costs Including a Split Pay Award of 5.5% & 7.4% (2024/25)	Additional Pressure
£ 25,077,590.94	£ 25,919,418.87	£ 26,434,367.60	£ 514,948.73

All costs detailed above are for uplifts to take effect from the 1st April 2024 and are inclusive of NI and Pension impact.

Assessment

As an uplift of 5% of the overall pay budget was included for in the 2024/25 budget. By only implementing the award for the Agenda for Change NHS terms and conditions staff there is an opportunity to make a saving against the pay budget of £0.411m. However, this would have significant implications for staff retention and recruitment, as this would further disincentivise the majority of staff on the already lesser QE Facilities terms and conditions.

As detailed within Option 2 the cost of implementing the 5.5% pay award for all QE Facilities staff, regardless of terms and conditions, would be £1.218m. However, as £0.842m was included for as part of the budget setting exercise for 2024/25 this would leave an additional cost pressure to be found of £0.376m. This would provide equity for all members of staff but fail to support the QE Facilities commitment to the Real Living Wage putting the organisation at risk of increasing staff turnover in our lowest paid staff groups due to the availability of better paid employment available locally, see below. It is worth noting that in the last 12 months 11% of leavers gave "Pay and Reward" as their reason for leaving the organisation, the 3rd highest category behind "Not Known" and "Relocation".

1. Mobile Domestic Cleaner, Daisymaid NE Ltd, £12 / hr.
2. Store Cleaner, Aldi Gateshead, £12 / hr.
3. Food Services Assistant, Sodexho, £12 / hr.
4. Evening Cleaner, Sodexho, £12 / hr.
5. Housekeeping Assistant, Hilton, £11.80 / hr.

If the organisation were to implement option 3 and remain a Real Living Wage employer this would result in an unfunded pressure of £0.515m, meaning that the cost of the Real Living Wage equates to £0.139m.

Funding

It is assumed that, as in previous years, the Group will be able to claim for the pay award for all staff within Group, including QEF with this transferred to QE Facilities via an uplift in the Unitary Payment.

If the national award is fully funded centrally for all QE Facilities staff then there may be a financial benefit to the Group as it would be able to secure an additional £1.379m against an unbudgeted cost pressure of £0.515m to implement the full uplift, inclusive of Real Living Wage commitments.

If the decision is made to implement a pay rise for some staff in excess of the Agenda for Change uplift (5.5%) then the additional cost pressure of this increase (£0.139m) would need to be met through further increases to the external to Group contracts.

Recommendations

Bearing in mind the Organisations previous commitment to the Real Living Wage and noting the potential impact on the level of turnover within our lowest paid staff groups the Board is asked to support the recommendation to the Group Board that QE Facilities:

1. Implement the national Agenda for Change pay award of 5.5% for all staff groups regardless of terms and conditions with the exception of those on the National Living Wage.

And

2. Implement a pay award of 7.7% for those staff on QE Facilities terms and conditions currently on the national living wage to ensure an hourly pay rate of £12.

With all increases to take effect from the 1st April 2024.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 11

Report Title:	**QE Facilities' Chair and Non-Executive Director Appointments**			
Name of Meeting:	Board of Directors			
Date of Meeting:	24 September 2024			
Author:	Jennifer Boyle, Company Secretary			
Executive Sponsor:	Alison Marshall, Chair of the Group Board			
Report presented by:	Alison Marshall, Chair of the Group Board			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To ratify the proposal to extend the terms of the current QE Facilities Chair and Non-Executive Director for a further 12 months.			
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*	Group Remuneration Committee – 19 August 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 proposal to extend the terms of Maggie Pavlou as QEF Chair and Hilary Parker as QEF NED for a further 12 months seeks to continue the positive progress made since the subsidiary governance review. • Retaining the current postholders mitigates risks of destabilising the Board and organisation and provides continuity at a time when changes and improvements are embedding. • There are no additional finance implications in relation to this proposal. • The proposal was considered and approved by the Group Remuneration Committee, which recommends ratification by the Board.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Group Remuneration Committee recommends the Board ratifies the proposal to: • Retain an internally-appointed Chair and NED for a further 12 months; • Extend the term of Maggie Pavlou in the role of QEF Chair for a period of 12 months commencing			

<table>
<tr><td></td><td colspan="5">on 1 October 2024 with remuneration for the Chair role of £10k and a time commitment of 3-4 days per month, in line with the existing job description; and
• Extend the term of Hilary Parker in the role of QEF NED for a period of 12 months commencing on 1 October 2024 with remuneration for the NED role of £5k and a time commitment of 2-3 days per month, in line with the existing job description;</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust strategic objectives that the report relates to:</td><td colspan="5">QEF contributes towards key objectives including:
• Review and revise the 22-25 Green Plan and align with the group structure by the end of Q2
• Development and implementation of an Estates strategy that provides a 3 year capital plan to address the key critical infrastructure and estates functional risks across the organisation by March 2025</td></tr>
<tr><td>Links to CQC Key Lines of Enquiry (KLOE):</td><td>Caring
☐</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☐</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):</td><td colspan="5">No direct link</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>

QEF Chair and Non-Executive Director Appointments

1. Introduction

1.1. Following the subsidiary governance review in summer 2023 the Group Board of Directors considered the composition of the QE Facilities Board of Directors at an extraordinary meeting on 4 September 2023.

1.2. The Deloitte report recommended that QEF transitioned to a new Board structure over time, recognising the volume of work being undertaken to reset and strengthen the governance and strategy for the Group.

1.3. The Group Board approved the proposal to retain an internally-appointed Chair for the QE Facilities Board for a period of 12 months. This aimed to provide opportunities for a period of reflection and embedding of new governance arrangements to then be reviewed in 12 months. This was with a view to moving towards a model with a greater degree of independence on the Board in the future.

1.4. Following the internal expressions of interest / recruitment process Maggie Pavlou was appointed as QEF Chair effective from 1 October 2023. This left Maggie's previous role as the QEF Non-Executive Director (NED) vacant.

1.5. The Group Board approved the proposal to maintain an internally-appointed NED for a period of 12 months, in line with the rationale provided for the appointment of the Chair. Following the internal expressions of interest process Hilary Parker was appointed to this role, which was also effective from 1 October 2023.

1.6. The 12 month term of both the QEF Chair and NED positions ends on 30 September 2023. This paper outlines a proposed extension of these terms for a further year The proposal has been considered and approved by the Group Remuneration Committee which now recommend this for Board ratification.

2. Proposed term extension

2.1. It is recommended to extend Maggie Pavlou as QEF Chair and Hilary Parker as QEF NED for a further 12 month period from 1 October 2024 to 30 September 2025. This section outlines the rationale for this proposal.

2.2. The **QEF Board composition** has continued to evolve and embed over the last 12 months with the appointment of Gavin Evans as the substantive Managing Director and the very recent appointment of Darren Warneford as an external NED.

2.3. In addition, there is currently a QEF management restructure with a proposal to appoint an additional director to the Board. This is outlined in more detail as part of a separate agenda item. Should this proposal be approved, then this represents a further future change to the Board.

2.4. Darren Warneford only commenced in post in mid-June 2024 and it is therefore too early to assess whether the QEF Board is appropriately balanced between internally and externally appointed members. This needs further time to be evaluated once both Darren and the potential new director post have settled in their roles.

2.5. Given the volume of change in the QEF Board composition, it is important to maintain a level of continuity, as well as knowledge of the evolution of the subsidiary over the last few years. There is a significant risk that any further change to the existing core members of the QEF Board at this time would be destabilising and have a negative impact on the Group as a whole.

2.6. Over the last 12 months a significant amount of progress has been made in relation to developing a **positive and productive relationship** between QEF and the Trust. This can be evidenced through the way in which the two organisations have worked collaboratively on the development of the Community Diagnostics Centre and to address key risks such as those linked to the age of the estate.

2.7. In addition, as evidenced at the last Group Board meeting, a significant amount of **progress has been made in improving the governance** within and between the Trust and QEF. Only one action remains open on the governance action plan which was developed following the review of subsidiary governance. It is recognised that a number of the governance improvements which have been made need a period of time to embed and become business as usual, such as those associated with the implementation of the new governance structures in both organisations. Any further changes to QEF Board leadership risks destabilising this.

3. Solutions / recommendations

3.1. It is important to recognise the significant improvements that have been made in governance, leadership and the relationship between QEF and the Trust over the last 12 months, as well as the ambition to continue on this journey.

3.2. Recognising the importance of continuity, stability, positive relationships and organisational knowledge in continuing to enhance QEF, it is therefore proposed to extend the appointment of Maggie Pavlou as Chair and Hilary Parker as NED for a further 12 month term to 30 September 2025.

3.3. There are no proposed changes to the previously agreed remuneration, time commitment or job descriptions for these roles.

3.4. The Group Remuneration Committee approved the proposal to retain an internally-appointed Chair and NED for a further 12 months and further approved the proposal to retain the current postholders in these roles.

3.5. The Group Remuneration Committee therefore recommends that the Board ratifies the proposal to:

- Retain an internally-appointed Chair and NED for a further 12 months;
- Extend the term of Maggie Pavlou in the role of QEF Chair for a period of 12 months commencing on 1 October 2024 with remuneration for the Chair role of £10k and a time commitment of 3-4 days per month, in line with the existing job description; and
- Extend the term of Hilary Parker in the role of QEF NED for a period of 12 months commencing on 1 October 2024 with remuneration for the NED role of £5k and a time commitment of 2-3 days per month, in line with the existing job description;

Gateshead Health NHS Foundation Trust

Chair's Report

Alison Marshall, Chair of the Board of Directors

24 September 2024

Gateshead Health NHS Foundation Trust

Announcements

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

Lisa Robson sadly passed away on 30 July after a courageous fight.

Lisa worked with us for over 38 years across catering, paediatrics and SCBU and her absence is profoundly felt by her team and wider colleagues.

She is very much missed and on behalf of the Board I express our deepest condolences to Lisa's family, friends and colleagues, particularly her sister who also works at the Trust.

Board updates and Partnership working

Gateshead Health NHS Foundation Trust

Board of Directors

- Anna Stabler had been fulfilling the role of a Non-Executive Director (NED) on a temporary basis on the Board at Newcastle Hospitals, as well as continuing to undertake her role on as a Non-Executive Director on our Board.
- Anna has been successful at securing a substantive Non-Executive Director role on the Board of Directors at Newcastle Hospitals. As the two roles are huge commitment Anna has decided to step down as a Non-Executive Director on our Board, effective from 18 October.
- Anna has been a much-valued member of our team since July 2021, chairing the Quality Governance Committee and taking on the role of Board Maternity Safety Champion.
- She will be a huge miss to our Board, Council of Governors and the wider Trust and I would like to record our sincere thanks to Anna for her commitment and valued contribution to Gateshead Health.
- Our Governor Remuneration Committee is working with us to lead the recruitment process for a clinical Non-Executive Director replacement and also a Non-Executive Director with significant NHS finance experience (to replace Mike Robson when he leaves the Board next year).
- Both vacancies are now live on NHS Jobs and can be found here: Job Advert (jobs.nhs.uk)

Governor and Member Updates

- We held our latest Medicine for Members event on our women's health services on 3 September. This included a marketplace with stalls for different services, as well as a number of showcase presentations. We hope our members, the public, Governors, staff and stakeholders found this to be enjoyable and informative evening and look forward to holding another event soon.
- Our Governor elections are in full flow, with 10 seats included in the election. This includes 3 vacant seats in Eastern Gateshead. Governor colleagues are supporting us in identifying opportunities to promote membership and Governor nominations, with a particular emphasis on Eastern Gateshead given the vacancies here. The closing date for nominations is 5pm on Wednesday 25 September. You can find out more here: Home (cesvotes.com)

Engagement

Gateshead Health NHS Foundation Trust

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

- Attended Alliance Steering Groups
- Attended meetings of the North Area ICP
- Introductory meetings with new appointed Governors
- Appraisals with Non-Executive Directors
- Meetings to judge and prepare for our annual Star Awards
- Meeting with the Maternity and Surgery teams as part of a Board session on maternity strategy
- Meeting with Professor Alison Machin, Northumbria University
- Attended North East England Chamber of Commerce Summer Event

We were delighted to open the Jubilee courtyard garden, which has been named the **Garden of Hope**. The Garden of Hope was officially opened by the Lord Lieutenant of Tyne and Wear, Ms Lucy Winskell OBE (King Charles' representative in our region). It has a number of sensory features and provides a private, peaceful outdoor sanctuary for our patients who cannot access other areas of the hospital.

The Garden of Hope was made possible by kind donations to the Gateshead Health Charity and we are grateful to all those who contributed to the project.

Star of the Month Nominations

July

- Mark Dryden - Ann Coleman
- Louisa Turner - Kirsty Gould
- Mike Bowe - Janet Gault
- Laura Henry - Louis Stephenson
- Sophie Baker - Alison Carr
- Clare Dent - Charlotte Conn
- Brian Morris - Mark Turner
- Julie Taylor - Imogen Riley
- Kamilla Ball-Kiklowicz - Toni-Leigh Duff
- Georgie Scurfield - Louise Frizzell
- Jessica Griffin - Drew Griffiths
- Sally Bell - Sharon Surrey
- Melanie Harriott - Craig Million
- Rachel Hills

Alison Ryder
(June)

You're a Star Winner

Louise Frizzell

Star of the Month Nominations

August

- Magda Jazeri
- Nataliya Vakulyk
- Mandi Elrick

You're a Star Winner

Nataliya Vakulyk

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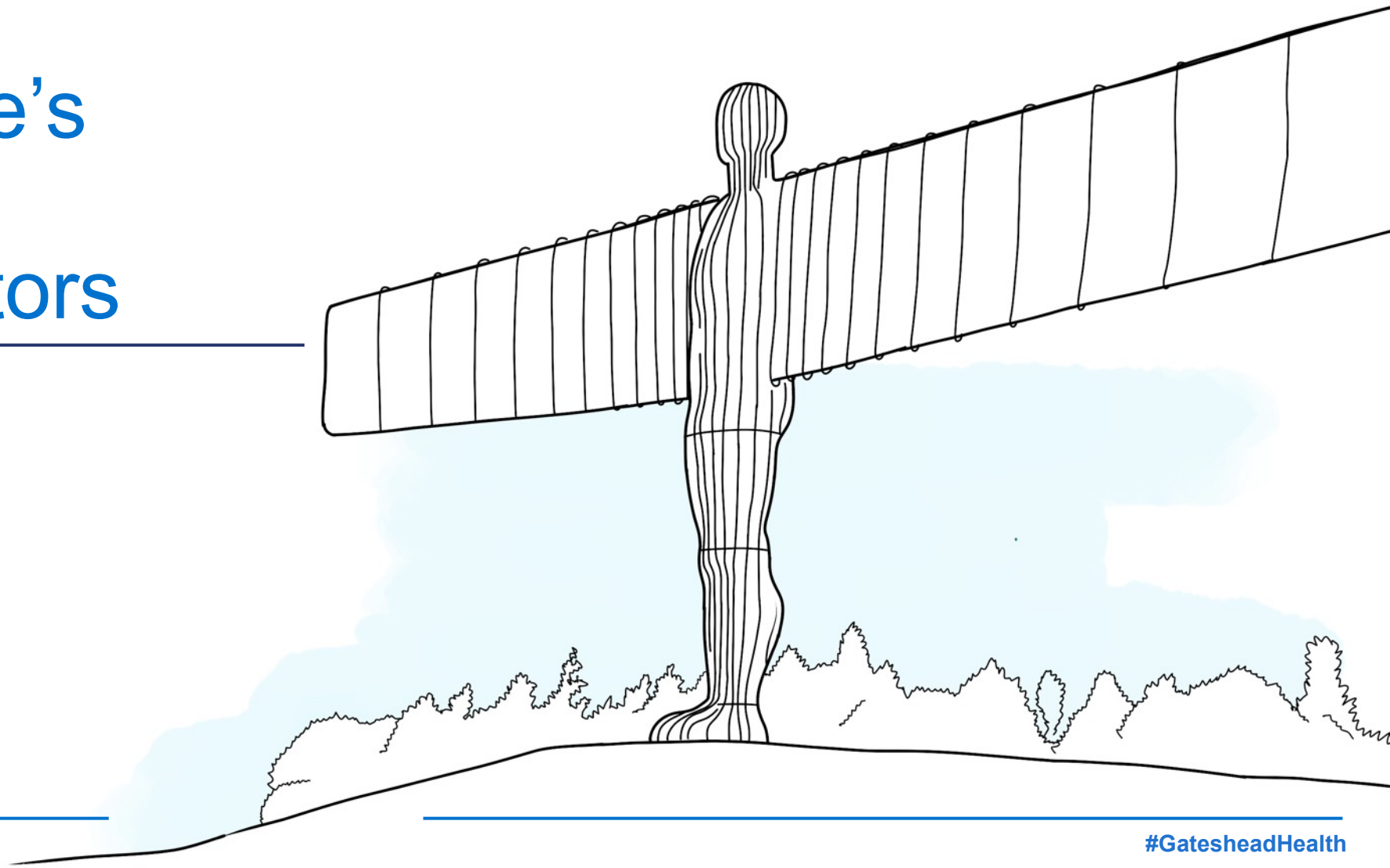
Chief Executive's Update to the Board of Directors

Trudie Davies, Chief Executive

24 September 2024



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

Gateshead Health NHS Foundation Trust

- We are delighted to be named as a **finalist for Trust of the Year at the Health Service Journal (HSJ) Awards 2024**. This is a fantastic achievement and is a testament to the dedication and hard work of all of our colleagues and volunteers. We are one of nine trusts to be shortlisted and the winners will be announced on 21 November.
- We are monitoring the emerging situation regarding **GP collective action**. As there is variation in the action being taken between different GPs / practices and no central communication of this, the extent and impact of this on our patients and clinical services cannot yet be ascertained. We have therefore identified this as one of our top 3 organisational risks. Our Clinical Strategy Group are key to our response.
- In July 2024 the Care Quality Commission (CQC) undertook unannounced **Mental Health Act (MHA) monitoring visits to Cragside and Sunniside** wards. We have received the reports from these visits. The findings were largely very positive about the care provided and included positive feedback from staff and patients. The actions identified as part of previous MHA monitoring visits were confirmed as being resolved. Well done to all involved!
- We have made significant improvements in **reducing the numbers of overdue complaints**, which is now down to 3. We recognise the importance of timely complaint response so that we can learn from our patients and ensure that we are providing the highest standards of care and service.
- We are delighted that two of our teams have been shortlisted for Team Awards in the **Northern Cancer Alliance Awards 2024**. Well done to the Gynae Oncology, Colorectal and Stoma Clinical Nurse Specialist Teams and the Specialist Breast Care Nursing Team.
- We took part in the national **Falls Awareness Week** in September, highlighting the important work of the Trust Falls Prevention Group and some of the ongoing workstreams. This includes initiatives such as a decaffeinated drinks pilot on the care of the elderly wards and the introduction of new falls assessment tools. Falls is a Patient Safety Incident Response Plan (PSIRP) area of focus. The volume of falls resulting in harm have increased slightly in August, however we have seen a reduction in the rate of falls rates per bed day for the second month in a row.

Engagement, involvement and visits:

- Theatre team

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

- We have **supported colleagues during the recent period of civil unrest** across the UK, seeking to ensure that all our staff feel safe, welcomed and supported. We worked closely with our staff networks and our Freedom to Speak Up Guardian to provide a range of support mechanisms.
- We would like to record our sincere thanks to **Dr Issac Evbuomwan** for his hard work and dedication in chairing both the Medical Staffing Committee (MSC) and Local Negotiating Committee (LNC). We look forward to working with **Dr Andrew Lowes** as the incoming Chair of the MSC and **Ian McClintock**, incoming Chair of the LNC.
- We launched three new policies in recent weeks to support our **zero tolerance approach** to any kind of bullying, harassment or abuse – a new sexual safety policy and updated bullying and harassment and violence and aggression policies.
- Our **sickness absence rates** are higher than planned and work is ongoing to compassionately support improvements in this area.
- We have been ranked among the **top 10 performing units nationally for professional development in obstetrics and gynaecology** by the Royal College of Obstetricians and Gynaecologists (RCOG). Congratulations to the entire team for their outstanding effort and dedication in delivering exceptional support to our new trainees.
- We held our first **Senior Leadership Roadshow** on 30 July, providing colleagues with an opportunity to ask questions and voice any concerns or ideas. The roadshows aim to increase visibility and access to our senior leadership team, providing colleagues with a voice in decision-making.
- We received the **NHS England Workforce Training and Education (WTE) Directorate Annual Quality Report 2024** for our Trust. This provides good assurance on the overall quality of education and training provided to all clinical professionals and the levels of engagement and support over the last training year. The full report is appended for information.

Engagement, involvement and visits:

- Senior Leadership Roadshow
- Gateshead Health Leadership Group launch

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

NHS Gateshead Health NHS Foundation Trust

- There is a significant focus on improving our **financial position** and making the best use of the resources available to us. Two of our current top three risks as an organisation relate to financial sustainability – the risk of not achieving our planned deficit position, including the delivery of our cost reduction programme, and the risk of medical staffing overspend within the division of medicine. We are working with our clinical and non-clinical teams to look at how we can ensure efficiency, effectiveness and quality in the delivery of our services. This links to our planning for winter and future strategy development. More information can be found in the Finance Report.
- A key focus for us is preparing for winter, focussing on how we can provide high-quality care in a timely and efficient manner within the resources available to us. We recognise that we are in a strong position in relation to vacancy rates and our focus is therefore on local improvement initiatives. **Connectivity** between our teams and timely, accurate and compassionate **communication** will be key.
- During early September we faced a significant **business continuity issue with our radiology image viewing solution**. We implemented a formal incident management approach to implement a co-ordinated response to mitigate risks and work towards recovery and followed business continuity plans in each area to maintain clinical safety.
- We launched the **Gateshead Health Leadership Group (GHLG)** in late July. The GHLG seeks assurance over the effective management and key strategic clinical and non-clinical activities across our Group, supporting our core value of being clinically-led and management supported. Through its membership the GHLG informs the reporting to the Tier 1 Board Committees and to the Board.
- Key performance exceptions (further information is included in the separate agenda item):
    - **Length of stay** has increased to over 7 days. Barriers remain in prompt discharge processes, early discharge planning and capturing accurate estimated discharge dates and out of hospital support. There are three focused programmes for continuous improvement, two of which will support A&E performance - the Urgent and Emergency Care Improvement Programme and the Discharge Improvement Programme.
    - The **A&E 4-hr standard** improved to 72% in August, below national target level of 78% and planned improvement levels. A weekly clinically-led task and finish group is in place to identify drivers of performance variation and supporting improvement actions.
    - The stretch target of achieving zero > **52 week** RTT waiters was not achieved by the end of Q1 and at the end of August the number of long waits have increased to 108. Recovery trajectories in gynaecology and surgery are improving, and mutual aid is in place to support urology. Current improvement projections include both Urology & Gynae achieving <52 week waiters in Q3, and Trauma & Orthopaedics achieving 52 weeks in Q4.

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

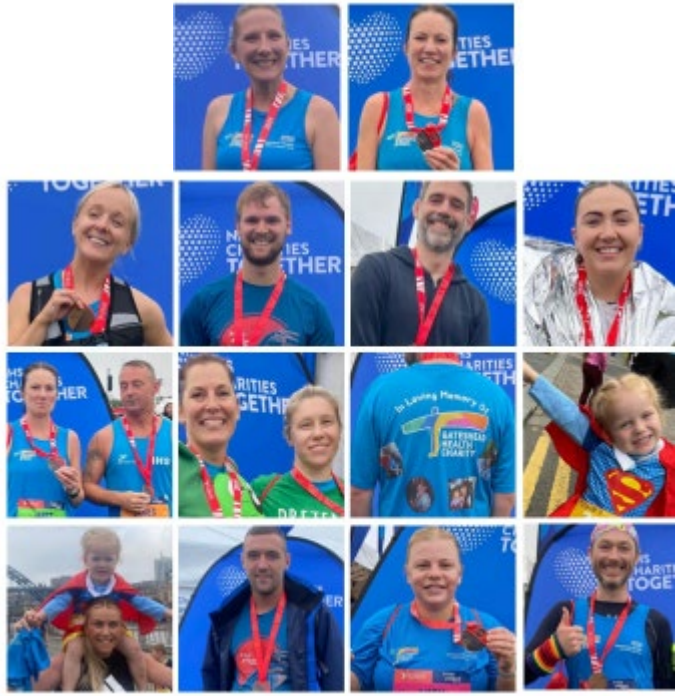
- The Chief Executive attended a national meeting in London in early September where all provider Chief Executives met together to discuss key issues such as **winter** and to hear from the Secretary of State for Health and Social Care, Wes Streeting. The **10 year plan for the NHS** was the key area for discussion – this will focus on the integration of health, social care and mental health services, recognising the importance of local planning and local health needs.
- The 10 year plan for the NHS will be informed by the key themes emerging from the **Lord Darzi report into the NHS in England**, which was published on 12 September. The report seeks to 'diagnose' the issues facing the NHS. We welcome the findings of the review, which reflects the challenges in the NHS including population health, health inequalities, productivity, condition of estate and funding. The report recognises the importance of patient empowerment, digital technology, prevention, care closer to home and ensuring funding streams and capital support these principles. We recognise the challenges and welcome the principles that Lord Darzi has identified as being important to the solution for the NHS – this is a great opportunity to work together to develop an NHS which is fit for the future (further detail is included on the slides at the end of this presentation).
- We have been commended for our support of **Armed Forces Reservist Medical Services** in global Military Medical Operations. This coincides with being awarded the **Gold Award from the Armed Forces Covenant Employer Recognition Scheme**. This highlights the Trust's commitment to supporting our armed forces community. This recognition demonstrates that the Trust has provided employment opportunities and support for veterans, reservists, and their families.
- Our CEO, Trudie Davies, Place Director, Lyn Wilson and Local Authority CEO, Dale Owens, are delivering a presentation to system partners in October on the **benefits of system working**. This follows a commitment to work on increasing collaboration and partnership within our community contract. This builds on existing great work.

Engagement, involvement and visits:

- National CEO meeting with the Secretary of State for Health and Social Care and the NHS England CEO
- Provider Collaborative workforce meetings
- Great North Healthcare Alliance meetings ICS Chair and CEO workshop
- Place-based meetings
- Meeting with Mark Ferguson MP (Gateshead Central and Whickham)
- Visit to County Durham and Darlington NHS FT hosted by their CEO
- Urology Alliance meeting

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

- A huge well done and thank you to everyone who took place in the **Great North Run** events and raised money for our Gateshead Health Charity.
- The opening of the **Community Diagnostics Centre (CDC)** at the Metrocentre in partnership with Newcastle Hospitals is fast approaching. The CDC and diagnostic services will feature as a showcase presentation at our Annual General Meeting and Annual Members' Meeting on 25 September.



The Darzi report findings

- Lord Darzi completed an independent review into the NHS, to explore the challenges it faces and the impact of this on patients, service users and staff.
- The report was published on 12 September and will inform the forthcoming 10 year plan for the NHS.
- The report provides a helpful ‘state of the nation’ summary of the NHS nationally and recognises most of the key findings as being relevant to Gateshead and the wider NHS across our region.

NHS performance findings

- Ageing population = increased demand for healthcare = pressure on access to care. E.g. 62 day cancer target not met since 2015, long waits for mental health and community services.
- Recognise improvements to patient safety but clinical negligence claims at highest levels – maternal deaths, avoidable deaths, mental health and children and young people’s health
- Health inequalities clearly prevalent – people in poverty are getting sicker and accessing services later
- Obesity and diabetes on the rise, coupled with cuts to public health grants
- Under-investment in community based care leading to pressure on hospitals.
- Decline in NHS productivity – still below 2019 levels.
- Lack of clarity re: the role of the ICB in population health
- Significant long-term sickness for working age adults. Improve access to care = improve the contribution the NHS makes to the economy

The Darzi report findings

Drivers of performance

- Spending increases by the government were lower than planned between 2019 and 2024 – with spending per capita lower than other predominantly English-speaking countries.
- Capital investment has declined since 2009 – leading to deteriorating infrastructure and significant backlog maintenance (now £11.6 billion).
- The pandemic had a significant impact on the NHS after a decade of underinvestment – led to fewer resources and lower resilience than other health systems
- Voices of patients are not sufficiently heard leading to compensation claims of circa £3 billion per annum.
- Many staff feel disempowered and overwhelmed – leading to higher sickness absence.
- Identified cultural challenges, such as developing open, transparent and just cultures, take time to resolve and change.
- Changes to NHS structures and system, such as the creation of ICBs and the CQC's inspection regime, have caused a lack of clear understanding and inconsistent approaches across the country

- In summary, the report recognises that there are significant challenges facing the NHS but its '*vital signs are strong*'.
- The report reflects the importance of patient empowerment, digital technology, prevention, care closer to home and ensuring funding streams and capital investment support these principles.
- Lord Darzi identifies the following themes for how to 'repair' the NHS:
    - *Re-engage staff and re-empower patients*
    - *Lock in the shift of care closer to home by hardwiring financial flows*
    - *Simplify and innovate care delivery for a neighbourhood NHS*
    - *Drive productivity in hospitals*
    - *Tilt towards technology*
    - *Contribute to the nation's prosperity*
    - *Reform to make the structure deliver*
- We recognise the challenges and welcome the principles that Lord Darzi has identified as being important to the solution for the NHS – this is a great opportunity to work together to develop an NHS which is fit for the future.

NHS
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NHS England - Workforce, Training and Education (WTE) Directorate

Annual Quality Report 2024

Gateshead Health NHS Foundation Trust

Background to NHSE NENC WTE Annual Quality Report

This 2024 Annual Training and Education Quality Report gives a 'year-end' summary to the named LEP of the education and training it has provided to all clinical professionals in approved training placements over the course of the full 2023-24 training cycle (August 2023-July 2024) It also outlines the funding NHSE WTE has given to the LEP to provide training and education and this specifically includes funding to remunerate trainers and educators employed by the LEP for time to undertake their training and educational roles.

The report's purpose therefore is to promote a board level overview of the training related strengths and weaknesses of the LEP including both the educational governance and the associated financial governance of monies it has been provided through the NHS Education Contract in order to ensure that, as an organisation, the LEP meets the required training and education standards and actively addresses areas where it may fall short. To this effect, the report details priorities identified for action over the 2024-25 training cycle.

Further detail supporting this report is contained in the LEP's own Self-Assessment Report (SAR) as submitted to NHSE WTE in February 2024 and also in the LEP's ongoing Quality Improvement Plan (QIP). The end of year position detailed in the report and attached overview grid (Appendix 1) was confirmed with the LEP's senior leadership attendees at the 2024 Annual Dean's Quality Meeting (ADQM). A brief overview of NHSE NENC WTE quality management processes is given in Appendix 2.

NHSE NENC WTE – Postgraduate Dean and Lead Employer Trust responsibilities

1 Postgraduate Dean is responsible for the governance of Training and Education
The Postgraduate Dean leads NHSE NENC WTE in its role as the guardian of all clinical learning environments and has responsibility for both monitoring and providing onward assurance to NHS England, NHS system and professional regulators, and to the wider NHS; of the quality of training and education being delivered in all approved clinical training and education placements. Through its Training Directorates and Programmes, NHSE NENC WTE both commissions and delivers Medical and Dental training across its Local Education Providers (LEPs). It also shares governance processes with other system partners including the Medical Schools and HEIs who hold responsibility for the oversight of undergraduate education of healthcare students across all professions including their placements in LEPs and for which NHSE WTE provides funding.

It is important to note all the longstanding statutory duties and responsibilities of the Postgraduate Dean continue to apply in NHSE NENC WTE and that, in addition to their management role within NHS England, the PGD also has separate statutory accountability to the General Medical Council for assuring the quality of all medical training placements for ongoing approval by the GMC. The PGD is also accountable for the overall delivery and governance of all approved medical training programmes across NENC.

2 The Postgraduate Dean is the Responsible Officer for ALL Doctors in Training
In addition to their responsibilities for training quality and delivery, the PGD is the Responsible Officer (RO) for NHS England Education North East which is the Designated Body for revalidation purposes for **ALL** doctors training in approved training placements across the North East and North Cumbria.

Should any revalidation or fitness to practice concerns arise concerning any doctor in training then, as that doctor's RO, the Postgraduate Dean **MUST** be informed as soon as possible via direct contact and the locally agreed Revalidation Live Flow processes. The PGD must also lead any fitness to practice decision-making processes concerning any doctor in training and is also available for RO to RO communications as described by the GMC revalidation processes regarding both Doctors in Training employed by the Lead Employer Trust for whom the PGD is RO and regarding any other doctors (eg Trainers) employed by other designated bodies (e.g. Foundation Trusts) whose RO is commonly their Medical Director.
The NHSE NENC WTE Revalidation Team should be contacted when needed using the Revalidation email inbox: england.traineerevalidation.ne@nhs.net

3 The Lead Employer Trust is the employer of ALL Doctors in Training

Similarly, for **ALL** doctors training in approved training placements across the North East and North Cumbria, the Lead Employer Trust (LET) is each individual doctor's employer and manages both their contract of employment and any Maintaining High Professional Standards (MHPS) concerns that may arise. The LET must therefore be informed of any concerns relating to the conduct and/or health of individual doctors in training using the agreed processes including Revalidation Live Flow.

The LET therefore works very closely with the PGD and their deputies but it is important to note that the LET and NENC WTE are separate organisations with the LET being responsible for the management of the employment of all trainees across NENC and with the PGD being responsible for the revalidation of all trainees as well as for the quality and provision of all the approved postgraduate medical training programmes and placements.

It is most important that the Postgraduate Dean and/or the Lead Employer Trust are contacted by any LEP **BEFORE** any investigation of Fitness to Practice or management of Health or Conduct concerns concerning a doctor in training are initiated as it is for the PGD and/or LET to take the lead in all such matters and NOT the LEP currently hosting the placement of that doctor.

KEY CONTACTS for NHSE NENC WTE:

Postgraduate Dean: england.pgdean.ne@nhs.net

Quality Team: england.quality.ne@nhs.net

Revalidation Team: england.traineerevalidation.ne@nhs.net

Quality overview and NHSE WTE statement of assurance

NHSE WTE thanks Gateshead Health NHS Foundation Trust for its engagement and hard work which has enabled the North East and North Cumbria to collectively deliver the highest rated clinical training in the UK over the past decade. This shared commitment to work together has been maintained throughout the most challenging years in NHS history and is a credit to all concerned from your clinical 'shop floor' to Trust Board level in prioritising education and training alongside the numerous clinical service pressures.

The table below shows a high-level view of your organisation at 31st July 2024 and a clinical service level overview is provided in the grid overleaf. The background to any escalation was discussed in depth at your 2024 ADQM and outline details are given at the end of this section. NHSE NENC WTE quality management processes are described in Appendix 1.

Gateshead Health NHS Foundation Trust WTE NENC Summary View of LEP for Training Cycle August 2023 to July 2024							
Initial Education WTE NE Funding 2023-24: £9,987,816							
Current WTE Intensive Support Framework Escalation Levels							
	Overall	**Domain 1** Learning Environment & Culture	**Domain 2** Educational Governance & Leadership	**Domain 3** Supporting & Empowering Learners	**Domain 4** Supporting & Empowering Educators	**Domain 5** Delivering Curricula & Assessments	**Domain 6** Developing a Sustainable Workforce
WTE ISF LEVEL	**0**	**0**	**0**	**0**	**0**	**0**	**0**

WTE ISF Escalation Level Key:	
PGD Oversight using WTE NENC Quality Meeting (DEMQ) & WTE NENC Quality Processes	0* - Programme Level Management
	0 - Programme Level Management
	1 - Directorate Level Management
	2 - System Level Notification
	3 - High Risk of Training Suspension
	4 - Training Suspended

NHS England Workforce Training and Education works with all Local Education Providers via its Training Programmes and Directorates and uses the levels of the NHSE Intensive Support Framework to describe Quality in terms of the level of activity at which it is having to work with each LEP and Programme and with the wider system for any given issue.

With the exception of any escalated issues identified at ISF Level 1 and above at organisational level in the above table, and at clinical service level in the grid overleaf, NHSE WTE is currently assured of the overall quality of education and training provided by Gateshead Health NHS Foundation Trust and also with the organisational levels of engagement and support provided over the past training year. It is important to note that the quality management of education and training is a live process and that any concerns or escalations arising after the end of July 2024 will be communicated separately as part of the 2024-25 training cycle.

LEP	Gateshead Health NHS Foundation Trust	Last HEE review	Jul-24
		Last LEP review	

Quality Information	Finance Educational Contract	HEE Overall ISF Level
	£9,987,816	0

Regulator/System Ratings			
CQC Domains	CQC Ratings	NHSI Segment Rating	SQG Monitoring
Safe	G	3	Routine
Effective	G		
Caring	O		
Responsive	G		
Well Led	G		
Use of resources	RI		

National Survey Data			
	GMC NTS Trainee	GMC NTS Trainer	NETS
Date	Jul-23	Jul-23	Nov-23
UK Rank	120/229	86/220	
England Rank	109/207	83/198	94/211

Services	CQC Current View	WTE Current View							
	Rating Aug 2019	1 Learning Environment & Culture	2 Educational Governance & Leadership	3 Supporting & Empowering Learners	4 Supporting & Empowering Educators	5 Delivering Curricula & Assessments	6 Developing a Sustainable Workforce	Comments: Positives	Comments: Negatives
Trust Overall	Good	0	0	0	0	0	0		
Urgent & Emergency Care	Good	0	0	0	0	0	0		
Medical Care	Good	0	0	0	0	0	1		Cardiology WF
Surgery	Outstanding	0	0	0	0	0	0		
Critical Care	Good	0	0	0	0	0	0		
Maternity & Gynaecology	Good	0	0	0	0	0	0		
Children & Young People	Good	0	0	0	0	0	0		
End of Life	Good	0	0	0	0	0	0		
Outpatient & Diagnostic	Good	0	0	0	0	0	1		Histopathology WF Radiology WF
Mental Health	Requires Improvement	0	0	0	0	0	0		
Pharmacy	No rating	0	0	0	0	0	0		

Notes on 2024 ISF Levels requiring other than routine Deanery monitoring

ISF Level 0 – Specialty Directorate	Cardiology

Following the 2023 Quality-led Deanery Review of the Cardiology training programme, no specific issues were identified at Gateshead requiring monitoring beyond routine programme and School of Medicine processes and the monitoring level has returned from ISF1 to ISF0.

ISF Level 1 – Quality Directorate	Workforce Fragility (assorted specialties)

In 2023-24 Gateshead noted workforce fragility in the following areas: Cardiology, Histopathology, and Clinical Radiology. Whilst Educational Supervision of training is still being delivered satisfactorily in these programmes, the Trust feels that further expansion in trainee placements would be challenging at this time. The Specialty Directorate will continue to monitor the situation.

Overview of 2024 North East & North Cumbria Annual Dean's Quality Meetings and NENC Reporting Priorities for the 2024-25 Training Cycle

For over 10 years, the Annual Dean's Quality Meetings (ADQM) have provided a structure for senior level engagement between the Deanery team and the NENC Local Education Providers to discuss and resolve specific education and training issues within each LEP. The serial nature of ADQMs also allows common challenges and long-term strategies for education and training across the whole of the North East and North Cumbria to be shared over the years and for priorities for the next training cycles to be outlined and planned together.

As the UK enters a new electoral cycle, the NHS is once again facing significant change, the collaborative approaches already embedded locally, including the formation of new organisational alliances and groupings, places the NENC in a strong position to face the imminent structural, financial and workforce challenges outlined below.

Workforce, Training, Education, and the NHS Education Funding Agreement

All ADQMs reviewed the multiprofessional workforce of the LEP including measures being taken towards workforce expansion through the emerging Long Term Workforce Plan (LTWP) and identified areas where there were potential workforce shortages to deliver both clinical services and time needed for training. The use of monies allocated to each LEP to support education and training were reviewed with a focus on how resources are used to provide the time needed by those holding trainer and educator roles.

For medical training, with the exception of one LEP, which is already actively addressing the issues, feedback from trainers is very positive and job planning principles to include time for training roles is generally clear. The main challenge for expanding medical training placements is the mismatch in funding needed for each post and the tariff funding provided. This will become a bigger issue unless it is addressed clearly by the LTWP in areas where workforce expansion is required.

Many innovative training models for undergraduate placements were described across NENC including how placement capacity was being increased to accommodate the predicted rise in undergraduate student Healthcare Professionals (HCPs). Concern was expressed that the number of HCP students currently being placed by the Higher Education Institutions (HEIs) was less than expected, especially in Adult and Learning Disability Nursing, and also in the smaller Allied Health Professions. Compared to medical training, it was generally less clear how time for training was provided to those holding educational roles.

2024-25 Reporting Priorities: To achieve the anticipated workforce expansion needed, an expansion of the educator workforce will be necessary, and the Educator Workforce Strategy was discussed in outline. This strategy, together with progress toward the LTWP will be a focus of the NENC 2024-25 Self-Assessment Report (SAR) which will also try to obtain greater detail as to how educational resources are provided to the LEP clinical education teams and to the clinical educators and trainers themselves.

Equality, Diversity, and Inclusion

The 2023-24 EDI focus was on individual LEP strategies and structures, and ADQM discussions focussed on how LEPs deal with discriminatory behaviours toward staff from patients and their families and also discussed how staff new to the LEP, particularly those from overseas, are supported including staff groups and buddying/role modelling. Discussions were also held on how individuals returning to work after a period of absence were supported back into their role including a particular focus on how the HEE/WTE SuppoRTT programme was working at an LEP level for trainees returning to training. These discussions will be taken forward through the work of the Deanery EDI Group.

Over the past year, challenging working environments and cultures have again been noted, and the updated GMC Good Medical Practice (2024) now stresses that it is a duty of all doctors to act on harassment and bad behaviours. Particular challenges have been noted in Maternity Services and by the Royal College of Surgeons England to whom sexual harassment has been reported as a particular issue by doctors in training.

Preliminary work has shown issues to be more widespread than just specific clinical areas or professional groups. National charters have been published including a Sexual Safety in Healthcare Charter which has been signed by all NENC LEPs, and the HEE/WTE Safe Learning Environment Charter which provides suggestions as to how specific workplace culture challenges can be addressed. The Deanery is currently developing an Active Bystander Awareness programme including educational resources for use across NENC.

2024-25 Reporting Priorities will include LEP assessment of the working/learning environment and where their specific challenges lie, together with feedback on the WTE Safe Learning Environment Charter and Active Bystander awareness in relation to reporting of harassment and sexual safety at work.

Patient Safety

All ADQMs discussed the current work of the NENC Faculty of Patient Safety, including the use of Simulation and Human Factors-based training in each LEP, as well as the National Patient Safety Syllabus, elements of which are now included in mandatory training.

The Faculty, together with the wider NENC system, is helping to introduce the new Patient Safety Incident Response Framework (PSIRF) which aims to strengthen patient safety response systems and improvement through compassionate engagement and involvement of those affected, and to provide considered and proportionate responses and a system-based approach to learning. The Deanery aims to embed PSIRF principles in the supportive management of doctors in training involved in incidents and in their Revalidation processes.

2024-25 Reporting Priorities: The embedding of PSIRF is underway in all organisations and we shall be seeking views on how processes are working so we can best coordinate learning and support for all doctors in training and learners involved in patient safety incidents.

Changes to the structure of Pharmacy Training

David Gibson, Lead Pharmacist for NHSE NEY WTE has been working with all LEPs regarding significant changes to the way in which Pharmacy training will be delivered. This includes all future Pharmacists becoming prescribers at time of registration, and also the introduction of a Pharmacy Foundation Programme. The scale of change is large, and implementation is proceeding quickly. Many challenges, including the financial model, are being identified.

To assist the NEY Pharmacy Programme in its work, and to help the programme develop consistently across all LEPs, we will be including a specific Pharmacy reporting template in the 2024-25 SAR paperwork to help capture progress and issues as they arise across NENC. David Gibson and his team will remain the main point of contact for management of the changes.

Veterans' Health

In the 2024-25 SAR paperwork, we will be including a section where your approach to Veterans Healthcare can be detailed. This will allow Dr Sarah Troughton, Associate Dean for Veterans Health, to better identify and coordinate the learning needs across NENC.

Finally, a huge thank you to you and all of your teams for engagement in the planning, delivery and management of health education and training across NENC in times of great change and limited resources. By working collaboratively, we are able to not only deliver great healthcare and training but can also demonstrate this through the year-on-year feedback we receive from students, doctors in training and trainers. Collectively the North East and North Cumbria delivers some of the highest rated education and training in the UK and that is something we should all be proud of and celebrate together.

On behalf of NHSE WTE North East & North Cumbria 31st July 2024

		
Mr Pete Blakeman	**Dr Dawn Ashley**	**Professor Namita Kumar**
Deputy Postgraduate Dean, Clinical Quality Director	Interim Postgraduate Dean NHSE WTE NENC	Regional Postgraduate Dean NHSE WTE NEY

APPENDIX 1

Overview of NHSE NENC WTE Quality Management processes

The quality of clinical education and training is defined by the standards of the NHSE *Quality Framework* and other specific regulatory standards such as GMC *Promoting Excellence* which share common language and themes. Using locally agreed and shared quality reporting processes, including the submission of a Self-Assessment Report (SAR) and Quality Improvement Plan (QIP), all LEPs and all NHSE NENC WTE Training Directorates provide board-level assurance to the Postgraduate Dean via the Quality Directorate who oversee the live monitoring and quality management of training and education issues via a monthly governance meeting, the Dean's Executive Meeting for Quality (DEMQ).

Using the multiple standards contained in the six themes of the NHSE Quality Framework (QF), together with the five escalation levels defined by the NHSE Intensive Support Framework (ISF), 'Quality' is described both in terms of QF standards being met in any LEP or individual clinical environment, and also in terms of the ISF level of shared activity by which NHSE WTE Training Directorate and Programme is having to work with each LEP. This activity may involve individual clinical service groups within a LEP, the relevant WTE Training Programme, and the wider NHS including the relevant professional and educational regulators for any given issue relating to the provision, delivery, and support of clinical training.

All ISF levels and the underlying reasons for any escalation were discussed at each LEP's 2024 ADQM and are summarised within this report. NHSE-WTE and the GMC are made aware of any escalations at ISF1 and above and the wider system is aware of escalations at ISF2 and above.

NHSE-WTE works with and provides support to each LEP throughout every training cycle and provides significant amounts of funding to each organisation through the NHS Education Funding Agreement in order to support the clinical placements, the trainers and educators employed by the LEP, as well as to support the provision of education and training related resources and facilities within the LEP.

NHSE-WTE gains assurance through the scheduled programme-led monitoring of training placements including Quality Reporting, Visits, and Meetings, and through triangulation of data and information. Relevant information is shared with and received from programmes managed at a regional or national level (e.g. Libraries, Pharmacy, Healthcare Science), and with other organisations including Higher Education Institutions (HEIs), other NHS bodies and the system regulators including the Care Quality Commission (CQC) and the professional regulators.

NHSE-WTE continues to use the escalation processes of the HEE-ISF to describe and monitor any concerns identified, and it describes concerns based on the level at which it is having to work with any individual organisation, department, programme, or the wider system to ensure consistency in the way that concerns are identified, described, and shared, and also to ensure the appropriate steps are taken to clarify, improve and resolve the concerns raised.

When there are concerns that a LEP is failing to meet required NHSE or regulator standards, either as a whole organisation, in individual training departments, or when there is system-wide concern about an organisation, NHSE-WTE works directly with the wider NHS via the System Quality Group (SQG) led by the Integrated Care Board (ICB), and also through NHSE Quality Improvement Boards and Risk Summits to discuss the issues of concern, to confirm and agree

plans for improvement with the LEP, and to agree outcome measures of success with a realistic timeframe for these to be achieved.

As with its predecessor HEE, NHSE-WTE remains keen to provide support to improve training and education in all locations. Should programme-level actions fail to resolve issues then the relevant NHSE-WTE Deputy Postgraduate Deans/Directors responsible the Foundation, Specialty, and General Practice training programmes and the Director for Quality and Revalidation are available for consultation, advice and to coordinate further actions as deemed necessary, as are the Postgraduate Dean and the Postgraduate Dental Dean. All will work with the LEP at Director and Board Level to help resolve issues and concerns.

Appendix 2

2024-25 Quality Cycle – Reporting Timeline and Planned Interactions

The annual Education and Training Cycle starts on 1st August 2024 and ends on 31st July 2025. The table below outlines key dates in the cycle and the scheduled activities and planned interactions between NHSE WTE NENC and its LEPs. The WTE NENC Quality Team is always available for consultation and should be contacted using its dedicated mailbox: england.quality.ne@nhs.net

2024 WTE Annual Reports to be sent to LEPs	August 2024
2024-25 reporting documentation and guidance to be sent to LEPs	September 2024
WTE analysis and circulation of benchmarked data from 2024 GMC NTS Trainee & Trainer Surveys	September 2024
LEPs to submit mid-year QIP updates to WTE Quality Team	30 September 2024
NHSE National Education and Training Survey (NETS) scheduled	1 October 2024 (to be open for 8 weeks)
WTE Quality Team to offer meetings to LEPs to support annual reporting and to discuss any emerging issues or concerns	November 2024 to January 2025
LEPs to return completed 2024-25 reporting documentation (SAR/QIP/Unit reports) to WTE Quality Team	28 February 2025
2025 GMC NTS Trainee & Trainer Surveys – anticipated dates	April - May 2025
2025 Annual Dean's Quality Meetings (ADQMs) with LEPs	April - June 2025
2025 WTE Annual Reports to be sent to LEPs	From end July 2025

Gateshead Health NHS Foundation Trust

Agenda Item: 15i

Report Title:	**Organisational Risk Register (ORR)**			
Name of Meeting:	Board of Directors			
Date of Meeting:	24th September 2024			
Author:	Marie Malone, Corporate and Clinical Risk Lead.			
Executive Sponsor:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals/Deputy CEO			
Report presented by:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals/Deputy CEO			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	To ensure the Board and Committees are clearly sighted on those risks that have an organisational -wide impact, the organisational risk register is compiled by the Executive Risk Management Group (ERMG) of those risks that impact on the delivery of strategic aims and objectives. This includes risks included within the Board Assurance Framework (BAF) as well as risks identified by the Group for inclusion as having an organisational impact and impact on delivery of strategic aims and objectives. The supporting report shows the risk profile of the ORR, includes a full register, and provides details of review compliance, and risk movements.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	The attached report is received in the Executive Team Meeting, and at the Executive Risk Management Group meeting every month.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience*	Risks on the ORR were comprehensively discussed at previous ERMG meetings in August and September, and the following updates and movements agreed. The accompanying Report shows the following changes and is detailed within this report. -There were 3 risks added, 1 risk removed, 0 closed. 0 escalations or reductions.			

<table>
<tr><td>

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

</td><td colspan="5">-Compliance with reviews has improved since last reporting period and sits at 86% for risks and 78% for associated actions.

-Risk management Policy has been updated with changes agreed by the executive risk management group and Audit committee.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The Board are asked to:

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

Organisational Risk Register

Executive Summary

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

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

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

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

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

Organisational Risk Register

Movements:

Following ERMG meeting in August and September 2024, 3 risks have been added to the ORR. There have been 0 escalations, 0 reductions or closures. 1 ORR risk has been moved to managed.
There are currently 21 risks on the ORR, agreed by the group as per enclosed report.

New Risks:
3 new risks added in period:

- **4591 (CEO)** Risk of significant service disruption due to GP collective actions including reduction in shared care service provision (20)

    - Monitoring via central database
    - Task and finish group- impact assessment
    - EPRR co-ordination and oversight

- **4577 (Finance)** The trust does not achieve its 2024/25 planned deficit totalling £12.6 M (20)

    - Financial & Sustainability workstream
    - Roster management and additional spending controls in place
    - Temporary staff reduction group

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

    - Review the current trust evacuation and shelter plan
    - Pre-determined areas being scoped in review of business continuity plans

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

1 risk moved to managed, to remain on the ORR:

2545 (Medicine) Risk of delay in transfer to community for patients who are on pathway 3 or who live in a non-Gateshead area. Due to lack of complex care provision and difficulties in accessing social care teams from other locations. (8)

- Patients delays have reduced significantly in the last 18 months
- Meetings with social care to progress pathways are part of standard business as usual
- Cannot yet achieve target score as Sunderland remains an external pressure that we that we are unable to influence. This could only be achieved if systems works with Sunderland were fully realised.
- Unable to mitigate further internally.

Risk removed
1 risk has been removed, to be managed locally by the DART service

- **4564 (COO)** Risk of clinical safety for patients out-of-hours due to junior workforce currently in deteriorating patient service. This could result in patient care being impacted without clinical lead to guide teams required development. (16)

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

Top 3 Organisational Risks:

1- **(4577) Finance and CRP-** both the lack of a clearly defined CRP plan and medical staffing overspend continues to drive the financial constraints, with significant financial pressures on the organisation. The risk that the Trust does not achieve the 2024/25 planned deficit and does not deliver its CRP plan, resulting in a significant impact on future financial sustainability; (20)

2- **(4591) CEO- GP shared care and collective actions-** concern continues around uncertainty and potential impact this could have on services and patient care that is not yet quantifiable or realised. The risk of significant service disruption due to GP collective action, particularly given that the extent and impact of this cannot yet be ascertained. (20)

3- **(4559) POD** – **Medical staffing overspend** Medical staffing spend within the division of Medicine (which links to the finance risk) - remains a challenge and we lack confidence in the delivery plan. (20)

Current compliance with Risk reviews:

Risk review compliance is currently at 86%. Action review compliance is 78%. This is a an improvement since the previous report.

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

Risk Management policy

A Full review of Risk Management policy has been undertaken and circulated to the group and key changes discussed and agreed. The group supported the change to divisional risk registers being presented at a score of 12+ (previously 15+) and confirmed the revised risk governance framework structure as a key element of the risk escalation process.
The policy was ratified at Audit committee in September's meeting.

Recommendations

The Board of Directors are asked to:

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

Organisational Risk Report - Board

Total Risks (Current/Managed)
21

People

5

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Resources	People & OD	4559	There is a risk that the appropriate support is not available to our medical staff to support good rota management and strategic medical workforce modelling	20
		4525	Risk of Lack of a strategic workforce planning	12
	Chief Operating Officer	4574	A risk of being unable to relocate in the event of an evacuation due to capability and capacity issues within the estate that may potentially result in patient safety issues	12
Staff Safety	People & OD	3132	Exposure to incidents of violence and aggression in ECC	15
Wellbeing	People & OD	4417	Increase in incivility and disrespectful behaviours being reported	12

Quality

6

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Effectiveness	Chief Executive Office	4591	Risk of significant service disruption due to GP collective actions including reduction in shared care service provision	20
Effectiveness	Medical Services	2545	Risk of delayed transfers of care and increased hospital lengths of stay	8
Safety	People & OD	2432	Risk of Significant, unprecedented service disruption due to industrial action	16
Safety	Digital	4554	Cyber Threats and Vulnerabilities	15
Safety	Surgical Services	3107	Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings	15
Safety	Nursing, Midwifery & Quality	2438	Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures.	8

Finance

6

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Finance	Finance	4577	Achievement of 2024/25 revenue financial plan	20
Finance	Finance	2425	Activity is not deliverved in line with planned trajectories, leading to reduction in income	16
Finance	Finance	2424	Risk that efficiency requirements are not met.	16
Business Continuity	QE Facilities	2341	There is a risk to ongoing business continuity of service provision due to ageing trust estate	16
Effectiveness	Planning & Performance	2582	Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI.	12

Regulation

5

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Compliance	Digital	4402	Inability to support legislation and best practice associated with records management	16
Compliance	Digital	4405	Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure.	16
Compliance	Digital	4575	Non compliance with FoI response turnaround time could result in ICO imposed penalties.	16
Compliance	Digital	4576	Non compliance with SARs response turnaround time could result in ICO imposed penalties.	15
Compliance	Nursing, Midwifery & Quality	4541	Risk of governance failure as we transition to new governance arrangements	16

This report does not contain any data

Reputation

Organisational Risk Register (Current/Managed)

21

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date moved to current risk	Next review Date	Stage	Open Form
4591	BU Dir. Governance Meeting Finance & Performance Committee Organisational Risk Quality Governance Committee	Risk of significant disruption to services due to GP collective action to "work to contract" including withdrawal from shared care agreements. The impact of this is currently unknown, however, may result in suboptimal quality of care, reduced performance against targets, realignment of clinical resources and reputational harm.	Neil Halford	Chief Executive Office	Chief Executive Office	-monitoring via central database -task and finish group- impact assessment -collated list of drugs which will continue to be provided -controls are limited at this time	SA 1.2 Full delivery of the actions within the Quality Improvement Plan leading to improved outcomes and patient experience with particular focus on improvements relating to mental health, learning disabilities and cancer. SA 3.1 Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025. SA 4.1 Work at place with public health, place partners and other providers to ensure that reductions in health inequalities are evidenced with a focus on women's health	25	20	10	16 Aug 2024	16 Oct 2024	Current Risk	
4559	BU Dir. Governance Meeting Organisational Risk People and OD Committee Quality Governance Committee Finance & Performance Committee	There is a risk that the appropriate support is not available to our medical staff to support good rota management and strategic medical workforce modelling. This could result in errors and non compliance with contractual obligations as well as a lack of engagement and morale. As such a negative impact on the Trust's reputation as a training provider and employer.	Amanda Venner	People & OD	Workforce Development	Recruitment of a band 4 post into medical staffing to increase capacity Standard operating procedures and FAQ's developed	SA 1.2 Full delivery of the actions within the Quality Improvement Plan leading to improved outcomes and patient experience with particular focus on improvements relating to mental health, learning disabilities and cancer. SA 2.2 Growing and developing our people in order to improve patient outcomes, reduce reliance on temporary staff and deliver the 24-25 workforce plan SA 3.1 Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025. SA 3.2 Evidence of reduction in cost base and an increase in patient care related income by the end of March 2025 leading to a balanced financial plan for 2025-26.	20	20	12	11 Jun 2024	19 Oct 2024	Current Risk	
4577	Finance & Performance Committee BU Dir. Governance Meeting Organisational Risk	Risk that the trust does not achieve its 2024/25 planned deficit totalling £12.6 M and does not deliver its CRP, resulting in significant impact on financial sustainability.	Kris Mackenzie	Finance	Finance	Financials & Sustainability workstream Vacancy control, non-pay discretionary spend, temporary staff reduction group, medical & nursing staff workstreams, roster management, updated SFI's and scheme of delegation, additional spending controls	SA 3.1 Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025. SA 3.2 Evidence of reduction in cost base and an increase in patient care related income by the end of March 2025 leading to a balanced financial plan for 2025-26.	25	20	10	22 Jul 2024	17 Oct 2024	Current Risk	

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date moved to current risk	Next review Date	Stage	Open Form
4575	BU Dir. Governance Meeting Digital Committee Organisational Risk	The trust performance against the mandatory 20 day turnaround (as per the Freedom of Information Act) for Freedom of Information requests is below tolerance of 90%. Increasing the likelihood of complaints/reports to the ICO from requestors. The ICO can investigate these complaints resulting in regulatory fines where it feels the organisation is not supporting the requirements of FoIs, resulting in potential financial and reputational damage and complaints	Kris Mackenzie	Digital	Digital Transformatic and Assuranc	FoI Policy and Procedures FoI central coordination and reporting	SA 1.3 Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.	20	16	8	16 Jul 2024	27 Sep 2024	Current Risk	
4541	BU Dir. Governance Meeting Finance & Performance Committee Quality Governance Committee Organisational Risk	There is a risk of the failure of governance arrangements as we transition to a new governance structure. This may result in critical information being lost or missed and Executives being unaware of risks within the organisation.	Gill Findley	Nursing, Midwifery & Quality	Corporate Nursing	Date to be agreed for start of new meeting structure. This will not take place until all controls and actions are in place. Cycles of business for existing committees continue to be followed until the date of transfer.	SA 1.2 Full delivery of the actions within the Quality Improvement Plan leading to improved outcomes and patient experience with particular focus on improvements relating to mental health, learning disabilities and cancer. SA 4.2 Work collaboratively as part of the Gateshead system to improve health and care outcomes to the Gateshead population SA 5.1 Contribute effectively as part of the Great North Healthcare Alliance to maximise the opportunities presented through the regional workforce programme	20	16	4	13 May 2024	20 Sep 2024	Current Risk	
4402	BU Dir. Governance Meeting Digital Committee Organisational Risk BAF PPAI	Risk of breaching legislative requirements due to lack of long term strategic approach to the management and storage of health records [both digital and paper]. This could lead to regulatory and reputational harm.	Catherine Bright	Digital	Digital Transformatic and Assuranc	Action to scope and procure an EPR to support robust record management requirements [Record Lifecycle - creation to destruction]	SA 1.3 Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.	20	16	8	24 Nov 2023	27 Sep 2024	Current Risk	
4405	BAF BU Dir. Governance Meeting Digital Committee Organisational Risk	Risk of data mismanagement, leading to inappropriate access, misuse or inappropriate disclosures. Due to failure to incorporate best practices in the management of information across the organisation. Resulting in patient harm and/or failure to comply with UK law, national standards and contractual requirements.	Dianne Ridsdale	Digital	Digital Transformatic and Assuranc	Trust Policies, procedures, guides, materials and tools. Staff training, awareness and communication programmes Internal and external auditing and IG spot check programme	SA 1.3 Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan. SA 3.1 Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025.	20	16	4	24 Nov 2023	20 Oct 2024	Current Risk	

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date moved to current risk	Next review Date	Stage	Open Form
2432	BAF BU Dir. Governance Meeting Organisational Risk Quality Governance Committee People and OD Committee	Risk to quality of care and service disruption due to Industrial Action of various trade unions across various sectors affecting staffing levels and potential impact on patient care, safety and quality.	Amanda Venner	People & OD	Workforce Development	Industrial action working group established and meeting regularly. Focused planning sessions have taken place to explore the planning, response and recovery elements of industrial action with reasonable worse case scenarios considered. A detailed work plan has been produced with a number of actions, lead officers and timescales. Set up of command and control and coordination (wef 12/12/2022). Local strike committee in place (wef 09/05/2022). Citrep position updated daily during period of IA. Business continuity planning, including an EPRR work place that runs along each period of IA. Command and control structure standards up in the event of IA. Close partnership working and regular local discussions with staff-side and respective trade union representatives as part of the IA Internal Working Group and the Sub-group of the JCC. Cancellation of some elective services to reduce need for junior medical staff. Consideration of utilisation of other staffing sources- consultants and/or specialist nurses and pharmacy support. Review of on call teams.	SA 1.2 Full delivery of the actions within the Quality Improvement Plan leading to improved outcomes and patient experience with particular focus on improvements relating to mental health, learning disabilities and cancer. SA 2.1 Caring for our people in order to achieve the sickness absence and turnover standards by March 2025 SA 2.2 Growing and developing our people in order to improve patient outcomes, reduce reliance on temporary staff and deliver the 24-25 workforce plan	20	16	8	07 Nov 2022	17 Oct 2024	Current Risk	
2425	BU Dir. Governance Meeting Finance & Performance Committee Organisational Risk BAF	Activity is not delivered in line with planned trajectories, resulting in the Trust having reduced access to elective recovery funding.	Kris MacKenzie	Finance	Finance	2024-25 activity plans informed 24-25 planned income targets. Monthly reporting against planned income targets, including performance analysis by speciality, point of delivery and HRG. Attendance at system elective recovery meetings Weekly access and performance clinics to monitor performance and agree actions plans Coding & counting workstream to support the capture of activity data	SA 3.2 Evidence of reduction in cost base and an increase in patient care related income by the end of March 2025 leading to a balanced financial plan for 2025-26. SA 5.2 Evidenced business growth by March 2025 with a specific focus on Diagnostics, Women's health and commercial opportunities SA 1.2 Full delivery of the actions within the Quality Improvement Plan leading to improved outcomes and patient experience with particular focus on improvements relating to mental health, learning disabilities and cancer.	20	16	4	22 Nov 2022	17 Oct 2024	Current Risk	
2424	BU Dir. Governance Meeting Finance & Performance Committee Organisational Risk BAF	Risk that Efficiency requirements are not achieved.	Kris MacKenzie	Finance	Finance	Efficiency delivery closely monitored as part of month end reporting. Weekly CRP working group in place to ensure traction, delivery and ongoing engagement. Finance and performance assurance group to over see CRP performance on a monthly basis.	SA 3.2 Evidence of reduction in cost base and an increase in patient care related income by the end of March 2025 leading to a balanced financial plan for 2025-26. SA 5.2 Evidenced business growth by March 2025 with a specific focus on Diagnostics, Women's health and commercial opportunities	20	16	8	22 Aug 2022	17 Oct 2024	Current Risk	

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date moved to current risk	Next review Date	Stage	Open Form
2341	BU Dir. Governance Meeting Organisational Risk Finance & Performance Committee Health and Safety Committee BAF Operations Oversight Group PPAI	There is a risk to maintaining business continuity of services and recovery plans due to the estate infrastructure, age and backlog maintenance requirements which exceed the Trusts capital allocation.	Anthony Pratt	QE Facilities	Estates	Clinically led estates strategy developed and prioritsied on priority versus affordability	SA 3.1 Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025. SA 3.2 Evidence of reduction in cost base and an increase in patient care related income by the end of March 2025 leading to a balanced financial plan for 2025-26. SA 1.4 Development and implementation of an Estates strategy that provides a 3 year capital plan to address the key critical infrastructure and estates functional risks across the organisation by March 2025	16	16	4	20 Feb 2023	13 Sep 2024	Current Risk	
3107	BAF BU Dir. Governance Meeting Organisational Risk Quality Governance Committee Operations Oversight Group PPAI	There is a risk of delayed treatment due to maternity estate being a separate building resulting in the potential for severe harm to mothers and babies. Rising acuity of maternity patients and more frequent use of CCU, theatre staff and Paediatric teams creates additional likelihood of the need for these teams to attend the maternity department and delays to be incurred.	Kate Hewitson	Surgical Services	Surg 2	Pre-assessment - Women deemed likely to require critical care after elective procedures have their operation in main theatre to allow swift access to critical care. This only applies to elective patients and not emergency procedures or those in spontaneous labour. Any incidents are investigated to identify potential learning. major haemorrhage protocols in place	SA 1.1 Evidence full compliance with the Maternity Incentive Scheme (MIS) and the Ockenden actions SA 1.2 Full delivery of the actions within the Quality Improvement Plan leading to improved outcomes and patient experience with particular focus on improvements relating to mental health, learning disabilities and cancer.	20	15	5	28 Dec 2018	23 Sep 2024	Current Risk	
3132	BU Dir. Governance Meeting Organisational Risk Quality Governance Committee People and OD Committee Health and Safety Committee BAF	Staff exposure to incidents of violence and aggression from patients and visitors. Risk of harm to staff, risk to staff well-being through challenging behaviour demonstrated by some patients and/or visitors to ECC resulting in injury, increased absence from work, potential effect on recruitment and retention of staff, staff morale and confidence	Laura Farrington	People & OD	Workforce Development	policies in place to support staff training available reporting tools available forums for debrief/discussion and support available	SA 2.1 Caring for our people in order to achieve the sickness absence and turnover standards by March 2025	20	15	6	27 Oct 2021	20 Sep 2024	Current Risk	
4554	BU Dir. Governance Meeting Organisational Risk Digital Committee	There is a risk that the trust is not sufficiently protected against the current and evolving cyber threats. Vulnerabilities in protection increase the risk of significant service disruption due to unavailability of business critical systems. Vulnerabilities in protection could also increase the risk of data loss or breaches due to cyber attacks (ransomware etc).	Kris Mackenzie	Digital	IT	HSCN – National data network with enhanced and robust network security which benefits from the Network Analytics Service (NAS) which monitors all network traffic on HSCN for anomalous behaviour. Secure Boundary Service (SBS) – Perimeter network security solution offering additional protection against security threats, with increased network traffic visibility and content identification within encrypted traffic as well as enriched threat intelligence. Enhanced Domain Name System (DNS) - integration into the NCSC protective DNS to help disrupt the use of DNS for malware distribution and operation Network Management – All networking equipment is within manufacturer support for maintenance and security updates. Network segmentation in place to allow for compartmentalisation of sub networks to allow for additional security protection and controls Community of Interest Network (CoIN) – Private secure health network to allow for secure access to data and applications Resilient Data Centre – 2 on site data centres to	SA 1.3 Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.	20	15	10	05 Jun 2024	20 Sep 2024	Current Risk	

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

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date moved to current risk	Next review Date	Stage	Open Form
4576	BU Dir. Governance Meeting Digital Committee Organisational Risk	The trust is performing below tolerance of 95% for responses to Subject Access Requests within the mandated calendar month turnaround time. Lower performance levels could result in increased complaints to the ICO about the trust from requestors. The ICO may choose to investigate these complaints and as a result impose significant financial penalties on the organisation - causing financial and reputational damage and complaints.	Kris Mackenzie	Digital	Digital Transformatic and Assuranc	Trust policy and procedure in place	SA 1.3 Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.	20	15	5	16 Jul 2024	20 Sep 2024	Current Risk	
4417	BU Dir. Governance Meeting Organisational Risk People and OD Committee BAF	There is a risk that promoting an environment that encourages speaking out and creating a psychologically safe culture may lead to increased reports of poor behaviour. This could have a negative impact on staff and require addiitional time and capacity to appropriately address the concerns. This could result in further health and well being concerns and staff absence.	Amanda Venner	People & OD	Workforce Development	Zero-Tolerance Campaign underway, focusing on clarifying expectations and providing training and support for colleagues in identifying and responding to bullying, harassment and discrimination from colleagues, patients or service users. Establishment of a full time, permanent Freedom to Speak Up Guardian and increasing number of FTSU Champions, creating an increasing number of avenues for colleagues to report incidents.	SA 2.1 Caring for our people in order to achieve the sickness absence and turnover standards by March 2025	15	12	6	26 Oct 2023	17 Oct 2024	Current Risk	
4525	BU Dir. Governance Meeting Organisational Risk People and OD Committee	There is a risk that the lack of a strategic workforce plan that delivers our specific future priorities (women's health, diagnostics, etc) leads to a lack of appropriate skilled staff and negative impacts on service delivery, patient safety and staff engagement and an increase in costs for temporary staffing.	Sophia Grainger	People & OD	Human Resources	International recruitment team established Refreshed absence management policy oversight meetings with BUs around WTEs Operational workforce plan submitted as part of the 2024/2025 Operating Planning submission NHS Long Term Workforce Plan published to set a direction of travel and commit to an ongoing programme of strategic workforce planning	SA 1.2 Full delivery of the actions within the Quality Improvement Plan leading to improved outcomes and patient experience with particular focus on improvements relating to mental health, learning disabilities and cancer. SA 2.2 Growing and developing our people in order to improve patient outcomes, reduce reliance on temporary staff and deliver the 24-25 workforce plan	16	12	8	26 Mar 2024	17 Sep 2024	Current Risk	
4574	Business Resilience Group BU Dir. Governance Meeting Organisational Risk Quality Governance Committee	A risk of being unable to relocate in the event of an evacuation due to capability and capacity issues within the estate that may potentially result in patient safety issues and impact quality.	David Patterson	Chief Operating Officer	EPRR	Ongoing work to review the current trust evacuation and shelter plan Pre-determined areas being scoped in review of business continuity plans	SA 1.2 Full delivery of the actions within the Quality Improvement Plan leading to improved outcomes and patient experience with particular focus on improvements relating to mental health, learning disabilities and cancer.	16	12	8	16 Jul 2024	09 Oct 2024	Current Risk	
2582	BU Dir. Governance Meeting Finance & Performance Committee Organisational Risk BAF	Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely business intelligence to deliver and improve services	Debbie Renwick	Planning & Performance	Planning & Performance		SA 3.1 Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025.	15	12	3	13 Oct 2021	01 Sep 2024	Current Risk	

								Initial Risk Rating	Rating	Target Rating			Stage	
						Programme of work established to work on improving access to BI and improve board reporting along with service line access to quality performance and workforce data Project Manager appointed to lead on this work with support from NECS. Programme involves 3 projects Static reporting – Look back - this is what we achieved update January 2024- Activity Plan & Operational Recovery Monitoring: Information Team produce weekly and monthly activity against plans, excel manipulation required to produce business unit and Board level reporting views from weekly and monthly outputs. Business partners realign outputs to support business unit need. Key Performance & Recovery Reporting: Information Team produce weekly PTL views for DM01, RTT and Cancer WLs from weekly WLMS reporting submissions. Business partners collate & manipulate views for weekly Access & Performance meetings. Realtime cancer performance dashboards developed in line with revised cancer standards for FDS, 31 Day, and 62 Day Treatments. SItRep Reporting: Outputs from Sit-reps are shared in PPAI platform: Manual review and manipulation is then available to the end user. Integrated Board Reporting: Manual compilation from existing excel outputs (from various sources) and co-ordination by Planning & Performance Team. Leading Indicators: Manual compilation from existing excel outputs (from various sources) and co-ordination by Planning & Performance Team. Health Inequalities Data: Information team produce HIE view of RTT and Cancer PTL's on a monthly basis. Deprivation Scores and Protected characteristics are available on PTLs for operational review. Real-time UEC Dashboards Real-time Length of Stay Dashboard Live reporting – this is how we are doing now and where we need to intervene to prevent poor performance Forecasting – these are the trends to be able to plan services much more effectively to meet demand the later two points need further development Some BI available in sitreps and excel format							

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date moved to current risk	Next review Date	Stage	Open Form
2545	BAF BU Dir. Governance Meeting Finance & Performance Committee Organisational Risk Operations Oversight Group	Risk of delay in transfer to community for patients who are on pathway 3 or who live in a non Gateshead area. Due to lack of complex care provision and difficulties in accessing social care teams from other locations. This delay adds significant pressure to acute bed availability and significant risk of problems with flow through the hospital impacting national standard achievement. There is a risk of falls, nosocomial infection and deconditioning to patients experiencing delays. This leads to poor patient and staff experience and adversely impacts quality of care delivery.	Joanna Clark	Medical Services	Medical Services - Divisional Management	Daily meeting with LA to examine capacity in out of hospital system and match with demand for discharges. Target discharges of 40 per week to keep pace with demand. Monitoring of Delayed transfers of care twice weekly meeting Escalation of delays of care to the community BU and social services at twice weekly meetings. Monitoring of Breach levels and times. Monitoring of Ambulance delays. Monitoring increased LOS of medically optimised patients. Escalation of patients requiring social services support raised weekly at Discharge Systems group which includes Social services management and ICB representative. Medically Optimised meeting 2x week, passed to IPC/ICB Pilot on 2 wards re improving discharges.	SA 3.1 Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025. SA 4.2 Work collaboratively as part of the Gateshead system to improve health and care outcomes to the Gateshead population	20	8	4	07 Dec 2021	16 Feb 2025	Managed Risk	
2438	BAF BU Dir. Governance Meeting Organisational Risk Quality Governance Committee	Quality - There is a risk of quality failures in patient care (patient safety, patient experience and effectiveness) due to external causes such as delayed discharges and pressures from other Trusts resulting in patient harm, regulatory action, and reputational impact	Gill Findley	Nursing, Midwifery & Quality	Quality Governance	Daily report provided detailing all delayed discharges within the Trust. regular meetings now established with social care. Discharge liaison staff available to support wards and facilitate earlier discharge. surge plan is in place and is being managed	SA 1.2 Full delivery of the actions within the Quality Improvement Plan leading to improved outcomes and patient experience with particular focus on improvements relating to mental health, learning disabilities and cancer.	15	8	4	16 Aug 2022	01 Oct 2024	Current Risk	

Risks Moved to Managed in Period

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Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Unknown - [b6b56e64_cd61_4	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date moved to manage risk	Next review Date	Stage	Oper Form
2545	BAF BU Dir. Governance Meeting Finance & Performance Committee Organisational Risk Operations Oversight Group	Risk of delay in transfer to community for patients who are on pathway 3 or who live in a non Gateshead area. Due to lack of complex care provision and difficulties in accessing social care teams from other locations. This delay adds significant pressure to acute bed availability and significant risk of problems with flow through the hospital impacting national standard achievement. There is a risk of falls, nosocomial infection and deconditioning to patients experiencing delays. This leads to poor patient and staff experience and adversely impacts quality of care delivery.	Joanna Clark	Medical Services	Medical Services - Divisional Management	Daily meeting with LA to examine capacity in out of hospital system and match with demand for discharges. Target discharges of 40 per week to keep pace with demand. Monitoring of Delayed transfers of care twice weekly meeting Escalation of delays of care to the community BU and social services at twice weekly meetings. Monitoring of Breach levels and times. Monitoring of Ambulance delays. Monitoring increased LOS of medically optimised patients. Escalation of patients requiring social services support raised weekly at Discharge Systems group which includes Social services management and ICB representative. Medically Optimised meeting 2x week, passed to IPC/ICB Pilot on 2 wards re improving discharges.		SA 3.1 Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025. SA 4.2 Work collaboratively as part of the Gateshead system to improve health and care outcomes to the Gateshead population	20	8	4	05 Aug 2024	16 Feb 2025	Manage Risk	

Risks Added to ORR in Period (all levels) 3

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date added to ORR	Next review Date	Stage	Open Form
4577	Finance & Performance Committee BU Dir. Governance Meeting Organisational Risk	Risk that the trust does not achieve its 2024/25 planned deficit totalling £12.6 M and does not deliver its CRP, resulting in significant impact on financial sustainability.	Kris Mackenzie	Finance	Finance	Financials & Sustainability workstream Vacancy control, non-pay discretionary spend, temporary staff reduction group, medical & nursing staff workstreams, roster management, updated SFI's and scheme of delegation, additional spending controls	SA 3.1 Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025. SA 3.2 Evidence of reduction in cost base and an increase in patient care related income by the end of March 2025 leading to a balanced financial plan for 2025-26.	25	20	10	22 Jul 2024	17 Oct 2024	Current Risk	
4591	BU Dir. Governance Meeting Finance & Performance Committee Organisational Risk Quality Governance Committee	Risk of significant disruption to services due to GP collective action to "work to contract" including withdrawal from shared care agreements. The impact of this is currently unknown, however, may result in suboptimal quality of care, reduced performance against targets, realignment of clinical resources and reputational harm.	Neil Halford	Chief Executive Office	Chief Executive Office	-monitoring via central database -task and finish group- impact assessment -collated list of drugs which will continue to be provided -controls are limited at this time	SA 1.2 Full delivery of the actions within the Quality Improvement Plan leading to improved outcomes and patient experience with particular focus on improvements relating to mental health, learning disabilities and cancer. SA 3.1 Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025. SA 4.1 Work at place with public health, place partners and other providers to ensure that reductions in health inequalities are evidenced with a focus on women's health	25	20	10	16 Aug 2024	16 Oct 2024	Current Risk	
4574	Business Resilience Group BU Dir. Governance Meeting Organisational Risk Quality Governance Committee	A risk of being unable to relocate in the event of an evacuation due to capability and capacity issues within the estate that may potentially result in patient safety issues and impact quality.	David Patterson	Chief Operating Officer	EPRR	Ongoing work to review the current trust evacuation and shelter plan Pre-determined areas being scoped in review of business continuity plans	SA 1.2 Full delivery of the actions within the Quality Improvement Plan leading to improved outcomes and patient experience with particular focus on improvements relating to mental health, learning disabilities and cancer.	16	12	8	05 Aug 2024	09 Oct 2024	Current Risk	

Risks Removed from ORR in Period (all levels) 1

Risk Id	Report Inclusion Summary	Risk Description	Risk Owner	Business Unit	Service	Existing Controls	Which Strategic Objectives are threatened by this risk? Summary	Initial Risk Rating	Rating	Target Rating	Date Removed from ORR	Next review Date	Stage	Open Form
4564	BU Dir. Governance Meeting Operations Oversight Group	Risk of clinical safety for patients out-of-hours due to junior workforce currently in the deteriorating patient service. (DART) Limited governance structure in place and future development of the team requires clinical lead and clinical manager to improve clinical supervision and oversight to the team. No clear escalation process in place for referral to medical team. Junior workforce currently responsible for clinical triage of all Out-of-hours clinical tasks. Team are currently providing unnecessary clinical tasks that could be covered by other existing services. This is limiting teams development and increasing the risk of a delay in response for patients who are critically unwell. This could result in patient care being impacted without clinical lead to guide teams required development.	Jo Halliwell	Chief Operating Officer	Site Resilience	Organisational Change has commenced to improve current structure and purpose of team within the organisation. Clinical proformas being developed to guide patient triage, assessment and escalation in line with National Guidelines. Learning and development plans as per a ratified skills and competency matrix completed for all team members. Clinical workload being offloaded with organisation - education and training to staff being arranged and provided. Clinical supervision for all team members with trust PNA service on a monthly basis arranged.	SA 1.2 Full delivery of the actions within the Quality Improvement Plan leading to improved outcomes and patient experience with particular focus on improvements relating to mental health, learning disabilities and cancer. SA 2.2 Growing and developing our people in order to improve patient outcomes, reduce reliance on temporary staff and deliver the 24-25 workforce plan	20	8	4	05 Aug 2024	06 Dec 2024	Current Risk	

Changes in CRR (Current/Emerging) (select filters below for this table) v2

Business Unit: All 8 selected | Service Line: All 10 selected | Organisational Risk: Organisational | Report Inclusion: All 10 selected | Risk ID: All 18 selected | Risks currently (or previously) rated: 0 to 25

Changes in CRR (Current/Emerging) v2

Owner: All 11 selected

Risk ID	Risk Stage	Open	Risk Title	Owner	Business Unit	Service	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024
4577	Current Risk		Achievement of 2024/25 revenue financial plan	Kris Mackenzie	Finance	Finance				20	20	20
4559	Current Risk		There is a risk that the appropriate support is not available to our medical staff to support good rota management and strategic medical workforce modelling	Amanda Venner	People & OD	Workforce Development			20	20	20	20
4575	Current Risk		Non compliance with FoI response turnaround time could result in ICO imposed penalties.	Kris Mackenzie	Digital	Digital Transformation and Assurance				16	16	16
4541	Current Risk		Risk of governance failure as we transition to new governance arrangements	Gill Findley	Nursing, Midwifery & Quality	Corporate Nursing		16	16	16	16	16
4402	Current Risk		Inability to support legislation and best practice associated with records management	Catherine Bright	Digital	Digital Transformation and Assurance	16	16	16	16	16	16
4405	Current Risk		Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure.	Dianne Ridsdale	Digital	Digital Transformation and Assurance	16	16	16	16	16	16
2432	Current Risk		Risk of Significant, unprecedented service disruption due to industrial action	Amanda Venner	People & OD	Workforce Development	16	16	16	16	16	16
2425	Current Risk		Activity is not deliverved in line with planned trajectories, leading to reduction in income	Kris Mackenzie	Finance	Finance	16	16	16	16	16	16
2424	Current Risk		Risk that efficiency requirements are not met.	Kris Mackenzie	Finance	Finance	16	16	16	16	16	16
2341	Current Risk		There is a risk to ongoing business continuity of service provision due to ageing trust estate	Anthony Pratt	QE Facilities	Estates	12	16	16	16	16	16
3132	Current Risk		Exposure to incidents of violence and aggression in ECC	Laura Farrington	People & OD	Workforce Development	15	15	15	15	15	15
4576	Current Risk		Non compliance with SARs response turnaround time could result in ICO imposed penalties.	Kris Mackenzie	Digital	Digital Transformation and Assurance				15	15	15
4554	Current Risk		Cyber Threats and Vulnerabilities	Kris Mackenzie	Digital	IT			15	15	15	15
3107	Current Risk		Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings	Kate Hewitson	Surgical Services	Obstetrics	15	15	15	15	15	15
2582	Current Risk		Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI.	Debbie Renwick	Planning & Performance	Planning & Performance	12	12	12	12	12	12
4417	Current Risk		Increase in incivility and disrespectful behaviours being reported	Amanda Venner	People & OD	Workforce Development	12	12	12	12	12	12
4525	Current Risk		Risk of Lack of a strategic workforce planning	Sophia Grainger	People & OD	Human Resources	9	12	12	12	12	12
4574	Current Risk		A risk of being unable to relocate in the event of an evacuation due to capability and capacity issues within the estate that may potentially result in patient safety issues	David Patterson	Chief Operating Officer	EPRR				12	12	12

No slicers

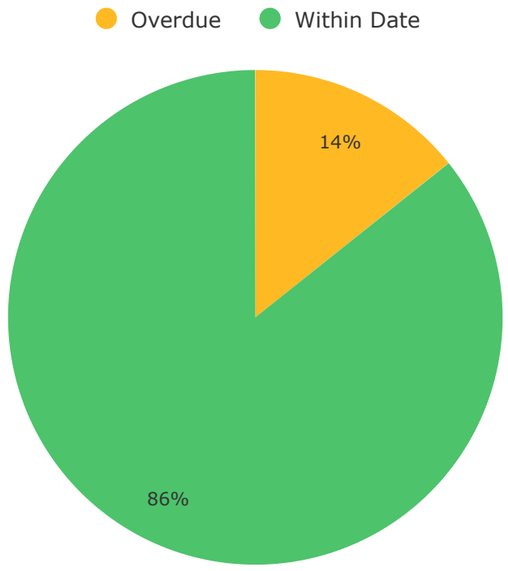
Open Risk Actions (select filters below for this table and graph)

Business Unit: All 12 selected | Service Line: All 46 selected | Organisational Risk: Organisational | Report Inclusion: All 16 selected | Risk ID: All 195 selected | Current Rating: 0 to 25

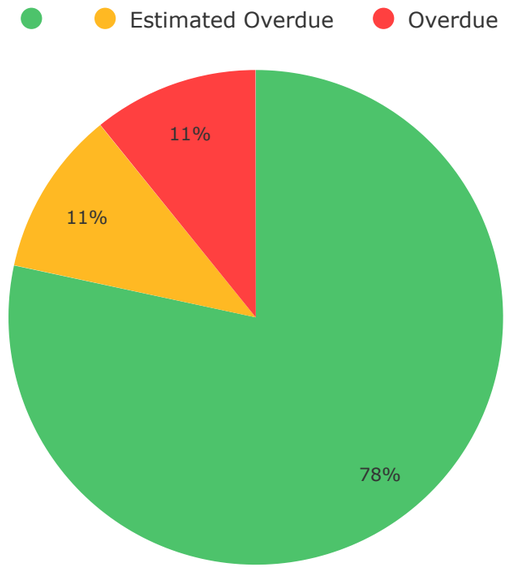
Risk ID	Risk Description	Priority	Total Actions	Action Description	Action Stage	Details	Owner	Owner Dept	Overdue	% Complete	Start Date	Due Date
Risk 00002341	There is a risk to maintaining business continuity of services and recovery plans due to the estate infrastructure, age and backlog maintenance requirements which exceed the Trusts capital allocation.	Normal	1	commission full estates review as part of Bensham retraction programme	In Progress		Anthony Pratt	QE Facilities	Estimated Overdue	20%	31/03/2023	31/07/2024
Risk 00002424	Risk that Efficiency requirements are not achieved.	Normal	2	CRP group	In Progress		Jane Fay	Finance		0%	17/09/2024	31/12/2024
				delivery oversight group and finance focus sessions	In Progress		Kris Mackenzie	Finance		30%	07/11/2023	17/09/2024
Risk 00002425	Activity is not delivered in line with planned trajectories, resulting in the Trust having reduced access to elective recovery funding.	Normal	2	Counting and Coding Review	In Progress		Kris Mackenzie	Finance		60%	31/05/2023	31/12/2024
				Timely and detailed reporting information	In Progress		Jane Fay	Finance		30%	17/03/2023	31/12/2024
Risk 00002432	Risk to quality of care and service disruption due to Industrial Action of various trade unions across various sectors affecting staffing levels and potential impact on patient care, safety and quality.	Normal	1	Support twice weekly co-ordination cell and fortnightly industrial action Trust wide working group.	In Progress		Amanda Venner	People and OD		70%	18/10/2022	01/10/2024
Risk 00003107	▪ There is a risk of delayed treatment due to maternity estate being a separate building resulting in the potential for severe harm to mothers and babies. ▪ Rising acuity of maternity patients and more frequent use of CCU, theatre staff and Paediatric teams creates additional likelihood of the need for these teams to attend the maternity department and delays to be incurred.	Normal	2	looking into estate options	In Progress		Kate Hewitson	surg 2		10%	29/04/2021	31/03/2025
				Work with EPRR lead to develop improved & strong BCP	Not Started		Karen Parker	surg 2		0%	23/08/2024	31/12/2024
Risk 00003132	Staff exposure to incidents of violence and aggression from patients and visitors. Risk of harm to staff, risk to staff well-being through challenging behaviour demonstrated by some patients and/or visitors to ECC resulting in injury, increased absence from work, potential effect on recruitment and retention of staff, staff morale and confidence	Normal	1	Policy review -to include clinical teams, group policy	In Progress		Lee Taylor	People and OD		80%	24/11/2023	30/09/2024
Risk 00004402	Risk of breaching legislative requirements due to lack of long term strategic approach to the management and storage of health records [both digital and paper]. This could lead to regulatory and reputational harm.	Normal	2	develop FBC for integrated EPR	In Progress		Catherine Bright	Digital		25%	29/11/2023	31/03/2025
				Establish the scope and procurement options for an EPR	In Progress		Catherine Bright	Digital		75%	05/06/2023	31/12/2024
Risk 00004405	▪ Risk of data mismanagement, leading to inappropriate access, misuse or inappropriate disclosures. ▪ Due to failure to incorporate best practices in the management of information across the organisation. ▪ Resulting in patient harm and/or failure to comply with UK law, national standards and contractual requirements.	Normal	3	Development of role of IAO/IAA	In Progress		Catherine Bright	Digital		75%	01/02/2024	27/09/2024
				Esablish IAO network with link to SIRO	Parked		Catherine Bright	Digital		45%	02/02/2024	27/09/2024
				Review process by which the asset registers and data flows are managed - investigate options for sim	Parked		Dianne Ridsdale	Digital		50%	02/02/2024	31/01/2025
Risk 00004417	There is a risk that promoting an environment that encourages speaking out and creating a psychologically safe culture may lead to increased reports of poor behaviour. This could have a negative impact on staff and require addiitional time and capacity to appropriately address the concerns. This could result in further health and well being concerns and staff absence.	Normal	3	Create a zero-tolerance campaign	In Progress		Laura Farrington	People and OD		50%	26/10/2023	31/10/2024
				Embed FTSU Champions within the Organisation	In Progress		Tracy Healy	People and OD		10%	31/10/2023	01/10/2024
				Review existing Bullying & Harassment policy	In Progress		Laura Farrington	People and OD		60%	26/10/2023	30/09/2024
Risk 00004525	There is a risk that the lack of a strategic workforce plan that delivers our specific future priorities (women's health, diagnostics, etc) leads to a lack of appropriate skilled staff and negative impacts on service delivery, patient safety and staff engagement and an increase in costs for temporary staffing.	Normal	7	1. Workforce planning	Not Started		Amanda Venner	People and OD		0%	22/05/2024	31/10/2024
				Develop and ensure good rostering practice across the organisation	Not Started		Laura Edgar	People and OD		0%	26/03/2024	30/10/2024
				Develop systems, processes ,comms to support increasing exit interview completion rates across trust	In Progress		Sophia Grainger	People and OD	Overdue	20%	26/03/2024	31/08/2024

Risk ID	Risk Description	Priority	Total Actions	Action Description	Action Stage	Details	Owner	Owner Dept	Overdue	% Complete	Start Date	Due Date
				Education, learning and Workforce development group to continue work on the implications of the LTWF	In Progress		Sarah Neilson	People and OD		50%	26/03/2024	30/10/2024
				Focus on absence management	Not Started		Carol O'Flaherty	People and OD	Overdue	0%	26/03/2024	30/06/2024
				Reduce turnover in line with the leading indicator target of 9.7% with a focus on retention	In Progress		Sophia Grainger	People and OD		5%	22/04/2024	12/03/2025
				robust management of leading indicators for WTE	In Progress		Amanda Venner	People and OD		0%	26/03/2024	31/03/2025
Risk 00004541	There is a risk of the failure of governance arrangements as we transition to a new governance structure. This may result in critical information being lost or missed and Executives being unaware of risks within the organisation.	Normal	1	implementation plan	In Progress		Gill Findley	Nursing, Midwifery & Quality		50%	01/06/2024	30/09/2024
Risk 00004554	▪ There is a risk that the trust is not sufficiently protected against the current and evolving cyber threats. ▪ Vulnerabilities in protection increase the risk of significant service disruption due to unavailability of business critical systems. ▪ Vulnerabilities in protection could also increase the risk of data loss or breaches due to cyber attacks (ransomware etc).	Normal	1	Proposal and costing for a centralised asset inventory encompassing all aspects of asset management	Not Started		Kingsley Okojie	Finance		0%	20/08/2024	29/11/2024
Risk 00004559	There is a risk that the appropriate support is not available to our medical staff to support good rota management and strategic medical workforce modelling. This could result in errors and non compliance with contractual obligations as well as a lack of engagement and morale. As such a negative impact on the Trust's reputation as a training provider and employer.	Normal	4	In-person options for medical staff to get support	In Progress		Carol O'Flaherty	People and OD	Estimated Overdue	0%	26/07/2024	29/07/2024
				Monitor compliance against newly created SOP's	In Progress		Carol O'Flaherty	People and OD		0%	26/07/2024	01/11/2024
				Monitoring progress of team following training	In Progress		Carol O'Flaherty	People and OD	Estimated Overdue	0%	26/07/2024	29/07/2024
				Ongoing monitoring and quality checking of medical staffing team following training	In Progress		Carol O'Flaherty	People and OD	Estimated Overdue	0%	26/07/2024	29/07/2024
Risk 00004574	A risk of being unable to relocate in the event of an evacuation due to capability and capacity issues within the estate that may potentially result in patient safety issues and impact quality.	Normal	2	No notice table top exercising with ward areas	In Progress		David Patterson	COO		50%	17/06/2024	30/09/2024
				Review of trust evacuation and shelter plan	In Progress		David Patterson	COO		25%	14/07/2024	31/10/2024
Risk 00004575	The trust performance against the mandatory 20 day turnaround (as per the Freedom of Information Act) for Freedom of Information requests is below tolerance of 90%. Increasing the likelihood of complaints/reports to the ICO from requestors. The ICO can investigate these complaints resulting in regulatory fines where it feels the organisation is not supporting the requirements of FoIs, resulting in potential financial and reputational damage and complaints	Normal	1	FoI Status Reporting	In Progress		Catherine Bright	Finance		80%	16/07/2024	30/09/2024
Risk 00004576	The trust is performing below tolerance of 95% for responses to Subject Access Requests within the mandated calendar month turnaround time. Lower performance levels could result in increased complaints to the ICO about the trust from requestors. The ICO may choose to investigate these complaints and as a result impose significant financial penalties on the organisation - causing financial and reputational damage and complaints.	Normal	2	Link in with Transformation - possibility of RPIW	In Progress		Catherine Bright	Finance	Overdue	80%	16/07/2024	30/08/2024
				Task and Finish Group to be established to review processes	In Progress		Mark Smith	Finance	Overdue	75%	16/07/2024	30/08/2024
Risk 00004577	Risk that the trust does not achieve its 2024/25 planned deficit totalling £12.6 M and does not deliver its CRP, resulting in significant impact on financial sustainability.	Normal	2	F.A.P framework	In Progress		Kris Mackenzie	Finance		0%	17/09/2024	31/12/2024
				sustainability group	In Progress		Kris Mackenzie	Finance		0%	17/09/2024	31/12/2024

Risk Review Compliance



Risk Action Compliance



Gateshead Health
NHS Foundation Trust

Committee Escalation and Assurance Report

Name of Board Committee	Finance and Performance Committee
Date of Board Committee:	27 August 2024
Chair of Board Committee:	Mr M Robson

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

- Financial Position - the financial position at month four is on plan as required but this has required internal flexibilities and there are underlying risks. More detailed forecasting information to be provided in the finance report for the next meeting to increase understanding of cost control and risk.

- Community Diagnostic Centre (CDC) – An issue has arisen over the timing of the CQC registration for the CDC which the CEO is addressing with the CQC.

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

- 4hour target – this is a concern but the work set out in the deep dive presentation provided assurance that a plan is in place.

- Bed occupancy – this remains one of the highest rates in the region and needs to see a reduction;

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

The Committee received assurance through a number of reports including on Procurement, the Community Services Contract, the Capital Steering Group, Alliance work and Audit actions.

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

- There were no changes to risk scores.

- The risk register to be updated in line with actions on the action log.

Gateshead Health
NHS Foundation Trust

Cross-referrals to Executive Directors
• None

Gateshead Health
NHS Foundation Trust

Committee Escalation and Assurance Report

Name of Board Committee	Quality Governance Committee
Date of Board Committee:	27 August 2024
Chair of Board Committee:	Mrs A Stabler

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

- Shared Care Arrangements – concerns remain in relation to shared care and there is a need to keep pressure on the ICB to provide support.

- Health Inequalities – the Committee had concerns that this work is not yet clearly articulated or moving forward quickly enough. The Committee was of the view that an owner needs to be identified for this work and clear timescales set.

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

The Committee identified the following advisory issues:

- Patient Safety – a new process has been developed to improve learning and sharing of information and this is due to be implemented from September.
- Quality Improvement Plan – the Quality Improvement Plan has been reviewed by the Committee but there are still areas to do more.
- Fuller Inquiry – there is a concern about staffing issues due to long term sickness and difficulties in recruiting locum cover. A verbal update on staffing will be provided to the next meeting.
- Learning Disabilities – the ICB have commissioned an external body to undertake the LeDeR reviews – further liaison with the ICB is needed to clarify how this approach is going to work.
- Freedom To Speak Up – a good report was received but more work is needed on how better to triangulate information in relation to protected characteristics.
- Key person dependencies – the Committee is seeing a trend of escalating issues due to single points of failure due to sickness of key staff, e.g. Adoption medicals.

Gateshead Health
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Assure ***(key assurances received and any highlights of note for the Board)***
Positive assurances were agreed in relation to: • Performance Metrics • Cancer Patient Report – positive outcome • Health and Safety Annual Report – the Committee was pleased with progress made since the last annual report.
Risks (any new risks / proposed changes to risk scores)
• There were no changes to risks on the ORR • In relation to the BAF – Quality Improvement Plan – the Committee agreed to move the overall score down from 15 to 12 by reducing the likelihood score down from 5 to 4. (4 x 3 – 12)
Cross-referrals to Executive Directors
• Quality Improvement Plan – Appraisals – to refer to POD the need to ensure communications are put in place to highlight the link that has been added to appraisal forms to make it easier for appraisals to be uploaded in order to increase compliance rates.

Gateshead Health
NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	People and OD Committee
Date of Committee / Group:	Tuesday 10 September 2024
Chair of Committee / Group:	Mrs Maggie Pavlou

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

- There were no issues requiring escalation to the Board.

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

The Committee identified the following advisory issues:

- Sickness absence – the sickness absence rate remains an issue of concern and the Committee has requested a further update to the next meeting to keep a focus on this issue.
- Staff turnover – the staff turnover rate is worsening and the Committee has requested a deep dive report for assurance.
- Whole Time Equivalent Headcount – this was noted as an issue of focus through the Director's report and a report will be provided to the next meeting.
- Disappointing pulse survey responses – the response to the pulse survey's continues to be low but action is being taken to increase the rate, including the use of local questions in the survey from January.
- Guardian of Safe Working - Exception Reporting – the Committee have raised questions about the possible under reporting of exception reports and are not fully assured that there is clarity on whether this is an issue or not. They are seeking further assurance on this.
- Senior Medical Staffing – concerns continue in relation to the robustness of processes around medical staffing levels and associated costs.

Gateshead Health
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Assure ***(key assurances received and any highlights of note)***
Positive assurances were agreed in relation to: • EDI Update on key milestones, vision, strapline and dashboard • WRES and WDES – considered and approved the action plan following approval by EMT for publication to the website in October 2024 • Occupational Health Referrals – positive movement seen in waiting times for Occupational Health referrals during the pilot. • Senior Medical Staffing Audit – audit actions are now complete.
Risks (any new risks / proposed changes to risk scores)
• There were no changes to risks.
Cross-referrals to Tier 1 Board Committees
• None

Gateshead Health
NHS Foundation Trust

Committee Escalation and Assurance Report

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

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

- ICB Controls Review - the CEO has received a letter from David Chandler of the ICB in relation to action being taken in relation to reviewing financial governance across the system. The letter sets out a proposal to undertake a similar independent review to that being mandated across other systems. The review will be undertaken by AuditOne and is expected to involve 15-20 audit days per organisation. The proposed process will be intense and is intended to be a learning exercise, although it is noted that it may influence System Oversight Framework (SOF) ratings depending upon the findings.

- Finance Team - to highlight capacity issues within the Finance Team – they are currently working under intense pressure and there is a need for this to be managed.

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

- Medical Devices Training – identified as a continuing issue but is being addressed in response to the audit report with plans in place to complete all actions by May 2025.

- No significant weaknesses had been identified in the external audit annual report, but one 'other' recommendation had been raised as part of the value for money work in relation to the challenge in achieving CRP of £22m. The Trust is cognisant of this risk and it is reflected in the organisational risks, with a significant organisational focus in this area. The Finance and Performance Committee seeks assurance over this risks on behalf of the Board.
- Clinical Audit – the Committee has requested a further report on clinical audit to provide more assurance that effective processes are in place.

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

The Committee received assurance from:

- The process for the Board Assurance Framework
- Freedom to Speak Up – processes and control
- Effectiveness reviews for the internal audit, counter fraud and external audit functions, as well as the Audit Committee itself. The reviews were largely positive, with consistency between the views expressed by the firms and the views of the Trust / QEF colleagues. The Group Audit Committee Chair will inform the Council of Governors of the outcome of the external audit effectiveness review at the next Council meeting.
- Routine progress reports from the Executive Risk Management Group, internal auditors, external auditors and counter fraud, including the counter fraud workplan..

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

There were no changes to risks.

Cross-referrals to Tier 1 Board Committees

- ICB Controls Review – to be referred to Finance and Performance to oversee the outputs from the process.

- Data Security and Protection Toolkit (DSPT) – to cross reference to the Digital Committee that the Audit Committee are to be formally sighted on the DSPT.

Gateshead Health
NHS Foundation Trust

Committee Escalation and Assurance Report

Name of Board Committee	Remuneration Committee
Date of Board Committee:	19 August 2024
Chair of Board Committee:	Martin Hedley

Alert ***(matters of significant concern requiring escalation to the Board for further action or to bring to the attention of the full Board)***
• No alerts
Advise ***(areas subject to ongoing monitoring where some assurance has been noted / further assurance sought or emerging developments that the Committee is seeking assurance over)***
• The committee reviewed a paper to extend the roles of the QEF Non-Executive Director and QEF Chair who also sit on the main Board. The committee found assurance that it is in the best interest of the Trust to continue with the incumbent for a period of one year while the new governance structure between QEF and the main Board settles. The situation should be reviewed again in one year.
Assure ***(key assurances received and any highlights of note for the Board)***
• The committee reviewed a paper to affirm the Queen Elizabeth Facilities (QEF) Board's approval for the role of Commercial Director. The new Commercial Director will be a non-voting member of the QEF Board and therefore this paper was presented as a courtesy to the Remuneration Committee.
Risks (any new risks / proposed changes to risk scores)
• There were no risks identified during the meeting.
Cross-referrals to Tier 1 Board Committees / Executive Directors
• None

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 17

Report Title:	**Board Walkabout Feedback**			
Name of Meeting:	Board of Directors			
Date of Meeting:	24 September 2024			
Author:	Dr Gill Findley, Chief Nurse Anna Stabler, Non-Executive Director Adam Crampsie, Non-Executive Director			
Executive Sponsor:	Dr Gill Findley, Chief Nurse			
Report presented by:	Dr Gill Findley, Chief Nurse			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To provide Board Members with an overview of observations and reflections from Board walkabouts, supporting triangulation with other sources of information and assurance			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☒
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	-			

Key issues:
Briefly outline what the top 3-5 key points are from the paper in bullet point format
 	
Consider key implications e.g.
• *Finance*
• *Patient outcomes / experience*
• *Quality and safety*
• *People and organisational development*
• *Governance and legal*
• *Equality, diversity and inclusion*
	• This is the second iteration of this report to formally share the feedback from Board Member walkabouts at public Board.
	• This supports Board Members in their triangulation of information from different sources and will feature on every Board agenda.
	• Over time this will enable key themes and trends to be identified, as well as any material actions from visits.
	• This report covers three visits:
	  • Emergency Department (ED), Same Day Emergency Care (SDEC), Paediatric Emergency Assessment Pod (PEAPOD) and the Urgent Treatment Centre (UTC) – 6 August 2024;
	  • Maternity – 7 August 2024; and
	  • Maternity – 4 September 2024.
	• All visits were concluded as being positive, with			

<table>
<tr><td></td><td colspan="2">evidence of innovative initiatives for patients and colleagues and a focus on keeping the areas visited clean and tidy including where there is high footfall (cleanliness was also a key theme reported in the July feedback report to Board).
• On all visits issues were raised relating to staffing: for maternity this relates to addressing staffing gaps in the Special Care Baby Unit (SCBU) and staff wellbeing issues and for the other areas this relates to staff from other areas being asked to help out who may not have the skills to work in the highly pressurised environment. Some suggestions on how to reduce this risk were discussed with colleagues during the visit.
• Assurance is provided that recruitment is underway in SCBU and that there is a focus on reducing staff moves between areas wherever possible. There is currently a low vacancy rate across the Trust, but it is recognised that sickness absence is high – this is a key focus and a reduction in absence rates should support in mitigating these staffing risks.
• It was noted that there appeared to be scope for closer working and integration between ED, SDEC, PEAPOD and UTC.
• As Board Members will be aware, the maternity estate presents a number of challenges and this was evident during the visit, with the environment being uncomfortably hot. It was noted that the teams are working incredibly hard in a challenging environment and exhibited great team working and pride in patient outcomes.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="2">Board Members are requested to review the feedback from the walkabout process and consider this in the context of other items on the Board’s agenda for consistency and triangulation.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td>We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td>We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☐</td><td>We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td>We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td>We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust strategic objectives that the report relates to:</td><td colspan="2">Full delivery of the actions within the Quality Improvement Plan leading to improved outcomes and patient experience with particular focus on improvements relating to mental health, learning disabilities and cancer.</td></tr>
</table>

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

Board of Directors' Walkabout Feedback

Board Members in attendance:	Gill Findley – Chief Nurse and Deputy Chief Executive Adam Crampsie – Non Executive Director
Area visited:	Emergency Department, SDEC, Paepod, UTC
Date of visit:	6.8.24
Observations about the environment visited if applicable (e.g. clean, tidy, welcoming, health and safety considerations, colleague wellbeing or patient wellbeing considerations)	Overall positive visit. The department was busy, but we were able to talk to a wide range of staff and some patients. There was some litter in the department, but the cleaning staff were visible and were working through the department throughout the visit
What were you impressed by?	Particularly impressed by the work in peapod to introduce neurodiverse children to the environment with fidget toys and patient information. Interesting discussion with the matron covering SDEC in relation to ideas that she has for developing the SDEC service.
Any areas of concern / things to follow up?	Staff expressed their concerns about occasions when staff are sent to help from other areas and they may not have the requisite skills to work in the highest pressure areas. We discussed options for staff working in the less pressurised parts of the department to release suitably trained staff.
Overall summary	Whilst the visit was overall positive, it felt very much like 4 separate teams working independently and there did appear to be scope for closer working between the teams.

Board Members in attendance:	Anna Stabler -Non Executive Director Gill Findley – Chief Nurse and Deputy Chief Executive
Area visited:	Maternity (SCBU and post natal ward)
Date of visit:	7.8.23
Observations about the environment visited if applicable (e.g. clean, tidy, welcoming, health and safety considerations, colleague wellbeing or patient wellbeing considerations)	The maternity unit appeared to be clean and tidy. It was busy with a lot of women on the post natal ward. We spoke with members of staff and asked if they felt safe and supported. They were very happy with the support given by the trust. I asked if they had all the equipment that they needed and they could not think of anything additional that they needed at this time. Staff on SCBU told us about the new ventilators and the planned training, They also advised the new ANP was having

	a positive impact on education and supporting staff in the unit.
What were you impressed by?	We were impressed with the newly updated notice boards with information for families and staff. The maternity support worker on post natal ward was very helpful and knowledgeable about the area.
Any areas of concern / things to follow up?	SCBU were concerned about the gaps in their staffing and were concerned about burnout.
Overall summary	Overall this was a positive visit. We are aware that work is underway to address the gaps in staffing for SCBU and staff are aware that interviews are taking place shortly.

Board Members in attendance:	Amanda Venner – Executive Director of People & OD Adam Crampsie – Non Executive Director
Area visited:	Maternity
Date of visit:	4th September 2024
Observations about the environment visited if applicable (e.g. clean, tidy, welcoming, health and safety considerations, colleague wellbeing or patient wellbeing considerations)	Very positive visit. The unit was very busy when we visited. The environment was clean and tidy. The main areas (corridors and some offices) were extremely hot to the point of uncomfortable – linked to heating pipes under the unit. Many team members told us of how it can be unbearable at times. Colleague wellbeing concerns raised by most people we spoke to linked to burnout. As we know, the building/environment is a challenge and this was raised by everyone we met. There is a lot of suspicion/scepticism that anything will ever change because of previous work in this area that went nowhere. There is a need for the comms linked to future plans to be carefully managed.
What were you impressed by?	Impressed by the care and passion that we experienced from everyone we met. There was an overwhelming sense of pride from the teams about the great work that maternity do for both Gateshead and the region.
Any areas of concern / things to follow up?	- Concerns raised by consultants over the challenges with working with primary care and maternity monitoring and prescribing – e.g. aspirin prescribing meaning mothers are attending the hospital. - Some issues raised over the visibility of the sign-in register on maternity reception as the identity of patients and their visitors can be seen and requires a confidential solution - Staff welfare concerns raised by numerous team members citing burnout and reports of long-term sick linked to work. Discussed with Head of Maternity who is looking at staff wellbeing initiatives. -
Overall summary	Very good visit. It was a pleasure to be on the unit and meet the team and families. The team are working their best in a challenging environment with a fantastic sense of ‘team’ and pride in their outcomes.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 18

Report Title:	**Consolidated Finance Report – Part 1**			
Name of Meeting:	Trust Board			
Date of Meeting:	24th September 2024			
Author:	Mrs Jane Fay, Deputy Director of Finance			
Executive Sponsor:	Mrs Kris Mackenzie, Group Director of Finance & Digital			
Report presented by:	Mrs Kris Mackenzie, Group Director of Finance & Digital			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	The purpose of this paper is to provide assurance against corporate objectives and address financial risks			
Proposed level of assurance – to be completed by paper sponsor:	**Fully assured** ☐ **No gaps in assurance**	**Partially assured** ☒ **Some gaps identified**	**Not assured** ☐ **Significant assurance gaps**	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	**Not applicable**			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity, and inclusion*	The Trust has an approved 2024-25 planned deficit of **£12.650m** before adjustments for donated asset depreciation, and **£12.405m** after. As of August 24, the Trust has reported an actual deficit of **£9.437m** after adjustments for donated asset depreciation. This is a favourable variance of **£0.073m** from its year-to-date target for reasons detailed in the body of this report. The Trusts approved 2024-25 capital plan totals **£16.553m,** including £6.737m PDC supported. As of August 24, the Trust has reported net capital spend totalling **£7.995m**, which is **£1.367m** less than planned. As of August 24 the Trusts is forecasting achievement of its planned deficit and capital plan.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper.*	The recommendation to Board is to receive the report, discuss the potential implications and record partial assurance for the achievement of the 2024-2025			

<table>
<tr><td></td><td colspan="5">planned deficit as a direct consequence of the reported year to date position and financial risks.

To note the summary of performance as of June 2024 (Month 3) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds).</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 robust governance structures to enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☐</td><td>Responsive
☐</td><td>Well-led
☒</td><td>Effective
☐</td><td>Safe
☐</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">Financial Risks</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

1 Introduction

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

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

2 Key Financial Performance Indicators

2.1 Performance against key performance indicators is detailed in Table 1

Finance KPIs	Aug-24 Plan	Aug-24 Actual	Aug-24 Variance	RAG	Apr-24 to Aug-24 Plan	Apr-24 to Aug-24 Actual	Apr-24 to Aug-24 Variance	RAG
I&E (Surplus) / Deficit (adjusted perf.) £m	1.1	1.0	(0.1)	●	9.5	9.4	(0.1)	●
Income £m	(32.3)	(32.4)	(0.1)	●	(160.5)	(160.0)	0.5	◆
Pay Expenditure £m	21.4	21.8	0.4	◆	109.1	110.9	1.8	◆
Non Pay Expenditure £m	11.6	11.2	(0.4)	●	58.9	56.8	(2.1)	●
Non Operating Income £m	(0.1)	(0.2)	(0.1)	●	(0.5)	(0.8)	(0.3)	●
Non Operating Expenditure £m	0.5	0.5	0.0	◆	2.7	2.8	0.1	◆
Agency Expenditure £m	0.5	0.1	(0.4)	●	2.0	1.0	(1.0)	●
CRP Delivery £m	(1.6)	(2.1)	(0.6)	●	(5.6)	(6.1)	(0.6)	●
Capital Expenditure £m	2.3	1.2	(1.1)	●	9.4	8.0	(1.4)	●
Cash position £m	(1.8)	(2.9)	(1.2)	◆	16.0	27.9	11.9	●
Liquidity (days)	(12.7)	(9.7)	3.1	●	(12.7)	(9.7)	3.1	●

Table 1: Finance KPIs

2.2 For the period of August 24 only the Trust has reported a deficit of **£0.994 m** after the adjustment for donated asset depreciation which is a **£0.069m** favourable variance against plan.

2.2.1 Year-to-date the Trust has reported a deficit of **£9.437m** which a favourable variance of **£0.073m** against plan.

2.2.3 The key drivers of this adverse variance are use of escalation beds, including overnight boarders in SDEC, in response to increased admissions, and high numbers of patients not meeting the medical criteria to reside. In addition management of operational pressures and elective recovery performance means higher than planned medical workforce costs across medicine **£2.095m** and surgical business units **£0.753m** driven by staffing approved junior medical rota's, premium rate payments on bank, agency and WLI; with additional pressures on clinical supplies.

2.2.4 Variable income performance (£1.147m), pathology testing income (£0.685m) and interest receivable (£0.336m) mitigate the cost pressures.

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

STATEMENT OF COMPREHENSIVE INCOME

August 24-25	NHSE APRIL - MARCH 25 FINAL PLAN							
	Annual Plan £000's	Plan In Month £000's	Actual In Month £000's	Plan to Date £000's	Actual to Date £000's	Variance (Actual - Plan) £000's	Previous Month Variance £000's	Movement in Month £000's
Operating								
Operating Income from Patient Care activities								
Income From NHS Care Contracts	(344,635)	(29,082)	(29,343)	(144,867)	(143,802)	1,065	1,326	(261)
Income From Local Authority Care Contracts	(90)	(63)	(85)	(129)	(159)	(30)	(8)	(22)
Private Patient Revenue	(684)	(57)	(68)	(286)	(374)	(89)	(78)	(11)
Injury Cost Recovery	(504)	(42)	(41)	(208)	(99)	109	109	0
Other non-NHS clinical revenue	(1,700)	(19)	(13)	(93)	(103)	(10)	(15)	5
Total Operating Income From Patient Care activities	**(347,613)**	**(29,262)**	**(29,550)**	**(145,583)**	**(144,538)**	**1,046**	**1,334**	**(289)**
Other Operating Income								
Education and Training Income	(11,257)	(949)	(685)	(4,751)	(4,444)	307	42	**265**
R&D Income	(564)	(122)	(94)	(494)	(470)	23	(4)	**28**
Other Income	(21,790)	(1,990)	(2,055)	(9,593)	(10,527)	(934)	(868)	**(65)**
Donations & Grants Received	0	(8)	0	(42)	0	42	33	**8**
Total Other Operating Income	**(33,611)**	**(3,069)**	**(2,834)**	**(14,879)**	**(15,441)**	**(562)**	**(798)**	**235**
Total Operating Income	**(381,224)**	**(32,331)**	**(32,384)**	**(160,462)**	**(159,979)**	**483**	**537**	**(53)**
Operating Expenses								
Employee Expenses - Substantive	242,176	20,129	20,738	102,984	104,927	1,944	1,335	**609**
Employee Expenses - Bank	7,502	688	840	3,639	4,405	767	614	**153**
Employee Expenses - Agency	3,993	475	105	1,958	953	(1,004)	(633)	**(371)**
Employee Expenses - Other	1,104	97	112	485	569	85	70	**15**
Total Employee Expenses	**254,775**	**21,389**	**21,795**	**109,064**	**110,855**	**1,791**	**1,385**	**406**
Purchase of Healthcare - NHS bodies	8,172	642	511	3,355	3,250	(105)	26	**(131)**
Purchase of Healthcare - Non NHS bodies	3,300	238	384	1,375	1,722	348	202	**146**
Purchase of Social Care	0	0	0	0	0	0	0	**-**
NED's	192	16	15	78	76	(2)	(2)	**(0)**
Supplies & Services - Clinical	37,782	3,606	3,981	16,804	18,449	1,645	1,271	**374**
Supplies & Services - General	2,943	238	261	1,244	1,292	47	24	**23**
Drugs	24,772	2,136	1,843	10,640	9,799	(840)	(548)	**(293)**
Research & Development expenses	0	0	2	0	6	6	3	**2**
Education & Training expenses	1,488	98	121	700	603	(98)	(121)	**23**
Consultancy costs	276	20	75	138	300	162	107	**55**
Establishment expenses	4,344	351	348	1,818	1,758	(60)	(57)	**(3)**
Premises	19,123	1,531	1,660	8,211	8,028	(183)	(313)	**129**
Transport	1,545	142	104	763	528	(235)	(197)	**(38)**
Clinical Negligence	9,120	760	752	3,798	3,484	(314)	(306)	**(8)**
Operating Leases	1,212	107	22	513	190	(323)	(238)	**(85)**
Other Operating expenses	5,513	524	504	3,576	2,668	(908)	(889)	**(20)**
Reserves	0		0		0	0	0	**-**
Operating Expenses included in EBITDA	**119,782**	**10,409**	**10,585**	**53,013**	**52,153**	**(860)**	**(1,035)**	**581**
Depreciation & Amortisation - Purchased / Constructed	10,287	864	633	4,235	3,170	(1,065)	(834)	**(232)**
Depreciation & Amortisation - Donated / Granted	245	19	24	104	119	15	10	**4**
Depreciation & Amortisation - Finance Leases	3,540	295	263	1,475	1,322	(153)	(121)	**(32)**
Impairment & Revaluation	96	8	(291)	42	(6)	(48)	251	**(299)**
Operating Expenses excluded from EBITDA	**14,168**	**1,187**	**629**	**5,856**	**4,604**	**(1,252)**	**(694)**	**(558)**
Total Operating Expenses	**388,725**	**32,985**	**33,008**	**167,933**	**167,612**	**(321)**	**(344)**	**23**
(Profit)/Loss from Operations	**7,501**	**654**	**624**	**7,471**	**7,633**	**163**	**193**	**(30)**
Non Operating								
Non-Operating Income								
Finance Income	(1,220)	(102)	(155)	(510)	(847)	(336)	(284)	**(53)**
Total Non-Operating Income	**(1,220)**	**(102)**	**(155)**	**(510)**	**(847)**	**(336)**	**(284)**	**(53)**
Non-Operating Expenses								
Finance Costs	824	69	50	343	300	(43)	(24)	**(19)**
Gains / (Losses) on Disposal of Assets	0	0	0	0	0	0	0	**0**
PDC dividend expense	4,420	368	368	1,842	1,842	(0)	(0)	**(0)**
Total Finance Costs (for non-financial activities)	**5,244**	**437**	**418**	**2,185**	**2,142**	**(43)**	**(24)**	**(19)**
Other Non-Operating Expenses								
Misc. Other Non-Operating expenses	0	0	0	0	0	0	0	
Total Non-Operating Expenses	**5,244**	**437**	**418**	**2,185**	**2,142**	**(43)**	**(24)**	**(19)**
(Surplus) / Deficit Before Tax	**11,525**	**989**	**887**	**9,146**	**8,929**	**(217)**	**(115)**	**(102)**
Corporation Tax	1,125	94	131	469	627	159	121	**37**
(Surplus) / Deficit After Tax	**12,650**	**1,083**	**1,018**	**9,615**	**9,556**	**(59)**	**6**	**(65)**
(Surplus) / Deficit After Tax from Continuing Operations	**12,650**	**1,083**	**1,018**	**9,615**	**9,556**	**(59)**	**6**	**(65)**
Remove capital donations / grants I&E impact	(245)	(19)	(24)	(104)	(119)	(15)	(10)	(4)
Adjusted Financial Performance (Surplus) / Deficit	**12,405**	**1,064**	**994**	**9,510**	**9,437**	**(73)**	**(4)**	**(69)**

Table 2: Statement of Comprehensive Income

3 Cost Reduction Programme

3.1 Included in the Trusts 2024-25 financial plans is an annual CRP requirement of £22.800m. As of August £15.445m potential CRP schemes have been identified, which is a shortfall of £7.355m.

Business Unit	2024-25 Annual Target £000	2024-25 YTD Target £000	2024-25 YTD Achieved 000	2024-25 YTD Variance £000	2024-25 Annual Achieved £000	2024-25 Planned Schemes £000	2024-25 Shortfall £000	2024-25 FYE Planned Schemes £000	2024-25 FYE Achieved £000	Recurring Shortfall £000
Chief Executive	138	34	0	34	0	64	74	64	0	138
Chief Operating Officer	138	34	0	34	0	0	138	0	0	138
Clinical Support & Screening Services	4,307	1,050	0	1,050	0	2,559	1,748	304	0	4,307
Community Services	1,475	359	78	282	187	448	1,027	546	187	1,288
Estates & Facilities	233	57	0	57	0	400	(167)	400	0	233
Finance and Digital	800	195	140	55	335	460	340	241	213	587
Medical Director	58	14	0	14	0	26	32	4	0	58
Medicine & Elderly	3,861	941	75	866	180	678	3,183	1,693	180	3,681
Nursing & Midwifery	239	58	61	(2)	146	185	54	125	86	153
People & Organisational Development	251	61	0	61	0	337	(86)	152	0	251
Surgical Services	4,231	1,031	99	933	237	2,633	1,598	2,448	237	3,994
Trust Financing	4,069	992	0	992	0	4,655	(586)	0		4,069
Sub-total Trust Performance	19,800	4,825	452	4,373	1,085	12,445	7,355	5,977	903	18,897
QEF	3,000	750	1,540	(790)	1,540	3,000	0	3,000	3,000	0
Sub-total QEF Performance	3,000	750	1,540	(790)	1,540	3,000	0	3,000	3,000	0
Total Group Performance	**22,800**	**5,575**	**1,992**	**3,583**	**2,625**	**15,445**	**7,355**	**8,977**	**3,903**	**18,897**

Table 3: Cost Reduction Target Performance

4 Capital

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

4.2 Variations to the approved programme at August 2024 include an additional PDC award totalling £0.534m relating to Digital Diagnostics and charitable funded schemes totalling £0.130m, resulting in available capital funding of £17.211m as summarised in table 4 below.

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

* After principal loan repayments

Table 4: Internal CDEL

5 Cash and Liquidity

5.1.1 Group cash as of 31st August totalled £27.909m, a decrease of £2.904m from July (£30.813m). The cash balance is equivalent to an estimated 26.20 days operating costs (July 28.93 days).

5.1.2 The liquidity metric for August was (9.67) days; 3.05 days better than Plan of (12.72) days.

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

Statement of Position - August 2024

	2024/2025 July 2024 Group	2024/2025 August 2024 Group	Movement from Prior Month	2024/2025 July 2024 QEF	2024/2025 July 2024 FT
	£000's	£000's	£000's	£000's	£000's
Assets					
Non-Current Assets					
Investments	80	80	0	80	16,824
Property, Plant and Equipment, Net	166,223	167,123	901	1,131	165,993
Right of Use Assets	7,702	7,439	(263)	3,573	3,866
Trade and Other Receivables, Net	2,151	2,146	(5)	755	1,391
Finance Lease - Intragroup				40,579	0
Trade and Other Receivables - Intragroup Loan	0	0	0		2,988
Total Non Current Assets	176,155	176,788	633	46,118	191,062
Current Assets					
Inventories	5,255	5,007	(248)	2,964	2,043
Trade and Other Receivables - NHS	3,293	3,597	304	383	3,215
Trade and Other Receivables - Non NHS	9,846	7,596	(2,250)	3,332	4,264
Trade and Other Receivables - Intragroup				11,259	247
Trade and Other Receivables - Other	0	0	0	0	0
Prepayments	6,588	6,581	(7)	765	5,817
Cash and Cash Equivalents	30,813	27,909	(2,904)	3,153	24,756
Other Financial Assets - PDC Dividend	0	0	0	0	0
Accrued Income - NHS	3,865	4,466	601	85	4,381
Accrued Income - Other	1,404	1,737	333	858	879
Finance Lease - Intragroup				438	0
Trade and Other Receivables - Intragroup Loan					2,594
Total Current Assets	61,063	56,894	(4,170)	23,236	48,195
Liabilities					
Current Liabilites					
Deferred Income	10,254	10,046	(207)	81	9,965
Provisions	4,543	4,458	(85)	632	3,826
Current Tax Payables	4,993	4,837	(156)	397	4,440
Trade and Other Payables - NHS	1,373	1,036	(337)	802	235
Trade and Other Payables -Intragroup				247	11,259
Trade and Other Payables - Other	11,166	9,298	(1,868)	2,493	6,805
Lease Liabilities	2,706	2,446	(260)	490	1,956
Trade and Other Payables - Capital	2,371	1,870	(502)	0	1,870
Other Financial Liabilities - NHS Accruals	5,518	5,864	346	397	5,467
Other Financial Liabilities - Accruals	21,973	22,154	181	7,759	14,395
Other Financial Liabilities - Borrowings FTFF	999	999	0	0	999
Other Financial Liabilities - PDC Dividend	1,257	1,626	368	0	1,626
Other Financial Liabilities - Intragroup Borrowings	0	0		2,594	0
Finance Lease - Intragroup	0	0		0	438
Total Current Liabilities	67,153	64,634	(2,519)	15,892	63,280
NET CURRENT ASSETS (LIABILITIES)	(6,089)	(7,740)	(1,651)	7,344	(15,085)
Non-Current Liabilities					
Deferred Income	2,011	2,010	(0)	1,719	292
Provisions	2,487	2,487	0	0	2,487
Trade and Other Payables - Other	-	0	0	0	0
Lease Liabilities	5,397	5,397	0	3,138	2,259
Other Financial Liabilities - Accruals	0	0	0	0	0
Other Financial Liabilities - Intragroup Borrowings	0	0	0	2,988	0
Other Financial Liabilities - Borrowings FTFF	11,013	11,013	0	0	11,013
Finance Lease - Intragroup				0	40,579
Total Non-Current Liabilities	20,908	20,908	(0)	7,845	56,631
TOTAL ASSETS EMPLOYED	**149,158**	**148,140**	(1,018)	**45,617**	**119,347**
Tax Payers' and Others' Equity					
PDC	170,535	170,535	0	0	170,535
Taxpayers Equity	0	0	0	0	0
Share Capital	0	0	0	16,824	0
Retained Earnings (Accumulated Losses)	(34,656)	(35,674)	(1,018)	28,793	(64,467)
Other Reserves	0	0	0	0	0
Revaluation Reserve	13,180	13,180	0	0	13,180
Misc Reserve	99	99	0	0	99
TOTAL TAXPAYERS EQUITY	149,158	148,140	(1,018)	45,617	119,347
TOTAL ASSETS EMPLOYED	**149,158**	**148,140**	(1,018)	**45,617**	**119,347**

Table 5: Statement of Financial Position

6 Conclusion

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

6.2 The Trust has reported an adjusted deficit of **£9.437m** for the period up to 31st August 2024; which is a favourable variance of **£0.073m** from its year-to-date target.

6.3 The cost reduction programme planned to achieve £5.575m, including £2.835m vacancy factor, at 31st August 24; and whilst not fully transacted in the Trust ledger has delivered £6.143m, reporting an overachievement of £0.568m.

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

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

Kris Mackenzie, Group Director of Finance & Digital
September 2024

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 19

Report Title:	Strategic Objectives & Constitutional Standards			
Name of Meeting:	Board of Directors			
Date of Meeting:	24th September 2024			
Author:	Deborah Renwick, Associate Director of Planning & Performance			
Executive Sponsor:	Kris Mackenzie, Group Director of Finance and Digital			
Report presented by:	Kris Mackenzie, Group Director of Finance and Digital			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☒
	This report presents progress, risk and assurance in relation to our Strategic Objectives for M5 2024/25.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*				
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal*	**We will continuously improve the quality and safety of our services for our patients**. **Maternity** compliance with Ockenden recommendations has improved to 89% as has compliance with Maternity Incentive Scheme (MIS) to 83%. Delivery of the **Quality Improvement Plan** has improved in month to 88% of actions on back on track. **PSIRP**: The volume of falls resulting in harm have increased slightly, however we have seen a reduction in the rate of falls rates per bed day for the second month in a row and continue to be reviewed by the Trust wide Falls Group. A comprehensive plan to understand and prevent falls across the Trust is in place. **QA**: The Trust's 2024/25 C. difficile threshold is 37; at the end of M5 there have been 15 cases reported against this threshold. Rates per 100k bed days have increased to 27.8 and community prevalence remains high. The 10 point			

• *Equality, diversity and inclusion*	reduction plan is in place with a 'back to basics approach' to improving our position. **QA**: Performance against learning disability and autism training improved in month from 41.5% to 46.9%, although challenges remain in the Trust and across the ICB in finding suitable training locations, we await the publication of the national code of practice for the Oliver McGowan training. Mental Health Act Policy training Medicines management indicators are still under review to support high impact SMART and measurable KPI's. The Trust is on track with an **agreed strategic approach to EPR.** Project teams are established to support Outline Business Case OBS review and update. Work is ongoing to support procurement planning against in-scope best of breed systems and alignment to EPR plans. **Development & implementation of an Estates strategy** that provides a 3 year capital plan to address key critical infrastructure and estate functional risks across the organisation by March 2025. • A clinically prioritised capital plan is now in place. • Baseline risk assessments from Inphase has been undertaken; a full review of risks and incidents is planned to support an accurate reflection of risks and scoring. • At the end of M5, the Trust is now in line with the target reduction of safety incidents reported linked to estate issues. The supporting indicator looking at the severity of risk scores linked to estates has however increased due to a score of 12 for the laparoscopic theatre. • Multi-disciplinary PLACE audits have haven place in four areas across the Trust. Scoring remains outstanding as the Team continue to implement PLACE Lite. • A reduction in the value of backlog maintenance score will be heavily influenced by the work to rationalise aging estate. **We will be a great organisation with a highly engaged workforce.** • Vacancy rates have slightly improved in month from 3.2% to 3.1%. Vacancy pressures continue in key service delivery areas and workforce realignment is underway whereby over recruited areas are supporting workforce critical gaps. • Staff engagement score remains at 6.6; below target levels of 7.3. • Turnover rates have remained the same at 11.7% and are higher than our target of <9.7%. • Sickness absence rates continue to be above target at 5.7%. • Temporary staffing spend has slightly increased again and is now 0.5% of total pay bill.

	We will enhance our productivity and efficiency to make the best use of our resources. **Improve the quality-of-care delivery and accessibility for patients by meeting locally agreed stretch targets.** Average NEL length of stay has increased to 7.10 days in August, the current rate and trend is influenced by changes in SDEC counting & recording in May – which accounts for circa 2 days in the figures since the change. Other factors influencing this indicator include: the discharge profile and the patients who remain in hospital who no meet the criteria to reside: the daily average was 46 in Aug. The ED 4-hr standard improved to 72% in August, below national target level of 78% and planned improvement levels – both admitted and non-admitted are also below their differential standards. A weekly clinically led Task and Finish delivery meeting is now in place to: (i) Review drivers of variation in performance, (ii) Establish quick PDSA improvement cycles (iii) identify supporting planned improvement trajectories (iv) Deploy more sophisticated predictor tools. Creating flow and discharging patients earlier in the day is impacting on our patients spending longer time in ED and waiting longer for bed. The group are also reviewing alternative options to SDEC overnight surge capacity, in support of maximising the full SDEC footprint to achieve the 4-hr target. A further workshop is planned in for the end of Sept, to firm up the areas of targeted improvement and review additional findings from the deeper dive. The stretch target of achieving zero > 52 week RTT waiters was not achieved by the end of Q1 and at the end of August the number of long waits have increased to 108. Risks remain around specific recruitment and transformation plans to shore up capacity deficits and improve upon internal administrative process. Shared pathways remain problematic and are supported by GNHCA discussions. Recovery trajectories in gynaecology and surgery are improving, and mutual aid is in place to support urology. Current improvement projections include: both urology & gynae achieving <52 week waiters in Q3, and T&O achieving 52 weeks in Q4. Plans to improve counting & coding and productivity in outpatients are underway. Clinical engagement in changing pathways to reduce follow-up outpatients is highlighted as a risk factor to this improvement work.

	Evidence of reduction in cost base & an increase in patient care related income by the end of March 2025 to a balanced financial plan for 2025/26. At the end of month 5 we are reporting a deficit of £9.4m, representing a £73k positive variance from planned levels of £9.5m. We continue to plan to achieve the forecast outturn deficit position of £12.6m. Risks remain around achieving the year end plan due to overspending against delegated budgets largely in medical and nursing workforce and non-delivery against recurrent CRP targets. Cost Reduction Plan (CRP) is ahead of plan with a positive variance of £570k with £6.1m transacted in M5 against a plan of £5.5m. Risks remain in the proportion of non-recurrent savings made to date & the CRP plan heavily weighted towards Q3 and Q4. Focus remains in recurrent savings to support financial sustainability. The Trust is planning to deliver a forecast outturn deficit position of £12.6m via the tighter grip and control in Sustainability Task and Finish Group and is on plan to achieve £5m cash forecast at the end of March. **We will be an effective partner and be ambitions in our commitment to improving health outcomes.** Our fragile services review will feed into the annual planning cycle and inform provider collaborative sustainability. Improvements in health inequalities will be driven by the Health Inequalities Strategy and plan. Digital teams will continue to support efforts to reduce digital exclusion by repurposing hardware in 2024/25 and have achieved the target to date. Gynaecology transformation plans are supporting waiting times reducing in line with planned trajectory and are currently at 8 weeks, mainly due to IVF activity. Maintaining gynaecology waiting times will be affected by the recent reduction in consultant capacity. Improvement work supporting paediatric autism assessments and diagnosis have not yet delivered waiting time reductions; waits continue at higher levels, currently at 82 weeks. **We will develop & expand our services within and beyond Gateshead.** Plans to increase QEF generated income by 0.5% are ahead of schedule with Month 5 performance improving to 1.8%.
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The recommendations to the Committee are to receive this report, discuss the potential implications and note the improvement or challenge in key areas.

<table>
<tr><td rowspan="6">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="6">All Strategic Objectives.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td></td><td colspan="6">Key areas to establish reporting:
• PLACE audit scores
• SMART Medication metrics

No movement in key quality measures:
• Quality Improvement Plan
• Okenden

Areas requiring attention:
Quality & Safety:
• C.difficile 15 cases at M5 against an annual allowance of 37.
• Mental health act compliance training

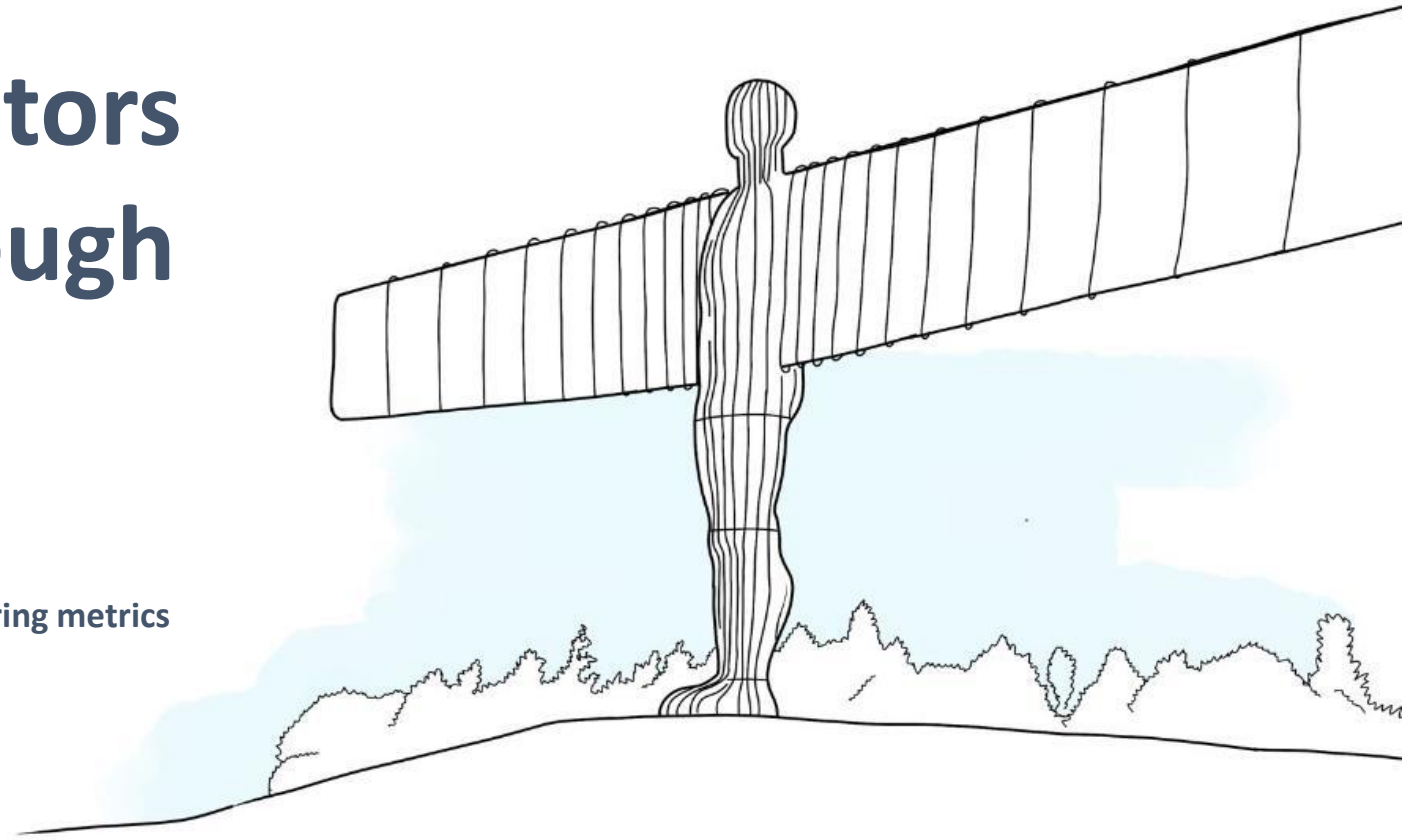
Workforce: Staff engagement, vacancy rates, sickness absence

Productivity & Efficiency:
Discharge and flow issues impacting on Urgent and Emergency Care metrics and 4hr A&E target & Outpatients with procedures.
Risk in achieving financial plan: Reducing expenditure and achieving CRP.
Waiting times reductions in gynaecology and ASD pathway improvements</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>

NHS
Gateshead Health
NHS Foundation Trust

Strategic Objectives 2024/25

Leading Indicators and Breakthrough Objectives



Including Constitutional standards monitoring metrics

Reporting Period: August 2024

Strategic Objectives 2024/25	What are we aiming for

NHS Gateshead Health NHS Foundation Trust

Our patients Our people Our partners

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

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

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

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

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

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

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

Our Strategic aims:

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

Our strategic intent:

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

Strategic Objectives 2024/25 — Executive Summary

NHS Gateshead Health NHS Foundation Trust

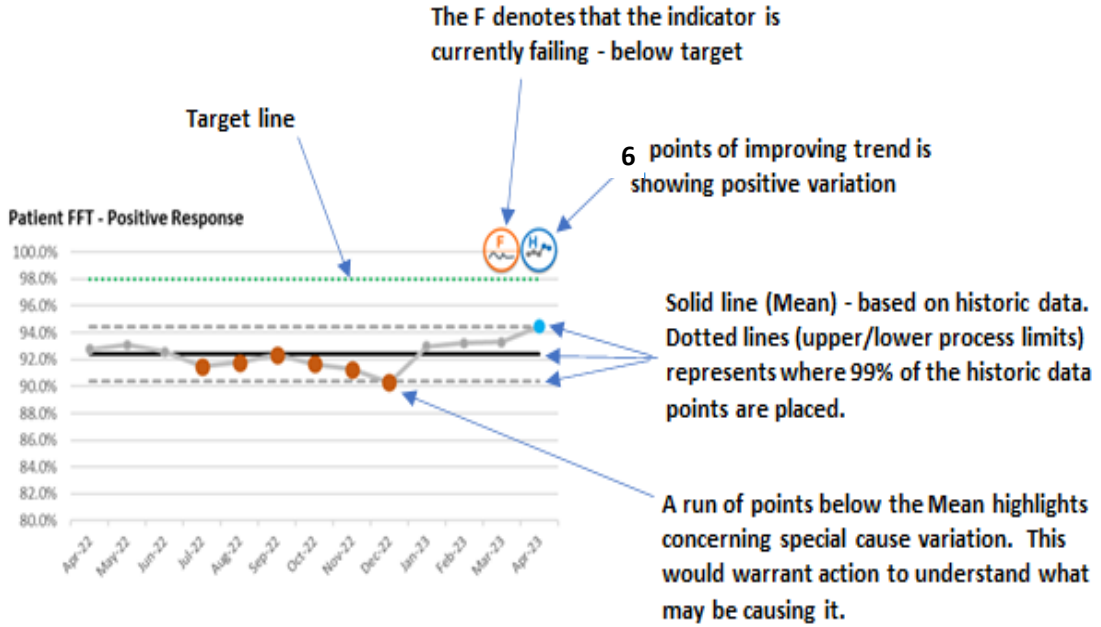
Improved	No Change	Needs further attention
We will continuously improve the quality and safety of our services for our patients		
Compliance with Level 1 training plans for learning Disability & Autism training improved to 46.93%	Scoring in domains in areas of PLACE inspection not available	Mental Health Act Training requires a training package for all registered staff reduced to 77.6%
Strategic approach to development of EPR is on track		Increase in of severity of risk scores linked to estates to 279
Maternity Incentive Schemes Compliance improved to 83%		C.Difficile rate has decreased to 27.8.
Reduction in patient safety incidents linked to estate issues: reduced to 3		
Harm rate from falls improved to 3.5		
Quality Improvement Plans back to 88% compliance		
Okenden recommendations compliance improved to 89%		
We will be a great organisation with a highly engaged workforce		
	Improve the staff engagement score to 7.3 (currently at 6.63)	Achievement of the internal turnover standard of 9.7% (currently at 11.7%)
	Reduction in temporary staffing spend evidenced early month reduction to 0.4% of pay bill.	Internal sickness absence standard at 5.7%
		Maintain the vacancy rate at <=2.5%, currently at 3.1%
We will enhance our productivity and efficiency to make the best use of our resources		
	Review and revise 2022/25 Green Plans: Align governance to group structure - Meetings underway	Average non-elective length of Stay < 4 Days
		Achievement of Zero 52 weeks at the end of Q1 (forecast > 100). Revised delivery in Q2.
		Reduce the number of patients with no Criteria to Reside (July - 48)
		Achievement of 4-hr A&E target (Below planned trajectory and target)
		Achievement of the trajectory to achieve 60% RTA to Bed within 1 hour
		Risk in achievement of financial plans including CRP at end of M4
		Reduce >12 hour total time in Emergency Department
		Increase in New & Follow up value added activity to 33% (reduced to 27.3% in August)
We will be an effective partner and be ambitious in our commitment to improving health outcomes		
Reduction in the wait for gynaecology outpatients to no more than 26 weeks by March 2025.	Evidence a reduction in the number of 'fragile' and 'vulnerable' services as a direct outcome of Alliance working	Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 weeks by March 2025
	Evidence in an improvement in health inequalities in the key focus areas linked to the determinants of Health for Gateshead	Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients by March 2025
	Increase in the number of digital devices repurposed to the local community	
We will develop and expand our services within and beyond Gateshead		
Increase in QEF externally generated turnover to 1.8%		

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

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

What are Statistical Process Control (SPC) charts

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



SPC Rules

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

Icon Colours Explained

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

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

Strategic Objectives 2024/25	Leading Indicator and Breakthrough Objectives Assurance Heatmap

NHS Gateshead Health NHS Foundation Trust

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

Strategic Objectives 2024/25

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

Gateshead Health NHS Foundation Trust

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

Full delivery of the actions within the Quality Improvement Plan leading to improved outcomes and patient experience with particular focus on improvements relating to mental health, learning disabilities and cancer.

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

Development & implementation of an Estates strategy that provides a 3 year capital plan to address the key critical infrastructure and estates functional risks across the organisation by March 2025

Metric	Target	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Ass/Var	Trend
LEADING INDICATORS																	
Ockenden Recommendations % compliance with Total Recommendations	100%	55.5%	55.5%	55.5%	88.8%	88.8%	88.8%	77.7%	77.7%	77.7%	78.0%	78.0%	74.0%	74.0%	89.0%		
Maternity Incentive Schemes % compliance with Total Recommendations	100%										62.9%	70.8%	76.4%	77.5%	83.0%		
Reduction in patient safety incidents linked to estate issues	<=4			2	2	1	9	1	4	4	3	4	6	4	3		
Compliance with the quality improvement plan indicated by the % of actions on track	100%		68%	76%	76%	84%	80%	84%	88%	88%	88%	88%	76%	84%	88%		
BREAKTHROUGH OBJECTIVES																	
Scoring in domains in areas of PLACE inspection composite score > 95%	> 95%																
Reduction in severity of risk score linked to estates	TBA										252	252	252	267	279		
Harm falls rate per 1000 bed days	12	2.21	2.13	1.27	2.54	2.37	4.48	4.16	3.96	2.58	3.60	3.17	4.21	3.57	3.50		
Cdiff Healthcare associated rate per 100,000 occupied bed days	<=3.20	14.6	14.7	36.2	41.2	7.0	33.5	20.1	36.5	21.0	21.1	20.9	22.1	14.2	27.8		
90% of staff to complete Mental Health Act training.	90%							92.2%	92.2%	89.7%	89.7%	87.9%	87.9%	78.9%	77.6%		
85% of staff to complete GHFT Level 1 learning disability and autism training from April 2024. Develop plans for Level 1 Face to face interactive training as part of mandatory training offer.	85%												33.72%	41.53%	46.93%		

Strategic Objectives 2024/25

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

Gateshead Healt
NHS Foundation Tru

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

Development & implementation of an Estates strategy that provides a 3 year capital plan to address the key critical infrastructure and estates functional risks across the organisation by March 2025

Measures requiring focus this month

	Measure	Summary
1	Ockenden recommendations % compliance with total recommendations	The Trust is reporting compliance at 89%. Areas non-compliant are: Managing complex pregnancy, Informed consent and workforce. LMNS audits implemented from Q1. Capacity challenges in QUIT smoking in pregnancy team – additional support provided from specialist midwife & public health lead. Present workforce plan to reach new compliance with 2024 BR+ report – GHLG, F&P, Trust board. MNVP support for website review. Q1 LMNS review has been completed – review of feedback is underway. Q1 documentation (risk assessment) audit results reported, still to complete PCP audit of 5%.
	Maternity incentive schemes % compliance with total recommendations	The Trust is reporting compliance at 83%. Areas non-compliant are: Safety Action 5 (Midwifery Workforce) Safety Action 6 (SBL Care Bundle) Safety Action 7 (MVP) and Safety action 9 (Trust Board Oversight). Ongoing work with board and finance teams to achieve compliance with BR+, Q1 LMNS PQSOG assurance meeting & Saving Babies Lives review meeting held, QI projects approved by LMNS – smoking & fetal well-being, Ongoing work with board and finance teams to achieve compliance with BR+ - Trust board 24/9/24, Culture feedback sessions completed – final QUAD sessions planned & development of improvement plan – draft report for September safety champion meeting. Workforce (Birthrate+ establishment compliance ongoing). Update of maternity governance structure in line with Trust, ongoing work to correct midwifery workforce establishments.
2	Compliance with the quality improvement plan indicated by the % of actions on track.	Latest reported data relates to August 2024 with 88% of the Improvement Plan actions on track to deliver. Updates received in August continue to demonstrate good progress is being made overall. Bi-monthly updates against the QIP are taken to the Trusts Senior Leadership Group to monitor progress and escalate any issues when necessary. In relation to the Complaints Process, an action plan is now in place and a new process and policy update are in development. Engagement sessions have taken place with members of the Trusts senior leadership team and this piece of work is on track and implemented in the coming months. Compliance against daily resus trolley checks continue to be a cause for concern. Work is underway to address data quality issues with safe COSHH Storage. Anomalies noted are likely to be due to the audit tool. A new process from collecting and reporting is being rolled out from September/October which should see a marked improvement in compliance. This is currently at risk of non-achievement.
	85% of staff to complete GHFT Level 1 learning disability and autism training from April 2024. Develop plans for Level 1 Face to face interactive training as part of mandatory training offer.	Training went live in June 2024, performance stands at 46.93%. Regional challenges remain in (I) Completion rates reporting , and (ii) finding suitable face to face training locations. The Trust awaits a regional fix for the reporting issue. Face to face training likely to restart in the coming months. Future discussions planned regarding the Oliver McGowan training, and to look at what the trust would like to do in terms of the different level requirements for this. Awaiting national steer and publication of the Code of Practice to guide this. ICB aware of current position, and is in line with alliance partners.
	Improve Mental Health Act Policy Training Compliance to 95% for all *registered* staff via training and audit.	There has been a drop in performance to 77.6% this is due to new staff in post requiring training. Mental Health Act training for qualified staff has been limited due to staff not being able to be released to attend training. However, additional training sessions have been offered in Sept/Oct to support compliance. General nursing staff training mapping has been completed, due to the volumes (426) this will be a challenge for the limited numbers of training staff but additional sessions for 2025 have been put in place. Competencies can only be added annually so the training for General nursing staff cannot yet be added to ESR.
	Improve our IPC C.Difficile infection rates per 100 000 occupied bed days.	The Trust has now received the C-diff threshold for 24/25 from NHSE, we have received a 38% increase from 24 cases to 37 (April to August - 15). Rates per 100 000 bed days have increased to 27.8 (National rate in Q1 was 28). A 10 point c-diff reduction plan is in place, with a drive to 'back to basics' for clinical areas particularly around hand hygiene, AMP and learning. A review into antimicrobial prescribing is ongoing. Community prevalence continues to be higher than normal levels, reflecting national and local elevated levels of CDiff.
	Harm related falls will reduce by 5% by March 2025.	The number of falls reported in August has continued to decrease which is positive indication that the falls prevention work is potentially having an impact on our rate of inpatient falls. The positive reporting culture for falls continues and staff continue to report falls robustly, investigate, and manage them in a timely manner. Falls with harm have increased very slightly, however harm falls per 1000 bed days have reduced slightly indicating increased patient activity. Increased patient frailty on non-COTE wards is believed to be impacting on some recent inpatient falls. This is thought to be due to significant hospital pressures and known issues with patient flow. The Trust falls steering group has continued to meet and progress planned actions. New pilot studies offering decaffeinated drinks to the COTE patients, and 'cuffed' pyjama bottoms are being planned and will be monitored for any reduction in falls. The trust has been unable to participate in the National Audit of Inpatient Falls pilot due to resource concerns, but it is hoped discussions will be held about participation prior to it's launch in January 2025.
3	Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.	Work is on track - A project team has been established to support the delivery of the objective; the core focus of this group will be to review and refresh the draft 2023 Outline Business Case to further localise the case and reflect on the current position/drivers/risks to the Trust. Capacity issues are impacting the start of the development of the Output Based Specification which would be required for the procurement activity. Current drivers are due to the contractual limitations of the existing provision decision regarding strategic route will be required in Dec 2024 to allow sufficient time for procurement of a solution, including due diligence. It has therefore been agreed that the case will be considered at the November Trust board. At this stage, the re-development of the business case has been split into workstreams with leads identified for each. There are also discussions at an alliance level, to explore potential options for collaboration and to establish the core 'digital standards'. Current digital contracts directly associated with the delivery scope of the core EPR are currently being reviewed; the constraints against these are being used to inform the schedule of work required for the procurement options that have been identified. Required activity for the identified options commences in Q4 24/25 and completes before Dec 2027. Constraints associated with the existing contracts inform the timelines for the EPR programme and subsequent plan.
4	Reduction in risks and severity of scores linked to estate issues	22 Risks with combined critical infrastructure risk score of 279. Current High scoring risks include: Theatre ventilation UPS (20), Maternity (20) Bensham Retraction (16) Audiology ventilation (16) Audiology clinical diagnosis (16) Endoscopy washers (16) Records management (16) Laparoscopic theatre (12). A full review of these risks is planned.
	Reduction in patient safety incidents linked to estate issues	There are 3 estates related incidents reported in August, ,there are no consistent themes with the current incidents.
	Scoring in domains in areas of PLACE inspection composite score > 95%	PLACE lite has still not been implemented to produce percentage scores. In August x-ray, surgery PODS, colposcopy and ward 28 have been reviewed with minor dust concerns which were addressed at time of visit. Work ongoing with the PLACE app, over the next 12 months a more robust plan for PLACE visits to be created.
	Reduction in value of backlog maintenance score as reported via the ERIC return	There is now a clinically prioritised plan to review and deliver the backlog maintenance programme. The challenges are limitations on capital available to support the plan & CDEL allocation. Rationalisation of our existing aging estate is required to meet the 25% reduction target (equating to £3.5m reduction). The capital programme has been confirmed and an update will be available when capital projects are completed.

Strategic Objectives 2024/25

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

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

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

Metric	Target	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Ass/Var	Trend
LEADING INDICATORS																	
Maintain the vacancy rate at <=2.5%	<=2.5%	3.7%	3.1%	2.3%	1.8%	2.5%	2.5%	2.3%	2.2%	2.4%	1.7%	1.7%	1.6%	3.2%	3.1%		
Improve the staff engagement score to 7.3	>=7.3	5.92			7.00			6.60			6.60			6.63			
BREAKTHROUGH OBJECTIVES																	
Achievement of the internal turnover standard of 9.7%	<=9.7%	14.2%	13.1%	13.0%	13.1%	13.2%	13.2%	12.8%	12.9%	12.5%	12.0%	11.8%	12.1%	11.7%	11.7%		
Achievement of the internal sickness absence standard of 4.9%	4.90%	5.3%	5.7%	6.0%	6.2%	5.9%	6.0%	6.3%	5.6%	5.2%	5.5%	5.7%	5.8%	5.8%	5.7%		
Reduction in temporary staffing spend of pay bill evidenced month on month	<=2.3%										1.4%	1.0%	0.9%	0.4%	0.5%		

Measures requiring focus this month

Measure	Summary
Maintain the vacancy rate at <=2.5%	Current vacancy rate of 3.1% is higher than target but a 0.1% decrease from July. The overall percentage masks critical vacancies that are causing operational pressure and additional pay spend. A review of the VCF process is in progress to scrutinise all vacancies.
Improve the staff engagement score to 7.3	A refreshed approach to increasing completion rates will take place for the July quarterly people pulse, with an aim to increase completion which will better allow the Trust to measure engagement on a quarterly basis. A number of actions in place to address staff engagement such as L&D, FTSU, improved comms, revised appraisal process.
Achievement of the internal turnover standard of 9.7%	Turnover rate has remained at 11.7%. Staff are leaving the NHS across all providers given the significant work pressures and burnout. High staff turnover adds pressure in maintaining safe, high quality services. To provide a countermeasure The People Promise Exemplar programme is now underway, good feedback has been forthcoming from the ICB.
Achievement of the internal sickness absence standard of 4.9%	Sickness absence performance is 5.7% in August across the Group, which is 0.8% above the target. The trust continues a monthly case management approach of all long-term sickness absences. Ongoing training, development and support against our new absence management policy.
Reduction in temporary staffing spend evidenced month on month reduction and no higher than 2.3 % of pay bill.	Temporary staffing spend increased slightly to 0.5% but remains under target. Off framework agency usage has dramatically decreased but additional pay spend remains high. Further controls have been instigated to support Bank and Agency spend reduction, supported by a Trust wide monitoring group.

Strategic Objectives 2024/25

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

NHS Gateshead Health NHS Foundation Trust

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

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

Metric	Target	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Ass/Var	Trend
LEADING INDICATORS																	
Average Length of Stay Non-Elective (Emergency) <4 days	<=4	4.80	4.80	5.00	5.70	5.00	5.10	5.10	5.00	4.30	5.00	6.96	6.30	6.60	7.10		
Achievement of the 4 hours trajectory	≥78% (Local ≥80%)	71.8%	71.3%	71.4%	70.6%	70.5%	66.1%	68.6%	69.0%	72.2%	71.8%	72.0%	76.3%	71.0%	72.2%		
Achievement of the 52 week RTT standard	Apr 24 - 58 May 24 - 42 Jun 24 - 18 Jul 24 - 0	236	237	293	273	263	143	113	112	76	72	109	88	81	108		
Achievement of 2024/25 financial Plan - Variance (£k)	Figure in brackets favourable										2,312	2,609	0.009	(0.004)	(0.073)		
Finance - Forecast Out-turn Deficit (Plan)	12,650										12,650	12,650	12,650	12,650	12,650		
BREAKTHROUGH OBJECTIVES																	
Achievement of the trajectory to reduce >12 hour total time in Emergency Department	0	380	404	614	562	453	750	692	458	362	358	413	225	531	391		
	2.0%	3.9%	4.4%	6.5%	5.7%	4.9%	7.4%	7.0%	4.9%	3.6%	3.8%	4.1%	2.3%	5.4%	4.4%		
Reduce the number of patients with no Criteria to Reside	<10	52	46	40	40	42	41	39	44	36	35	35	55	48	46		
Achievement of the trajectory to achieve RTA to Bed within 1 hour	60.0%	11.6%	12.2%	9.5%	9.1%	12.3%	10.0%	10.6%	8.8%	13.6%	9.7%	5.5%	6.1%	5.2%	5.6%		
Increase % of Outpatient % with procedures	>=33%	27.9%	28.3%	27.6%	29.0%	28.9%	28.5%	27.9%	28.4%	27.9%	31.3%	31.8%	31.5%	30.4%	26.8%		
2024-25 CRP Delivery Variance	Figure in brackets favourable										0	0	98	0	(570)		
No less than £5m cash as per forecast at March 2025	>=£5m										£5m	£5m	£5m	£5m	£5m		

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

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

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

Measures requiring focus this month

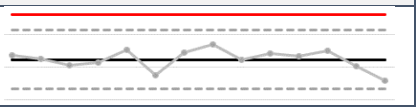
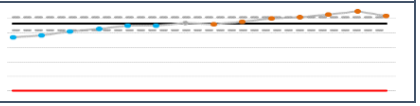
Measure		Summary
1	**Average Length of Stay Non-Elective (Emergency) <4 days**	Length of stay has increased to over 7 days; barriers remain in prompt discharge processes, early discharge planning and capturing accurate EDD and out of hospital support. There are three focused programmes for continuous improvement, two of which will support ED performance. The UEC improvement programme and the Discharge improvement programme. Details of future risks and planned developments are contained therein.
	Achievement of the 4 hours trajectory	Performance against the 4-hr target is similar to the same period last year but remains below planned performance levels. Risks to this relate primarily to staffing, flow, streaming and redirection. August has been a challenging month for performance and a paper is being prepared to identify a trajectory for improvement. Availability of RAT in evenings, staffing overnight matched to demand and admission profile, availability of hot clinics for referral, inappropriate conveyances, appropriate allocation of work between SDEC, UTC and ED, appropriate use of Emergency Health Care Plans to avoid admission. Challenges with Flow including use of SDEC at times of surge. The team are working with the UEC guidance and Metrics as part of an improvement project to deliver the 78% target.
	Achievement of the trajectory to reduce >12 hour total time in Emergency Department	Current performance at 4.4% has reduced but remains above <2% target. Availability of beds on EAU and back of house is key to achieving this objective. Focus on ensuring flow earlier in they day, use of the discharge lounge, estimated date of discharge and actual date of discharge enable this to be reviewed. Patient discharge early in the day, achieving this would enable us to ensure that patients did not remain within ED. Also reviewing non admitted waits to understand times of day and improvements required. The discharge improvement project is focusing on measurably improving discharges. Changes to the Dashboards implemented at the end of August should improve visibility of this issue in order to address this.
	Achievement of the trajectory to achieve 60% RTA to Bed within 1 hour	Performance of 5.6%. This is driven by late bed availability in the day, specifically EAU. Appropriate streaming to SDEC. Discharge profile is later in day, address planning for tomorrow's discharges today. Discharge work and review of mechanism to alert Patient Flow team to timeframe.
	Reduce the number of patients with no Criteria to Reside	Average number of patients per day who do not meet the criteria to reside has decreased to 46. Availability of services in the Community to support patients who no longer need acute hospital care and ensuring that we are maximising our use of our own services is a key risk. Challenge in improving the process and outcomes for patients who do not need a hospital bed but do need support in the Community. Daily review with Social Care, review by Discharge Co-ordinators, service improvement plan developed.
	Achievement of the 52 week RTT standard by end Q1 and delivery of the trajectory for 40 weeks	Achievement of our internal stretch target to eradicate 52 week waiters by the end of Q1 was not achieved although the number of patients has decreased; delivery challenges remain in T&O, Gynaecology and Urology due to capacity and demand imbalances and challenged shared pathways in key service areas. Planned recruitments, service transformation and GNCA collaboration are counter measures to support improvements to get back on track in a phased approach during Q2-Q3.
	Increase in New Outpatient activity	Current performance is at 27.3%, below the 33% target. Plans to support robust counting and recording are underway across surgery and medicine. Modelling to support achievement of 33% is now required to quantify the planned additional work and understand variance from target levels. Risks include clinical engagement to support plans to reduce non-value added follow-up activity in outpatients and capacity conversion to support delivery of the elective care programme. Increase noted in previous four months.
2	**Evidence achievement of the 24-25 financial plan**	The Trust has a planned deficit at M5 of £9.510m and actual performance of £9.437m deficit which is a positive variance of £0.073m. We continue to plan to achieve a forecast outturn deficit position of £12.6m although risks remain around overspending against delegated budgets and identification and delivery of CRP targets. The Trust has a planned CRP target at M5 of £5.573m and actual performance of £6.143m which is a positive variance of £0.570m. However the proportion of recurrent is £1.235m less than planned. CRP as the plan is more heavily loaded and weighted towards year end delivery. Focus remains on identifying recurrent savings schemes to support future financial sustainability. As the trust is forecasting to achieve its planned deficit cash is also forecast to deliver as planned and be no less than £5m at the financial year end. However, should the deficit exceed £12.6m then cash will also fall below £5m.
3	**Review & revise the 2022/25 green plan & align with the group structure by the end of Q2.**	Q1 - Q2 plans to embed the Green plan governance structure and align with group governance. The first sustainability was held in June, where 10 workstreams will provide update reports aligned to our sustainability objectives. Work plan priorities include: waste, active travel, fleet, procurement, estates & facilities, workforce/communications, sustainable care, medicine, digital transformation and adaptation. Q4 plans include a survey of understanding across the Board/EMT and Senior Leadership Group members.

Strategic Objectives 2024/25

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

NHS Gateshead Health NHS Foundation Trust

Work at place with public health, place partners and other providers to ensure that reductions in health inequalities are evidenced with a focus on women's health
Work collaboratively as part of the Gateshead system to improve health and care outcomes to the Gateshead population
Work collaboratively with partners in the Great North Healthcare Alliance to evidence an improvement in quality and access domains leading to an improvement in healthcare outcomes demonstrating 'better together'

Metric	Target	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Ass/Var	Trend
LEADING INDICATORS																	
Evidence a reduction in the number of 'fragile' and 'vulnerable' services as a direct outcome of Alliance working																	
Evidence in an improvement in health inequalities in the key focus areas linked to the determinants of Health for Gateshead																	
BREAKTHROUGH OBJECTIVES																	
Increase in the number of digital devices repurposed to the local community	>300										100	100	50	58			
Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients by March 2025	>=98%	91.8%	91.2%	90.2%	90.6%	92.6%	88.7%	92.2%	93.4%	91.1%	92.1%	91.6%	92.5%	90.1%	87.8%	F	
Reduction in the wait for gynaecology outpatients to no more than 26 weeks	<=26	23.2	23.6	26.7	26.8	27.9	25.9	28.1	28.0	39.7	35.9	27.0	37.0	37.0	8.0	? L	
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 by March 2025	<=30	67.0	68.5	71.0	73.0	75.0	75.0	77.0	76.0	78.0	80.0	81.0	83.0	85.0	82.0	F H	

Measures requiring focus this month

Measure	Summary
Evidence a reduction in the number of 'fragile' and 'vulnerable' services as a direct outcome of Alliance working	This will be reviewed quarterly as part of the Provider Collaborative Sustainability review. Outputs and products from this work will be reviewed to inform the annual planning process and is contained in the Project Plan for 2024/25 to support planning for 2025/26.
Evidence in an improvement in health inequalities in the key focus areas linked to the determinants of Health for Gateshead	Key determinants of Health for Gateshead are to be defined through the Health Inequalities Group workstream. Evidence/measures and controls will be implemented as part of the focused work to progress in 2024/25.
Increase in the number of digital devices repurposed to the local community	Digital exclusion is where members of the population have inadequate access and capacity to use digital technologies that are essential to participate in society. The risk to this target is that the quantity of devices being made available for recycling and repurposed is dependant on Trust usage and need. This is therefore entirely variable throughout the course of the year. To date in 24/25 308 devices have reached end of life and the Trust will continue to recycle equipment as swiftly and efficiently as possible.
Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients by March 2025	In 2022 the Trust moved from recording smoking status at discharge to recording smoking status on admission (within 6 or 24 hours). This helps care workers understand and support patient needs in managing withdrawal from tobacco and identifying target cohorts of patients who require support from the tobacco dependency treatment service. The Trust is currently reporting performance at 87.8% against this measure. Deterioration in the % of inpatient with smoking status recorded coincides with increase in numbers recorded as 'Unknown not recorded'.
Reduction in the wait for gynaecology outpatients to no more than 26 weeks by March 2025.	The median wait has significantly reduced due to ongoing fertility clinic activity with shorter waits whilst Gynaecology activity has been minimal due to annual leave and consultant reduced capacity. Working with the clinical team to review OP pathways to maximise opportunity for additional New appointments. Managing current risk with unexpected loss of consultant capacity. Recruitment process underway.
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 weeks by March 2025	Current waits are at 82 weeks for autism assessment pathways, which does not yet reflect the transformed pathways and revised clinical model. New workforce operation model to commence Sept/ Oct 24 to increase capacity. To monitor trajectory on monthly basis

Strategic Objectives 2024/25

We will develop and expand our services within and beyond Gateshead

NHS Gateshead Health NHS Foundation Trust

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

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

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

Measures requiring focus this month

Measure	Summary
0.5% increase in QEF externally generated turnover	Current cumulative performance is 1.8% which is ahead of target plan. Performing well at engagement VAT consultancy, risk surrounding new business due to lack of Business Development resource and existing contracts without renewal dates. Additional income received YTD re: VAT consultancy. Challenge around business development resource to source new contracts and support bid writing. Work ongoing around external homecare, additional VAT consultancy and a bid for NUTH transportation services. Discussions ongoing on current contracts to agree extensions where appropriate.

NHS
Gateshead Health
NHS Foundation Trust

Constitutional Standards 2024/25

Reporting Period: August 2024

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

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

Constitutional Standards

Metrics

Gateshead Health NHS Foundation Trust

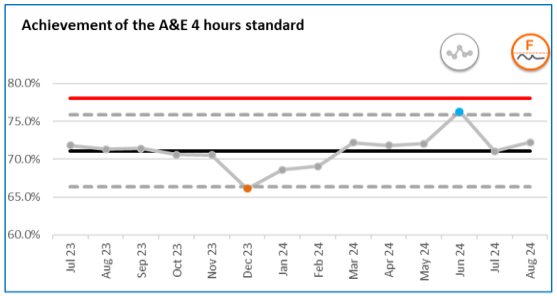
Metric	Target	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Ass/Var
Achievement of the A&E 4 hours standard	>78%	71.8%	71.3%	71.4%	70.6%	70.5%	66.1%	68.6%	69.0%	72.2%	71.8%	72.0%	76.3%	71.0%	72.2%	
12 hour trolley waits (DTA to left department)	0	11	0	50	24	0	7	1	0	0	1	4	0	3	0	
% of ED attendances > 12 hours in department	<2%	3.9%	4.4%	6.5%	5.7%	4.9%	7.4%	7.0%	4.9%	3.6%	3.8%	4.1%	2.3%	5.4%	4.4%	
Ambulance handover delays 30-60 minutes	0	59	77	123	99	80	110	25	1	0	0	2	1	10	4	
Ambulance handover delays 60 minutes +	0	62	16	122	100	51	50	2	0	0	0	0	0	13	0	
Achievement of the RTT 18 week standard	>92%	70.6%	68.9%	67.0%	66.9%	67.7%	67.2%	68.3%	67.8%	67.9%	68.9%	70.6%	70.6%	70.3%	69.2%	
Achievement of the 52 week RTT standard	Apr 24 - 58 May 24 - 42 Jun 24 - 18 Jul 24 - 0	236	237	293	273	263	143	113	112	76	72	109	88	81	108	
Achievement of the 6 week diagnostic standard	>95%	91.9%	90.7%	88.6%	92.4%	94.1%	91.4%	90.0%	92.1%	91.2%	88.8%	86.0%	83.8%	84.7%		
Achievement of the Cancer 28 day standard	>77%	77.4%	77.6%	76.0%	76.8%	78.5%	80.4%	75.9%	83.0%	81.1%	79.8%	82.1%	81.1%	81.4%	80.4%	
Achievement of the Cancer 31 day standard	>96%	100.0%	99.6%	99.5%	100.0%	99.4%	99.4%	99.6%	100.0%	97.9%	99.1%	99.6%	100.0%	98.9%		
Achievement of the Cancer 62 day standard	>70%	69.1%	73.5%	70.4%	68.6%	70.0%	64.6%	72.4%	71.2%	73.9%	75.3%	67.9%	70.7%	69.6%		

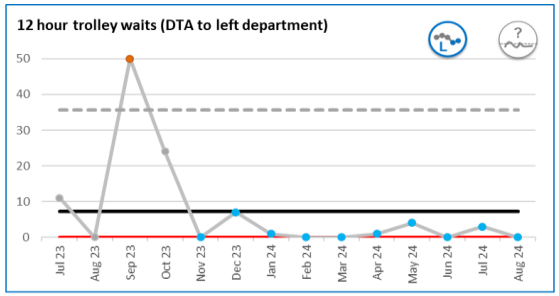
Validated data unavailable at time of report

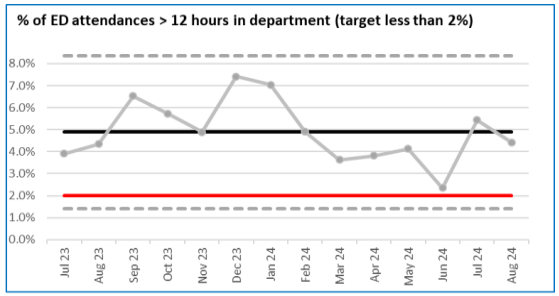
Constitutional Standards

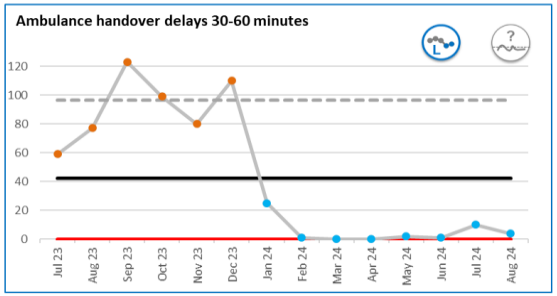
Metrics (SPC)

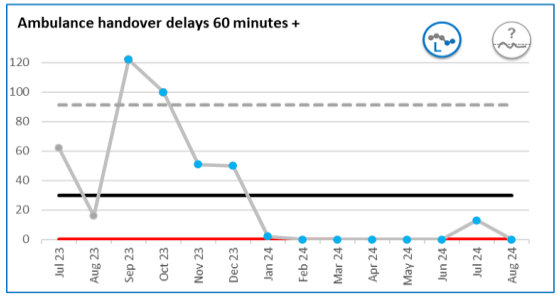
Gateshead Health NHS Foundation Trust

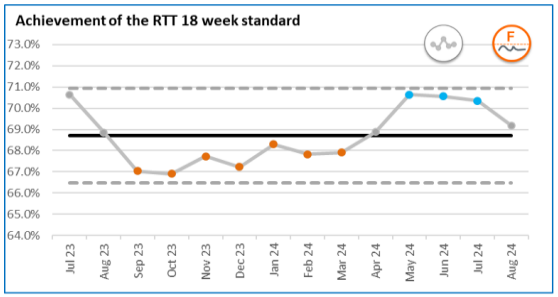


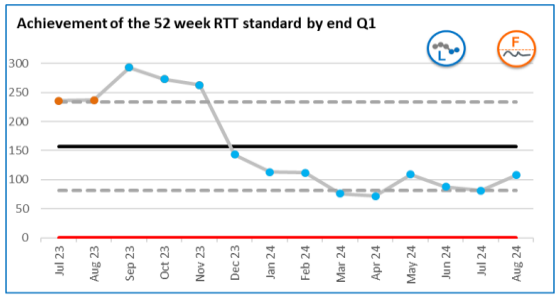


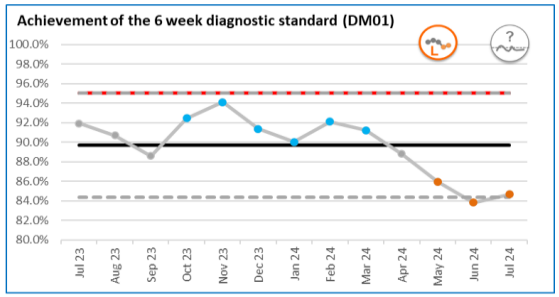


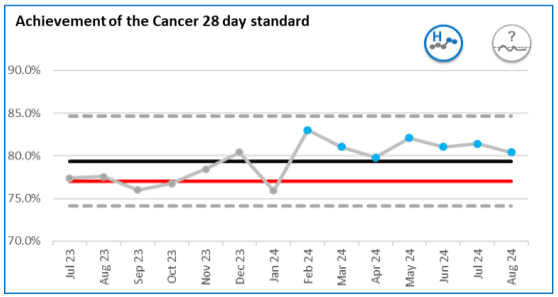


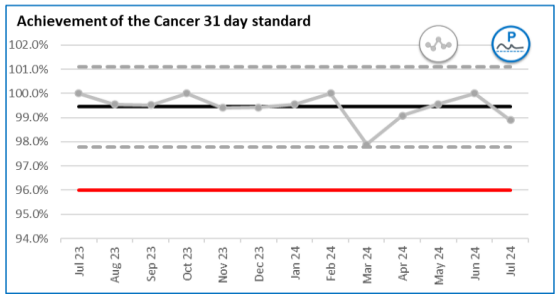


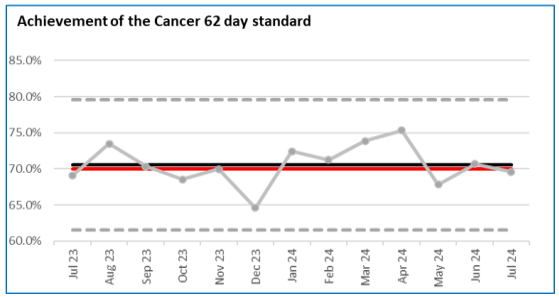












Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 20

Report Title:	**Freedom to Speak up Guardian Report**			
Name of Meeting:	Trust Board of Directors.			
Date of Meeting:	24TH September 2024			
Author:	Tracy Healy Freedom to Speak Up Guardian (FTSUG)			
Executive Sponsor:	Dr Gillian Findley, Chief Nurse, Professional Lead for Midwifery & Allied Health Professionals. Deputy CEO. Amanda Venner Director of People & OD.			
Report presented by:	Tracy Healy FTSUG			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☒
	To provide an update of FTSU activity for year –2023-2024 to date.			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐	**Partially assured** ☒	**Not assured** ☐	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Version 1 covering 2023-2024 data presented to POD Committee 9th July 2024. Version 2 covering as above and including Q1 for 2024 presented to QGC.			
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*	**April 2023 – April 2024 Period:** • Total of 59 concerns raised, (35 raised the year prior). *Q1 – 7 Concerns* *Q2 – 7 Concerns – 0% increase.* *Q3 – 18 Concerns – 157% increase.* *Q4 – 27 Concerns – 66.7% increase.* *2024. Q1 – 15 Concerns – 44% decrease.* • A 71.4% increase in reporting from 2022/3 – 2023/4. • 42 cases managed and closed in this period. • Categories of concerns raised in the year period: *44% Bullying & Harassment* *20% Patient Safety* *19% Culture* *8% Detriment for speaking up.* *8% Worker Safety.* *(Nationally data collection for B&H has been broken down to B&H and Inappropriate behaviours and attitudes future reports will reflect this).* • Where concerns have been raised these are being managed in a variety of ways. Initially being rag			

	rated for current risk and safety for patients and / or staff. Any cases rated high risk to patient or staff safety are escalated immediately to Chief nurse / Deputy CEO. • Increased the network of FTSU champions from 8 to 30. Currently 23 are fully trained and the final ones completing training in September. • Action Plan developed from NHSE/I following the Lucy Letby case – awaiting Thirwall enquiry results for further actions. (Appendix 1) • In October 2022 it was agreed all Board members would undertake the necessary three levels of FTSU training. At the time of writing 15 out of 15 Board members had completed this 100% compliance. • FTSU Guardian Service Changes and development. • NGO Self-assessment changes for NHS Trust Boards. • FTSU Policy – compliance with NGO standards October 2023 and supporting standard operating procedure October 2024.	
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	• The committee is asked to receive this report by way of assurance on FTSU concerns and broader activity. • The committee are asked to note that due to some of the complexities of cases not all have been resolved in this period but all that remain open are being monitored. • The committee is asked to note the current Board member training compliance of 100%. • The committee is asked to be cited on future projects and developments for the service and support Business case for FTSU system.	
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead

Trust strategic objectives that the report relates to:	Strategic aims 1 & 2. 1.1 Caring for all our patient communities. 1.2 Providing safe, high-quality care. 1.4 Making every contact compassionate. 2.1 Caring for the health and wellbeing of our people. 2.2 Being a great place to work. 2.3 Ensuring a diverse, inclusive, and engaged culture.				
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	Risk to lone workers. Current Risk 3298- Promoting an environment that encourages speaking out and creating a psychologically safe culture may lead to increased reports of poor behaviour, with a negative impact on staff and additional time needed to appropriately address the concerns. The current culture suggests that staff may not feel safe to speak out and discriminatory behaviours continue, unaddressed. This could lead to further health and wellbeing concerns and staff absence. Emerging Risk 3318 - Risk of staff not having an anonymous platform to raise staff or patient safety concerns- mitigation in place and procurement of InPhase App for FTSU now completed. App currently being developed for service.				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☒	**Not applicable** ☐		

Freedom to Speak Up Guardian Report

1. Executive Summary

1.1 April 2023 – April 2024 there has been 59 concerns raised via FTSUG.
7 concerns were raised in Q1.
7 concerns were raised in Q2.
18 concerns were raised in Q3.
27 concerns were raised in Q4.
15 concerns were raised in Q1.
21 concerns were raised in Q2 currently.

1.2 Total concerns for 2022-2023 was 34. This is a 71.4% increase this year of concerns raised. Although we have seen a decrease in Q1 for 2024 there were large number raised in Q4 which were at the end of March. Also benchmarking nationally there has also been a drop in Q1 to Q4. We have seen an increase in Q2 currently up to date of report written (9/9/24) we have 21 cases.

1.3 In October 2022 it was agreed that all Board members should complete all three levels of FTSU training. At the time of writing, 15 out of 15 Board members had completed this training giving now a 100% compliance rate.

1.4 FTSUG position now full time since the start of Q3 2023.

1.5 FTSUG attended the Trust Board development day in October 2023 to present development and changes to the Freedom to Speak Up Service and seek Trust Board members support with action plans for the service.

1.6 FTSUG held roadshows in October 2023 for the National FTSU month this allowed launch of the new FTSUG in full time role and service changes. For FTSU October 2024 the focus is on listening up we will be holding some listening sessions with colleagues from our staff forums, as well as undertaking a promotional campaign for FTSU to again raise awareness and share feedback of actions taken over the last 12-month period. We will also be working with our communication team to deliver other social media platform updates for staff. We hope to be able to launch the FTSU Month at the Millennium Bridge and have it lit green for FTSU colour in collaboration with Newcastle Trust's and their FTSUG and executive representatives.

1.7 Working collaboratively with POD team and joined the Culture Board program and working on current projects to support Zero Tolerance, Show Racism the Red Card, and development of Bystander Training. Further projects now underway alongside zero tolerance is "it's not ok" champaign, and part of this includes sexual safety in the workplace. The trust has signed up to the sexual safety charter to support this the FTSUG has support with the development of a Trust policy to support sexual safety in the workplace. Running parallel to this is training program development supported by Northumbria Police, and Kindling services- Active bystander sexual safety training. Several staff will be certified trainers for the Trust and will be used to educate and support Trust managers and staff.

1.8 Completed National Guardians Office Training and is registered as Trusts FTSUG with the NGO.

1.9 Undertaken review of service as requested by NHSE / I following Lucy Letby case

1.10 Undertaken audit as requested by ICB of current FTSU Service which was presented to Trust Board.

1.11 Actioned results from audit – developed formal feedback process to allow service improvement and service / outcome satisfaction. (See results p9).

1.12 Review of reporting of FTSU systems undertaken and Business Case completed for decision. – InPhase System now procured for FTSU reporting expected date for installation was August 2024, now this has been moved September / October.

1.13 Developed wider Comms plan with support of Comms Team. Posters for campaigns and FTSU Service designed still awaiting printing.

1.14 Attended various Trust BU / services meetings and staff forums to promote FTSU and changes in service.

1.15 Developed different education packages and bespoke training to be able to support awareness and training for staff at all levels or when requested.

1.16 FTSUG has changed with support from Data Analysist current data analysis and presentation to enable greater identification of key themes, trends, and hotspots to be presented to POD committee, QGC and Trust Board of Directors.

1.17 Development of data triangulation meeting being scoped with key stakeholders.

1.18 Undertaking bespoke listening sessions with POD leads and business unit teams to review historical cases and take forward lessons learnt for future practice supporting change in culture, and staff who have been harmed.

1.19 Undertaking bespoke listening sessions with Surgical BU in response to incidents within theatres, to support COO and medical director response.

1.20 Collaborative working with Staff forums and EDI lead to develop joint listening sessions to support many unheard staff voices – breaking down barriers. Recently supporting listening sessions with following civil unrest and continuing to support staff when required.

1.21 Quarterly FTSU newsletter developed and published. This has been agreed to be shared via Trust Newsletter quarterly.

1.22 Education and training of FTSU widened to different staff groups including junior doctor forum, care certificate, & Trust preceptorship. To scope further opportunities for other training sessions.

1.23 Development of Trust Freedom to speak up strategy in line with national requirement, this will include a key stakeholder event. To be completed by April 2025.

1.24 Yearly data quality review and submission as per NGO guidelines.

2. Introduction:

2.1 The Board has a key role in shaping the culture of the Trust. FTSU is an important component in respect of developing an open, transparent, and learning culture.

2.2 The NGO expects Boards to lead in this area, ensuring that the Board activity promotes learning, encourages staff to speak up and sends a clear message that the victimisation of workers who speak up will not be tolerated. It is also the responsibility of the Board to ensure that there is a well-resourced Guardian with named Board lead and to ensure that there is investment in leadership and development.

2.3 The FTSUG reports to the Board twice per annum and presents a paper to People and OD committee and is now presenting a paper to Quality Governance Committee (QGC).

2.4 This report provides the Committee with a summary of FTSU activity from April 1-2023 – September 9th. As a new reporting metric, it will also demonstrate to the board the feedback information from staff following raising FTSU concerns.

2.5 This report provides the Committee with a national update and current statutory requirements from the NGO and NHSE / I which the board is required to be cited on.

2.6 Future reports will need to include as per NHSE/I and NGO guideline changes a Trust action plan following the undertaking of the FTSU self-assessment tool. This action plan will need to be completed with all Executive team input and monitored for compliance through the FTSU papers as well as potentially more frequently with the executive team members.

3. Key issues / findings

April 1st 2023- September 9th 2024

It was agreed at Trust Board in October 2023 that to support learning from FTSU concerns the format of the reports moving forward would be adapted to give the most optimal data and understanding whilst still maintaining staff confidentiality.

Table 1 below shows an oversight of the FTSUG cases from 2023-2024, Q1 and up to 9/9/2024 of Q2, with the added information fields from Q3 – to date only (since changes in data collection has been made see p10-12).

- Since changing FTSU to a full-time position and the promotion of the service from both the FTSUG and the executive team we have seen an increase in cases through year 2023-2024 seeing an annual increase of 68.5% the current data in Q1 of 2024 does show a decrease of 15 cases however, there has been up to the point of data collection (9/9/24) a total of 21 cases in Q2. Looking at benchmarking this against other areas nationally we are not outlying in the rates in which cases have been raised as nationally Q4 saw increase nationally and a drop in Q1 of cases raised.

- In Q3 we have added a subcategory of concern to gain better information of where improvements are needed which can inform our culture board plans. The highest trend in Q3 is unfair treatment of staff from managers or individuals / teams they are working with.

- The current data demonstrates that there is a split of 80% which are concerns raised about staff – culture, bullying and harassment, treatment at work etc. The other 20% concerns raised is directly about patient safety. Which as per pg.13 shows again, we are in line with national reporting for categories of concern.

- There is a distribution across areas of the Trust. In the last 2 quarters we have added learning from concerns, key phrases, cases broken down to department level and added any protected characteristics to gain a better understanding of concerns, specific hotspots, themes and trends.

- We will need to consider this is a small volume of data currently available however this will be continued to be collected to build a picture moving forward.

What currently is this telling us?

- Staff with protected characteristics are the group of staff who are less likely to raise concerns currently we have 38 out of the 81 cases (46.9%) demonstrating since we have started to collect this data in Q3 we have started to achieve confidence with this group of staff but still further work with our staff forums and EDI planned to support this.

- It is not possible to identify any key hotspot areas by departmental level currently as numbers are yet too low to support this however support from POD team has been identified to support two areas currently this includes maternity services due to several concerns relating to behaviours of a manager and other staff members and Paediatric Diabetes services which several staff have raised concerns of incivility.

- Further interventional work has been undertaken in two other areas of the Trust following both number and nature of concerns raised and incidents which have occurred within this financial year. This includes listening sessions in ECC for historic cases, and theatres to support staff following recent incidents which have occurred.

- To support Business Unit awareness and learning monthly meetings are now established with both medicine and surgery and plans to develop this with QEF and CSS are being scoped.

- We can start seeing some themes emerging in several areas which include:

  - Incivility in the workplace Theatres being one of the areas which has several different concerns which have been raised. Alongside in Q2 some listening sessions following incidents which had occurred.
  - Changes in clinical pathways and services which have either been undertaken without all relevant clinical stakeholders or clinical views not been considered or listened too.
  - Processes when staff are being appointed to roles were staff feel that "*jobs are being made for people", "people know who is going to be appointed before interviews are held"* due to nepotism / favouritism and "*clicks*". The recruitment process is being seen to be followed but staff feel this is just to tick a box.
  - There are cases as well which highlight that performance management processes are not been addressed with staff correctly which is leading to staff then feeling they are being bullied and raising concerns.
  - The has been an increasing number of cases which are highlighting problems arising for staff who are neurodivergent regarding lack of support and understanding of their condition as well as lack of support for reasonable adjustments to allow them to be able to undertake their role. Including both at local

level and Trust level which includes lack of provision for disability sickness / absence due to long term conditions whether this is physical disability or secondary to neurodiversity and mental health conditions.

- Although in this report we have seen as predicted and highlighted at QGC an increase in sexual assault / harassment case numbers rise secondary to some of the bespoke work undertaken collaboratively with OD and FTSU. To assure the board that there is significant work already underway in response to address this.
- The data tree map allows us to be able to see where our key areas of improvement are still required. Intimidation, communication, oppression and verbal abuse, being the highest priority areas. The continued collection of the data has also highlighted the requirement of other categories to be included in the key word findings to support learning which will be incorporated and collected in future reports.

What are we doing to improve this?

- Continue to promote the service and diversify ways in which this is being done using different media platforms, listening sessions, education and training as well as walk arounds.

- The introduction of increased number of FTSU Champions will also support the service being able to in reach to as many departments as possible. Please see Appendix 2 for our new network of Champions.

- Alternatively having policies which support the changes we are making to support staff from being verbally or physically abused will allow appropriate actions to be taken and give staff increased confidence. The launch of the 3 policies is underway currently.

- The POD team and culture program members are supporting when key areas of concern are identified this helps us structure the program of work examples of this being the show racism the red card, it's not ok campaign, sexual safety in the workplace, and civility saves lives being support collaboratively with the members of the zero-tolerance working group.

- The development of a group to support sharing of data for triangulation will also support future improvement programs. We have started this work already comparing our staff survey results with our FTSU concerns and the "So what" actions as per pg18 table showing work being collaboratively undertaken.

- All cases have been discussed with the appropriate Senior Manager and Deputy CEO / Chief Nurse. Since the data collection for this report was undertaken there has been a further 4 cases closed, and feedback requested leaving 30 cases open. This is a larger number of cases due to current listening sessions which are being undertaken with outcomes not fully concluded until the end of September. To scope through POD Steering group a panel of staff to support decision making of actions required when concerns are raised as currently there is different actions depending on individual managers decisions. Also having a panel of different staff would allow for speciality advise and more transparency as well as equality of decision making and supporting managers.

- Since starting to collect formal feedback we have sent out 63 questionnaires and received 34 responses.

Summary of Feedback.

1. Were you satisfied with the freedom to speak up service in general?

34 Responses

Yes	34
No	0
Partially	4

2. If partially/no, what would help to change that?

4 Responses

ID	Name	Responses
1	anonymous	For the executives to have listened to and acted on the concerns raised
2	anonymous	Unable to escalate for full investigation if remaining anonymous
3	anonymous	Difficult getting responses from people
4	anonymous	Had delay in response from guardian

3. Were you satisfied with the FTSU Guardian and their approach/management of your case?

34 Responses

Yes	36
No	0
Partially	2

4. If partially/no, what could help to improve this?

2 Responses

ID	Name	Responses
1	anonymous	In the beginning I felt as though I had to chase the guardian I went to for updates but got none. However once I escalated to the new manager I felt I was being listened to and got the right approach.
2	anonymous	Once received response after delay was.

100% of people who had a good outcome would raise concern again however, those who did not get outcome they wanted there was only 50% who would raise concerns again. (These are currently very small numbers so need to be taken in context).

Table 1:


FTSU Report - Summary
Quarter 2 - 24/25
NHS
Gateshead Health
NHS Foundation Trust
New cases
95
Open cases
34
19
High risk
28
Medium risk
48
Low risk
20%
29%
51%
Cases raised by gender
19 (20%)
76 (80%)
Female
Male
Cases raised anonymously
7 (7%)
86 (91%)
No
Yes
Not recorded
Protected characteristic
Race
16
Disability
9
Religion Or Belief
7
Sexual Orientation
6
New FTSU cases by quarter
20
0
7
7
18
27
15
21
Qtr 1
Qtr 2
Qtr 3
Qtr 4
Qtr 1
Qtr 2
23/24
24/25
FTSU cases closed by quarter
20
0
4
5
15
24
12
11
Qtr 1
Qtr 2
Qtr 3
Qtr 4
Qtr 1
Qtr 2
23/24
24/25
Cases by staff group
Nursing and Midwifery Registered
35
Allied Health Professionals
17
Administrative and Clerical
15
Medical and Dental
11
Estates and Ancillary
9
Add Prof Scientific and Technical
5
Additional Clinical Services
2
Not recorded
1
Nature of concerns
Bullying and Harassment
45% 43
Patient Safety/Quality
20% 19
Worker Safety
15% 14
Culture
13% 12
Detriment for Speaking Up
Not recorded
Gateshead Health NHS Foundation Trust
Refreshed: 09/09/2024 14:51
#GatesheadHealth

Freedom to speak up

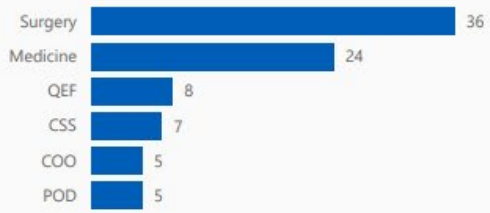
FTSU Report - Areas, concern & learning

Quarter 2 - 24/25

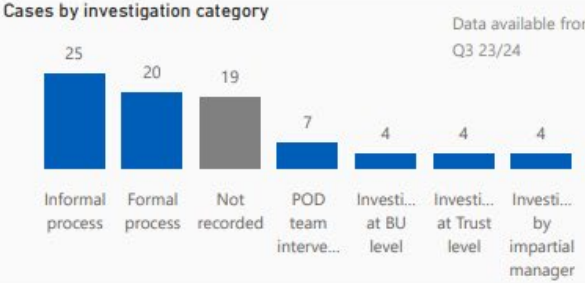
NHS Gateshead Health NHS Foundation Trust

Areas with 5 or less cases have been suppressed to protect anonymity

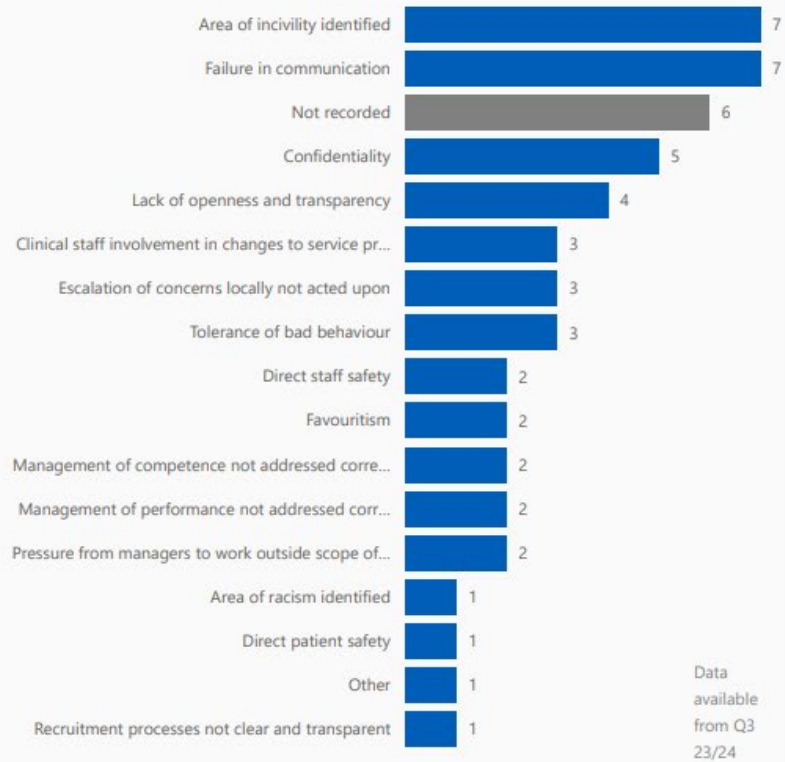
Cases by business unit since Apr23



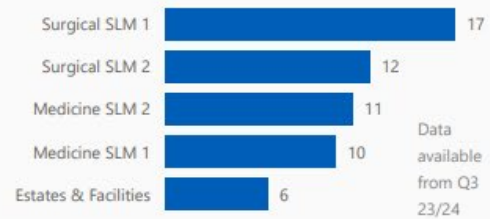
Cases by investigation category



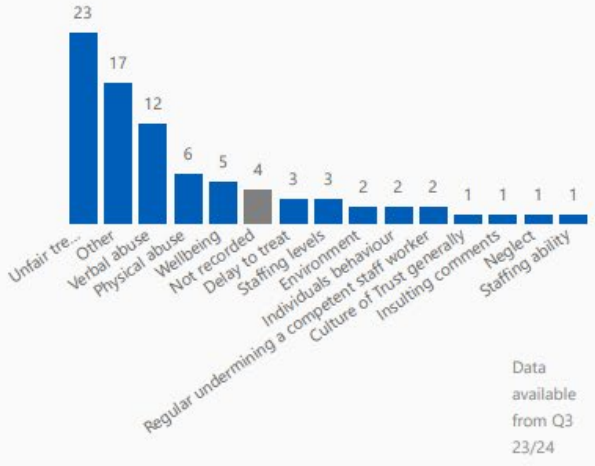
Closed cases by learning



Cases by SLM since Sep23



Concern sub categories

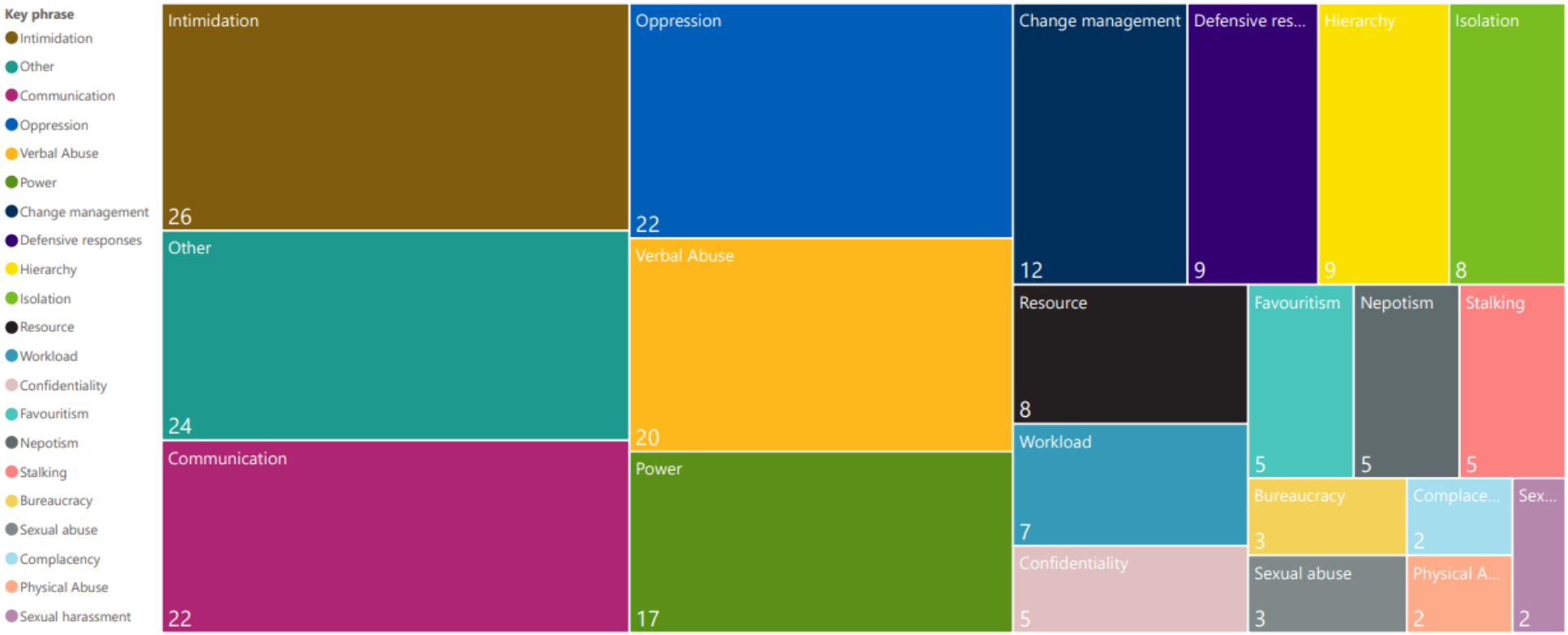


Cases by department since Sep23

FTSU Report - Key phrases

Quarter 2 - 24/25

NHS Gateshead Health NHS Foundation Trust



The treemap above shows key phrases & number of occurrences allocated to freedom to speak up cases. Each case recorded since Q3 23/24 has the opportunity to be allocated up to 3 key phrases.

4 Guardian Activity:

4.1 National update:

The Speaking Up data for 2023/24 report highlights:

TOTAL CASES

32,167 cases

were raised with
Freedom to Speak Up Guardians
In 2023/24

The highest number of cases recorded – a 27.6% increase from 2022/23.

QUARTER 3 HAD THE LARGEST AMOUNT OF CASES

Quarter 3 (Oct – Dec 2023) had the highest number of cases raised with Freedom to Speak Up guardians in a single quarter (9,138), a record number of cases.

This may be as a result of the awareness raising which takes place during Speak Up Month every October

PROFESSIONAL GROUPS

Workers from a range of professional groups spoke up to Freedom to Speak Up Guardians.

Nurses and midwives accounted for the biggest portion (28.3%) of cases raised.

ANONYMOUS CASES

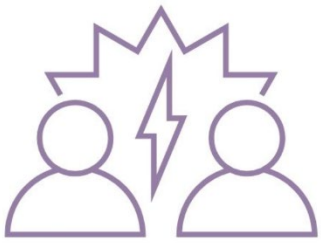
The percentage of cases which were raised anonymously is ten percent (9.5%).

This was similar to the percentage raised anonymously in 2022/23 (9.4%).

INAPPROPRIATE BEHAVIOURS

Two in every five cases (38.5%) involved an element of inappropriate behaviours and attitudes.

The most reported theme in 2023/24.



PATIENT SAFETY AND QUALITY

18.7% of cases raised included an element of patient safety/quality

a marginal drop compared to 2022/23 (19.4%).

WORKER SAFETY AND WELLBEING

One in every three cases raised (32.3%) involved an element of worker safety or wellbeing.

An increase from one in every four cases (27.6%) in 2022/23.

SOURCES OF CASES

Cases raised with Freedom to Speak Up guardians in NHS Trusts (29,204) accounted for 90.8% of cases in 2023/24.

A further 2,963 (9.2%) were raised in other organisation types.

Full Annual report available on the NGO website for 2023-2024. **https://nationalguardian.org.uk/wp-content/uploads/2024/07/FTSU-Case-Data-Annual-Report-23-24.pdf**

4.2 Local update:

- Period 2023 -2024:
  There was a total of 59 concerns raised, with a further 36 in Q1-2 of 2024 to date (9/9/24). Some cases taking weeks to months to support, and others being resolved with 24-48 hours.

- Since starting in Q3 the new FTSUG has had 600 plus meetings / contacts / interactions and delivered virtual and face to face training. Including all corporate induction sessions as well as developing a virtual training package for staff who are undertaking remote training.

- FTSU education and training was initially delivered at Trust Induction and managing well. Current FTSU training packages now developed and delivered to management teams, speciality services, business units, junior doctor forums, care certificate, preceptorship course, and overseas recruitment.

- FTSUG is supporting the identification of key programs for the Trust Culture Board utilising staff survey data, FTSU Concerns alongside softer intelligence from staff forums and interactions with teams across the Trust.

- Culture Board Program work the guardian is actively involved in - zero tolerance, show racism the red card, development of bystander training. Sexual safety in the workplace.

- The program work includes promotion campaigns / raising awareness, education, and training of staff, as well as audit / questionnaires to be undertaken collaboratively with junior doctor forums once InPhase APP is completed.

- 2023-2024 activity has been submitted to the NGO database.

- FTSUG has also been involved in team listening sessions for areas who have had incidents which have affected several staff members as way of not only listening in confidence but also supporting and signposting for health and wellbeing.

- Introduction of more robust data collection to allow improved identification of key themes and trends as well as hotspot areas, supported by data analyst (Table 1). This will continue to be developed to have live data with the introduction of InPhase App module for FTSU.

- Wrap around support services: Links with HWB lead to provide data to support HWB pages for staff. Links for referrals to Occupational Health services from FTSUG, POD and PNA services.

- External networks: attendance at Northeast, Cumbria, and Humberside Regional meetings to ensure fully updated on new guidelines, reports, and education.

- Attendance at National Guardian Office training, POD casts, teaching sessions, and seminars / conferences – shared practices, education, and training as well as networking nationally.

- Increased the number of FTSU Champions to 30 from 9 in the last 6 months to support the FTSU services allow in reach to greater area of wards, services, and departments. (Appendix 2)

- Currently supporting local response to the national civil unrest.

Summary:

4.3 Future developments:

- Intranet site for FTSU to be developed as a resource for staff and managers to access.

- Development of Microsoft teams' site for education and training for FTSU champions as well as a discussion forum for the Guardian and Champions.

- Further Comms work to be undertaken to align FTSU with our other Trust campaigns from the culture board program.

- Future workstreams linking with medical staff leads are currently being scoped to support Junior medical staff with FTSU concerns including sexual harassment in the workplace.

- Future reports will also include a staff story who have raised concerns both good and bad experiences they may have encountered. This will mirror the 100 voices which the NGO include in their reports.

- The FTSUG has undertaken training delivered by Northumbria Police / Kindling to support our sexual safety work and will be trained to deliver this training across the Trust.

- The FTSUG will lead the development of FTSU strategy to ensure compliance with NGO Guidelines, working and consulting with stakeholders.

- The FTSUG will develop standard operating procedure for the FTSU Policy in line with NGO /CQC best practice. This will enable audit against policy and standards for FTSU to allow greater clarity and assurance of FTSU concern management.

- In response to the concerns raised and the triangulation of data from our staff survey, forums and gathered intelligence as a part of a team of staff supporting the culture board program and POD team see below table of highlights of our local journey in the last year.

- The unheard voices: collaborative working to in reach to staff with protected characteristics who evidence shows are less likely to speak up. Introduction of listening session / safe spaces with representation from staff forum leads and FTSUG. FTSUG was invited to GEM listening sessions following civil unrest supporting building key networks.

5. **Recommendations:**

5.1 Previous FTSU reports have been submitted to Board and committee as assurance on FTSU. This committee is asked to receive this report as partial assurance of FTSU as there are significant developments with FTSU services we are undertaking working as a collective to change the culture and ensure we have a learning environment which if safe for both patients and staff. Developing a psychological safe space for staff voices to be heard.

5.2 The committee is asked to note that there have been 59 concerns raised in the reporting year, and a further 26 in Q1-2 of 2024. The current position for cases since data report has been completed is we have closed 4 cases leaving a total of 30 open cases which of which at different stages of investigation, these are being actively managed or monitored.

5.3 The committee are asked to note current Board member training compliance of 100% and support continued compliance.

5.4 The committee are asked to be cited and support the development of FTSU services and make any suggestions which need to be included in future work plans / workstreams.

5.5 The committee are asked to be aware of new guidelines that moving forward the NGO self-assessment reflection tool will need to be reviewed by the wider key stakeholders including execute management team meeting, QGC, Trust Board and this POD committee. Allowing a broader engagement to support the FTSUG to complete action plan for the Trust. This will be shared at the next POD committee. The committee is asked for support to ensure this is an agenda item for executive team at next meeting to be able to progress future planning.

5.6 The Board and the committee are asked to continue to support the listen up, follow up of the FTSU concerns to support the FTSUG and service for the staff building an open, honest, learning culture in line with the Trust ICORE values enabling staff to feel confident in reporting of concerns.

5.7 The committee is asked to give feedback on the presentation of new data fields and make any suggestions for continued development of FTSU reporting.

5.8 The committee is asked to support FTSU month and complete a pledge of how they will “listen up” and ways they will allow the voice of the staff to be heard.

Appendix 1:

NHSE - Lucy Letby Trust Guidance.docx

Appendix 2:

FTSU Champion Profile Picture.pptx

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 20

Report Title:	Workforce Race /Disability Equality Standard (WRES/ WDES) - update			
Name of Meeting:	Board of Directors			
Date of Meeting:	24 September 2024			
Author:	Kuldip Sohanpal, EDI and Engagement Manager			
Executive Sponsor:	Amanda Venner, Group Director of People and OD			
Report presented by:	Kuldip Sohanpal, EDI and Engagement Manager			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	This paper shares with Board the Group WRES and WDES metrics (taken from the staff survey) and the actions that are needed to address areas where need to improve. The report will be published on the Trust Website as per our statutory obligations.			
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*	People and OD Committee			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	Across all the indicators the Trust performance is as below compared to last year:			

	Improvement required ↘	Improving ↗	No Movement ↔
WRES	6	5	3
WDES	5	13	4

There remain some **key challenges** and poor behaviours experienced by our staff from patients, the public and other colleagues. The WRES and WDES metrics highlight some of this very clearly and will help us ensure that we are targeting our actions appropriately:

- Bullying, harassment and abuse

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

25.6% of our GEM staff experienced this from patients, relatives or the public
40.9% of our disabled staff experienced this from patients, relatives or the public
29.4% of our GEM colleagues experienced this from colleagues
49.5% of our disabled staff experienced this from colleagues

Discrimination

14.6% of staff have experienced this in the last 12 months

There have been a wide range of key highlights against our equality, diversity and inclusion objectives. These include:

Range of EDI related training initiatives delivered
EDI included in corporate induction
Trust have signed up to the Unison Anti-racism charter
Freedom to Speak up Guardian is embedded in role and making a positive difference
EDI metrics dashboard has been developed to track progress
Zero Tolerance campaign launched

High level action plans are included in the report addressing areas such as recruitment, employee relations, pay gaps, raising concerns and mentoring.
</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 is asked to note the content of this report and agree the associated actions and publication.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☐</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☐</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust strategic objectives that the report relates to:</td><td colspan="6">List corporate objective reference and headline – e.g. SA2.2: Growing and developing our workforce</td></tr>
<tr><td>Links to CQC Key Lines of Enquiry (KLOE):</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☐</td><td>Safe
☐</td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
</table>

Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	Risk 2760 - The People Plan places equality, diversity and inclusion as a critical strategic workforce priority; further work is needed to embed this fully across the trust		
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☐

NHS
Gateshead Health
NHS Foundation Trust

Workforce Race /Disability Equality Standard (WRES/ WDES) – update following May 2024 paper

1. Introduction

Equality, diversity and inclusion (EDI) is paramount in ensuring that the Trust has a diverse, inclusive and engaged culture that is everyone's responsibility, in order to deliver the mandatory and statutory reporting. It should be the golden thread in all that this Gateshead Health does.

Recognising that we need to improve if we are to achieve our ambitions and become a Trust where diversity is valued and celebrated. To ensure this vision becomes real, we have to take the stance that everyone is treated with dignity and respect, and that discrimination and inequalities are prevented and eradicated from all our services and functions.

2. Summary and Methodology

The WRES and WDES data is extracted from the annual NHS staff survey annually and we submitted our data in May 2024 following the discussions at Executive Management team and POD Committee.
The data was shared with the staff networks and the Trust EDI and Engagement lead met with the network chairs to discuss in detail. Acknowledging that a number of our indicators have deteriorated the discussions were focused on whether the actions from previous years were having the impact that is needed.
The revised high level action plans are in appendices 3 and 5.

3. Key WRES/WDES indicators

The 2023 WRES / WDES submissions showed the following:

	Improvement required ↘	Improving ↗	No Movement ↔
WRES	6	5	3
WDES	5	13	4

The detailed explanation of these indicators are in Appendices 2 and 4

4. Refreshing the WRES / WDES action plans

The data collected from the last staff survey, shared with the Networks, EMT and the POD committee in May 2024 shows that there has not been a significant difference in incidences of harassment from previous years, however the response rates have increased. This could be due to staff feeling more comfortable in reporting incidences. Hopefully utilising the momentum of SRTRC, raising the profile of Zero Tolerance, the role of the FTSU Guardian's engagement with the Networks will show a significant difference in our next year's submissions.

Areas identified for further work highlighted bullying and harassment across both the WRES and WDES indicators. A training programme addressing Racial Harassment has been produced for roll out during this year. This will be a follow up from the Z tolerance and the civility work which is happening across the Trust.

Using the 4 key pillars incorporated within our EDI strategy, members of the group had detailed discussions in respect of the milestones that sit under each of the 4 Key Pillars, these being:

- Empowering our people in investing time in engaging with one another through inclusive network, communities and forums
- Holding one another to account in living our values, by incorporating EDI into our core values, challenging unconscious bias and fostering diverse thinking
- Fostering an inclusive culture of belonging where everyone is seen, supported, respected and valued for their unique contributions
- Increasing opportunities for our people to have their voices heard.

5. Key highlights of our EDI ongoing work

The summary below highlights the progress that has been made against the equality, diversity and inclusion objectives.

- EDI continues to be the golden thread throughout the Managing Well training programme
- Conscious and unconscious bias within the recruitment and selection process has been added into the existing bite sized recruitment and selection training. This programme of work is being refreshed within the E and D supply Group and the development of a new R and S training package.
- Equality and Quality Impact Assessments for all policies and service changes are being used to assess and understand the impact upon all protected characteristics.
- A session around culture and faith and the impact on patient care was delivered by faith leads (chaplaincy) and evaluated well. Further delivery has been planned for October / November 2024. Specific bespoke EDI training has also been agreed for our Pathology Department.
- An EDI KPI metrics dashboard has been developed which collects data relevant to all protected characteristics. This dashboard is being further refined. The metrics capture the detailed recruitment data as well as the data that is required for the WRES and WDES submissions.
- A programme of Zero-tolerance approach to Bullying and Harassment has been undertaken, with 320 managers attending specific training on ‘Show racism the red card’. This is underpinned by the Trust having signed up to Anti-Racism Charter earlier in the year. The Freedom to Speak Up Guardian, the EDI manager and Cultural ambassadors are working to ensure there is triangulation of data collected and outcomes. Drawing on their skills will also aid our staff networks which are staff-led, funded and provided protected time to support and guide staff.
- Bullying and Harassment cases continue to be reviewed on a monthly basis by the Head of People Services as part of the Employee Relations Case Reviews. The appendix gives a breakdown of the specific areas relevant to the WRES and WDES.
- A variety of support channels are in place for staff with a concern around abuse, harassment, bullying and physical intimidation in the workplace. Amongst these include our Freedom to Speak Up Champion, an on-site Security team, a mediation service.
- Strengthening partnerships and regional cross-working from other Trusts.
- Current EDI objectives and EDI principles are incorporated into corporate induction.
- A one and half hour session on EDI principles are part of the Managing Well Programme and have evaluated well. A number of participants have contacted the EDI manager for further advice and information pertinent to their individual roles and services, and bespoke EDI training has been delivered.
- Senior members of staff undertaking any disciplinary investigations have undertaken EDI E-Learning and some have attended the Managing well programme.
- EDI training is offered to all International Students as part of their corporate induction.

- One session around Neuro divergence has been delivered and further training sessions and dates are planned.

6. Key Challenges of our EDI ongoing work related to the WRES and WDES

There remain some key challenges and some poor behaviours experienced by our staff from patients, the public and other colleagues. The WRES and WDES metrics highlight some of this very clearly and will help us ensure that we are targeting our actions appropriately:

- Bullying, harassment and abuse
  - 25.6% of our GEM staff experienced this from patients, relatives or the public
  - 40.9% of our disabled staff experienced this from patients, relatives or the public
  - 29.4% of our GEM colleagues experienced this from colleagues
  - 49.5% of our disabled staff experienced this from colleagues
- Discrimination
  - 14.6% of staff have experienced this in the last 12 months

7. Actions

High level action plans are included in this report for publication, and these have been co-produced with network colleagues.

More detailed action plans underpin these and will be worked through, overssn by the Trust EdI Manager ad the relevant stakeholders. Progress will be monitored via a dashboard at the monthly HREDI group, chaired by the Director of People and OD.

People and OD committee will receive regular updates in the dashboard to provide assurance on progress and ensure that any issues are escalated appropriately.

8. Summary

- Overall, for the WRES 6 questions require improvement, 5 are improving and 3 have had no movement. The WDES has 5 questions that require improvement, 13 that are improving and 4 that have had no movement.
- Action plans reflecting the changes required are attached.

7. Recommendations

Members are asked to note and approve the content of this report and acknowledge that a huge amount of work is underway to closely monitor progress against these indicators, along with the other elements of our Equality, Diversity and Inclusion agenda.

Board are asked to agree that the action plans can now be published on the Trust website.

Appendix 1 - The summary information below has been taken from the WRES and WDES metrics submissions. Detailed data is in **Appendix 2:**

	Improvement required ↘	Improving ↗	No Movement ↔
WRES	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants.	Percentage of BME staff overall in the Trust	No change at a VSM level in BME representation
	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff		Relative likelihood of BME staff entering the formal disciplinary process compared to White staff.
	Percentage of staff experiencing harassment, bullying or abuse from patient's relatives or public in the last 12 months **(BME)**	Percentage of staff experiencing harassment, bullying or abuse from patient's relatives or public **(White Staff)**	BME Board membership
	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months **(BME)**	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months **(White Staff)**	
	Percentage of staff experiencing discrimination at work from a manager / team leader or other colleagues **(BME and White Staff)**	Percentage of staff believing that the trust provides equal opportunities for career progression or promotion **(BME and White Staff)**	

There are 4 WRES indicators which require improvement.
1 is around recruitment and selection and 1 is around non Mandatory and Non mandatory training. There are 3 indicators which are indicative of harassment and bullying. 3 indicators show no movement of which 2 may change depending upon future recruitment.

	Improvement required ↘	Improving ↗	No Movement ↔
WDES		Marginal increase in number of Disabled colleagues in the workforce	No representation of disabled staff at VSM
		Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts.	Relative likelihood of Disabled staff compared to non-Disabled staff entering the formal capability process, as measured by entry into the formal capability procedure
			Staff engagement score for disabled staff compared to non-disabled staff and the overall engagement for
	Percentage of staff experiencing harassment, bullying or abuse from Managers **(Disabled Staff)**	Percentage of staff experiencing harassment, bullying or abuse from Managers **(Non-Disabled Staff)**	
	Percentage of staff experiencing harassment, bullying or abuse from Colleagues **(Non-Disabled Staff)**	Percentage of staff experiencing harassment, bullying or abuse from Colleagues **(Disabled Staff)**	
		Reporting incidents of harassment / bullying	
	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to	

	to perform their duties. **(Non-Disabled staff)**	work, despite not feeling well enough to perform their duties. **(Disabled staff)**	
	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which the organisation values their work. **(Disabled staff)**	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which the organisation values their work. **(Non-Disabled staff)**	
	Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion. **(Non-Disabled staff)**	Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion. **(Disabled staff)**	
		Percentage of disabled staff saying that their employer has made adequate adjustments to enable them to carry out their role. **(Disabled staff)**	
		Staff engagement score for disabled staff compared to non-disabled staff and the overall engagement for the organisation (out of 10). **(Disabled Staff)**	Staff engagement score for disabled staff compared to non-disabled staff and the overall engagement for the organisation (out of 10). (**Non Disabled staff)**

5 indicators overall that need improving. 3 of these are around Bullying and Harassment. Pressure to come to work, feeling satisfied that there work is valued, and equity in opportunity all require improvement for both Disabled and Non – Disabled staff. The majority of improvements are for non-disabled staff, whilst equity in opportunity in their work being valued , promotion, reasonable adjustments all show an improvement. Further work is required to assess how the non-movement scores can show an improvement.

Appendix 2.

WORKFORCE RACE EQUALITY STANDARD REPORT

WRES INDICATORS

The Trust submitted the Workforce Race Equality Standard (WRES) as per previous years. The purpose of this document is to identify inequalities and agree actions to ensure that staff from BME backgrounds have equal access to career opportunities and receive fair treatment in the workplace

Metric		2022	2023		Comment
Metric 1 - Staff representation Percentage of BME staff in each of the AfC bands 1 - 9 or medical and dental subgroups and VSM (including executive board members) compared with the percentage of staff in the overall workforce.	Overall BME Percentage	7.62%	9.97%	↑	**Non- Clinical areas** - Slight increase across Bands 1 to 8B - No movement across 8C to VSM **Clinical Areas** - Increase by 3.37% in Bands 1 – 4 - Increase by 2.86% in Bands 5 – 7 - A very small percentage decrease at Band 8A - 8B - Medical and Dental Consultants and Medical and Dental Non-Consultants have shown an increase (3.29% and 11.78% respectively) - !3.5% drop in the Medical and Dental Trainees from 2022 - *In March 2023, 26.4% of the workforce across NHS trusts came from a BME background (380,108 people). Across all NHS trusts there were 144,750 more BME staff in 2023 compared to 2018 (equating to a 61.5% increase). Over the same period, the number of white staff increased by 53,279 (equating to a 5.7% increase).* ***For our Trust, BME presentation is positive as 3.9% of our population are from the BME communities***
	Non Clinical				
	Non-clinical Band 1 - 4	1.98%	1.99%	↑	
	Non-clinical Band 5 - 7	3.88%	4.89%	↑	
	Non-clinical Band 8A - 8B	2.33%	3.57%	↑	
	Non-clinical Band 8C - VSM	0%	0%	**No Move**	
	Clinical				
	Clinical Band 1 - 4	3.22%	6.59%	↑	
	Clinical Band 5 - 7	5.58%	8.44%	↑	
	Clinical Band 8A - 8B	1.56%	1.55%	↓	
	Clinical Band 8C - VSM	0%	0%	**No Move**	
	Medical and Dental Consultants	31.34%	34.63%	↑	
	Medical and Dental Non-Consultants	32.18%	43.96%	↑	
	Medical and Dental Trainees	50.00%	37.50%	↓	

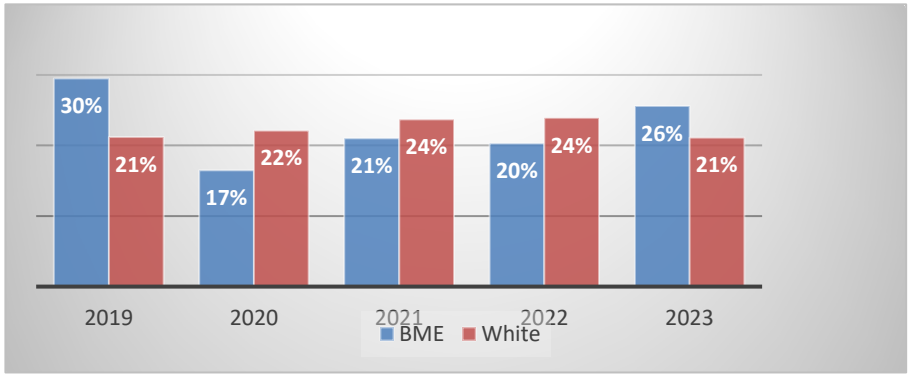
Metric 2	2022	2023		Comment
Metric 2 - Recruitment Relative likelihood of White staff being appointed from shortlisting across all posts *(A figure below 1.00 indicates that BME staff are more likely than white staff to be appointed from shortlisting)*	0.69	0.83		*This figure indicates that the relative likelihood of white staff being appointed from shortlisting compared to BME staff is 0.83 times greater. Detailed analysis of these figures will be examined as this figure seems to have increased significantly However this indicates an improvement.*

Metric 3	2022	2023		Comments
Metric 3 - Disciplinary Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation *Note: This indicator will be based on data from a two-year rolling average of the current year and the previous year.*	0	0	**No Move**	*Data collected is pertinent to a formal cabability process on grounds of ill Health and Performance. These figures may not capture the formal process. Further detailed analysis of the data collected will be undertaken*

Metric 4	2022	2023		Comments
Metric 4 - CPD Relative likelihood of staff accessing non-mandatory training and CPD *(A figure below 1.00 indicates that BME staff are more likely than white staff to be appointed from shortlisting)*	1	1.02		*Non-mandatory training refers to any learning, education, training or staff development activity undertaken by an employee, the completion of which is neither a statutory requirement or mandated by the organisation.* *Accessing non-mandatory training and CPD, in this context refers to courses and developmental opportunities for which places were offered and accepted. The data collected needs exploring as there is an expectation that all staff are expected to maintain internal consistency in training year to year, so that changes in uptake trends can be compared over time to assess equity in terms of the total numbers of staff accessing both mandatory and non-mandatory training.*

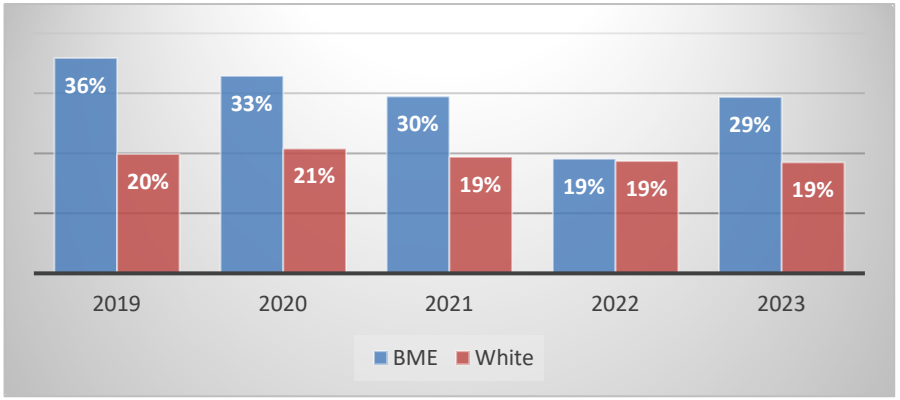
Detailed analysis of Metrics 5 – 7 (Bullying and Harassment)

Percentage of staff experiencing harassment, bullying or abuse from **patient's relatives or public** in the last 12 months					
	2019	*2020*	*2021*	*2022*	*2023*
BME	***29.5%*** ***(78 responses)***	***16.5%*** ***(85 responses)***	***21%*** ***(105 responses)***	***20.3%*** ***(133 response)***	***25.6%*** ***(164 Responses)***
White	***21.2%*** ***(1429 responses)***	***22.1%*** ***(1394 responses)***	***23.7%*** ***(1742 responses)***	***23.9%*** ***(1935 responses)***	***21.1%*** ***(1961 Responses)***



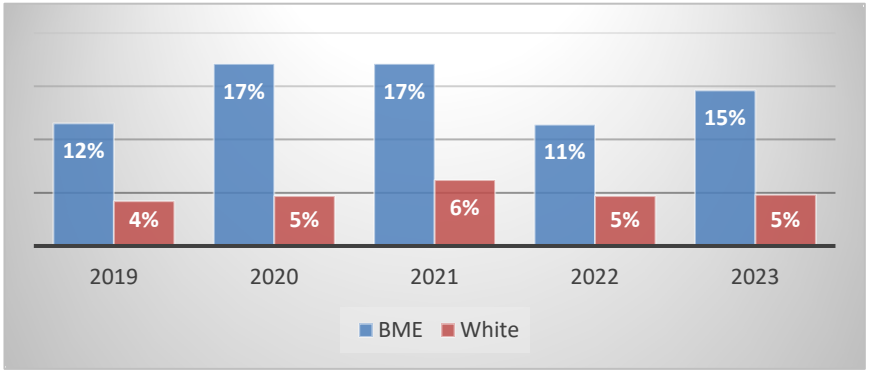
The % of staff overall experiencing harassment, bullying or abuse from patients, service users, relatives, or the public has increased from the previous year for BME staff and a decrease for the White staff. The response rates for both groups has also increased. For BME the % figure has been rising since 2019, (albeit with small dip in 2020), whilst for the White Group the 2023 figure is back to the 2019 figure of 21.2%

Percentage of staff experiencing harassment, bullying or abuse from **staff** in the last 12 months					
	2019	*2020*	*2021*	*2022*	*2023*
BME	***35.9%*** ***(78 responses)***	***32.9%*** ***(85 responses)***	***29.5%*** ***(105 responses)***	***19.1%*** ***(131 responses)***	***29.4%*** ***(164 Responses)***
White	***19.9%*** ***(1431 responses)***	***20.8%*** ***(1396 responses)***	***19.4%*** ***(1735 responses)***	***18.7%*** ***(1935 responses)***	***18.5%*** ***(1961 Responses)***



The overall % staff experiencing harassment, bullying or abuse from other staff in the last 12 months has increased for BME staff by nearly 10% and is back to the 2021 % figure. For the White staff there is very small increase. There remains a significant gap between the likelihood of bullying and this figure indicates that BAME staff are still more likely to experience harassment or bullying.

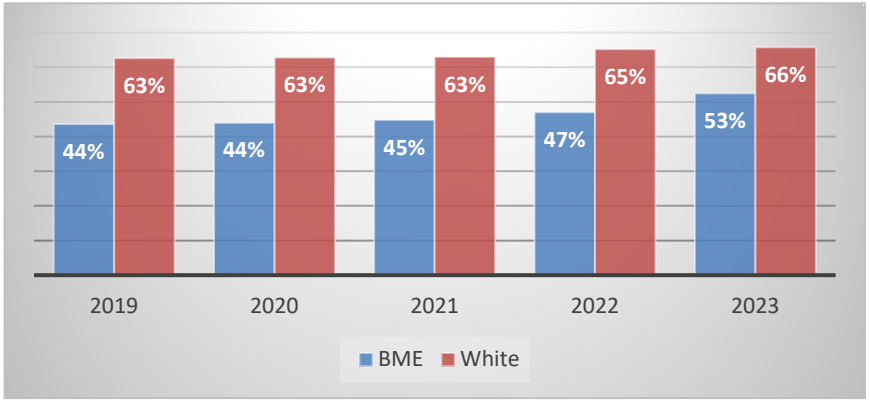
Percentage of staff experiencing discrimination at work from **a manager / team leader or other colleagues**					
	2019	*2020*	*2021*	*2022*	*2023*
BME	***11.5%*** ***(78 responses)***	***17.1%*** ***(82 responses)***	***17.1%*** ***(105 responses)***	***11.4%*** ***(132 responses)***	***14.6%*** ***(164 responses)***
White	***4.2%*** ***(1418 responses)***	***4.7%*** ***(1393 responses)***	***6.2%*** ***(1733 responses)***	***4.7%*** ***(1937 responses)***	***4.8%*** ***(1961 responses)***



The data shows a large disparity between BAME and White staff personally experiencing discrimination at work from a manager/team leader in the 2023 figures. Data collected over the last 5 years shows that the figures for the BME group has increased from 11.4% to 14.6%. For White staff this figure has remained approximately the same – apart from 2021 when it rose by 1.5%. However in comparison across all years, BME staff experience significantly more discrimination from a manager/ team leader or other colleague. In 2023, BME staff % difference from their White colleagues stood at 9.8%

Metric 8

Percentage of staff believing that the trust provides equal opportunities for career progression or promotion					
	2019	*2020*	*2021*	*2022*	*2023*
BME	***43.6%*** ***(78 responses)***	***44%*** ***(84 responses)***	***44.8%*** ***(105 responses)***	***47%*** ***(129 responses)***	***53%*** ***(164 responses)***
White	***62.6%*** ***(1427 responses)***	***62.8%*** ***(1401 responses)***	***63%*** ***(1725 responses)***	***65.2%*** ***(1927 responses)***	***66%*** ***(1961 responses)***



An increasing proportion of staff in both groups indicated that there was equity for career progression and/or promotion understanding whether there is equity in terms of take up of Career Progression or promotion. However a **13 %** gap still remains between White and BME staff

Metric 9

BAME Board membership (difference between the organisations Board voting membership and its overall workforce					
	2019	*2020*	*2021*	*2022*	*2023*
BME	***0***	***0***	***1 Associated NED***	***1 Associated NED***	***0***

There has not been any change in this indicator. However in principle it has been agreed where external agency is undertaking a recruitment exercise at this level, due consideration will be paid in trying to readdress numbers of BME groups applying. As per previous recruitment exercises, the Trust will continue to have an independent external BME representative on the appointment panel.

Appendix 3

Workforce Race Equality Action Plan 2024/25					
	Action	**Lead**	**Time frame**	**WRES Metric**	**Rag Rating**
1	FTSU Guardian to report experiences of BME staff who have: - Reported issues pertaining to disciplinary (formal and informal) - Outcomes of who have been through the Disciplinary process to the HREDI Programme Board on a quarterly basis	Freedom to Speak Up Guardian	November 2024	3	
2	Develop a quarterly report monitoring the application of the Flexible working policy for GEM and White colleagues. This would monitoring Themes and Trends.	Head of People services	March 2025	3	
3a	Implement recommendations from the EDI supply group around inclusive recruitment and promotion programme and ensure each stage of the recruitment pathway is equitable by reviewing and updating the recruitment and values based recruitment training, to incorporate workforce planning and improve the length of time to hire	Recruitment Manager, EDI Manager and Head of People Services	December 2024	2, 4, 8	
3b	Ensure that our recruitment adverts have a diversity statement and are fully accessible	Recruitment Manager, EDI Manager and Head of People Services	December 2024	2	
3c	Draft a standard report which will be provided to the HREDI Group regarding recruitment activities across diversity metrics	Recruitment Manager, EDI Manager and Head of People Services	December 2024	2,8	
4	Zero tolerance and its impact on members of staff is part of any discussions – addressing and scoping areas where there may be perceived systemic racism and inequalities take place Draft a standard report which will be provided to the HREDI Group regarding Diversity metrics	Head of People Services	November 2024	5, 6	
5	As part of our EDI Dashboard, capture diversity data for member of staff referred to any capability and performance management procedure, both formal and informal. Data captured will help in the WRES submission for 2025	Head of People Services	November 2024	1	

	Draft a standard report which will be provided to the HREDI Group regarding performance and capability cases across diversity metrics.				
6	Collect and analyse ethnicity and gender pay gap report	Information team EDI Manager	November 2024	1	
7	Deliver cultural competency learning for all staff and managers	EDI Manager	Awaiting Senior Management decision	5	
8	Supporting Chair and Co-Chair of GEM network to launch monthly webinars for all staff highlighting different aspects of race inequalities	GEM network	November 2024	Across all	
9	Update management guidance and appraisal training for managers to include intersectional approach and unconscious bias in the context of objective setting and career development Diversity metrics captured of staff attending training/accessing CPD funding/Study leave/Managing well/leading well etc. Quarterly report into HREDI Programme Board.	Head of Learning and Development	December 2024	1 and 7	
10	Roll out reverse / reciprocal mentoring	Head of Leadership, OD & Staff Experience and EDI manger	March 2025	3	

Appendix 4

WORKFORCE DISABILITY EQUALITY STANDARD REPORT

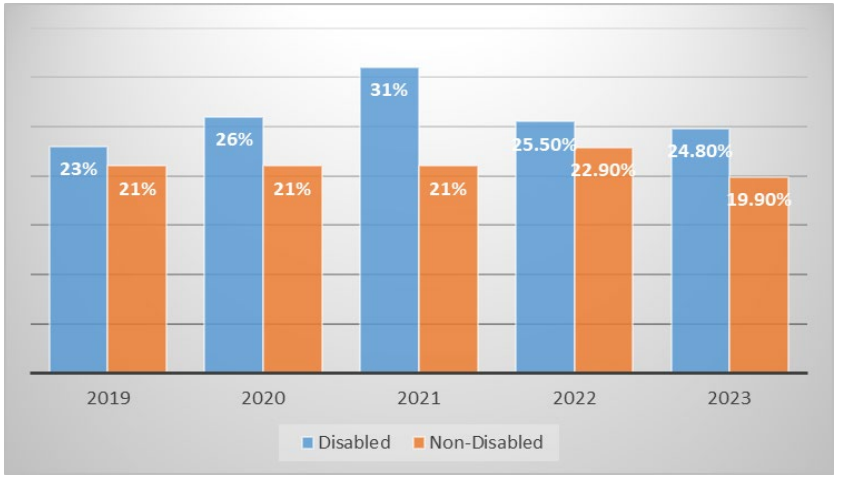
Metric 1		2022	2023		Comment
Metric 1 - Staff representation Percentage of Disabled staff in AfC paybands or medical and dental subgroups and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce	**Overall**	**5.24%**	**5.28%**	↑	**Non- Clinical areas** - Virtually equal parity for Bands 1- 7 - Greatest difference is at Bands 8A and 8B (3.1%) - An Increase of 3% at Bands 8C and VSM **Clinical areas** - Virtually equal parity for Bands 1- 7 - Small decrease at Band 8A – 8B (0.7%) - Medical and Dental Consultants have decreased by 0.35%, whilst for both Medical and Dental Non-Consultants and Medical and Dental Trainees the figure shown an improvement (1.8 and 5% respectively)
	Non - Clinical				
	Non-clinical Band 1 - 4	7.7%	7.6%	↓	
	Non-clinical Band 5 - 7	5.8%	5.9%	↑	
	Non-clinical Band 8A - 8B	5.3%	2.2%	↓	
	Non-clinical Band 8C - VSM	0%	3%	↑	
	Clinical				
	Clinical Band 1 - 4	5.4%	5.5%	↑	
	Clinical Band 5 - 7	5.5%	5%	↓	
	Clinical Band 8A - 8B	4.6%	3.9%	↓	
	Clinical Band 8C - VSM	0%	0%	**No Move**	
	Medical and Dental Consultants	3.35%	3%	↓	
	Medical and Dental Non-Consultants	3.30%	5.1%	↑	
	Medical and Dental Trainees	0%	5%	↑	

Metric 2	2022	2023		Comment
Metric 2 - Recruitment Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts. A figure of 1.0 represents equity of opportunity	1.09	1	↑	*Improvement of 0.09% compared to previous year. Reporting figure is less than 1 indicating a greater likelihood of disabled colleagues being appointed.*

Metric 3	2022	2023		Comment
Metric 3 - Recruitment Relative likelihood of Disabled staff compared to non-Disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	0	0	**No Move**	*Further detailed analysis of the data collected needs to be examined. Data collected is pertinent to formal cabability process on grounds of ill Health and Performance. These figures may not capture the formal process.*

Metric 4 – Percentage of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or the public in the last 12 months.

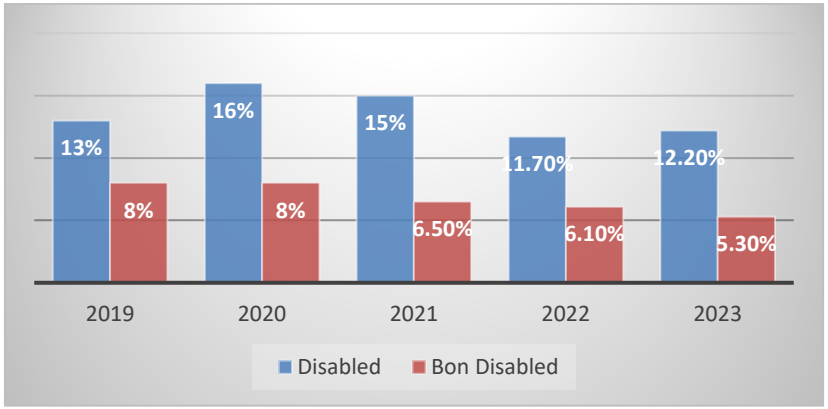
In the last 12 months, percentage of staff experiencing harassment, bullying or abuse from:		2019	2020	2021	2022	2023
a) Patients/ service users, their relatives or other members of the public	**Disabled (with LTC)**	**23%** *320 responses*	**26%** *365 responses*	**31%** *504 responses*	**25.5%** *534 responses*	**24.8%** *603 responses*
	Non Disabled (without LTC)	**21%** *1195 responses*	**21%** *1123 responses*	**21%** *1339 responses*	**22.9%** *1529 responses*	**19.9%** *1485 responses*



The data indication for this indicator in respect of Disabled staff (LTC) shows a marginal decrease 2022 (down by 0.7%)

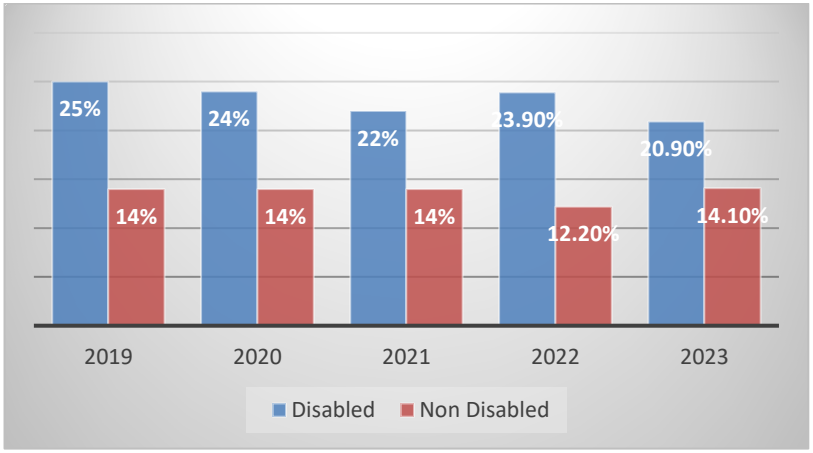
For Non-disabled staff there has been virtually no change apart from 2023 a decrease (3%). In comparison for 2023, the figures for this indicator show that disabled staff with LTC were 5.9% times more likely to experience harassment from user, relatives or members of the public.

In the last 12 months, percentage of staff experiencing harassment, bullying or abuse from:		2019	2020	2021	2022	2023
b) Managers	**Disabled (with LTC)**	**13%** *319 Responses*	**16%** *367 Responses*	**15%** *499 responses*	**11.7%** *532 responses*	**12.2%** *603 responses*
	Non Disabled (without LTC	**8%** *1191 Responses*	**8%** *1120 responses*	**6.5%** *1330 responses*	**6.1%** *1519 responses*	**5.3%** *1485 responses*



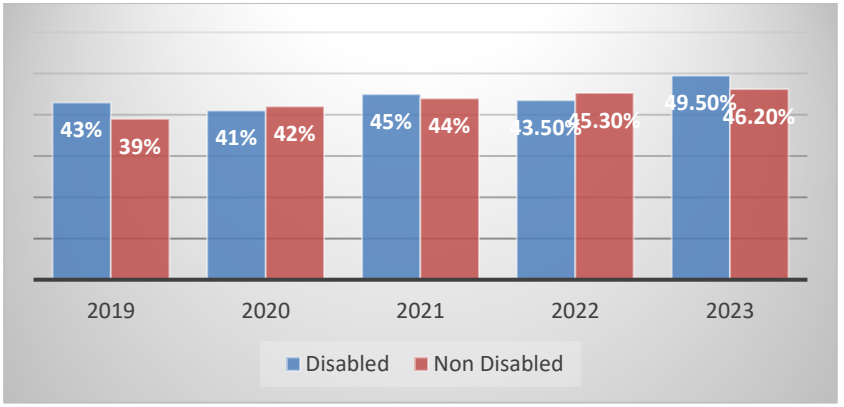
The data indication for this indicator in respect of Disabled staff (LTC) shows an increase since 2022 (0.5%)
The figure for Non-disabled is also decrease (from 0.8%). In comparison for 2023, the figures for this measure show that disabled staff with LTC were 6.9% times more to experience harassment from Managers

In the last 12 months, percentage of staff experiencing harassment, bullying or abuse from:		2019	2020	2021	2022	2023
c) Colleagues	**Disabled (with LTC)**	**25%** *311 responses*	**24%** *360 responses*	**22%** *496 responses*	**23.9%** *527 responses*	**20.9%** *603 responses*
	Non Disabled (without LTC)	**14%** *1184 responses*	**14%** *1105 responses*	**14%** *1323 responses*	**12.2%** *1513 responses*	**14.1%** *1485 responses*



Disabled staff (LTC) experiencing harassment / abuse from colleagues has decreased (by 3.9%).
Non-disabled shows an increase (1.9%). In comparison for 2023, the figures for this measure show that disabled staff with LTC were 6.8% times more to experience harassment from colleagues.

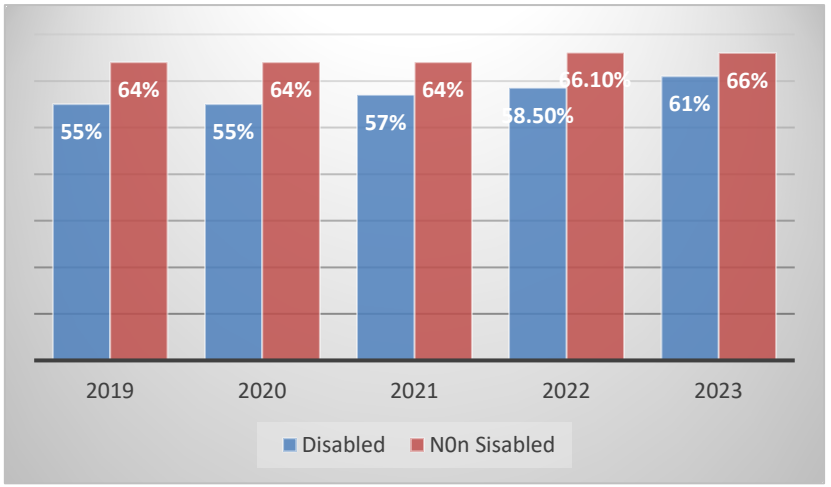
In the last 12 months, percentage of staff experiencing harassment, bullying or abuse from:		2019	2020	2021	2022	2023
d) They or their colleague reported it	**Disabled (with LTC)**	**43%** *126 responses*	**41%** *148 responses*	**45%** *195 responses*	**43.5%** *193 responses*	**49.5%** *603 responses*
	Non Disabled (without LTC	**39%** *341 responses*	**42%** *310 responses*	**44%** *367 responses*	**45.3%** *419 responses*	**46.2%** *1485 responses*



In terms of this measurement it can be seen that the figures for colleagues reporting incidences has increased (from 43% up by 6.5% to 49.5%). This is virtually the same for the Non-Disabled group (from 39% up by 7.2% to 46.2%). In comparison for 2023, the figures for this measure show that colleagues reported any harassment / abuse to disabled staff more than Non-Disabled staff (49.5% v 46.2)

Metric 5

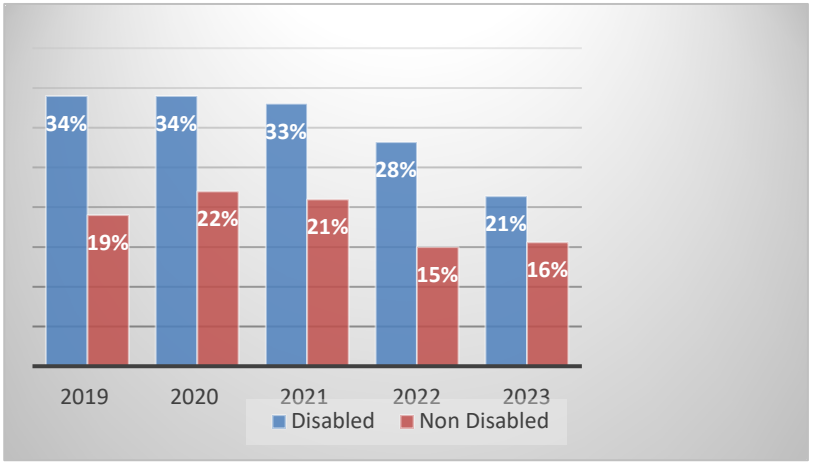
Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	2019	2020	2021	2022	2023
Disabled (with LTC)	**54%** *322 responses*	**55%** *367 responses*	**57%** *500 responses*	**58.5%** *537 responses*	**61%** *603 responses*
Non Disabled (without LTC)	**64%** *1191 responses*	**64%** *1127 responses*	**64%** *1328 responses*	**66.1%** *1515 responses*	**66%** *1485 responses*



For Disabled groups (LTC) the figure has increased – up by **2.5%** whilst for Non-Disabled staff this increase is small (up by **0.9%**).
In comparison for 2023, the figures for this measure show that disabled staff with LTC were **5%** less likely to have the same opportunities for career progression.

Metric 6

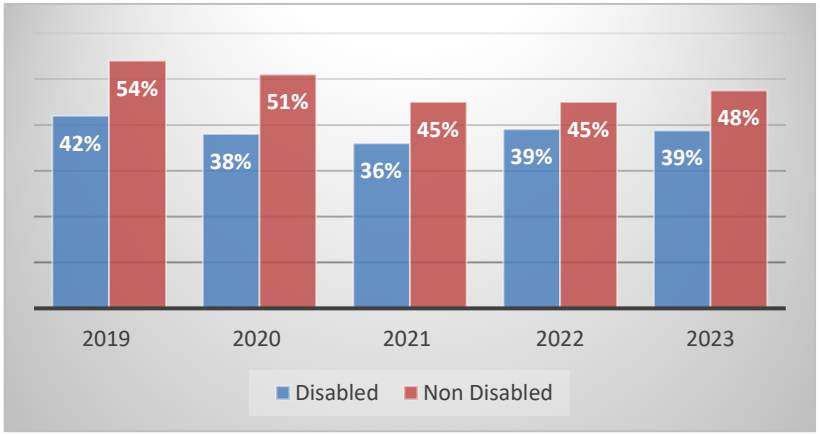
Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	2019	2020	2021	2022	2023
Disabled (with LTC)	34% *219 responses*	34% *228 responses*	33% *343 responses*	28.2% *397 responses*	21.4% *603 responses*
Non Disabled (without LTC)	19% *610 responses*	22% *420 responses*	21% *633 responses*	15% *824 responses*	16% *1485 responses*



The pressure to come to work for Disabled (LTC) staff has fallen by 6.8%, but it should be noted that the response rate has virtually doubled. For Non-Disabled staff there has been an increase of 1%. In comparison for 2023, the figures for this measure show that disabled staff with LTC were 5.4% more likely to be pressured to come to work.

Metric 7

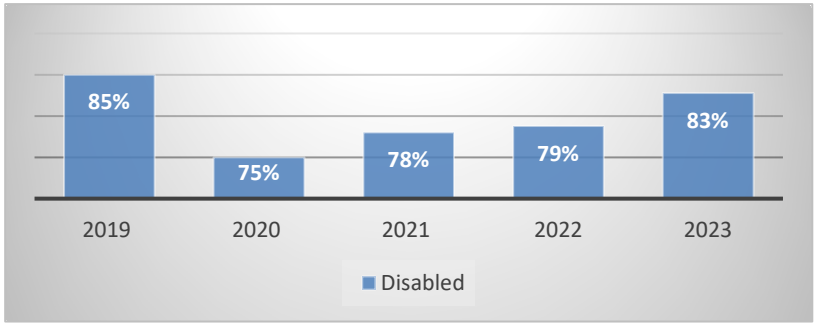
Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which the organisation values their work.	2019	2020	2021	2022	2023
Disabled (with LTC)	42% *323 responses*	38% *364 responses*	36% *506 responses*	39.1% *537 responses*	38.8% *603 responses*
Non Disabled (without LTC)	54 % *1191 responses*	51% *1120 responses*	45% *1333 responses*	45% *1528 responses*	47.5% *1485 responses*



There has been little change in the proportion of Disabled staff who do not feel that the organisation values their work. This figure has decreased slightly (0.3%). Non Disabled staff figures indicate that satisfaction satisfied with the extent to which their work is valued has increased by 2.5%

Metric 8

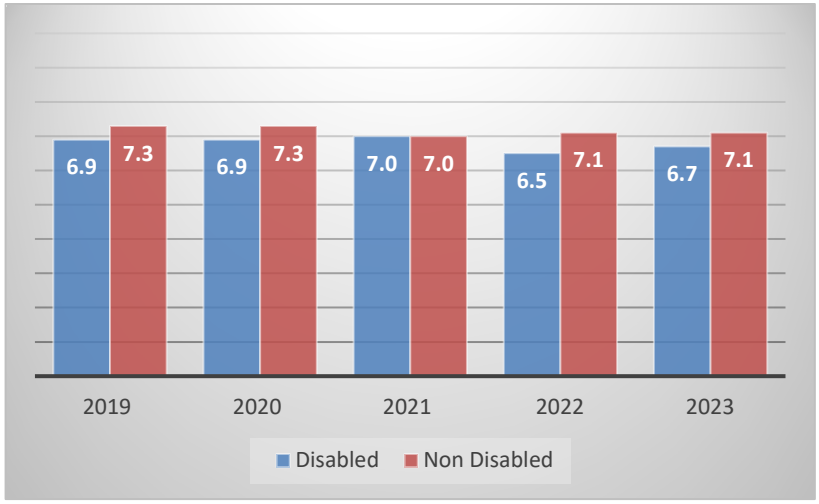
Percentage of disabled staff saying that their employer has made adequate adjustments to enable them to carry out their role.	2019	2020	2021	2022	2023
Disabled (with LTC)	**85%** *179 responses*	**75%** *221 responses*	**78%** *290 responses*	**78.8%** *824 responses*	**82.8%** *603 responses*



Whilst there was a slight increase from 2020 till 2023, it is clear that the figure around reasonable adjustments is not at the 2019 % point. The response rate has also gone down significantly in 2023. However in comparison with the 2022 figure there is a 4% rise in respect of this metric.

Metric 9

Staff engagement score for disabled staff compared to non-disabled staff and the overall engagement for the organisation (out of 10).	2019	2020	2021	2022	2023
Disabled (with LTC)	**6.9%** *324 responses*	**6.9%** *367 responses*	**7%** *508 response*	**6.5%** *539 rersponses*	**6.7%** *603 rersponses*
Non Disabled (without LTC)	**7.3 %** *1201 responses*	**7.3%** *1130 responses*	**7%** *1341 responses*	**7.1%** *1532 responses*	**7.1%** *1485 responses*



This measurement is a reflection of practical examples being used to provide equity for Disabled people. The national figure is around 7.1. Our figures show that our score has nearly always been on par across the years across Disabled and Non – disabled staff.

Appendix 5

Workforce Disability Equality Action Plan 2024/25					
	Action	**Lead**	**Time frame**	**WDES Metric**	**Rag Rating**
1	Review and develop guidance to ensure that reasonable adjustments are in place for our patients and are fit for purpose. Review current guidance around providing reasonable adjustments for our staff.	EDI Manager, PALS	March 2025	8	
2	Refresh the Accessible Information Standard and Learning Passport for the Trust	EDI Manager, Learning Disabilities Nurse	December 2024	8	
3a	Implement recommendations from the EDI supply group around inclusive recruitment and values based recruitment training to incorporate workforce planning, improve length of time to hire.	Recruitment Manager, EDI Manager and Head of People Services	December 2024	1,2 and 8	
3b	Ensure that our recruitment adverts have a diversity statement and are fully accessible by offering candidates the opportunity to request reasonable adjustments	Recruitment Manager, EDI Manager and Head of People Services	December 2024	2,5,8	
3c	Draft a standard report which will be provided to the HREDI Group regarding Diversity metrics specifically around Disability.	Recruitment Manager, EDI Manager and Head of People Services	December 2024	2,5,8	
4	As part of our EDI Dashboard, capture diversity data for member of staff referred to any capability and performance management procedure, both formal and informal. Data captured will help in the WRES submission for 2025 Draft a standard report which will be provided to the HREDI Group regarding Diversity metrics captured in Employee relations in respect of Disabled v Non-Disabled staff	Head of People Services	November 2024	3	
5	Draft a standard report which will be provided to the HREDI Group regarding Employee relations activities across diversity metrics specifically in relation to EDI Metrics around bullying, and harassment	Head of People Services	January 2025	4	

6	Collect and analyse disability pay gap data	Information team EDI Manager	December 2024	8	
7	Working in collaboration with the FTSU Guardian, create and launch EDI feedback form specifically for staff to raise concerns	FTSU Guardian, EDI Manager	November 2024	4	
8	Working with the Chair and Co-Chair of D-ability launch monthly webinars for all staff highlighting different aspects of disability.	D-ability network	Ongoing	4	
9	Promotion leadership and career development opportunities, specifically tailored to disabled staff. Link in with regional and national Disability rights programme of work	Learning and Development	January 2025	5	
10	**Metric 9 is around Staff engagement** • creating multiple channels to allow staff to speak up and raise concerns • utilising Schwartz Rounds to facilitate conversations on lived experience • training all line managers to hold supportive conversations with disabled staff • inviting staff networks to present at board meetings • ensuring staff networks have executive sponsors who meet with the networks regularly • providing training sessions to raise awareness and discussion on such as neurodivergence	Learning and Development	Ongoing	9	

Appendix 6

Key Finding – Benchmarked across all Trusts the WDES national team report indicates the following:

Workforce representation

4.9% of the workforce declared a disability through the NHS electronic staff record (ESR) in 2023, an increase of 0.7 percentage points since 2022. The number of people declaring a long-term condition or illness anonymously in the NHS Staff Survey has also increased, from 22.4% in 2021 to 23.4% in 2022.

Capability

The relative likelihood of a disabled colleague being in capability is 2.17. This means that disabled staff are more than twice as likely to be in the capability process on the grounds of performance.

Career progression

52.1% of disabled staff believed they had equal opportunities for career progression or promotion. This is an increase from 51.3% in 2022.

Feeling valued

35.2% of disabled staff reported that they felt valued for their contribution.

Staff engagement

The staff engagement score for disabled staff was 6.4, the third consecutive year it has fallen. 100% of trusts said that they had facilitated the voices of disabled staff to be heard.

Recruitment

The relative likelihood of a disabled job applicant being appointed through shortlisting has improved from 1.18 in 2019 to 0.99 in 2022. This national average suggests disabled and non-disabled applicants are equally likely to be recruited, but experience varies at trust level.

Harassment, bullying or abuse

33.2% of disabled staff reported having experienced bullying, harassment or abuse from patients, service users or the public, 16.1% from managers and 24.8% from other colleagues.

Presenteeism

27.7% of disabled staff experienced presenteeism. We continue to observe steady improvements in this metric since 2020.

Workplace adjustments

73.4% of disabled staff reported they had the reasonable adjustment(s) required to perform their duties.

Board representation

5.7% of board members declared a disability through ESR in 2023, an increase of 1.1 percentage points since 2022.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 22

Report Title:	**Maternity Integrated Oversight Report – August 2024**			
Name of Meeting:	Board of Directors			
Date of Meeting:	24 September 2024			
Author:	Ms Karen Parker, Lead Midwife for Risk and Patient Safety/Head of Midwifery			
Executive Sponsor:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Ms Karen Parker, Lead Midwife for Risk and Patient Safety/Head of Midwifery			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	This report presents a summary of the maternity indicators for the Trust from the month of August 2024			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Maternity Safecare 12/9/2024 Maternity Safety Champions meeting 13/9/2024 Safecare Steering Group 17/9/2024 Trust Board 24/9/2024 SBU Ops Board 25/9/2024			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	**Maternity dashboard:** • In August 2024, there were 187 births, 0 MNSI case and 1 perinatal loss. • Exceptions reported – positive reports for CO monitoring & breastfeeding **Q1 ATAIN:** • 36 term admissions to SCBU • Themes – escalation & recognition of abnormal CTG, early feeding, paediatric reviews			
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 August 2024

Maternity IOR contents

- Maternity Dashboard 2024/25:
  - August 2024 data

- Exception reports:
  - CO monitoring & smoking at booking
  - Initiation & early breastfeeding

- Items for information:
  - Strategic Objectives Perinatal Quality Surveillance minimum dataset
  - Incidents
    - 0 MNSI cases reported in August 2024
  - Perinatal Mortality and Morbidity
    - 1 perinatal losses in August 2024
  - Q1 ATAIN report

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Births	Aug 24	187	-			158	116	201
Spontaneous vaginal deliveries	Aug 24	85	-			76	52	99
Assited births	Aug 24	102	-			83	53	112
Induction of Labour	Aug 24	64	-			63	37	88
Maternity Readmissions	Aug 24	2	-			3	-3	10
Neonatal Readmissions	Aug 24	6	-			5	-2	13
Smoking at time of booking	Aug 24	11.76%	15.00%		P	8.92%	2.98%	14.85%
Smoking at time of delivery	Aug 24	7.53%	6.00%		?	7.42%	-0.30%	15.15%
In area CO at booking	Aug 24	96.77%	90.00%	H	?	89.60%	79.05%	100.15%
In area CO at 36 weeks	Aug 24	81.65%	80.00%		?	83.19%	71.80%	94.59%
Admitted directly to NNU (SCBU) (>37 weeks)	Aug 24	11	4		?	8	-1	17
Percentage Admitted directly to NNU (SCBU) (>37 we	Aug 24	6.08%	6.00%		?	5.56%	-0.45%	11.56%
Preterm birth rate <=36+6 weeks at birth	Aug 24	0.00%	6.00%		?	5.62%	-0.17%	11.42%
Continuity of Carer: Percentage placed on pathway (2	Aug 24	15.72%	-			16.90%	7.38%	26.42%
Continuity of Carer: Percentage from BAME backgrou	Aug 24	43.24%	-			28.91%	0.52%	57.29%
Spontaneous Vaginal Births (%)	Aug 24	45.70%	-			47.92%	35.72%	60.12%
Induction Rate	Aug 24	34.41%	-			40.21%	28.88%	51.55%
Instrumental Delivery Rate	Aug 24	13.98%	-			13.37%	5.68%	21.05%
Elective C Section Rate	Aug 24	16.13%	-			18.33%	7.32%	29.34%
Emergency C Section Rate	Aug 24	24.19%	-			20.52%	9.20%	31.83%
C Section Rate	Aug 24	40.32%	-			38.85%	24.72%	52.97%
3rd or 4th degree tear (Total) Precentage	Aug 24	1.08%	3.00%		?	1.07%	-1.05%	3.18%
Massive PPH >=1.5L (All births)	Aug 24	5	2		?	9	0	18
Breastfeeding: Percentage of Initiated Breasfeeding	Aug 24	83.30%	66.20%	H	?	74.60%	64.10%	85.11%
Breastfeeding: Breasfeeding at Discharge (Transfer to	Aug 24	71.11%	56.20%	H	?	56.28%	39.09%	73.46%

Safe

Responsive

Maternity

NHS

Gateshead Health

NHS Foundation Trust

Maternity Dashboard 2024/25

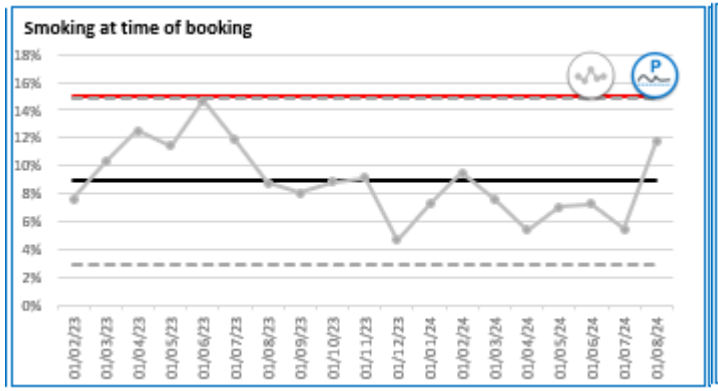
Maternity Dashboard 2024/25

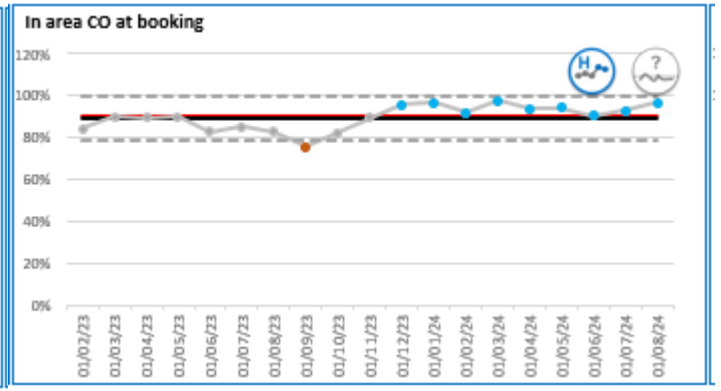
Maternity

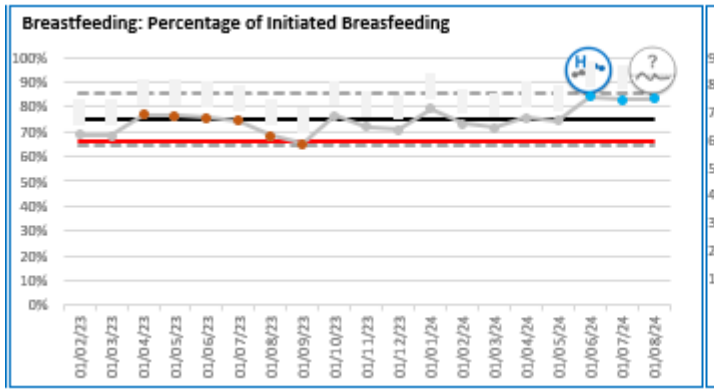
NHS Gateshead Health NHS Foundation Trust

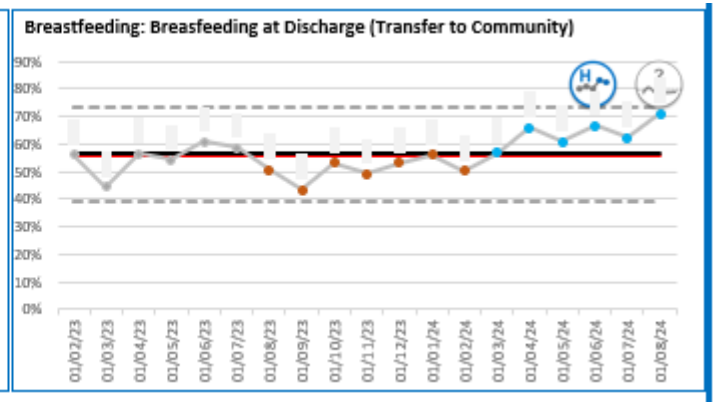
Responsive

Safe









Background

- Public health indicators

Assessment

- Positive outliers for both CO monitoring & early breastfeeding rates
- Risk to sustained compliance with both these areas due to capacity within QUIT team & no Infant Feeding lead in post (non-recurrent funding ceased therefore post ended)

Actions

- Continue with current resource

Recommendations

- Will not be compliant with UNICEF Stage 3 accreditation – part of three- year delivery plan for accreditation by 2027
- Include consideration of smoking & infant feeding within public health planning & ongoing BR+ discussions

Maternity

NHS
Gateshead Health
NHS Foundation Trust

Safe

Well Led

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

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total Areas	9	9	9	9	9							
Areas Not Applicable												
No. Compliant	7	7	5	5	3							
No. Non Compliant	2	2	4	4	6							
Percentage Compliance	78%	78%	74.0%	74%	89%							

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

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

How are we performing or Progress Made?
LMNS audits implemented from Q1
LMNS informed consent/PCP workstream representation in task & finish group

What is driving performance or what are the challenges
Capacity challenges in QUIT smoking in pregnancy team – additional support provided from specialist midwife & public health lead
Present workforce plan to reach new compliance with 2024 BR+ report – GHLG, F&P, Trust board
MNVP support for website review

What actions is being taken or future risks & planned developments
Q1 LMNS review completed – review of feedback underway
Q1 documentation (risk assessment) audit results reported
Need to complete PCP audit of 5%

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

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total Areas	89	89	89	89	89							
Areas not Applicable	6	6	6	6	6							
No. Compliant	56	63	68	69	74							
No. Non Compliant / Unassessed	35	26	15	14	15							
Percentage Compliance	63.0%	71.0%	76.0%	78%	83%							

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

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

How are we performing or Progress Made?
Ongoing work with board and finance teams to achieve compliance with BR+, Q1 LMNS PQSOG assurance meeting & Saving Babies Lives review meeting held, QI projects approved by LMNS – smoking & fetal well-being,
Ongoing work with board and finance teams to achieve compliance with BR+ - Trust board 24/9/24, Culture feedback sessions completed – final QUAD sessions planned & development of improvement plan – draft report for September safety champion meeting

What is driving performance or what are the challenges
Workforce (Birthrate+ establishment compliance ongoing)

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

2024/25		April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Number of perinatal losses		0	0*	1	0	1							
Number of HSIB cases		1	0*	0	0	0							
Number of incidents logged as moderate harm or above		1	0	0	0	0							
Minimum obstetric safe staffing on labour ward		100%	100%	100%	100%	100%							
Minimum midwifery safe staffing including labour ward (average fill rates)	Day shift	107.7	110.0%	98.4%	99.3%	100%							
	Night shift	105.2	109.7%	102.8%	103.6%	102.5%							
	CHPPD*	18.3	18.7	18.4	11.9	12.2							
Service user feedback	FFT "Overall how was your experience of our service" – total score for *very good* and *good* responses	100%	90%	100%									
	Complaints	2	1	1	3	0							
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust		0	0	0	0	0							
Coroner Reg 28 made directly to Trust		0	0	0	0	0							

*CHPPD overall care hours per patient per day

ATAIN- Avoiding term admissions to SCBU

Q1 2024/25 Total births	Births >37 weeks	Total term admissions	Reasons for admission
469	444	36	RDS, Monitoring, Jaundice, Sepsis, Hypoglycaemia, Feeding, Hypothermia.

Item No	Link to ATAIN admission criteria	Learning	Action
1	Recognition of abnormal, suspicious and pathological CTGSs	• Delay to recognition of abnormal, suspicious and pathological CTGS.	• Full day MDT Fetal wellbeing day • Monthly case study teaching – Q1 cases used for teaching. • Newsletter with learning from incidents – disseminated. • New fresh eyes protocol. • Fresh Eyes Audit – ongoing.
2	Escalation of abnormal, suspicious and pathological CTGs	• Delay to escalation of abnormal, suspicious and pathological CTGS.	• Introduced RCOG each baby counts escalation tool kit. • New fresh eyes protocol • Hourly review of antenatal CTGs • Twice month fetal wellbeing teaching
3	First feed within the hour of birth	• Only 8% of babies in Q1 were within the first 60 minutes of birth.	• Audit time of first feed within 120 minutes of delivery – commenced. • Feeding training on MMAT • Promote colostrum harvesting
4	Multiple reviews from neonatal team prior to admission	• Delayed reviews when requested and multiple reviews prior to admission.	• Improve staffing levels on SCBU (including ANNPs). • Promote regular consultant ward rounds • Link with senior neonatal consultant to implement guideline of escalation from neonatal concerns • AB taking escalation plan to paediatric SafeCare meeting. • New ANNP employed on SCBU • Outstanding - presentation of cases at Paediatric SafeCare.

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 23

Report Title:	**Nursing Staffing Exception Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	24th September2024			
Author:	Helen Larkin, Clinical Lead E-rostering			
Executive Sponsor:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Purpose of Report	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	This report is to provide assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis to provide adequate staffing levels.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by:				
Key issues:	This report provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls within the month of August 2024. August has demonstrated some areas with staffing challenges relating to sickness absence and enhanced care requirements. During August, we continued to experience periods of increased patient activity with surge pressure resulting in escalation areas. This has impacted on staffing resource. There is continued focused work around the recruitment and retention of staff and managing staff attendance. Wards where staffing fell below 75% of the funded establishment are shown within the paper. Detailed context and actions taken to mitigate risk are documented. A staffing escalation protocol is now in operation across all areas within the organisation and assurance of this operating as expected, is provided by			

<table>
<tr><td></td><td colspan="5">the number of staffing incident reports raised through the incident reporting system.</td></tr>
<tr><td>Recommended actions for this meeting:</td><td colspan="5">The Board of Directors is asked to:
• receive the report for assurance
• note the work being undertaken to address the shortfalls in staffing</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
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<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☐</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">There was eight staffing incident raised via InPhase during the month of August, of which there was one moderate psychological harm identified.</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

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

1. Introduction

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

2. Staffing

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

Day	Day	Night	Night
Average fill rate - registered nurses/midwives (%)	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
97.8%	**104.8%**	**97.6%**	**106.3%**

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

Exceptions:

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

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

Contextual information and actions taken

SCBU – Fill rates are due to recent recruitment still in progress (vacancies), sickness and peak annual leave demands. It is anticipated September data will see improvement.

Ward 28 report Lower elective orthopaedic activity and inpatient numbers on a Monday/ Friday and over weekends. Therefore, HCAs are rostered to days in the week where there is increased elective activity. Additionally during the month of August there was long-term sickness affecting the night fill rates.

Sunniside mitigated their low percentage of qualified day shift with additional HCA, this also supported three patients requiring 1-1 escort for treatment.

Cragside had a high percentage of HCA on nights to support two patients on eyesight observations.

The exceptions to report for August are as below:

August 2024	
Registered Nurse Days	**%**
Special Care Baby Unity	70.7%
Registered Nurse Nights	**%**
Healthcare Support Worker Days	**%**
Special Care Baby Unit	69.4%
Healthcare Support Worker Nights	**%**
Ward 28	45.6%

In August, 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 August, 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 August, the Trust total CHPPD was 8.2. 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.

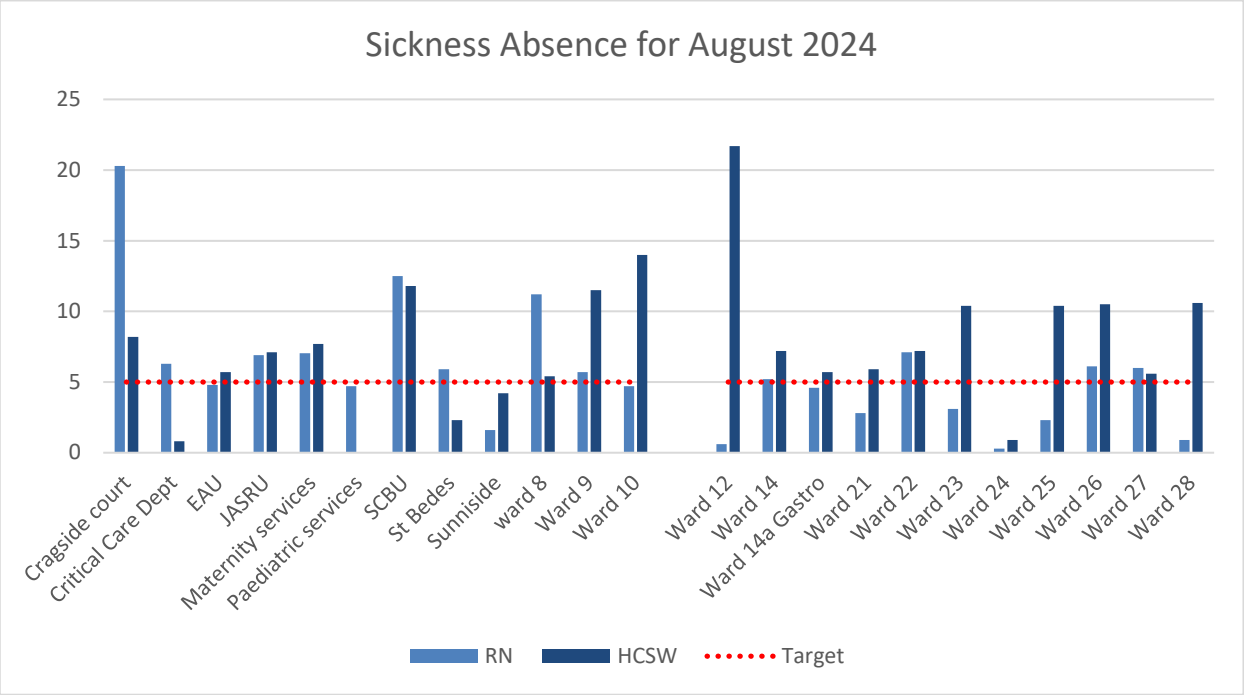
A report of staffing concern related incidents is generated monthly and discussed at the Nursing Midwifery Professional Forum. There was eight nurse-staffing incidents raised via the incident reporting system. Paediatric services raised four incidents due to insufficient nurses. One incident was raised by ward 9 as unable to provide enhanced care to cohort patients due to staff shortages. Ward 21 raised one incident due to insufficient nurses. Ward 14 raised one incident due to the redeployment of the third qualified nurse on nightshift. Ward 22 raised one incident also due to redeployment of third qualified nurse on shift. No physical harm was reported on any of the incidents. Ward 21 report a moderate level of psychological harm.

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 August there were 49 nursing red flags reported. This is compared to 67 red flags reported in July. Of those 49 Red flags raised, nine of those were in Paediatrics; Same Day Emergency Care (SDEC) raised nine. Ward 12 raised three. Ward 8 Acute Cardiology raised fourteen. Ward 25 raised ten. The A&E department raised two and two were raised by ward 14. There were no red flags raised by SCBU or Ward 28.

5. Attendance of Nursing workforce

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



6. Governance

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

7. Conclusion

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

8. Recommendations

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

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

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

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Cragside Court	94.9%	76.4%	88.4%	143.7%	307	6.5	6.5	13.1
Critical Care Dept	78.3%	119.9%	95.2%	96.6%	265	28.8	5.9	34.7
Emergency Care Centre - EAU	78.9%	117.3%	80.8%	124.4%	1381	6.0	4.5	10.4
JASRU	100.6%	96.1%	100.4%	87.4%	595	3.9	4.4	8.2
Maternity Unit	100.0%	102.5%	103.1%	91.7%	698	12.2	4.0	16.2
Special Care Baby Unit	70.7%	69.4%	116.6%	86.8%	70	23.6	7.2	30.9
St. Bedes	93.5%	101.8%	113.9%	93.5%	305	5.5	4.1	9.6
Sunniside Unit	75.6%	156.6%	100.5%	101.8%	296	5.1	5.0	10.0
Ward 08	121.4%	107.1%	94.5%	129.7%	613	4.1	3.6	7.7
Ward 09	104.6%	91.3%	118.6%	104.1%	795	3.1	2.3	5.4
Ward 10	70.7%	69.4%	116.6%	86.8%	70	23.6	7.2	30.9

	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	95.7%	98.7%	103.2%	112.2%	791	2.8	2.9	5.7
Ward 14 Medicine	111.6%	111.3%	96.6%	110.7%	782	3.1	2.9	6.0
Ward 14a Gastro	103.6%	118.9%	95.1%	135.6%	790	2.9	3.4	6.3
Ward 21 T&O	123.0%	135.4%	107.8%	106.9%	839	3.3	3.7	6.9
Ward 22	104.6%	105.7%	95.9%	92.8%	945	2.7	3.1	5.8
Ward 23	118.1%	98.8%	117.4%	95.4%	733	3.3	3.3	6.7
Ward 24	137.2%	79.1%	101.8%	99.7%	949	3.2	2.7	5.9
Ward 25	133.7%	105.9%	100.2%	96.3%	988	3.0	3.0	6.0
Ward 26	103.3%	106.1%	103.6%	124.0%	806	3.3	3.4	6.7
Ward 27	112.2%	112.7%	94.8%	103.7%	880	3.1	3.1	6.2

Ward 28	92.7%	95.2%	99.7%	45.6%	182	8.7	5.7	14.3
QUEEN ELIZABETH HOSPITAL - RR7EN	**97.8%**	**104.8%**	**97.6%**	**106.3%**	**14745**	4.6	3.5	8.2

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 24

Report Title:	**Provider Collaborative Managing Director's Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	24 September 2024			
Author:	Matt Brown, Managing Director of the North East and North Cumbria Provider Collaborative			
Executive Sponsor:	Trudie Davies, Chief Executive			
Report presented by:	Trudie Davies, Chief Executive			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	To share the Provider Collaborative update with the full Board of Directors for information and assurance.			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☒
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Provider Collaborative Leadership Board – 6 September 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*
	• This paper was presented at the Provider Collaborative Leadership Board to provide an update against four key work areas for the Collaborative:
	  • Elective programme
	  • Clinical strategy
	  • Corporate programme
	  • Aseptics programme			

Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is requested to receive the report for information.			

<table>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
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<tr><td>Aim 5
☒</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust strategic objectives that the report relates to:</td><td colspan="6">• Contribute effectively as part of the Provider Collaborative to maximise the opportunities presented through the regional workforce programme
• Work at place with public health, place partners and other providers to ensure that reductions in health inequalities are evidenced with a focus on women's health
• Work collaboratively as part of the Gateshead system to improve health and care outcomes to the Gateshead population</td></tr>
<tr><td>Links to CQC Key Lines of Enquiry (KLOE):</td><td>Caring
☐</td><td>Responsive
☒</td><td>Well-led
☐</td><td>Effective
☒</td><td>Safe
☐</td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):</td><td colspan="6">No direct links</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>

ENC – FOR INFORMATION

North East and North Cumbria Provider Collaborative

NENC PvCv Workstream Summary Slides

August 2024

NENC PvCv - Electives Programme

Summary Slide – August 2024

Mutual Support | SECB | Digital | GIRFT
Clinical Alliances | Performance | Outpatients | Theatre Data

Key Deliverables

Priority 1: Performance - Elective Recovery

- Elimination of long wait patients by September 24 (65ww) and 31st March 2025 (52ww)
- Validation of patients waiting over 12 weeks
- Mutual Aid and Support Mobilisation
- Once again, we are currently the best in the country for RTT performance and second for 52 & 65ww.

Priority 2: Productivity – Outpatients

- Further development of OP plans through OP Leads group to shape key areas and actions
- 5.6% (25% reduction from baseline) in missed appointments
- Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25
- Increase in % of PIFU Activity to 4.7%

Priority 2: Productivity - GIRFT

- 85% Day Case rates across Specialities
- 85% Theatre Utilisation achieved
- Further Faster Implementation delivery across all 3 Cohorts
- Maximising Elective Surgical Hubs

Key Actions

Priority 1: Performance - Elective Recovery

NENC have seen an increase in the number of 78ww (147) and 65ww (1586) projected for the end of September. MSCG supporting weekly assurance on delivery to SECB and ICB.

The Mutual Support Coordination Group (MSCG) has met fortnightly over the summer break – attendance **from all Trusts** attending. Work has been undertaken to understand capacity across system including estate, workforce and clinical support (diagnostic etc). Alongside focus on performance targets areas of focus include equitable waiting times across trusts and sustainable waiting list.

Priority 2: Productivity- Outpatient Transformation

The monthly **Outpatient Leads group** will deliver against the OP section of the delivery plan (against MTFP and Planning Guidance targets). Focused activity to provide financial opportunities against Missed Appointments, PIFU and Advice and Guidance is underway with DoF leads

Working with NEY NHSE BI and NECS BI to have access to regional and peer related data so that trusts can identify areas of good performance and focus action. NHS Insights asks trusts to meet performance of peer best for PIFU and A&G.

Priority 2: Productivity - GIRFT

The **GIRFT Co-ordination group meeting set for 20th September.** Team have been working closely with the National GIRFT team to support system visits across a number of specialities including diabetes, APOM and Gynaecology. Group will support NENC System visit on 18th November

Development of Theatre and Peri-op group underway. ToR have been developed together with COO lead. First meeting to be planned for October with Core Group members and discussion of governance moving forwards.

Priority 3: Pathways

In the **Spines** Delivery Group, the Business Case and EIA has been submitted to ICB Exec. Feedback is being incorporated into a refreshed version. Awaiting update on Commissioning intentions process for 25/26 to understand potential implementation and engagement timeframes.

CYP Steering group. Working with NEY & NECS BI on updated data packs to inform refresh of workplan and group membership. ENT focus to feed into new ENT alliance. Refreshed membership being reviewed by SECB.

GIRFT System visit for Gynaecology re-scheduled for 11th September.

ENT Alliance: Second meeting will be held in September. Successful initial meeting on 19th July. Providers are to bring back priority areas for discussion next time. Demand and Capacity Work being looked into for the system.

MSK and Eye Care Alliance: Continue to engage in the development of work plans for the alliances to support the elective care delivery plan and overarching strategy. MSK alliance new chair appointed. Eyecare Alliance bringing together a case for change paper to be presented to SECB in October to support SPoA models.

Key Issues

Priority 1: Performance - Elective Recovery

Waiting list size remains a challenge, with large number of patients within 52ww cohort. T&O, Urology and Gynae flagged as at-risk specialities across trusts

Clinical engagement will be essential for the MSCG to be effective.

Priority 2: Pathways - Outpatient Transformation

Extra reporting requirements have been added from NEY NHSE regarding Outpatients and Further Faster

Priority 2: Productivity - GIRFT

Potential for **conflicting priorities** across different specialities and trusts.

Priority 3: Pathways

Urology remains a high-risk speciality across a number of trusts for 65ww.

T&O is a risk speciality for all trusts in delivery of 52ww

Understand that ICB Commissioning Intentions for pathway transformation alongside MTFP work needs to be understood as high volume of work could be needed across clinical specialities.

MTFP:

KPIs refreshed and dashboard being developed to focus on ERF income maximisation. Work to refresh ERF group underway to support standardised and optimised coding across all trusts

NENC PvCv - Clinical Strategy - Summary Slide – August 2024

Key Deliverables

Strategic approach to clinical services – developing approach:

Provider Trust co-dependencies and service evaluations – POAP developed, actions progressing.

Clinical and Operational Delivery Networks (ODNs) - Development of clinical oversight and support.

Response to identified clinical/service issues:

OMFS - Developing a sustainable model for OMFS services across NENC ; including on call, H&N cancer pathways and Collaborative Service provision. Meeting with Medical Directors to agree short term and long direction and timeframes.

NSO - Implementing a new sustainable model for NSO across NENC .

Pain Services - Scoping work for support to this area for long term support, in terms of feasible model. Supporting current immediate term solutions to imminent changes in workforce.

Neurology Services - Detailing work on areas for collaboration

Network:

PHEM with GNAAS/NTN - how to fund and operationalise

Paeds Critical Care with PCC ODN - Case Development for agreement to work collaboratively to reshape and redesign PCC Services suitable for regional need.

Service/Issue based:

Repatriations – development of NENC approach.

Support to Diabetes Network - for revised procurement approach.

Key Actions

Strategic approach to clinical services – developing approach:

Provider Trust co-dependencies and service evaluations – 2nd meeting with planning colleagues conducted. Refining methodology of ascertaining service concerns across the region.

Clinical and Operational Delivery Networks – Session 26/4 outlined areas for working together. Paper on options to July PLB.

Response to identified clinical/service issues:

OMFS – Key points had been discussed with Medical Directors and agreement on direction of support for NCIC and STHFT. PvCv have linked with Specialised commissioning to **develop a Steering Group** to work through the long-term Strategic direction. In the hope the then develop a further **MCN for OMFS**. Development work to be looked into for teams.

NSO - Check and challenge from Ca alliances from NEY supported the model. Positive feature from JHOSC.

Pain Services – Task and Finish group has been set up with providers to outline the position as a system for chronic pain. Discussions with ICB have indicated a pain review following the completion of the Back Pain work.

Neurology Services – Focus on key pathway and staffing in hand 2/7 session on headache. Draft review complete.

Network:

PHEM with GNAAS/NTN Engaging with ICB/ UECB ref funding.

Paeds Critical Care with PCC ODN - Following discussions with key stakeholders work to be revisited in the autumn. Deferred from presentation to PLB.

Service/Issue based:

Repatriations – Issues with escalation process being worked on.

Support to Diabetes Network – Support to HCL implementation through national funding in hand.

Key Issues

Strategic approach to clinical services – developing approach:

Provider Trust co-dependencies and service evaluations - Regional teams understanding of rationale for work varies resulting in limited progression in some areas.

Clinical and Operational Delivery Networks. Agreement process; managing capacity & capability.

Response to identified clinical/service issues:

OMFS - Short term agreements on support arrangements have been reached and changes to commence on 15th July. Requires detail of long-term workforce strategy, requiring engagement and input. Cultural development work would be of benefit for developing a MCN for OMFS.

NSO - Agreement of digital mechanism to support shared clinical working.

Pain Services - Assessment of current pressures and potential for collective action. Short term transfer of patients is the key priority at present

Neurology Services - Assessment of current pressures and potential for collective action. Specific service issues in Cumbria. Framework development. Pathway review of headache

Network:

PHEM with GNAAS/NTN - Awaiting commissioning intentions

Paeds Critical Care with PCC ODN. Requires wide scale agreement with MDT input. Links to clinical strategy work for highlighted priority around paediatric services.

Service/Issue based:

Repatriations, Revised framework with Operational Leads for assessment. Aim for sign off in September

Support to Diabetes Network Funding requirements flagged, event being panned

NENC PvCv – Corporate Programme

Summary Slide – August 2024

Workforce / Scaling Up
Networks
Estates/Capital
Nursing
Pay Rates
Capacity
People Digital
Community of Practice
Recruitment / Onboarding

Key Deliverables

Workforce MTFP Highlight Report prepared and submitted for August SRB meeting.

Appointment of Band 8C. Expected to be in post early September.

System Infrastructure Strategy submitted by deadline of 31.7.24 to NHSE. Feedback expected from NHSE over the coming weeks. Discussions ongoing regarding PMO provision to support the next stages of the Infrastructure programme of work.

Estates Directors Subgroup programmes expanded and now include Capital, Workforce and Sustainability. Two further sub-groups are being added (PFI and NHSP/LIFT) which, it is intended, will report directly into the Infrastructure Board.

Dashboard developed to support **Workforce MTFP** – good progress being made with M3 data being captured. Dashboard SOP revised for further discussion at September Workforce Board.

The Workforce Board workshop event is in development which aims to focus on dashboard benchmarking data KPIs, and delivery plan to achieve key milestones. Scheduled for September.

Scaling Up Programme Board recommendation paper socialised with CPOs for comments/feedback b7 16/8. Comments minimal – refreshed paper on 6/9 PLB agenda.

Agency and Bank Papers Following discussion of papers at August PLB it was agreed that a session would be arranged with all CPOs, MDs and DoFs so a collective set of recommendations could be submitted to a future PLB meeting. Session (led by Jeremy Cundall) in diaries 4/10.

Key Actions

Digital - Provider Collaborative Digital Workshop is currently being discussed with the CIO Network Chair, the CIO Network, the Digital SRO and key ICB colleagues. The date has been confirmed for 2 October 2024. CIOs have assigned leads for the six digital priorities workstreams and preparations are underway for the Digital Workshop. This includes ensuring appropriate delegate representation (all Trusts/relevant professional Networks/clinicians)

Workforce MTFP Highlight report prepared for August SRB meeting. **A Workforce mapping** exercise is being undertaken to capture where, across the system, local/regional workforce related discussions are taking place. The work is expected to be completed during August.

Continuing to work with DoF's, via the Capital Collaborative Group, to ensure **CDEL** discussions/information is included in the Infrastructure Board/Strategy work programme.

NENC Infrastructure Strategy – following submission of the Strategy by 31.7.24 to NHSE, discussions ongoing to determine next steps. Working with the Estates/Infrastructure SRO regarding system work programme and potential PMO arrangements to support delivery of the Strategy.

Scaling Up Programme Board recommendation paper discussed at Workforce Board on 12/7. Re-alignment of priorities to reflect Workforce MTFP requirements and refreshed paper on 6/9 PLB agenda.

Draft Elective rates, GP rates recommendation papers prepared and will be discussed with all CPOs, DoFs and MDs at the meeting taking place on 4/10 (along with Agency and Bank papers).

Key Issues

Capacity at Trust level to support programmes of work is challenging given their pressing priorities, particularly resource to support, at Trust level, the Scaling up Programme Board priorities.

Clinical and DoF engagement will be essential following executive position of payrate recommendations.

Potential for conflicting priorities across different trusts.

NENC PvCv - Aseptics Programme

Summary Slide – August 2024

Outline Business Case (OBC) | Full Business Case (FBC) | Workforce Plan
Design and Build (D&B) | Limited Liability Partnership (LLP) | Funding
Isolator | Implementation Plan | Medicines

Key Deliverables

- FBC presented to JISC on 22nd July 2024. Formal approval of the £29.7m capital allocation received on 2nd August 2025 (with conditions). Formation of the LLP is delayed due to DHSC financial regulations.
- Merit have been appointed as the **Design and Build contractor** and completed the design to RIBA stage 4 by end June 2024.
- Getinge have been appointed as the **isolator contractor. Order placed for all isolators which ensure project stays on track and on time**
- Drawdown of £1,5m capital secured for this financial year from NHSE. A further £864k has been approved for early drawdown to secure total isolator order
- Internal communications have been sent for cascade to staff via Chief Pharmacists. NHSE and DHSC have approved external communications and work is underway for press activity
- Detail activities and resource requirements for **production of FBC and implementation phase**
- Change of name of facility to **"Medicines Manufacturing Centre"**
- All planning permission obtained in a timely manner and included in FBC

Key Actions

- Contract to be signed with Merit as primary build contractor w/c 2nd September 2024
- **Work with DHSC, NHSE and independent financial advisors to agree the formation of the LLP to comply with DHSC finacial regulations**
- Review of the **workforce plan and numbers to ensure appropriate for the proposed facility. Ensure recruitment and training plans are robust**
- Commence recruitment of first 5 posts to the MMC, including Managing Director. Northumbria FT will lead to recruitment process until corporate services agreement reached with LLP
- Full review of financial implication trust by trust to be conducted. Working group of all 8 acute trust FD'S to be formed to finalise detail
- Appoint Interim LLP board and commence appointment of MMC Managing Director
- Work with NHFMI to understand **requirements and costs of infrastructure upgrade**, and the contribution the aseptics project will be liable for. Asbestos survey to be concluded and implications understood
- Work with all FT boards and SIntons legal team to complete Board Certification for the formation of the LLP. Produce draft Heads of Terms and Members agreement for the LLP.

Key Issues

- **Ensuring the LLP is set up in a timely manner and is compliant with DHSC regulations.**
- **Ensuring that the project stays within the capital envelope of £29.7, with resolution of the capitalisation of rent, asbestos removal and inflationary pressures**
- Recruitment commences and in a timely manner to ensure project stays on time. With LLP delay, staff will be recruited into NHFT and TUPE'ed across to LLP. Ensure Agenda for Change T's & C's and NHS pension scheme remains in place for LLP employees.
- Assessment of **infrastructure upgrade** to Seaton Delaval site is higher than expected.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 25

Report Title:	**Register of Official Seal**			
Name of Meeting:	Board of Directors			
Date of Meeting:	24th September 2024			
Author:	Diane Waites, Corporate Services Assistant			
Executive Sponsor:	Trudie Davies, Chief Executive			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To receive details of the use of the Trust's official seal between 1 September 2023 and 31 August 2024.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	-			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	In accordance with the Board's Standing Orders paragraph 25.5 the Board must receive an annual report documenting when the official Trust seal has been used throughout the year. This report is presented to the Board each September in accordance with the cycle of business and formally documents the use of the official seal in accordance with Standing Order paragraph 25.5.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is asked to formally note the use of the official seal during this current year (September 2023-2024).			

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

Register of Official Seal

1 September 2023 – 31 August 2024

Seal No	Date	Description	Signed	Witness
320	27.03.2024	Bowel Cancer Screening Services Ethical Wall Agreement (agreement dated 15.02.2024	Mrs T Davies Mrs A Marshall	Mrs K Curry

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 26

Report Title:	**CQC Statement of Purpose**			
Name of Meeting:	Trust Board of Directors			
Date of Meeting:	24 September 2024			
Author:	Mrs Lindsay Grieves, CQC Compliance Manager			
Executive Sponsor:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals			
Report presented by:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	The Statement of Purpose is a CQC registration requirement document that must be regularly reviewed and updated to reflect changes in the organisation and the description and location of services. The purpose of this paper is to provide an updated Statement of Purpose document to the Trust Board of Directors.			
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 previously considered.			
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*	This previous version of the Statement of Purpose share earlier this year included an addition of the Community Diagnostic Hub (CDC) as a location to our registration. After discussion with the CQC the Trust is no longer required to include the CDC as a separate location on our registration certificate. The Statement of Purpose has now been updated to reflect the changes, and the CDC has now been included in Location 1, Queen Elizabeth Hospital as a satellite site on page 14.			

<table>
<tr><td>

- *Governance and legal*
- *Equality, diversity and inclusion*

</td><td colspan="6">There is also a small change to note on page 37. Dr Carmen Howey has been added as the new Medical Director.

A notification of change form has been submitted to CQC.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">To receive this document for assurance.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☐</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="6"></td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td colspan="2">Safe
☒</td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="6">3111 – Regulatory requirements in relation to CQC registration</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>

Statement of purpose

Health and Social Care Act 2008

Part 1

The provider's name, legal status, address and other contact details

Including address for service of notices and other documents

Statement of purpose, Part 1

Health and Social Care Act 2008, Regulation 12, schedule 3

The provider's business contact details, including address for service of notices and other documents, in accordance with Sections 93 and 94 of the Health and Social Care Act 2008

1. Provider's name and legal status							
Full name[1]	Gateshead Health NHS Foundation Trust						
CQC provider ID	RR7						
Legal status[1]	Individual	☐	Partnership	☐	Organisation	☒	

2. Provider's address, including for service of notices and other documents	
Business address[2]	Gateshead Health NHS Foundation Trust Queen Elizabeth Hospital Sheriff Hill
Town/city	Gateshead
County	Tyne and Wear
Post code	NE9 6SX
Business telephone	0191 482 0000
Electronic mail (email)[3]	trudie.davies4@nhs.net

By submitting this statement of purpose you are confirming your willingness for CQC to use the **email address** supplied at Section 2 above for service of documents and for sending all other correspondence to you. Email ensures fast and efficient delivery of important information. If you do not want to receive documents by email please check or tick the box below. We will not share this email address with anyone else.

I/we do **NOT** wish to receive notices and other documents from CQC by email	☐

[1] Where the provider is a partnership please fill in the partnership's name at 'Full name' in Section 1 above. Where the partnership does not have a name, please fill in the names of all the partners at Section 3 below

[2] Where you do not agree to service of notices and other documents by email they will be sent by post to the business address shown in Section 2. This includes draft and final inspection reports. This postal business address will be included on the CQC website.

[3] Where you agree to service of notices and other documents by email your copies will be sent to the email address shown in Section 2. This includes draft and final inspection reports.

Please note: CQC can deem notices sent to the email or postal address for service you supply in your statement of purpose as having been served as described in Sections 93 and 94 of the Health and Social Care Act 2008. The address supplied must therefore be accurate, up to date, and able to ensure prompt delivery of these important documents.

3. The full names of all the partners in a partnership	
Names:	

Part 2

Aims and objectives

Aims and objectives

What are your aims and objectives in providing the regulated activities and locations shown in part 3 of this statement of purpose

Introduction

Established in 2005, we were one of the first Foundation Trusts in the country and since then have consistently delivered the highest levels of care for our patients. We now offer 478 hospital beds across the Gateshead region and employ approximately 5,100 people and have a revenue turnover of around £363m.

We provide a range of acute and community services across our key sites (Queen Elizabeth Hospital, Bensham Hospital and Blaydon Primary Care Centre) as well as a number of minor sites in Gateshead. In addition to providing a range of District General Hospital services, the Trust is also an Integrated Community Provider, which includes offering care in the homes of our patients.

The Trust received an overall rating of 'Good' following the last full site inspection in 2019, with 'Outstanding' for the Caring domain. In February 2023, CQC inspected Maternity Service at Queen Elizabeth hospital as part of their national maternity inspection programme and we received an overall rating of 'Good', with 'Good' from both the Well Led and Safe Domains.

Partnership working

The Trust is an active partner in the "Gateshead Cares" system board. We are committed to the Alliance Agreement which underpins collaborative system wide-working and accountability in Gateshead.

The Trust has worked in partnership with Newcastle Hospitals NHS Foundation Trust to develop a bespoke Community Diagnostic Centre located within the Metrocentre shopping centre this will provide for the population of the North East a host of screening services including MRI and CT scans as well as a many others.

Specialist services

Alongside a full range of local hospital services, we also provide specialist services, including:

- Breast screening service for Gateshead, South Tyneside, Sunderland and parts of Durham. The Trust offers high standards of treatment – from screening and diagnosis to treatment.
- Specialist gynaecological cancer treatments provided by the Trust have developed a positive reputation both nationally and internationally. Services are now provided beyond the Gateshead region to the Scottish borders, through to Cumbria and Whitby.
- The North East Bowel Cancer Screening Hub for the National Bowel Cancer and AAA Screening Programme, provides services for a population of around seven million people.
- Leading care in our state-of-the-art facilities including our Emergency Care Centre, Pathology Centre of Excellence and the North East Surgery Centre.
- Maternity services are rated as Good by the Care Quality Commission (CQC) and are among the best in the country.
- Robotic surgery capacity is available which allows for robotic keyhole surgery to be offered to patients.
- The Gateshead Fertility Centre is one of the top ten IVF clinics in the country, successfully having created hundreds of new families in the North East over the last decade.

Vision and Values

We undertook a significant amount of engagement with colleagues, governors and stakeholders to develop our new vision, values and strategy which launched in early 2022/23.

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

The Trust's vision was developed through engagement with our people to identify what matters to us as an organisation - now and in the future**. #GatesheadHealth, proud to deliver outstanding and compassionate care to our patients and communities**.

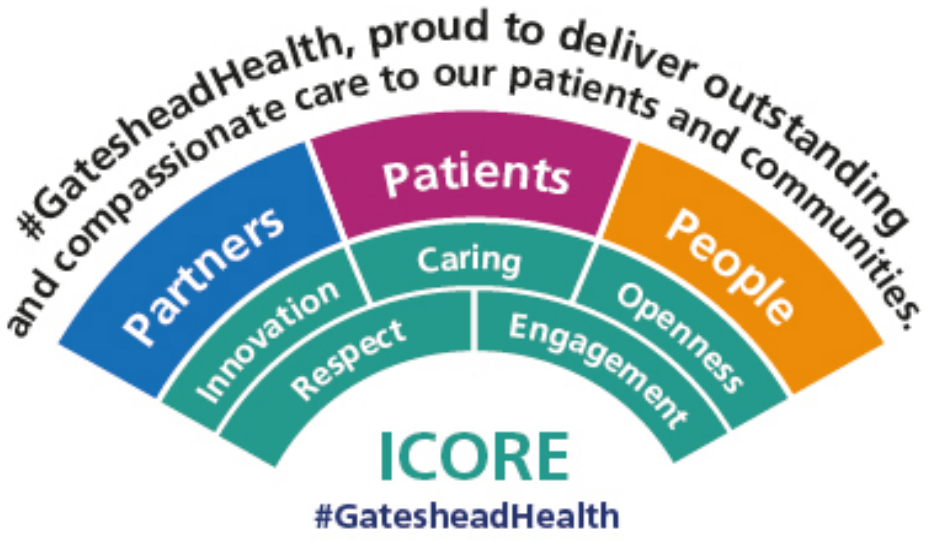
Through engagement with our people and partners, we have recognised how important it is that we use the title 'Gateshead Health' to be inclusive to all of the people who work for and represent the Trust.

- We believe in the patient being at the heart of everything we do
- We also want to work well with our partners to give you the best experience possible
- We want to be the best employer, creating the right conditions for our staff to excel
- We want to spend our money wisely, that means being held accountable to you by a board of non-executive directors and governors
- Living our values every day

Our values are the golden thread that runs through everything we do. Following a Trust-wide consultation with our people, they remain unchanged as the feedback was that our values continue to resonate and remain important.

Our values (demonstrate what we believe in and how we will behave)

The Trust values have been grouped together to form the acronym ICORE - Innovation, Care, Openness, Respect and Engagement. Our Trust values are the 'golden thread' which runs through everything we do; it is the core of who we are.



The aims and goals of Gateshead Health NHS Foundation Trust

Our aims:

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

Our goals: what success looks like by March 2025 and how we will measure this:

- **Patients - Compassionate care is at the very heart of everything we do at Gateshead Health**

The patient communities we serve at Gateshead Health are very important to us. Everyone who works at the Trust is committed to providing the highest standards of safe care to our patients at the right time and in the right place.

Our focus areas:
1. Caring for all our patient communities
2. Providing safe, high-quality care
3. Offering increasingly integrated care
4. Making every contact compassionate and caring

How will we measure our success:

- Friends and Family Test results
- An increase in compliments and reduction in common themes and trends within complaints
- Feedback via Governor engagement
- National Patient survey results
- National Audit results
- Delivering our Quality priorities
- Positive patient feedback
- Meeting our performance standards
- Improvements in statistical measures of health and care outcomes
- Delivery of safety priorities and improvement of maternity metrics in the Integrated Oversight Report
- An ‘Outstanding’ CQC rating for caring.

- **People - The people at Gateshead Health are our greatest asset**

Our people are key to achieving our aim of being a great organisation with a highly engaged workforce. In every conversation held while developing this strategy, the value and importance of our people has shone through.

Our focus areas:
1. Caring for the health and wellbeing of our people

2. Being a great place to work
3. Ensuring a diverse, inclusive and engaged culture

How will we measure our success?

- Reduction in sickness absence
- Improvements in the WRES/WDES for delivering improved staff experience
- A reduction in vacancy rates and staff turnover
- Improved responses to staff survey
- Annual staff survey overall staff engagement score within the top 20% of our benchmark group
- Increase in annual staff survey % of staff experiencing opportunities for career and skills development.

- **Partners - We respect and work closely with our partners to deliver outstanding care**

We have always recognised the value of working closely with others that share our values and commitment to patient care. Meaningful partnerships provide opportunities to address recruitment and retention challenges, generate economies of scale, and improve patient pathways.

Our focus areas:
1. Being a force for good
2. Acting as a key partner
3. Working with our education partners

How will we measure our success?

- Regularly seek and act on feedback from partners to become a truly collaborative organisation
- Increased footprint for service delivery
- Achieving our sustainability targets
- Positive feedback from members of the community
- Delivery of agreed health inequalities action plan
- Delivery of Gateshead Cares priorities and action plans
- Working with our key partners to deliver care closer to home to deliver a decrease in discharge times

Statement of purpose

Health and Social Care Act 2008

Part 3

Location(s), and

- **the people who use the service there**
- **their service type(s)**
- **their regulated activity(ies)**

Fill in a separate part 3 for each location

The information below is for location no.:	1	of a total of:	5	locations

Name of location	Queen Elizabeth Hospital
Address	Queen Elizabeth Hospital Sheriff Hill Gateshead Tyne and Wear
Postcode	NE9 6SX
Telephone	0191 4820000
Email	trudie.davies4@nhs.net

Description of the location

(The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc)

The main hospital building is based at the Queen Elizabeth Hospital (QEH) with a bed-base of 478 beds. The Queen Elizabeth Hospital site houses Inpatient Wards, Outpatient areas, hospital kitchens, Pharmacy, Physiotherapy, Diagnostic Imaging, Mortuary and office space.

The Maternity Unit is in a separate building and includes antenatal and postnatal wards, delivery suite, a special care baby unit and a pregnancy assessment unit. The 'Scheme Three' building is a six story building containing wards and operating theatres. The 'Jubilee Wing' is a four story building that includes the chapel of rest, several wards, DEXA scanning and the IVF Unit.

The Peter Smith Surgery Centre at the Queen Elizabeth Hospital is a three story purpose built surgery unit with operating theatres, anaesthetics, pre-assessment, pre-operative and post-operative care and includes wards with single room accommodation for patients.

The Emergency Care Centre (ECC) which opened in February 2015 provides one front entrance for all medical, surgical and paediatric emergencies, short stay, frailty assessment and integrated back-of-house services. Walk-in services for central Gateshead transferred to the Trust in 2014 are now integrated into the emergency services located in the new ECC.

The Pathology Department opened in 2014 providing services across Gateshead, Sunderland and South Tyneside. This is housed on the Queen Elizabeth Hospital site with staff from all three Trusts working together as one team.

The Tranwell Unit is also within the grounds of the Queen Elizabeth Hospital and houses the Trust's Chemotherapy Day Unit and a small number of Outpatient Clinics as well as Cragside, a 16 bedded Older Persons Mental Health Unit. Cragside serves the population of Gateshead for people with a diagnosis of Dementia and are experiencing crisis requiring admission to hospital.

Sunniside Unit is a 10 bedded Older Persons Mental Health Unit serving the population of Gateshead for people with a diagnosis of a functional mental health condition and are experiencing crisis requiring admission to hospital.

There are also separate buildings for:

- Children's Services Out-Patient Department
- Women's Health: an outpatient clinic for Obstetrics and Gynaecology
- St. Bede's Unit: an inpatient specialist palliative care ward for end of life care

All buildings are designed to be used as hospital buildings. All have wheelchair and vehicle access and other provisions and adaptations as necessary for disabled access.

Bensham Hospital is two miles away from the Queen Elizabeth Hospital in Gateshead and is classed as a large satellite site. A range of services are provided including the Gateshead Memory Hub which provides care and support for people aged 65 years and over who have been given a diagnosis of a Dementia as well as a Younger Person's Mental Health Clinic. Working in partnership with NEAS, our Rapid Response Service offer timely support to patients at home who have experienced a recent fall. A combined team of an Occupational Therapist (OT) and a Paramedic complete medical and functional assessments in the patient's own home referring on to other services and agencies as appropriate, aiming to keep the patient safe at home. Staff may arrange for further medical review, or rehabilitation assistive equipment in a bid to minimise the risk of further falls and support people to live as independently as possible. The Adult Speech and Language Therapy (SLT) Service clinic assesses and manages people with swallowing, communication, voice and fluency difficulties caused by a range of different conditions. Our Registered Audiologists provide high quality Audiology clinics and care from this site. The Podiatry service provides clinics facilitated by Podiatrists and Advanced Podiatry Assistants, who provide screening, treatment and education to patients, empowering them to self-care, and preventing future foot pathology. A Biomechanics Service provides gait analysis and the provision of insoles, pressure-relieving devices, and dynamic devices to realign the foot and improve gait and associated foot problems. There are no overnight beds Bensham Hospital.

The Community Diagnostic Centre is a modern purpose-built healthcare facility located within the Metrocentre shopping center and is designed to be accessible for people with disabilities. This will provide the following screening and diagnostic services to the population of the North East; MRI, CT, Ultrasound, Echocardiograph, ECG including holter monitoring, Respiratory assessments, Sleep investigations, Phlebotomy and Ambulatory BP monitoring.

The CDC have no overnight beds at this location. The building contains patient waiting areas, consultation rooms, toilets and reception areas.

The Queen Elizabeth Hospital and associated satellite sites are staffed by qualified doctors, nurses, allied health professionals and support staff. Supervised students and trainees in these fields are also present. All staff are appropriately qualified for their role in accordance with regulations.

The Queen Elizabeth Hospital also has a further 90 satellite sites as detailed below where Regulated activities may be delivered at or from. The management of these sites/services takes place from the Queen Elizabeth Hospital and as such, the Trust considers these satellite sites as exempt under CQC Locations Rule 9 from been classed as individual locations:

Satellite site name	Satellite site address	Services provided
Accrington PALS Primary Health Care Centre	1 Paradise Street, Accrington, BB5 2EJ	• AAA Screening

Acklam Medical Centre	Trimdon Avenue, Middlesbrough, Cleveland, TS5 8SB	• AAA Screening
Alnwick Bondgate Practice	Infirmary Drive, Alnwick, Northumberland, NE66 2NL	• AAA Screening
Barbara Castle Way Primary Health Centre	Blackburn, BB2 1AX	• AAA Screening
Berwick Infirmary	Infirmary Square, Berwick upon Tweed, Northumberland, TD15 1LT	• AAA Screening
Birtley Medical Group	Durham Road, Birtley, Tyne and Wear, DH3 2QT	• Anticoagulation/Warfarin Clinics
Bishop Auckland General Hospital	Cockton Hill Road, Bishop Auckland, Co Durham, DL14 6AD	• AAA Screening
Blaydon Primary Care Centre	Shibdon Lane, Blaydon - on- Tyne, Tyne and Wear, NE 21 5NW	• AAA Screening
Blyth Community Hospital and Health Centre	Thoroton Street, Blyth, Northumberland, NE24 1DX	• AAA Screening
Breast Screening Trailer 1	Car park location at University Hospitals North Durham	• Breast Screening
Breast Screening Trailer 2	Car Parking spaces at Blaydon PCC (Rotates between Blaydon, Palmer Community Hospital (Jarrow) & Chester-Le-St Hospital)	• Breast Screening
Carlisle Rugby Club	Warwick Road, Carlisle, Cumbria, CA1 1LW	• AAA Screening
CBC Head Office	Queens Park, Queensway N, Gateshead NE11 0QD	• QE Community Management Staff Offices
Chainbridge Medical Partnership	Shibdon Road, Blaydon, NE21 5AE	• Anticoagulation/Warfarin Clinics
Chowdene Children's Centre	Waverley Road, Harlow Green, NE9 7TU	• Children's Occupational Therapy - Staff Office • Children's Occupational Therapy Clinical Room • Children's Physiotherapy Clinic
Crawcrook Medical Centre	Pattinson Drive, Crawcrook	• Anticoagulation/Warfarin Clinics

	Tyne and Wear, NE40 4US	
Cresta Research Centre, Newcastle General	West Road, Newcastle upon Tyne, Tyne and Wear, NE4 6BE	• AAA Screening
Cumberland Infirmary	Newtown Road, Carlisle, Cumbria, CA2 7HY	• AAA Screening
Dunston Bank Health Centre	Dunston Bank, Gateshead, NE11 9PY	• Podiatry Clinic • Children's Speech and Language Therapy Clinic
Eccleston Health Centre	Doctors Lane, Eccleston, Chorley, PR7 5RA	• AAA Screening
Elgin Centre	Elgin Rd, Gateshead NE9 5PA	• Community Midwives Clinical Room
Felling Health Centre	Stephenson Terrace, Gateshead, NE10 9GQ	• Anticoagulation/Warfarin Clinics • Podiatry Clinic • Children's Speech and Language Therapy • District Nurses Office • East Locality Office
Flagg Court	Dale Street, South Shields, Tyne and Wear, NE33 2LX	• Audiology Clinic
Gateshead and Carlisle Hand Service	London Road, Carlisle, Cumbria, CA1 2NS	• Hand Service
Gateshead Health Centre	Prince Consort Road, Gateshead, NE8 1NB	• Anticoagulation/Warfarin Clinics • AAA Screening • Podiatry Clinic • Children's Speech and Language Therapy • Complex Wound Clinic
Glenpark Medical Centre	Ravensworth Road, Dunston, Gateshead, NE11 9FJ	• Anticoagulation/Warfarin Clinics
Glenroyd Medical Practice	1st Floor, Moor Park Health and Leisure Centre, Bristol Avenue, Blackpool, FY2 0JG	• AAA Screening
Gosforth Regent Medical Centre	Ridley House, Henry Street, Newcastle upon Tyne, Tyne and Wear, NE3 1DQ	• AAA Screening
Grange Road Medical Centre	Grange Road, Ryton, Tyne and Wear, NE40 3LT	• Anticoagulation/Warfarin Clinics
Hexham General Hospital	Corbridge Road, Hexham,	• AAA Screening

	Northumberland, NE46 1QJ	
Heysham Primary Care Centre	1st floor reception, Middleton Way, Heysham, Morecambe, LA3 2LE	• AAA Screening
HMP Durham	Old Elvet, Durham, Co Durham, DH1 3HU	• AAA Screening
HMP Frankland	Brasside, Durham, Co Durham, DH1 5YD	• AAA Screening
HMP Garth	Ulnes Walton Lane, Leyland, Preston, PR26 8NE	• AAA Screening
HMP Haverigg	North Lane, Haverigg, Millom, Cumbria, LA18 4NA	• AAA Screening
HMP Holme House	Holme House Road, Stockton-on-Tees, Cleveland, TS18 2QU	• AAA Screening
HMP Kirkham	Freckleton Road, Preston, Lancashire, PR4 2RN	• AAA Screening
HMP Kirklevington	Kirklevington Grange, Yarm, Cleveland, TS15 9PA	• AAA Screening
HMP Lancaster Farms	Stone Row Head, Quernmore Road, Lancaster, LA1 3QZ	• AAA Screening
HMP Northumberland	Acklington, Morpeth, Northumberland, NE65 9XG	• AAA Screening
HMP Preston	2 Ribbleton Lane, Preston, PR1 5AB	• AAA Screening
HMP Wymott	Ulnes Walton Lane, Leyland, Preston, PR26 8LW	• AAA Screening
Houghton Primary Care Centre	Brinkburn Crescent, Houghton, Co Durham, DH4 4DN	• AAA Screening
James Cochrane Practice	Maude street, Kendal, LA9 4QE	• AAA Screening
Kendal Leisure Centre	Burton Road, Kendal, Cumbria, LA9 7HX	• AAA Screening
Lawson Street Health Centre	Lawson Street, Stockton-on-Tees, Cleveland, TS18 1HU	• AAA Screening

Library House Surgery	Avondale Road, Chorley, PR7 2AD	• AAA Screening
London Road Medical Centre	Hilltop Heights, London Road, Cumbria, CA1 2NS	• AAA Screening
Long Rigg Medical Centre	2 Longrigg, Gateshead, NE10 8PH	• Anticoagulation/Warfarin Clinics
Lostock Hall Medical Centre	Brownedge Road, Lostock Hall, Preston, PR5 5AD	• AAA Screening
Low Fell Clinic	Beacon Lough Road, Gateshead, NE9 6TD	• Podiatry Clinic • Speech and Language Therapy • Community Nursing Office base
Molineux Primary Care Centre	Molineux Street, Newcastle upon Tyne, Tyne and Wear, NE6 1SG	• AAA Screening
Morpeth NHS Centre	Dark Lane, Morpeth, Northumberland, NE61 1JY	• AAA Screening
Mowbray House Surgery	Malpas Road, Northallerton, North Yorkshire, DL7 8FW	• AAA Screening
North Ormesby Village Resolution Health Centre	11 Trinity Mews, North Ormesby, Middlesbrough, TS3 6AL	• AAA Screening
One Life Primary Care Centre Hartlepool	Park Road, Hartlepool, Cleveland, TS24 7PW	• AAA Screening
Padiham Health Centre	Station Road, Padiham, Lancashire, BB12 8EA	• AAA Screening
Peaseway Medical Centre	2 Pease Way, Newton Aycliffe, Co Durham, DL5 5NH	• AAA Screening
Penrith Community Hospital	Bridge Lane, Penrith, Cumbria, CA11 8HX	• AAA Screening
Peterlee Health Centre	Bede Health Centre, Peterlee, Co Durham, SR8 1AD	• AAA Screening
Queens Road Surgery	83 Queens Road, Consett, Co Durham, DH8 0BW	• AAA Screening
Rawling Road Medical Centre	1 Rawling Road, Bensham, Gateshead, NE8 4QS	• Anticoagulation/Warfarin Clinics
Redcar Primary Care Centre	West Dyke Road, Redcare, Cleveland, TS10 4NW	• AAA Screening

Ribble Village Health Centre	200 Miller Road, Ribbleton, Preston, PR2 6NH	• AAA Screening
Richmond Community Hospital	Queens Road, Richmond, North Yorkshire, DL10 4AJ	• AAA Screening
Rossendale Primary Health Care Centre	Bacup Road, Rawenstall, Lancashire, BB4 7PL	• AAA Screening
Rowlands Gill Medical Practice	The Grove, Rowlands Gill NE39 1PW	• Anticoagulation/Warfarin Clinics
Ryton Clinic	Greens Road, Gateshead, NE40 3LT	• Podiatry Clinic • Children's Speech and Language Therapy • Children's Community Nursing Team
Sacriston Medical Centre	Front Street, Sacriston, Co Durham, DH7 6JW	• AAA Screening
Sandy Lane Health Centre	Skelmersdale, Lancashire, WN8 8LA	• AAA Screening
Sedgefield Community Hospital	Salters Lane, Sedgefield, Stockton on Tees, TS21 3EE	• AAA Screening
Shiremoor Resource Centre	Earsdon Road, Newcastle upon Tyne, Tyne and Wear, NE27 0HH	• AAA Screening
South Shore Primary Care Centre	Lytham Road, Blackpool, FY4 1TJ	• AAA Screening
South Tyneside Hospital	Harton Ln, South Shields NE34 0PL	• Pathology Hot Lab
St Fillan's Medical Centre	2 Liverpool Road, Penwortham, Preston, PR1 0AD	• AAA Screening
St Peters Primary Health Centre	Church Street, Burnley, BB11 2DL	• AAA Screening
Stanley Primary Care Centre	Clifford Road, Stanley, Co Durham, DH9 0AB	• AAA Screening
Sunderland Royal Hospital Site	Kayll Rd, Sunderland SR4 7TP	• Pathology Hot Lab
Teams Medical Practice	Watson Street, Gateshead, NE8 2PB	• Anticoagulation/Warfarin Clinics
The Elms Medical Practice	16 Derby Street, Ormskirk, L39 2BY	• AAA Screening

The Mount View Practice	Fleetwood Health and Wellbeing Centre, Dock Street, Fleetwood, FY7 6HP	• AAA Screening
Trinity Square	West Street, Gateshead Town Centre, NE8 1AD	• Retinal Screening • Podiatry (Diabetic) Clinic
Tyne View Children's Centre	Rose St, Gateshead NE8 2LS	• Community Midwives Office Base • Two Community Midwives Clinical rooms
Ulverston Community Health Centre	Stanley Street, Ulverston, Cumbria, LA12 7BT	• AAA Screening
Washington Primary Care Centre	Princess Anne Park, Parkway, Washington, NE38 7QS	• Orthopaedic Clinic • Rheumatology Clinic • AAA Screening
Whickham Health Centre	Rectory Lane, Whickham, Gateshead, NE16 4PD	• Anticoagulation/Warfarin Clinics • Bladder and Bowel Clinic • Podiatry Clinic • Children's Speech and Language Therapy
Whinfield Medical Practice	Whinbush Way, Darlington, Co Durham, DL1 3RT	• AAA Screening
Whitby Community Hospital	Spring Hill, Whitby, North Yorkshire, YO21 1DP	• AAA Screening
Wrekenton Health Centre	Springwell Road, Gateshead, NE9 7AD	• Anticoagulation/Warfarin Clinics • Bladder and Bowel Clinic • Podiatry Clinic • Children's Speech and Language Therapy • Complex Wound Clinic
Yarnspinners Primary Health Care Centre	Off Carr Road, Nelson, Lancashire, BB9 7SR	• AAA Screening

No of approved places / overnight beds (not NHS)	0

CQC service user bands The people that will use this location (‘The whole population’ means everyone).					
Adults aged 18-65	☐	Adults aged 65+		☐	
Mental health	☐	Sensory impairment		☐	
Physical disability	☐	People detained under the Mental Health Act		☐	
Dementia	☐	People who misuse drugs or alcohol		☐	
People with an eating disorder	☐	Learning difficulties or autistic disorder		☐	
Children aged 0 – 3 years	☐	Children aged 4-12	☐ Children aged 13-18	☐	
The whole population	☒	Other (please specify below)		☐	

The CQC service type(s) provided at this location	
Acute services (ACS)	☒
Prison healthcare services (PHS)	☒
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☒
Hospice services (HPS)	☒
Rehabilitation services (RHS)	☐
Long-term conditions services (LTC)	☒
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐
Hyperbaric chamber (HBC)	☐
Community healthcare service (CHC)	☒
Community-based services for people with mental health needs (MHC)	☒
Community-based services for people with a learning disability (LDC)	☐
Community-based services for people who misuse substances (SMC)	☐
Urgent care services (UCS)	☒
Doctors consultation service (DCS)	☒
Doctors treatment service (DTS)	☐
Mobile doctor service (MBS)	☐
Dental service (DEN)	☐
Diagnostic and or screening service (DSS)	☒
Care home service without nursing (CHS)	☐
Care home service with nursing (CHN)	☐
Specialist college service (SPC)	☐
Domiciliary care service (DCC)	☐
Supported living service (SLS)	☐
Shared Lives (SHL)	☐
Extra Care housing services (EXC)	☐
Ambulance service (AMB)	☐
Remote clinical advice service (RCA)	☐
Blood and Transplant service (BTS)	☒

Regulated activity(ies) carried on at this location		
Personal care	☐	
Registered Manager(s) for this regulated activity:		
Accommodation for persons who require nursing or personal care	☐	
Registered Manager(s) for this regulated activity:		
Accommodation for persons who require treatment for substance abuse	☐	
Registered Manager(s) for this regulated activity:		
Accommodation and nursing or personal care in the further education sector	☐	
Registered Manager(s) for this regulated activity:		
Treatment of disease, disorder or injury	☒	
Registered Manager(s) for this regulated activity: Medical Director		
Assessment or medical treatment for persons detained under the Mental Health Act	☒	
Registered Manager(s) for this regulated activity: Chief Nurse		
Surgical procedures	☒	
Registered Manager(s) for this regulated activity: Medical Director		
Diagnostic and screening procedures	☒	
Registered Manager(s) for this regulated activity: Medical Director		
Management of supply of blood and blood derived products etc	☐	
Registered Manager(s) for this regulated activity:		
Transport services, triage and medical advice provided remotely	☐	
Registered Manager(s) for this regulated activity:		
Maternity and midwifery services	☒	
Registered Manager(s) for this regulated activity: Chief Nurse		
Termination of pregnancies	☒	
Registered Manager(s) for this regulated activity: Medical Director		
Services in slimming clinics	☐	
Registered Manager(s) for this regulated activity:		
Nursing care	☐	
Registered Manager(s) for this regulated activity:		
Family planning service	☒	
Registered Manager(s) for this regulated activity: Medical Director		

Fill in a separate part 3 for each location

The information below is for location no.:	2		of a total of:	5	locations

Name of location	Blaydon Primary Care Centre
Address	Blaydon Primary Care Centre Shibdon Road Blaydon on Tyne
Postcode	NE21 5NW
Telephone	0191 2834500
Email	trudie.davies4@nhs.net

Description of the location

(The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc)

Blaydon Primary Care Centre is a modern purpose built health care building used by the Trust and Local Authority. The building has a room designed and constructed for Audiometrics including child hearing screening, an X-ray facility and a diagnostics suite for breast screening as well as AAA Screening. It has a number of consultation and treatment rooms and a minor surgery room for day case minor procedures.

The Podiatry service provides clinics facilitated by Podiatrists and Advanced Podiatry Assistants, who provide screening, treatment and education to patients, empowering them to self-care, and preventing future foot pathology. A Biomechanics Service provides gait analysis and the provision of insoles, pressure-relieving devices, and dynamic devices to realign the foot and improve gait and associated foot problems. The service also undertakes specialist services including Diabetes Outpatient Clinics, where the key function is rapid assessment and treatment for patients experiencing diabetic foot ulceration, with the aim of healing ulceration as quickly as possible and promoting better awareness of the risk factors and improving the prevention of further foot complications. Nail surgery is also facilitated which involves the full/partial removal of toenails for patients with recurrent toenail problems. This is carried out under local anaesthetic as well as Electrosurgery, which involves the removal of long-standing lesions such as plantar corns, and verrucae that have not responded to conventional treatment. These procedures are exempt from classification as the Regulated activity “Surgical Procedures” under Schedule 2, Paragraph 4 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, however this site has been registered for “Surgical Procedures” due to the minor surgery room for day case minor procedures.

Other clinics are provided including Anticoagulation/Warfarin clinics; a Complex Wound Clinic which provides assessment and ongoing management for patients with complex wounds and a Bladder and Bowel Clinic, which provides services for both adults and children. The Speech and Language Therapy (SLT) Service assesses and manages people with swallowing, communication, voice and fluency difficulties caused by a range of different conditions. A Walk in Centre service is also provided at this location.

There are no overnight beds at this location. The building contains patient waiting areas,

toilets, reception area and office space for the Macmillan team, West Locality team and Inner West Locality team. All staff are appropriately qualified for their role in accordance with regulations.

No of approved places / overnight beds (not NHS)	N/A

CQC service user bands

The people that will use this location ('The whole population' means everyone).

Adults aged 18-65	☐	Adults aged 65+			☐	
Mental health	☐	Sensory impairment			☐	
Physical disability	☐	People detained under the Mental Health Act			☐	
Dementia	☐	People who misuse drugs or alcohol			☐	
People with an eating disorder	☐	Learning difficulties or autistic disorder			☐	
Children aged 0 – 3 years	☐	Children aged 4-12	☐	Children aged 13-18	☐	
The whole population	☒	Other (please specify below)			☐	

The CQC service type(s) provided at this location	
Acute services (ACS)	☒
Prison healthcare services (PHS)	☐
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☐
Hospice services (HPS)	☐
Rehabilitation services (RHS)	☐
Long-term conditions services (LTC)	☐
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐
Hyperbaric chamber (HBC)	☐
Community healthcare service (CHC)	☒
Community-based services for people with mental health needs (MHC)	☐
Community-based services for people with a learning disability (LDC)	☐
Community-based services for people who misuse substances (SMC)	☐
Urgent care services (UCS)	☒
Doctors consultation service (DCS)	☒
Doctors treatment service (DTS)	☐
Mobile doctor service (MBS)	☐
Dental service (DEN)	☐
Diagnostic and or screening service (DSS)	☒
Care home service without nursing (CHS)	☐
Care home service with nursing (CHN)	☐
Specialist college service (SPC)	☐
Domiciliary care service (DCC)	☐
Supported living service (SLS)	☐
Shared Lives (SHL)	☐
Extra Care housing services (EXC)	☐
Ambulance service (AMB)	☐
Remote clinical advice service (RCA)	☐
Blood and Transplant service (BTS)	☐

Regulated activity(ies) carried on at this location		
Personal care	☐	
Registered Manager(s) for this regulated activity:		
Accommodation for persons who require nursing or personal care	☐	
Registered Manager(s) for this regulated activity:		
Accommodation for persons who require treatment for substance abuse	☐	
Registered Manager(s) for this regulated activity:		
Accommodation and nursing or personal care in the further education sector	☐	
Registered Manager(s) for this regulated activity:		
Treatment of disease, disorder or injury	☒	
Registered Manager(s) for this regulated activity: Medical Director		
Assessment or medical treatment for persons detained under the Mental Health Act	☐	
Registered Manager(s) for this regulated activity:		
Surgical procedures	☒	
Registered Manager(s) for this regulated activity: Medical Director		
Diagnostic and screening procedures	☒	
Registered Manager(s) for this regulated activity: Medical Director		
Management of supply of blood and blood derived products etc	☐	
Registered Manager(s) for this regulated activity:		
Transport services, triage and medical advice provided remotely	☐	
Registered Manager(s) for this regulated activity:		
Maternity and midwifery services	☒	
Registered Manager(s) for this regulated activity: Chief Nurse		
Termination of pregnancies	☐	
Registered Manager(s) for this regulated activity:		
Services in slimming clinics	☐	
Registered Manager(s) for this regulated activity:		
Nursing care	☐	
Registered Manager(s) for this regulated activity:		
Family planning service	☒	
Registered Manager(s) for this regulated activity: Medical Director		

Fill in a separate part 3 for each location

The information below is for location no.:	3	of a total of:	5	locations

Name of location	Cleadon Park Primary Care Centre
Address	Cleadon Park Primary Care Centre Prince Edward Road South Shields
Postcode	NE34 8PS
Telephone	0191 2832800
Email	trudie.davies4@nhs.net

Description of the location

(The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc)

The Trust provides Breast Screening and AAA screening services from Cleadon Park Primary Care Centre in South Shields. The centre is purpose built for the provision of health care and screening services and is designed to be accessible for people with disabilities.

There are no overnight beds at this location. The building contains patient waiting areas, toilets and reception areas.

All staff are appropriately qualified for their role in accordance with regulations.

No of approved places / overnight beds (not NHS)	N/A

CQC service user bands

The people that will use this location ('The whole population' means everyone).

Adults aged 18-65	☒	Adults aged 65+		☒	
Mental health	☐	Sensory impairment		☐	
Physical disability	☐	People detained under the Mental Health Act		☐	
Dementia	☐	People who misuse drugs or alcohol		☐	
People with an eating disorder	☐	Learning difficulties or autistic disorder		☐	
Children aged 0 – 3 years	☐	Children aged 4-12	☐ Children aged 13-18	☐	
The whole population	☐	Other (please specify below)		☐	

The CQC service type(s) provided at this location	
Acute services (ACS)	☐
Prison healthcare services (PHS)	☐
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☐
Hospice services (HPS)	☐
Rehabilitation services (RHS)	☐
Long-term conditions services (LTC)	☐
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐
Hyperbaric chamber (HBC)	☐
Community healthcare service (CHC)	☐
Community-based services for people with mental health needs (MHC)	☐
Community-based services for people with a learning disability (LDC)	☐
Community-based services for people who misuse substances (SMC)	☐
Urgent care services (UCS)	☐
Doctors consultation service (DCS)	☐
Doctors treatment service (DTS)	☐
Mobile doctor service (MBS)	☐
Dental service (DEN)	☐
Diagnostic and or screening service (DSS)	☒
Care home service without nursing (CHS)	☐
Care home service with nursing (CHN)	☐
Specialist college service (SPC)	☐
Domiciliary care service (DCC)	☐
Supported living service (SLS)	☐
Shared Lives (SHL)	☐
Extra Care housing services (EXC)	☐
Ambulance service (AMB)	☐
Remote clinical advice service (RCA)	☐
Blood and Transplant service (BTS)	☐

Regulated activity(ies) carried on at this location		
Personal care	☐	
Registered Manager(s) for this regulated activity:		
Accommodation for persons who require nursing or personal care	☐	
Registered Manager(s) for this regulated activity:		
Accommodation for persons who require treatment for substance abuse	☐	
Registered Manager(s) for this regulated activity:		
Accommodation and nursing or personal care in the further education sector	☐	
Registered Manager(s) for this regulated activity:		
Treatment of disease, disorder or injury	☒	
Registered Manager(s) for this regulated activity: Medical Director		
Assessment or medical treatment for persons detained under the Mental Health Act	☐	
Registered Manager(s) for this regulated activity:		
Surgical procedures	☐	
Registered Manager(s) for this regulated activity:		
Diagnostic and screening procedures	☒	
Registered Manager(s) for this regulated activity: Medical Director		
Management of supply of blood and blood derived products etc	☐	
Registered Manager(s) for this regulated activity:		
Transport services, triage and medical advice provided remotely	☐	
Registered Manager(s) for this regulated activity:		
Maternity and midwifery services	☐	
Registered Manager(s) for this regulated activity:		
Termination of pregnancies	☐	
Registered Manager(s) for this regulated activity:		
Services in slimming clinics	☐	
Registered Manager(s) for this regulated activity:		
Nursing care	☐	
Registered Manager(s) for this regulated activity:		
Family planning service	☐	
Registered Manager(s) for this regulated activity:		

Fill in a separate part 3 for each location

The information below is for location no.:	4	of a total of:	5	Locations

Name of location	Grindon Lane Primary Care Centre
Address	Grindon Sunderland Tyne & Wear
Postcode	SR3 4EN
Telephone	0191 525 2300
Email	trudie.davies4@nhs.net

Description of the location

(The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc)

The Trust provides Breast Screening and AAA screening services from Grindon Lane Primary Care Centre in Sunderland. The centre is a modern purpose built healthcare facility and is designed to be accessible for people with disabilities.

There are no overnight beds at this location. The building contains patient waiting areas, consultation rooms, toilets and reception areas.

All staff are appropriately qualified for their role in accordance with regulations.

No of approved places / overnight beds (not NHS)	N/A

CQC service user bands

The people that will use this location ('The whole population' means everyone).

Adults aged 18-65	☒	Adults aged 65+		☒	
Mental health	☐	Sensory impairment		☐	
Physical disability	☐	People detained under the Mental Health Act		☐	
Dementia	☐	People who misuse drugs or alcohol		☐	
People with an eating disorder	☐	Learning difficulties or autistic disorder		☐	
Children aged 0 – 3 years	☐	Children aged 4-12	☐ Children aged 13-18	☐	
The whole population	☐	Other (please specify below)		☐	

The CQC service type(s) provided at this location	
Acute services (ACS)	☐
Prison healthcare services (PHS)	☐
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☐
Hospice services (HPS)	☐
Rehabilitation services (RHS)	☐
Long-term conditions services (LTC)	☐
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐
Hyperbaric chamber (HBC)	☐
Community healthcare service (CHC)	☐
Community-based services for people with mental health needs (MHC)	☐
Community-based services for people with a learning disability (LDC)	☐
Community-based services for people who misuse substances (SMC)	☐
Urgent care services (UCS)	☐
Doctors consultation service (DCS)	☐
Doctors treatment service (DTS)	☐
Mobile doctor service (MBS)	☐
Dental service (DEN)	☐
Diagnostic and or screening service (DSS)	☒
Care home service without nursing (CHS)	☐
Care home service with nursing (CHN)	☐
Specialist college service (SPC)	☐
Domiciliary care service (DCC)	☐
Supported living service (SLS)	☐
Shared Lives (SHL)	☐
Extra Care housing services (EXC)	☐
Ambulance service (AMB)	☐
Remote clinical advice service (RCA)	☐
Blood and Transplant service (BTS)	☐

Regulated activity(ies) carried on at this location		
Personal care	☐	
Registered Manager(s) for this regulated activity:		
Accommodation for persons who require nursing or personal care	☐	
Registered Manager(s) for this regulated activity:		
Accommodation for persons who require treatment for substance abuse	☐	
Registered Manager(s) for this regulated activity:		
Accommodation and nursing or personal care in the further education sector	☐	
Registered Manager(s) for this regulated activity:		
Treatment of disease, disorder or injury	☒	
Registered Manager(s) for this regulated activity: Medical Director		
Assessment or medical treatment for persons detained under the Mental Health Act	☐	
Registered Manager(s) for this regulated activity:		
Surgical procedures	☐	
Registered Manager(s) for this regulated activity:		
Diagnostic and screening procedures	☒	
Registered Manager(s) for this regulated activity: Medical Director		
Management of supply of blood and blood derived products etc	☐	
Registered Manager(s) for this regulated activity:		
Transport services, triage and medical advice provided remotely	☐	
Registered Manager(s) for this regulated activity:		
Maternity and midwifery services	☐	
Registered Manager(s) for this regulated activity:		
Termination of pregnancies	☐	
Registered Manager(s) for this regulated activity:		
Services in slimming clinics	☐	
Registered Manager(s) for this regulated activity:		
Nursing care	☐	
Registered Manager(s) for this regulated activity:		
Family planning service	☐	
Registered Manager(s) for this regulated activity:		

Fill in a separate part 3 for each location

The information below is for location no.:	5	of a total of:	5	locations

Name of location	Breast Screening Unit
Address	Breast Screening Unit Sunderland Royal Hospital Kayll Road
Postcode	SR4 7TP
Telephone	0191 565 6256
Email	trudie.davies4@nhs.net

Description of the location (The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc)	
The Breast Screening Unit is based on the Sunderland Royal Hospital site. Access is through the Chester Road entrance. The building is a purpose built unit for screening and has suitable access for people with disabilities. The Trust have no overnight beds at this location. The building contains patient waiting areas, consultation rooms, toilets and reception areas. All staff are appropriately qualified for their role in accordance with regulations.	
No of approved places / overnight beds (not NHS)	N/A

CQC service user bands The people that will use this location (‘The whole population’ means everyone).						
Adults aged 18-65	☒	Adults aged 65+			☒	
Mental health	☐	Sensory impairment			☐	
Physical disability	☐	People detained under the Mental Health Act			☐	
Dementia	☐	People who misuse drugs or alcohol			☐	
People with an eating disorder	☐	Learning difficulties or autistic disorder			☐	
Children aged 0 – 3 years	☐	Children aged 4-12	☐	Children aged 13-18	☐	
The whole population	☐	Other (please specify below)			☐	

The CQC service type(s) provided at this location	
Acute services (ACS)	☐
Prison healthcare services (PHS)	☐
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☐
Hospice services (HPS)	☐
Rehabilitation services (RHS)	☐
Long-term conditions services (LTC)	☐
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐
Hyperbaric chamber (HBC)	☐
Community healthcare service (CHC)	☐
Community-based services for people with mental health needs (MHC)	☐
Community-based services for people with a learning disability (LDC)	☐
Community-based services for people who misuse substances (SMC)	☐
Urgent care services (UCS)	☐
Doctors consultation service (DCS)	☐
Doctors treatment service (DTS)	☐
Mobile doctor service (MBS)	☐
Dental service (DEN)	☐
Diagnostic and or screening service (DSS)	☒
Care home service without nursing (CHS)	☐
Care home service with nursing (CHN)	☐
Specialist college service (SPC)	☐
Domiciliary care service (DCC)	☐
Supported living service (SLS)	☐
Shared Lives (SHL)	☐
Extra Care housing services (EXC)	☐
Ambulance service (AMB)	☐
Remote clinical advice service (RCA)	☐
Blood and Transplant service (BTS)	☐

Regulated activity(ies) carried on at this location		
Personal care	☐	
Registered Manager(s) for this regulated activity:		
Accommodation for persons who require nursing or personal care	☐	
Registered Manager(s) for this regulated activity:		
Accommodation for persons who require treatment for substance abuse	☐	
Registered Manager(s) for this regulated activity:		
Accommodation and nursing or personal care in the further education sector	☐	
Registered Manager(s) for this regulated activity:		
Treatment of disease, disorder or injury	☒	
Registered Manager(s) for this regulated activity: Medical Director		
Assessment or medical treatment for persons detained under the Mental Health Act	☐	
Registered Manager(s) for this regulated activity:		
Surgical procedures	☐	
Registered Manager(s) for this regulated activity:		
Diagnostic and screening procedures	☒	
Registered Manager(s) for this regulated activity: Medical Director		
Management of supply of blood and blood derived products etc	☐	
Registered Manager(s) for this regulated activity:		
Transport services, triage and medical advice provided remotely	☐	
Registered Manager(s) for this regulated activity:		
Maternity and midwifery services	☐	
Registered Manager(s) for this regulated activity:		
Termination of pregnancies	☐	
Registered Manager(s) for this regulated activity:		
Services in slimming clinics	☐	
Registered Manager(s) for this regulated activity:		
Nursing care	☐	
Registered Manager(s) for this regulated activity:		
Family planning service	☐	
Registered Manager(s) for this regulated activity:		

Statement of purpose

Health and Social Care Act 2008

Part 4

Registered manager details

Including address for service of notices and other documents

The information below is for manager number:	1	of a total of:	2	Managers working for the provider shown in part 1

1. Manager's full name	Dr Carmen Howey

2. Manager's contact details	
Business address	Medical Director Trust Headquarters Queen Elizabeth Hospital
Town/city	Gateshead
County	Tyne and Wear
Post code	NE9 6SX
Business telephone	0191 482 0000
Manager's email address[1]	
Carmen.howey@nhs.net	

[1] Where the manager has agreed to service of notices and other documents by email they will be sent to this email address. This includes draft and final inspection reports on all locations where they manage regulated activities.

Where the manager does not agree to service of notices and other documents by email they will be sent by post to the provider postal business address shown in Part 1 of the statement of purpose. This includes draft and final inspection reports on all locations.

Please note: CQC can deem notices sent to manager(s) at the relevant email or postal address for service in this statement of purpose as having been served, as described in Sections 93 and 94 of the Health and Social Care Act 2008. The address supplied must therefore be accurate, up to date, and able to ensure prompt delivery of these important documents to registered managers.

3. Locations managed by the registered manager at 1 above (Please see part 3 of this statement of purpose for full details of the location(s))	
Name(s) of location(s) (list)	Percentage of time spent at this location

4. Regulated activity(ies) managed by this manager		
Personal care	☐	
Accommodation for persons who require nursing or personal care	☐	
Accommodation for persons who require treatment for substance abuse	☐	
Accommodation and nursing or personal care in the further education sector	☐	
Treatment of disease, disorder or injury	☒	
Assessment or medical treatment for persons detained under the Mental Health Act	☐	
Surgical procedures	☒	
Diagnostic and screening procedures	☒	
Management of supply of blood and blood derived products etc	☒	
Transport services, triage and medical advice provided remotely	☐	
Maternity and midwifery services	☐	
Termination of pregnancies	☒	
Services in slimming clinics	☐	
Nursing care	☐	
Family planning service	☒	

5. Locations, regulated activities and job shares

Where this manager does not manage all of the regulated activities ticked / checked at 4 above at all of the locations listed at 3 above, please describe which regulated activities they manage at which locations below.

Please also describe below any job share arrangements that include or affect this manager.

The Regulated Activities highlighted within Section Four are managed by Executive Directors of the Trust from their base at Trust Headquarters of the Queen Elizabeth Hospital, Gateshead.

The information below is for manager number:	2	of a total of:	2	Managers working for the provider shown in part 1

1. Manager's full name	Dr Gillian Findley

2. Manager's contact details	
Business address	Chief Nurse Trust Headquarters Queen Elizabeth Hospital
Town/city	Gateshead
County	Tyne and Wear
Post code	NE9 6SX
Business telephone	0191 482 0000
Manager's email address[1]	
Gillian.findley@nhs.net	

[1] Where the manager has agreed to service of notices and other documents by email they will be sent to this email address. This includes draft and final inspection reports on all locations where they manage regulated activities.

Where the manager does not agree to service of notices and other documents by email they will be sent by post to the provider postal business address shown in Part 1 of the statement of purpose. This includes draft and final inspection reports on all locations.

Please note: CQC can deem notices sent to manager(s) at the relevant email or postal address for service in this statement of purpose as having been served, as described in Sections 93 and 94 of the Health and Social Care Act 2008. The address supplied must therefore be accurate, up to date, and able to ensure prompt delivery of these important documents to registered managers.

3. Locations managed by the registered manager at 1 above (Please see part 3 of this statement of purpose for full details of the location(s))	
Name(s) of location(s) (list)	Percentage of time spent at this location

4. Regulated activity(ies) managed by this manager		
Personal care	☐	
Accommodation for persons who require nursing or personal care	☐	
Accommodation for persons who require treatment for substance abuse	☐	
Accommodation and nursing or personal care in the further education sector	☐	
Treatment of disease, disorder or injury	☐	
Assessment or medical treatment for persons detained under the Mental Health Act	☒	
Surgical procedures	☐	
Diagnostic and screening procedures	☐	
Management of supply of blood and blood derived products etc	☐	
Transport services, triage and medical advice provided remotely	☐	
Maternity and midwifery services	☒	
Termination of pregnancies	☐	
Services in slimming clinics	☐	
Nursing care	☐	
Family planning service	☐	

5. Locations, regulated activities and job shares

Where this manager does not manage all of the regulated activities ticked / checked at 4 above at all of the locations listed at 3 above, please describe which regulated activities they manage at which locations below.

Please also describe below any job share arrangements that include or affect this manager.

The Regulated Activities highlighted within Section Four are managed by Executive Directors of the Trust from their base at Trust Headquarters of the Queen Elizabeth Hospital, Gateshead.

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

	Lead	Type of item	Public/Private	Sep-24	Nov-24	Jan-25	Mar-26
Standing Items			Part 1 & Part 2				
Apologies	Chair	Standing Item	Part 1 & Part 2	√	√	√	√
Declaration of interests	Chair	Standing Item	Part 1 & Part 2	√	√	√	√
Minutes	Chair	Standing Item	Part 1 & Part 2	√	√	√	√
Action log	Chair	Standing Item	Part 1 & Part 2	√	√	√	√
Matters arising	Chair	Standing Item	Part 1 & Part 2	√	√	√	√
Chair's Report	Chair	Standing Item	Part 1	√	√	√	√
Chief Executive's Update Report	Chief Executive	Standing Item	Part 1 & Part 2	√	√	√	√
Cycle of Business	Company Secretary	Standing Item	Part 1 & Part 2	√	√	√	√
Patient & Staff Story	Company Secretary	Standing Item	Part 1	√	√	√	√
Questions from Governors	Chair	Standing Item	Part 1	√	√	√	√
Items for Decision			Part 1 & Part 2				
Annual Declarations of Interest	Company Secretary	Item for Decision	Part 1				√
Approval of new Strategic Objectives	Director of Strategy and Planning	Item for Decision	Part 1				√
Board Assurance Framework - approval of opening position	Company Secretary	Item for Decision	Part 1				
Board Assurance Framework - approval of closing position	Company Secretary	Item for Decision	Part 1				√
Standing Financial Instructions, Delegation of Powers, Constitution and Standing Orders - annual review	Company Secretary / Group Director of Finance	Item for Decision	Part 1				√
Calendar of Board Meetings	Company Secretary	Item for Decision	Part 1		√		
Winter Plan	Chief Operating Officer	Item for Decision	Part 1	√			
Board Committee Annual Reviews of Effectiveness and Terms of Reference Update	Company Secretary	Item for Decision	Part 1				√
CQC Statement of Purpose and Registration	Chief Nurse	Item for Decision	Part 1				√
SID and Deputy Chair Appointment	Company Secretary	Item for Decision	Part 1 & Part 2				
Items for Assurance			Part 1 & Part 2				
Board Committee Assurance Reports	Committee Chairs	Item for Assurance	Part 1	√	√	√	√
~~Trust Strategic Objectives - updates.~~ Now covered via the Leading Indicator reports rather than a separate report	~~Director of Strategy and Planning~~	~~Item for Assurance~~	~~Part 1~~		~~√~~	~~√~~	~~√~~
Board Assurance Framework - updates	Company Secretary	Item for Assurance	Part 1		√	√	
Organisational Risk Register	Chief Nurse	Item for Assurance	Part 1	√	√	√	√
Annual Staff Survey Results	Exec Director of People & OD	Item for Assurance	Part 1 & Part 2			√	√
Finance Report	Group Director of Finance	Item for Assurance	Part 1	√	√	√	√
Leading Indicator Report	Group Director of Finance	Item for Assurance	Part 1	√	√	√	√
Maternity Integrated Oversight Report	Chief Nurse	Item for Assurance	Part 1	√	√	√	√
Maternity Staffing Report	Chief Nurse	Item for Assurance	Part 1				
Nurse Staffing Exception Report	Chief Nurse	Item for Assurance	Part 1	√	√	√	√
Bi-annual Inpatient Safer Nursing Care Staffing Report	Chief Nurse	Item for Assurance	Part 1		√		
Learning from Deaths (6 monthly report)	Medical Director	Item for Assurance	Part 1		√		

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