Board of Directors (Part 1 – Public)

A meeting of the Board of Directors (Part 1 – Public) will be held at 09:30am on 27 March 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 January 2024	Decision	Chair	Paper
5.	09:40	Action log and matters arising	Assurance / decision	Chair	Paper
6.	09:45	Patient and Staff Story - Dietetic Oncology Service	Assurance	Dietetic Oncology Team	Presentation
ITEMS FOR DECISION					
7.	10:00	Governance Reports:			
		i) Corporate Governance Manual (Standing Orders, SFIs, Scheme of Delegation)	Decision	Company Secretary & Group Director of Finance and Digital	Paper
		ii) QE Facilities' SFIs and Scheme of Delegation	Decision	QE Facilities' Managing Director	Paper
8.	10:15	Deputy Chair and Senior Independent Director	Decision	Company Secretary	Paper
9.	10:20	Strategic Objectives 2024/25 and Leading Indicators	Decision	Interim Director of Strategy, Planning & Partnerships / Chief Operating Officer	Paper
10.	10:30	Board Assurance Framework 2023/24	Decision	Company Secretary	Paper
11.	10:40	Constitutional Amendment	Decision	Company Secretary	Paper
12.	10:45	Annual Declarations of Interest	Decision	Company Secretary	Paper
13.	10:50	CQC Statement of Purpose	Decision	Chief Nurse	Paper
ITEMS FOR ASSURANCE					
14.	10:55	Chair's Report	Assurance	Chair	Paper
15.	11:05	Chief Executive's Report	Assurance	Chief Executive	Paper
16.	11:15	Governance Reports:			
		i) Strategic Objectives – Quarter Four Update	Assurance	Interim Director of Strategy, Planning & Partnerships	Paper
		ii) Organisational Risk Register	Assurance	Chief Nurse	Paper
17.	11:25	Assurance from Board Committees:			

No	Start time	Item	Purpose	Lead	Paper / Verbal
		i) Finance and Performance Committee - February and March 2024	Assurance	Chair of the Committee	Paper
		ii) Quality Governance Committee - February 2024	Assurance	Chair of the Committee	Paper
		iii) Digital Committee - March 2024	Assurance	Chair of the Committee	Paper
		iv) People and Organisational Development Committee - March 2024	Assurance	Chair of the Committee	Paper
		v) Group Audit Committee - March 2024	Assurance	Chair of the Committee	Paper
18.	11:45	Annual Staff Survey Results	Assurance	Executive Director of People and Organisational Development	Paper
19.	11:55	Finance Report	Assurance	Group Director of Finance and Digital	Paper
20.	12:05	Leading Indicators	Assurance	Group Director of Finance and Digital	Paper
21.	12:20	Freedom to Speak Up Guardian Report	Assurance	Freedom to Speak Up Guardian	Paper
22.	12:30	Maternity Update			
		i) Maternity Integrated Oversight Report	Assurance	Head of Midwifery	Paper
		ii) Maternity Staffing Report – Quarters Two and Three	Assurance	Head of Midwifery	Paper
ITEMS FOR INFORMATION / MEETING GOVERNANCE					
23.	12:40	Nurse Staffing Exception Report	Assurance	Chief Nurse	Paper
24.	12:45	Cycle of Business	Information	Company Secretary	Paper
25.	12:50	Questions from Governors in Attendance	Discussion	Chair	Verbal
26.	13:00	Any Other Business	Discussion	Chair	Verbal
27.	13:05	Date and Time of Next Meeting – 09:30am on Wednesday 5 June 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

Gateshead Health NHS Foundation Trust

Trust Board

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

Present:	
Mrs A Marshall	Chair
Mr A Beeby	Medical Director
Mr A Crampsie	Non-Executive Director
Mrs T Davies	Chief Executive
Dr G Findley	Chief Nurse and Deputy Chief Executive
Mr N Halford	Medical Director of Operations
Mrs J Halliwell	Group Chief Operating Officer
Mr S Harrison	Interim Managing Director for QE Facilities
Mr M Hedley	Non-Executive Director
Mrs K Mackenzie	Group Director of Finance and Digital
Mr A Moffat	Non-Executive Director
Mrs H Parker	Non-Executive Director
Mrs M Pavlou	Non-Executive Director
Mr M Robson	Vice Chair / Non-Executive Director
Mrs A Stabler	Non-Executive Director
Mrs A Venner	Group Director of People & Organisational Development
In Attendance:	
Mrs J Boyle	Company Secretary
Ms A Okereke	Practice Development Nurse/Staff Governor (24/06)
Mrs K Parker	Head of Midwifery (24/15)
Ms D Waites	Corporate Services Assistant
Governors and Observers:	
Mrs H Adams	Staff Governor
Mr J Bewley	Member of the Public
Mr L Brown	Public Governor – Western
Mr S Connolly	Public Governor – Central
Ms R Farmer	Business Development Director, Liaison Workforce
Mr M Loome	Public Governor – Central
Mr G Main	Public Governor – Western
Dr L Murthy	Public Governor – Western
Ms S Sillett	People and OD Advisor/Graduate Management Trainee
Ms L Sore	Medical Education Manager
Dr G F Spiers	Appointed Governor
Apologies:	

Agenda Item	Discussion and Action Points	Action By
24/01	**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 public observers.	

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	She informed the Board that this will be the last meeting for Mr S Harrison as Interim Managing Director for QE Facilities and wished him well for the future. This will also be the last meeting for Mr A Beeby as Medical Director in advance of his retirement and the Board wished him well in his retirement and thanked him for his long length of service and commitment to the Trust. Mrs Marshall informed the Board that Agenda Item 7, Standing Financial Instructions and Delegation of Powers Annual Review has been removed from the agenda following discussion at the Finance and Performance Committee yesterday however will be presented at the next meeting.	
24/02	**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.	
24/03	**APOLOGIES FOR ABSENCE:** There were no apologies received.	
24/04	**MINUTES OF THE PREVIOUS MEETING:** The minutes of the meeting of the Board of Directors held on Wednesday 29th November 2023 were approved as a correct record after the following minor amendments: 23/243 Chief Executive's update report (page 5) – in relation to outstanding complaints, "all outstanding complaints are being addressed and plans are in place however Dr Findley highlighted that these are now back within normal targets" *and in line with reporting procedures prior to covid.* 23/245 Assurance from Board Committees/People and Organisation Development Committee (page 10) – "Mrs Pavlou drew attention to the items for escalation which included some historic bullying issues highlighted in the General Medical Committee survey" however this should read *General Medical Council Trainee survey.*	
24/05	**MATTERS ARISING FROM THE MINUTES:** Mrs A Stabler, Non-Executive Director, wished to raise a concern in relation to Section 23/250 of the previous minutes which highlighted that discussions have taken place at the Quality Governance Committee in relation to learning from deaths with learning disabilities due to the national standard not being met. It was noted at the time that the Trust	

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	only has one specialist Learning Disability Nurse within the service and Mrs Stabler highlighted that the nurse is currently absent therefore queried whether reasonable adjustments were being put in place. Dr G Findley, Chief Nurse and Deputy Chief Executive, confirmed that there was a current gap in the service however reported that discussions are taking place with the Chief Nurse at Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust and will provide feedback at the next Quality Governance Committee. The Board reviewed the action tracker as below: • Action 23/64 re. proposed rescheduling of committee meetings. POD Committee dates have now been approved therefore it was agreed to close this action. • Action 23/196 re. elective recovery presentation to Board. This took place at the December Board Development Day therefore it was agreed to close this action. • Action 23/199 re. progress of Healthcare Assistants pay rate review. This has been discussed at the People and Organisational Development Committee and will be discussed further within part 2 of the Board therefore it was agreed to close this action. • Action 23/206 re. Freedom to Speak Up Board training. Reminder sent to Board to complete training and to remain open until completed. • Action 23/247 re. how future rates should be reported following the introduction of the Patient Safety Incident Response Framework (PSIRF). Dr Findley highlighted that information is awaited from the regional teams as to how incidents will be reported to Boards across the region however assured the Board that all significant incidents are reviewed by the Chief Nurse and Medical Director and reported via the reportable issues log. It was agreed that this action will remain open until a process is agreed. A query was also raised in relation to the PSIRF training for the Board and dates provided. Dr Findley reported that a further date could be provided for those that have been unable to attend and whether a full day is required will also be reviewed. • Action 23/247 re. review of bed base in relation to staffing via the Quality Governance Committee. This has been reviewed by the Committee therefore action agreed for closure. • Action 23/249 re. future Maternity Integrated Oversight Reports to include trajectory for postpartum haemorrhage (PPH). This is now included in the maternity dashboard 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.	GF

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24/06	**STAFF STORY – MENTORING PROGRAMME:** The Board welcomed Adaeze Okereke, Practice Development Nurse and Staff Governor, who provided a summary of her experience as part of the mentoring programme working with Dr G Findley, Chief Nurse and Deputy Chief Executive. She reported that this has been a positive experience and has also supported her professional development and leadership skills. She has worked closely with the Trust's Global Ethnic Minority (GEM) Network as well as supporting work around the recognition of international educational needs. Miss Okereke felt that it would be beneficial for a running programme to be set up to develop cultural awareness and support transitional skills onto wards. The programme has been beneficial to both Miss Okereke and Dr Findley and a change to annual leave restrictions to wards over Christmas has been reviewed to allow international staff to visit families back home. Mrs A Venner, Group Director of People and Organisational Development, highlighted that benchmarking work is taking place around mentorship programme structures and this should be taken forward in the near future. Mrs A Stabler, Non-Executive Director, reported that the Integrated Care Board are launching a reciprocal training scheme and Mrs Venner will also review this as part of the benchmarking work. Following a query from Mr A Crampsie, Non-Executive Director, in relation to how staff are able to access the programme, Mrs Venner explained that this is currently arranged via the GEM Staff Network pilot however will be rolled out across other networks in the future. Mrs Marshall thanked Miss Okereke for sharing her story and the Board agreed that this programme is important in supporting international nurses during their transition period and recognising innovation and knowledge skills.	
24/07	**STANDING FINANCIAL INSTRUCTIONS AND DELEGATION OF POWERS ANNUAL REVIEW:** This report was withdrawn and will be presented at the next Board meeting in March 2024.	
24/08	**EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) CORE STANDARDS SELF-ASSESSMENT REPORT:** Mrs J Halliwell, Group Chief Operating Officer, presented the EPRR annual assurance report for 2023 which includes the NHS England core standards self-assessment final submission.	

Agenda Item	Discussion and Action Points	Action By
	She reported that an initial internal self-assessment of the EPRR core standards and evidence submission resulted in a self-assessment rating of substantial compliance however following the NHS England review, an assurance position of non-compliance was recommended. A further check and challenge process was undertaken with the Integrated Care Board (ICB) due to the discrepancy which resulted in a final position of 77% which is partial compliance. Mrs Halliwell felt that this was positive position following the complexities and further work is being undertaken with the ICB to focus on building collaborative practices and improvement plans. A work programme is also being developed with the EPRR team to ensure internal organisational learning and opportunities for improvement are embedded. Mr A Crampsie, Non-Executive Director, felt that it would be beneficial to receive ongoing assurances via the Quality Governance Committee and Mrs Halliwell agreed that a six-monthly report can be presented to the Committee for additional assurance. Following further discussion, it was: **RESOLVED:** i) to acknowledge the way in which the self-assessment process has been conducted for 2023, resulting in a final self-assessed position of 77% and partial compliance ii) to be assured that the differential gap in evidential requirements will form part of the 2024 EPRR development work plan iii) to endorse the assurance provided within the 2023 Annual Assurance Report iv) to support the inclusion of the compliance rating in the Trust's Annual Report for 2023/24.	JH/GF
24/09	**BOARD COMMITTEE TERMS OF REFERENCE:** Mrs J Boyle, Company Secretary, presented the revised terms of reference for the Group Remuneration Committee, Group Audit Committee and Quality Governance Committee. **Group Remuneration Committee** Mrs Boyle explained that these are a new set of terms of reference which incorporate recommendations from an external review and now also cover the Group role of the Committee. Following a query from Mr M Robson, Vice Chair, in relation to expected attendance of attendees, it was agreed to remove the 75% achievement rate due to the expected low amount of meetings that generally take place over the year. **Group Audit Committee:**	JB

Agenda Item	Discussion and Action Points	Action By
	The terms of reference have been reviewed by the Committee and no changes have been proposed. Following a query from Mr M Robson, it was agreed to adjust the terminology used in the terms of reference from 'Accountable Officer' to 'Accounting Officer'. **Quality Governance Committee:** The terms of reference have been amended to reflect the attendance of the Integrated Care Board to observe the Committee and other minor amendments to terminology were made following discussion at the Committee. After consideration, it was: **RESOLVED:** to ratify the reviewed and revised terms of reference for the three Committees, noting that they have been approved by the respective Committees.	JB
24/10	**CHIEF EXECUTIVE'S UPDATE REPORT** Mrs T Davies, Chief Executive, gave an update to the Board on current issues which have aligned to the Trust's Strategic Aims. She drew attention to the following updates in relation to Strategic Aim 1: *we will continuously improve the quality and safety of our services for our patients* – which highlights the achievement of the Paediatric Department in becoming the first in the region to be awarded the Gold Standard for Autism Acceptance from the North East Autism Society. An engagement event has also been held for clinical colleagues and managers to support identifying the most appropriate electronic patient record system for the Trust and Mrs K Mackenzie, Group Director of Finance and Digital, confirmed that work is now being undertaken around the next phase of the project. Mrs Davies also drew attention to the rebrand and relaunch of the Trust's charity which is now called Gateshead Health Charity. In relation to Strategic Aim 2: *we will be a great organisation with a highly engaged workforce* – Mrs Davies thanked colleagues and volunteers for their hard work over the busy holiday period as well as the challenges experienced as a result of strike action and further announcements are expected in the near future. The Trust is also committed to working with colleagues and trade unions on the implementation of the national Healthcare Assistant regrading process to ensure staff remain engaged and supported. In relation to Strategic Aim 3: *we will enhance our productivity and efficiency to make the best use of resources* – Mrs Davies reported that the Trust is currently engaged in the annual planning process and a number of engagement sessions have taken place with Council of Governors, Clinical Strategy Group and Senior Management Team.	

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	In relation to Strategic Aim 4: *we will be an effective partner and be ambitious in our commitment to improving health outcomes* – Mrs Davies drew attention to the Alliance model being pursued with Newcastle, Northumbria, and North Cumbria Foundation Trusts which has the potential to provide great opportunities in line with the sustainability agenda. In relation to Strategic Aim 5: *we will develop and expand our services within and beyond Gateshead* – Mrs Davies drew attention to the progress being made with the Community Diagnostic Centre at the Metro Centre in partnership with Newcastle Hospitals. This will have significant benefits to patients in Gateshead and Newcastle by enabling increased diagnostic capacity. Mrs K Mackenzie, Group Director of Finance and Digital, highlighted that a visit to the site is being arranged and will ensure an invite is sent out. Mrs A Stabler, Non-Executive Director, felt that it was important to recognise the reduction in the vacancy rate from 5.7% to 2.5% and Mrs Marshall highlighted that the Nurse Staffing Report is on the agenda for information due to no issues for escalation. Mr A Crampsie, Non-Executive Director, queried whether there had been any impact following the development of the zero-tolerance culture work and Mrs A Venner, Group Director of People and Organisational Development, reported that a working group is currently reviewing information however there has been good engagement across staff groups and networks. Mrs Marshall highlighted the positive stories within the report and congratulated the Executive Team on these achievements. Following discussion, it was: **RESOLVED:** to receive the report for assurance.	
24/11	**GOVERNANCE REPORTS** **Organisational Risk Register (ORR)**: Dr G Findley, Chief Nurse and Deputy Chief Executive, presented the updated ORR to the Board which shows the risk profile of the ORR, including a full register, and provides details of reviewed compliance and risk movements. This report covers the period 17th November 2023 to 17th January 2024. Dr Findley reported that there are currently 18 risks on the ORR, none of which have a current score of 16. There have been 2 additions to the ORR following the Executive Risk Management Group meetings in December 2023 and January 2024 which relate to digital health records and disclosure of information. There have been 2 reductions in risk scores, one relating to the MRI provision and confidence in services. One risk has been de-escalated from the ORR which relates to overdue	

Agenda Item	Discussion and Action Points	Action By
	policies and Dr Findley thanked the Corporate Services Team for their continued work around this. Compliance with actions reviews is currently at 100% and Dr Findley highlighted that this demonstrates the work being undertaken to actively review risks. After consideration, it was: **RESOLVED:** to receive the report for assurance.	
24/12	**ASSURANCE FROM BOARD COMMITTEES** **Finance and Performance Committee (F&P):** Mr M Robson, Chair of the F&P Committee, provided a brief verbal overview to accompany the narrative report following the December 2023 meeting and provided a verbal update of the meeting held yesterday (30th January 2024). He confirmed the decision by the Committee to defer the Standing Financial Instructions due to further review being required as well as linking in with the QE Facilities review of scheme of delegation. Other key areas of discussion from the January 2024 meeting included: • Positive changes in performance were noted including a detailed report on ambulance handovers which has significantly improved with no delays over 30 minutes being reported. • The Committee discussed the progress being made in relation to the Alliance work and it was felt that a more robust governance structure was required to ensure the Board is kept informed of developments. Mrs Marshall reported that a monthly steering group is taking place between the Alliance therefore it was suggested that a report could be provided to the Board and the Finance and Performance Committee when a Board is not planned however it may be some time before any decisions are required. Mrs M Pavlou, Non-Executive Director, raised concerns in relation to the already lengthy agendas, however Dr G Findley, Chief Nurse and Deputy Chief Executive, highlighted that work will be taking place following recommendations from the review by the Good Governance Improvement in relation to streamlining Board Committee agendas. Mr A Crampsie, Non-Executive Director felt that it would be beneficial for the Board to be aware of the vision and strategy in relation to the Alliance work however Mrs Marshall explained that this work is still in very early stages therefore governance structures requires further development however any decisions would need to come to all Boards within the Alliance group. Updates will continued to come to the Finance and Performance Committee in the meantime and Mrs K Mackenzie, Group Director of Finance and Digital, suggested a temporary amendment to the Terms of Reference to include the Alliance discussions. • The Committee reviewed the Leading Indicators which were mainly positive and it was felt that the Emergency Department	JB

Agenda Item	Discussion and Action Points	Action By
	performance targets should refer to the 4-hour standard, so that will be added moving forwards. • Discussion took place around the planned deficit and this will also be reviewed by the capital planning group to ensure assurances are being provided. • A report was provided to the Committee in relation to the Community Diagnostic Centre construction progress. • The Committee discussed the financial planning round and current lack of national guidance however the Integrated Care Board have provided a medium term financial plan which will be reviewed to ascertain impact. • Mr Robson reported that there is a lot of work being undertaken around planning for the new financial year and the Executive Management Team will be reviewing business unit plans via the oversight meetings. Mr A Crampsie, Non-Executive Director, queried whether the improvement in performance would result in potential risks from increased demand to support other providers however Mrs J Halliwell, Group Chief Operating Officer, reported that there was no evidence of this and weekly tracking meetings continue to take place. There has been an increase in ambulance divert requests and this will be monitored. Mrs T Davies, Group Chief Executive, highlighted that work around business intelligence would be required to provide effective monitoring mechanisms are in place. **Quality Governance Committee (QGC):** Mrs A Stabler, Chair of QGC, provided a brief verbal overview to accompany the narrative report following the December 2023 meeting and also highlighted that an extraordinary meeting had taken place yesterday (30th January 2024) to review the Maternity Incentive Scheme (MIS) Assurance Framework prior to Board approval. She reported that the Trust is one of a few organisations to achieve all targets and will ensure that the department receives the incentive for the development of services. Some concerns were raised in relation to health and safety due to the unavailability of key members and the Trust currently does not have a Health and Safety Manager. A further report to highlight recovery plans has been requested to provide assurances and will be presented at the next meeting. Mrs Stabler also highlighted that assurance has been requested in relation to do not attempt cardiopulmonary resuscitation (DNACPR) monitoring however this does not require escalation at this stage. **Digital Committee:** Mr A Moffat, Committee Chair, provided a brief verbal overview to accompany the narrative report following the November 2023 meeting. He reported that there were no items for escalation however drew attention to other key areas of discussion:	

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	• The Committee received an update for information and assurance relating to the Electronic Patient Records (EPR) system development and a supplier event took place in December therefore a formal update will be presented at the next meeting. • An overview of the Patient Engagement Portal (PEP) was presented for assurance and the Trust is the first to go-live with enhanced functionality. Following a query from Mrs Stabler in relation to the procurement timelines of a new EPR system, Mrs K Mackenzie, Group Director of Finance and Digital, reported that this has not been considered as yet however a full review of current services is taking place to establish functionalities. **People and Organisational Development (POD) Committee** Mrs M Pavlou, Chair of POD Committee, provided a brief verbal overview to accompany the narrative report following the January 2024 meeting. She drew attention to the items for escalation which included changes to NHS England data which has resulted in a different sign off route for the Annual Dean's Quality Meeting (ADQM) report, providing delegated authority to the Executive Management Team. A review has also taken place in relation to maintaining high professional standards (MHPS) cases and an update will be provided in Part 2 of the Board. Concerns have been raised in relation to the limited assurance provided following the internal audit review of senior medical staff planning and a summary report will be reviewed by the Executive Management Team and Audit Committee. Work around the health care support worker rebanding was also discussed and is currently a high priority area and a project plan has been agreed. Mrs Pavlou also wished to highlight the reduction in the Trust's vacancy rate and the sickness absence rate also continues to be monitored. **Audit Committee:** Mr A Moffat, Audit Committee Chair, provided a brief verbal overview to accompany the narrative report following the December 2023 meetings. He drew attention to the items for escalation which included incomplete management responses and target dates for implementation of audit actions. A decision was taken by the Committee to escalate these concerns to the Board and Chief Executive. Mrs T Davies, Group Chief Executive, apologised on behalf of the Executive Team and provided assurance that these issues were being addressed with training and support being reviewed. Mr A Crampsie, Non-Executive Director, queried whether these concerns should have been raised earlier however Mr Moffat confirmed that an escalation process is in place within the Committee. Mrs K Mackenzie, Group Director of Finance and Digital confirmed that a number of the outstanding actions have already been addressed and closed and a further update will be provided to the Audit Committee at the next meeting.	

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	Group Remuneration Committee: Mr M Robson, Committee Chair, provided a brief verbal overview to accompany the narrative report following the meetings on 29th November 2023 and 9th January 2024. This is the first assurance report for the Committee and there were no items for escalation. The report provides a summary of items discussed including role descriptions, senior manager pay and succession planning. **QE Facilities Board:** Mrs M Pavlou, QE Facilities Board Chair, provided a brief verbal overview to accompany the narrative report following the January 2024 meeting. She drew attention to the items for escalation which included the concerns raised at the Quality Governance Committee in relation to Health and Safety however they are now being addressed through the development of an improvement plan. She also drew attention to the implications of an upcoming increase in the Real Living Wage and the NHS pay review process has been deferred until discussions have taken place. Following a query from Mr Crampsie in relation to the timescales around this, Mr S Harrison, Interim QE Facilities Managing Director, highlighted that implications around the employer accreditation and current terms and conditions and would need to be looked at further. Mrs T Davies, Group Chief Executive, confirmed that this will be reviewed as a Group and a report is due to be presented to the Board in Part 2. Mr M Robson, Vice Chair, explained that this would also be reviewed via the work being undertaken around the Standing Financial Instructions. Mrs Marshall thanked the Committee Chairs for their reports and after consideration, it was: **RESOLVED**: to receive the reports for assurance	
24/13	**FINANCE REPORT:** Mrs K Mackenzie, Group Director of Finance and Digital, provided the Board with a summary of financial performance as of 31st December 2023 (Month 9) for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds). Mrs Mackenzie highlighted some of the key points and reported that the year-to-date position is currently on plan with an adverse variance of £200k and is forecasting achievement of the planned deficit. The Trust is also forecasting an underspend against the capital programme which relates to the Community Diagnostic Centre. Mr M Robson, Finance and Performance Committee Chair, reported that the Committee discussed forecast outturn scenarios including actions and mitigations therefore demonstrating a structured approach. Following consideration, it was:	

Agenda Item	Discussion and Action Points	Action By
	RESOLVED: to receive Month 9 financial position and note partial assurance for the achievement of the forecast 2023/24 planned deficit as a direct consequence of the reported year to date position and financial risks.	
24/14	**LEADING INDICATORS:** Mrs K Mackenzie, Group Director of Finance and Digital, presented progress, risks and assurance in relation to the Trust's Leading Indicators and Elective Recovery for December 2023. Mrs Mackenzie explained that the report continues to be under development and will be supported by a new member of staff within the business intelligence team. Detailed discussions took place around the report at the Finance and Performance Committee however Mrs Mackenzie drew attention to the summary provided in relation to elective recovery and the Board acknowledged the significant achievements in relation to waiting lists and ambulance handovers. Mrs M Pavlou, Non-Executive Director, requested further information in relation to ambulance handovers and Mrs J Halliwell, Group Chief Operating Officer, explained that a significant amount of work has been undertaken around organisational culture and staff engagement which has been positively received across the department. Mr N Halford, Medical Director of Operations, reported that this is a complicated pathway however improved communications and support from the teams has assisted in the achievements. Mrs T Davies, Group Chief Executive, felt that principles agreed via leadership methodology has supported this work and highlighted that the Executive Team are committed to addressing organisational challenges. Mrs Halliwell explained that a set of key performance standards is being developed for the Trust and will be discussed in more detail at a future Board Development Day. Following a query from Mrs A Stabler, Non-Executive Director, in relation to length of stay, Mrs Halliwell explained that patients are generally staying longer however some delays relate to out of area placements and engagement with local authorities continues. Mr A Crampsie, Non-Executive Director, requested further assurances in relation to falls and Dr G Findley, Chief Nurse and Deputy Chief Executive reported that a detailed reported in relation to falls is presented to the Quality Governance Committee as part of the cycle of business. Mrs Marshall reminded the Board that this is a developing report and requested any feedback to be directed to Mrs Mackenzie. Mrs Mackenzie highlighted that discussions took place at the Finance and Performance Committee and suggestions included reintroducing the	JB

Agenda Item	Discussion and Action Points	Action By
	breakthrough indicators and further work around data visualisation including statistical process control (SPC) charts. After consideration, it was: **RESOLVED:** to receive the report for assurance, noting the improvements and ongoing challenges in key areas.	
24/15	**MATERNITY UPDATE:** **Maternity Integrated Oversight Report:** Ms K Parker, Head of Midwifery, presented a summary of the maternity indicators for the Trust for November and December 2023. She drew attention to the key performance indicators within the Maternity Dashboard and highlighted that post-partum haemorrhages (PPH) continues to show above target however this is in line with national and regional data. A deep dive investigation is taking place and will be linking with the Emergency Preparedness, Resilience and Response (EPRR) team to conduct skills drills to support effective management of blood loss incidents. Mr A Beeby, Medical Director, indicated that further investigation around thresholds has been raised and an audit is being undertaken by the obstetric trainee team. Ms Parker highlighted the increase to birth rates and noted that whilst this is positive for the Trust, is creating some additional pressure to the service. Ms Parker explained that there has been some recent engagement work undertaken with the Jewish community which may have encouraged local families to choose Gateshead. Following a query from Mr A Crampsie, Non-Executive Director, around future planning, Ms Parker explained that mapping work is taking place and Mrs T Davies, Group Chief Executive, felt that it was important that forecasting and trends are included in business planning processes and service demand and capacity assessments. Following discussion, it was: **RESOLVED:** to receive the report for assurance. **Maternity Incentive Scheme Assurance Framework Compliance Report:** Ms Parker presented a summary of the evidence held to meet full compliance with the Maternity Incentive Scheme Year 5 ten safety standards. She reminded the Board that full compliance has been achieved and the report has been approved by the Quality Governance Committee and has also been accepted by the Integrated Care Board. The Trust is required to submit the completed Board declaration to NHS Resolution by 12 noon on 1st February 2024. Mrs A Stabler, Non-Executive Director, highlighted that this achievement will result in a rebate of at least 10% of the Trust's maternity contribution to the Clinical Negligence Scheme for Trusts	

Agenda Item	Discussion and Action Points	Action By
	(CNST) and will be ringfenced for maternity safety in line with national recommendations. The Board congratulated the team and after consideration, it was: **RESOLVED:** to receive the report for assurance and recommend the submission of the Board declaration to NHS Resolution.	
24/16	**NURSE STAFFING UPDATE:** **Monthly Nurse Staffing Exception Report**: Dr G Findley, Chief Nurse and Deputy Chief Executive, presented the report for December 2023 which provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls. She highlighted that the report indicates that there was one red flag raised however this was due to an anomaly within the system where a shift had not been recorded. Following a query from Mrs T Davies, Group Chief Executive, in relation to realignment of staffing levels, Dr Findley reported that this will be undertaken within the next stage of the process and Mrs K Mackenzie, Group Director of Finance and Digital, highlighted that this will be discussed within the Business Unit Oversight meetings. The Board recognised that this was a positive position and further work will now take place around alignment of current resources. Following discussion, it was: **RESOLVED:** to receive the report for assurance and note the work being completed to address the remaining gaps.	
24/17	**CYCLE OF BUSINESS:** Mrs J Boyle presented the cycle of business which outlines forthcoming items for consideration by the Board. This provides advanced notice and greater visibility in relation to forward planning. The cycle of business for 2024/25 will be presented to the Board at the next meeting which will provide the opportunity for detailed review. After consideration, it was: **RESOLVED:** to receive the cycle of business for 2023/24.	

Agenda Item	Discussion and Action Points	Action By
24/18	**QUESTIONS FROM GOVERNORS IN ATTENDANCE:** Mr J Bewley felt that it would be beneficial to gain a better understanding in relation to the functionality and structure of the organisation and felt that further visits to service areas would be useful. Mrs Marshall reminded him that Governors are invited to attend PLACE assessment visits and the 15 steps visits. He also queried provisions in place for home births and Dr G Findley, Chief Nurse and Deputy Chief Executive, confirmed that the Trust does provide a home birth service and Mrs A Stabler, Non-Executive Director, reiterated that the Trust has an excellent model of care in this area.	
24/19	**DATE AND TIME OF THE NEXT MEETING:** The next meeting of the Board of Directors will be held at 9:30am on Wednesday 27th March 2024.	
24/20	**CLOSURE OF THE MEETING:** Mrs Marshall declared the meeting closed.	
24/21	**EXCLUSION OF THE PRESS AND PUBLIC:** **RESOLVED:** to exclude the press and public from the remainder of the meeting due to the confidential nature of the business to be discussed	

PUBLIC BOARD ACTION TRACKER

Gateshead Health NHS Foundation Trust

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

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
23/206	27/09/2023	FTSU Guardian Report	To provide details to Board members re. FTSU training	29/11/2023	GR / AV	**Nov 23 –** details shared at POD Committee however a reminder will be sent to Board members. To remain open until completed	
23/247	29/11/2023	IOR and Leading Indicators	To consider how future rates should be reported following introduction of PSIRF. To be discussed with planning and performance team	31/01/2024	GF	**Jan 24** - in progress. Awaiting information from the regional team as to how incidents will be reported to Boards across the region. In the meantime, all significant incidents are reviewed by the Chief Nurse and Medical Director and reported via reportable issues log. To remain open until process agreed to ensure the Trust is aligned with other trusts.	
24/08	31/01/2024	EPRR Core Standards Self Assessment Report	Six monthly reports to be presented to the Quality Governance Committee to ensure ongoing assurances around compliance	27/03/2024	GF/JH		
24/11	31/01/2024	Board Committee Terms of Reference	To amend the Group Audit Committee and Group Remuneration Committee terms of reference to reflect the feedback received	27/03/2024	JB	**March 24** – terms of reference amended to reflect the feedback received. **Action therefore recommended for closure**.	
24/12	31/01/2024	Assurance from Board Committees	To amend the Finance and Performance Committee Terms of	27/03/2024	JB	**March 24** – terms of reference amended to reflect the feedback received and this has been factored into the cycle of	

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
			Reference to include the Alliance discussions.			business. **Action therefore recommended for closure.**	
24/14	31/01/2024	Leading Indicators	To discuss development of new set of key performance standards in more detail at a future Board Development Day.	27/03/2024	JB	**March 24** – this was incorporated into the annual planning discussions at the Board development day in February 2024. **Action therefore recommended for closure.**	

Closed Actions from last meeting

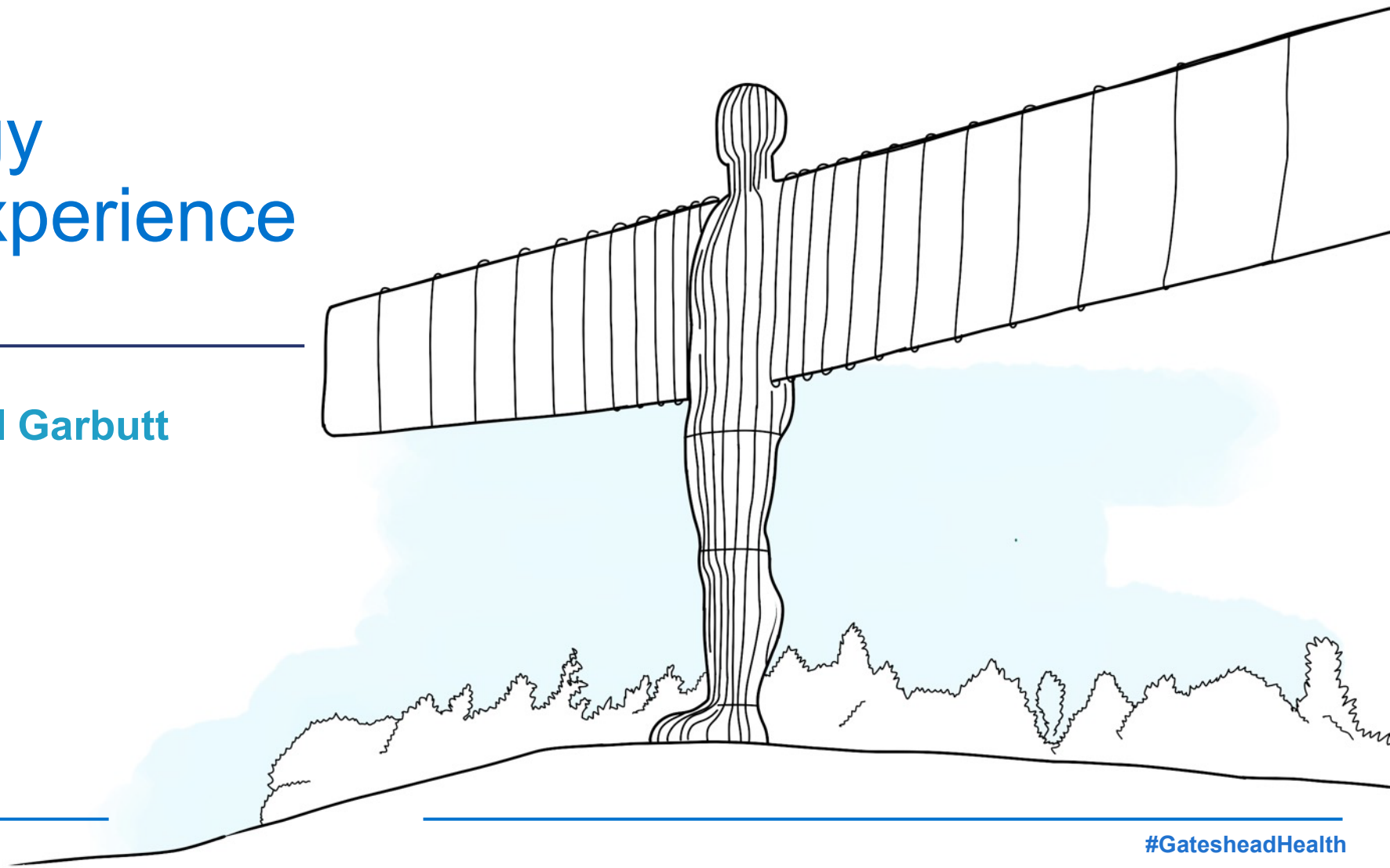
Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
23/64	29/03/2023	Board Committee Assurance Report	Discussion around proposed rescheduling of committee meetings required – to be discussed at Exec Team	24/05/2023	Exec	May 23 – outcome to be provided July 23 – to be reviewed as part of GGI review. Action to be retained as open until this review concludes. Sept 23 – review is due to conclude in early October. Board discussion planned for October Board Development day. Nov 23 – POD committee dates to be agreed. Action to remain open until approved. Jan 24 – dates approved therefore action agreed for closure	
23/196	27/09/2023	F&P Committee Assurance Report	Discussions re. implications of validation in relation to elective recovery board self-assessment to take place at future Board Development Day	31/12/2023	JH / JB	Oct 23 – scheduled for the Dec 23 Board development day Dec 23 – discussed as part of elective recovery presentation at Dec 23 Board development day. Action recommended for closure. Jan 24 – actions agreed as closed on this basis.	
23/199	27/09/2023	HCA pay rates	The Board to be kept informed of progress in the HCA pay rate review via the People and OD Committee update reports	31/12/2023	GF/AV	Nov 23 – coversheet enclosed to provide update. Full PID being developed and working group established. Progress report to go to POD Committee in January 2024 and updated position shared with Board. Jan 24 – discussed at POD Committee in January 24 and will be discussed further within part 2 of the Board therefore it was agreed to close this action.	
23/247	29/11/2023	IOR and Leading Indicators	To review bed base in relation to staffing via the Quality Governance Committee	31/01/2024	GF / JH	Jan 24 - work ongoing and bed base has been agreed internally. Action	

						recommended for closure and Board agreed as closed on this basis.	
23/249	29/11/2023	Maternity IOR	Future reports to include an assessment of PPH as a proportion of volume, as well as a trajectory to demonstrate training compliance.	31/01/2024	GF / JC	Jan 24 – to be included in reports going forward. Action recommended for closure and Board agreed as closed on this basis.	

MACMILLAN CANCER SUPPORT

NHS Gateshead Health NHS Foundation Trust

Dietetic Oncology Service: Staff Experience



Emma Atkinson and Abigail Garbutt

Macmillan Dietitians

March 2024

Local picture & drivers

- Nationally- around 3 million people in the UK were living with cancer in 2020 (Macmillan 2023), this is estimated to increase by 2030 (Macmillan, 2019)

- 15,585 people in the Newcastle and Gateshead area diagnosed with cancer (2020/21), increased from 2018/19 data (Gateshead Joint Strategic Needs Assessment, 2023)

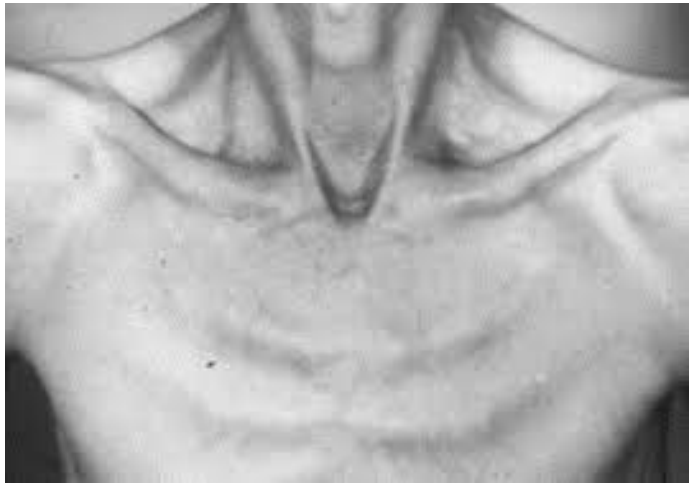
- Demand for oncology dietetic services have increased at Gateshead, this is likely to continue

Importance of nutrition in cancer

- Oncology – one of the highest prevalence of malnutrition compared to other diseases (Marshall *et al* 2019), with 20-70% of patients malnourished (Arends *et al* 2017)

- Cancer cachexia affects 50-80% (Ryan *et al* 2016)

- Nutritional status impacts on Quality of life, treatment tolerance, response and survival.



The initial service

- One of the lowest provisions of dietetic services in the region 0.65 WTE Band 6
- Dietetic cover for all tumour groups and stages of disease (except surgical gynea) – large area to cover
- Dietetic contacts have increased by 18% comparing 2022 and 2016 data
- No change to dietetic resource – increasing pressure and unable to meet demand

- Unable to see patients early enough to optimise, also impact to palliative patients / QOL

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What the service looked like

- Unable to undertake home visits
- Lack of time for enteral queries – ad hoc calls not returned promptly
- Limited time to St. Bedes (Max 3.5hrs day per week), no MDT attendance
- No chemo day unit service – long wait for clinic appts
- Lack of resource to develop the service, deliver education etc – negative impact to quality of service
- No cover during periods of leave – single point of failure. Ad hoc cover from rest of team.

What the service looked like

- Long waiting times: 26 weeks face to face, 27 weeks telephone (Dec 22 – New patient Appointments)
- Long wait for review appointments – up to 6 months (after initial wait)
- Delay for palliative patients – negative impact on quality of life
- Seeing patients too late. Some patients passed away before seen
- Lack of confidence in service from staff. Less referrals made by teams – service bypassed from pre-secondment evaluation / staff surveys
- Poor reputation for Gateshead regionally, particularly within UGI teams

Gateshead Health NHS Foundation Trust

Potential patient impact

- Increased risk of anticancer treatment-related toxicity, lower response rates, lower dose intensity, a lower quality of life and higher mortality (Arends et al 2021)
- Poorer oncological outcomes & reduced survival (Marshall et al 2019; Sullivan et al 2020; Prado et al 2020)
- In 2022, 37 patients at QE who had their chemotherapy dose reduced, also experienced loss of body weight of 5% or more during treatment.
- Higher financial and treatment costs, increased admissions and length of stay

Dietetic staff impact

- Feeling set up to fail each day as unable to meet the demands of the service
- Stressful post due to increased caseload, didn't feel pride in waiting times
- Would not have wanted a loved one to experience a service like this, feeling of guilt
- Unable to make a difference to patients and provide the level of care I wanted to – unable to work to own values
- Staff retention / potential for role to become vacant

Current secondment service

- Support and funding from Macmillan to develop the dietetic oncology service
- Initial 12 month secondments, commenced February 2023 – extended to July 2024
- Current staffing: 0.65 Band 7 and 1.0 WTE Band 6 dietitians
- Aiming to expand & develop the service, increase capacity, and improve quality
- Gather necessary evidence to show impact

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Progress so far

- On the day assessment at the chemotherapy day unit (zero day wait)
- Home visit capacity
- Increase clinics / capacity for enterally fed patients as well as oral nutritional support patients – reduction in waiting times
- Increased time to St Bedes Unit / attendance at weekly MDT
- Incoming queries dealt with promptly – rapid access, same day usually
- Dedicated cover during leave
- Patient education – womens health
- Promotion of service / visibility
- Quality improvements

Dietetic capacity and contacts have increased, waiting times reduced

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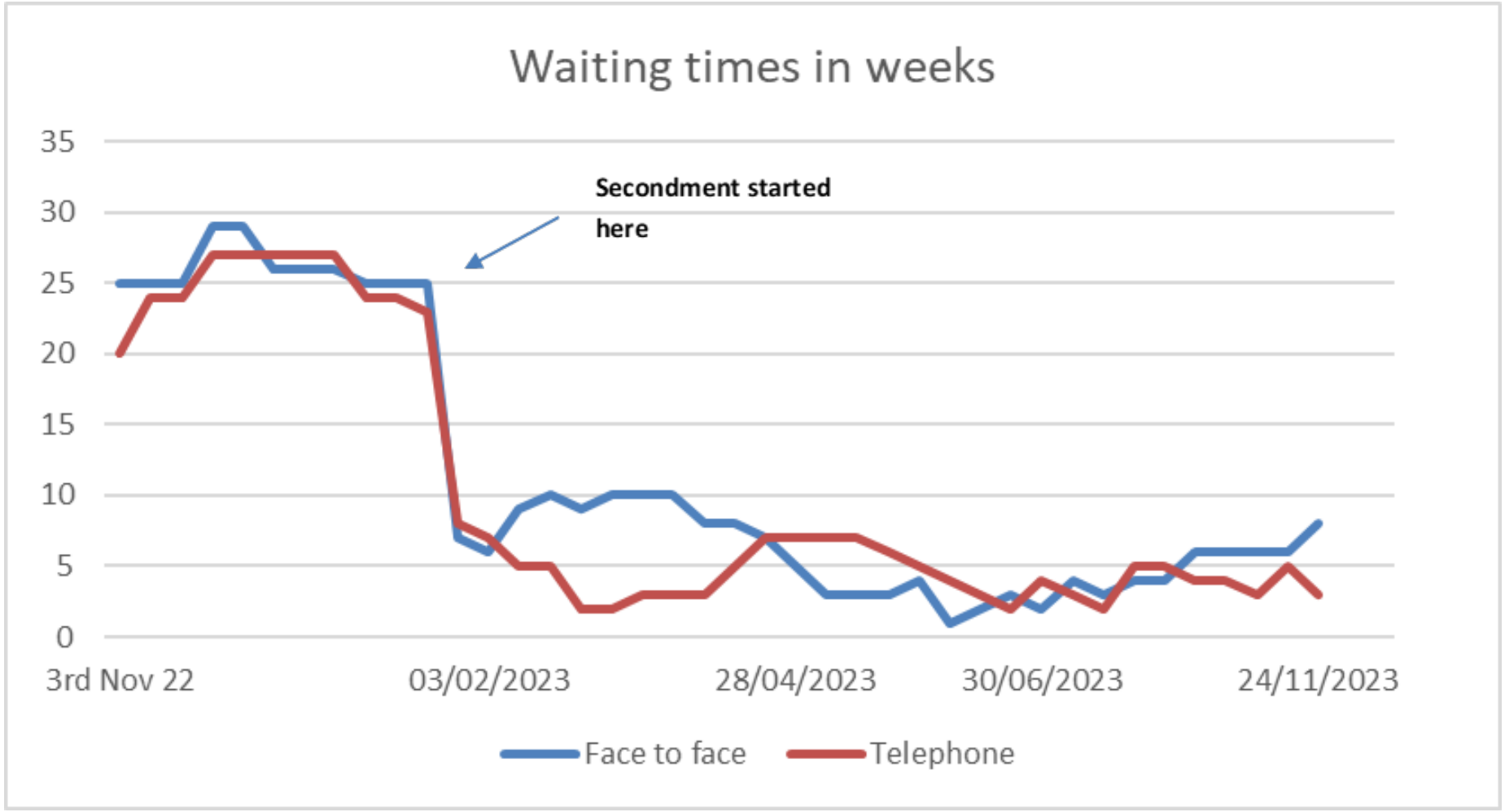

Patient example 1 – Pre secondment

Diagnosis: Adenocarcinoma of rectosigmoid with large volume liver mets, having palliative chemotherapy at QEH, prognosis noted as less than 12 months

Initial assessment- loss of 19kg / 17% body weight (significant). Limited oral intake / appetite. Appropriate dietetic advice provided.

Follow up delayed due to capacity (6 month wait). Recent admission with chemotherapy induced side effects, chemo regimen changed.

Further loss of 11.3kg body weight at next dietetic review, overall loss now 30.3kg / 28% body weight (severe loss) – impacted by delay in reviewing patient – this resulted in reduced tolerance of chemotherapy and negative impact to QOL (weight loss was a worry)

Patient example 2 – Post secondment

Diagnosis: Chronic lymphocytic leukaemia (CLL) with progressive disease

Chemotherapy at QEH for disease control. Referred via staff at Chemotherapy day unit - Assessed on unit on the same day (capacity due to secondment)

Assessment showed loss of 14kg / 14.4% body weight (significant)

Reduced appetite – appropriate dietetic advice given.

ONS tasted on unit – same day GP prescription organised

Further review 3 weeks later - weight stable (82.8kg)

Regular dietetic review allows for nutritional problems or concerns to be highlighted early and provides a valuable opportunity to offer timely advice and support

Staff surveys - Pre / post secondment

- Pre secondment, 64.3% felt that waiting times were a cause for concern, compared to 54.5% post secondment.

- Pre secondment – 21.4% staff reported making less referrals to our service due to the high waiting time. Post secondment, this reduced to 0% with 18.2% feeling that they now refer to the service more often.

- Pre secondment – 42.9% staff felt that patients seemed less engaged with the service, compared to 18.2% post secondment

Quality

- Development of service - Improved quality / experience for patients
- Quality assessments i.e. anthropometrics, GLIM, blood monitoring for cachexia etc
- Improved reputation for dietetics and trust. Staff member won a Star award
- Cachexia work
  - ESPEN 2023
  - Presented at Nutricia Congress Oct 23 (national conference)
  - Presented Free Paper at Palliative Care Congress March 24 – Award for best AHP abstract
  - Regional sharing of results (Northern Nutrition Network and Northern Cancer Alliance)
  - Present at BAPEN 2024
  - Link with Caledonian Cachexia Collaborative – ENERGISE funded research from 2025
  - Article underway
  - Project planning for next steps
- Band 7: Leadership and clinical supervision for complex patients, lead on evaluation and development, scoping out of research

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The future

- A sustainable service - ensure capacity is maintained / low waiting times
- Longer term planning and ongoing development of service – continuous growth of the service to meet changing future needs
- 5 year plan
- Cachexia project work – ambition to become a centre of excellence for palliative care and cachexia
- Scope out other funded research opportunities – potential income to the trust
- Look to expand education and resources – potential income generation

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The future

- National / international opportunities to share and promote our work, promoting Gateshead as a quality hospital and ensuring reputation and quality
- Trail blazing for Gateshead with innovative work
- Patient support groups / education
- Target specific localities within Gateshead and link to inequalities in health i.e. Felling and Dunston wards
- Cancer prevention

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Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 7i

Report Title:	**Corporate Governance Manual**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 March 2024			
Author:	Kris Mackenzie, Group Director of Finance and Digital Jennifer Boyle, Company Secretary			
Sponsor:	Alison Marshall, Chair of the Board of Directors Trudie Davies, Chief Executive			
Report presented by:	Kris Mackenzie, Group Director of Finance and Digital Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To present the Board of Directors with a draft revised copy of the Corporate Governance Manual (Board of Directors' Standing Orders, Standing Financial Instructions and Scheme of Delegation).			
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 Audit Committee Chair of the Board of Directors Individual Board Members – Standing Financial Instruction (SFI) consultation			
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 Corporate Governance Manual consists of the Board of Directors' Standing Orders, Standing Financial Instructions and Scheme of Delegation. • The document has not been reviewed in its entirety for a number of years (2019). • The Company Secretary has undertaken a comprehensive review of the Standing Orders, including benchmarking against other trusts. • The Group Director of Finance and Digital and her team have undertaken a comprehensive review of the SFIs, incorporating recommendations from reviews. • The Group Audit Committee reviewed the component parts of the Corporate Governance Manual and recommend them to the Board of Directors for approval and adoption.			
Recommended actions for this meeting:	The Board of Directors is recommended to review, approve and adopt the Corporate Governance Manual			

Outline what the meeting is expected to do with this paper	and its component parts on the recommendation of the Group Audit Committee. .				
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☒	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☒	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☒	We will develop and expand our services within and beyond Gateshead			
Trust strategic objectives that the report relates to:	Having effective governance, practice and procedures for the Board of Directors should support the Trust in developing a strong control environment, which in turn supports the delivery of the strategic objectives.				
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** ☒		

Corporate Governance Manual

1. Introduction

1.1. The Standing Orders, the Standing Financial Instructions (SFIs) and Scheme of Delegation and Reservation of Powers together form the Corporate Governance Manual for the Trust.

1.2. The documents have not been comprehensively reviewed for a number of years (2019), although small amendments have been approved in the last few years (for example amendments to the procurement limits to keep pace with changing legislation).

1.3. A comprehensive review has been undertaken, including benchmarking the current documents against those of a number of other trusts.

1.4. The Group Audit Committee's terms of reference describe the role of the Audit Committee in relation to this document:

- *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.*

1.5. The Standing Orders, Standing Financial Instructions and Scheme of Delegation were presented to the Group Audit Committee for review. Some minor amendments were made to the Standing Orders to incorporate feedback from Members. The Group Audit Committee now recommend the documents for approval by the Board in the form of the Corporate Governance Manual.

2. Key overview – Standing Orders

2.1. The Standing Orders for the Board of Directors are a core governance document which outlines the practice and procedure for the Board of Directors, its members and its committees.

2.2. Following the review process, the format and structure of the Standing Orders have been substantially revised. Using a track changes function to log all amendments would have therefore been difficult to follow. As such, colour coding has been used as an alternative, with new text shown in blue and major revisions shown in purple.

2.3. The following table also seeks to summarise the major changes made:

Section	Summary of Changes
1) Statutory Framework	• Updated references to regulators and regulations. • Reference made to the framework under which the Board operates as corporate trustee of the charity.
2) Interpretation	• A number of additions have been made and some existing definitions have been

Section	Summary of Changes
	expanded.
4) The Role of the Board of Directors	• New section setting out the general duties and role of the Board
5) Composition of the Board	• Significantly expanded in order to define the roles of key Board Members.
6) Appointment of Board Members	• Removed reference to the Governor Remuneration Committee having 6 members (this is the case in practice, but may change). • Ensured that the appointment of the Deputy Chair and Senior Independent Director positions are in line with the new Provider Code of Governance.
7) Terms of Office of Board Members	• Replaced previously generic statement on this with the specifics which align to the Code of Governance.
8) Calling Meetings	• Modernised this section – e.g. removed the need for a requisition to call a meeting to be physically signed and updated this with the option of electronic evidence of support being permitted. • Included a new clause regarding the calling of extraordinary meetings. • Included an explanation of public and private Board meetings (was previously a separate section).
9) Setting the Agenda	• Included a new clause to state that requests for agenda items should propose whether agenda items are included in the public or private Board meeting.
13) Notices of a Motion	• Inclusion of a new clause to enable a Director to give notice of an emergency motion up to one hour before the meeting, in agreement with the Chair.
14) Voting	• New clause to clarify the voting rights of officers when attending Board to act up and to represent Executive Directors.
15) Minutes	• Removed the need for minutes to be signed once approved.
16) Quorum	• Quorum was previously 4 Board Members including at least 1 NED and 1 Executive Director. The proposal is to strengthen this by requiring one third of appointed Directors to be present (currently 5), with at least 2 NEDs and 2 Executive Directors present. • A new clause has been added to explain how quorum requirements should work when Members are excluded from the meeting.
17) Observers of the Board	• Section expanded to include staff

Section	Summary of Changes
	members and members of the public – this previously only referred to Governors
21) Delegation to Committees and Officers	• New paragraph added to explain that where Board functions have not been reserved for the Board or delegated to a specific committee, they shall be exercised by the Chief Executive on behalf of the Board.
22) Committees	• Updated to reflect the current Board committees. • New clauses added regarding the ability of the Board to establish other committees, confidentiality and NED attendance at committees.
23) Declaration of interests	• New paragraph added regarding fit and proper person compliance.
25) Custody of the Seal and the Sealing of Documents	• Included a new clause to clarify what the seal should be used for.
26) Signature of Documents	• New clause added which provides the Chief Executive with authority to sign agreements when authorised by the Board of Directors
27) Waiver of Standing Orders	• Amended to match the new quorum requirements of needing at least 2 NEDs and 2 Executive Directors to form part of the two-thirds of the Board who must be present.

2.4. The following sections have been removed:

- Public Meetings – shortened and merged into the 'Calling Meetings' section.
- Fit and Proper Persons – shortened and merged with the 'Declaration of Interests' section, cross-referenced to regulations to avoid being too prescriptive and enabling it to keep up to date with new requirements.
- Disability of the Chair and Members in Proceedings on Account of Pecuniary Interest – removed as the principles within this section are already covered in other sections re: conflicts of interest.
- Consultation – no other examples of the legal duties of consultation being included in Standing Orders could be located.
- Tendering and Contract Procedure – covered extensively in the SFIs and therefore removed.

3. Key overview – SFIs and Scheme of Delegation

3.1. The SFIs are designed to ensure regularity and propriety of financial transactions. They define the purpose, responsibilities, legal framework and operating environment of the Trust. They are also intended to be a practical tool to support staff in fulfilling their delegated responsibilities.

3.2. In April 2022, the Healthcare Financial Management Association (HFMA) produced a briefing *Improving NHS financial sustainability: are you getting the basics right?*

3.3. This document included a requirement to ensure standing financial instructions are fit for purpose, readily available to all staff and are an effective tool to support strong financial governance.

3.4. An internal audit undertaken in late 2022 identified inadequacies in the existing scheme of delegation, and a detailed Deloitte review undertaken in 2023 resulted in an additional recommendation to update documentation.

3.5. In response an updated set of SFIs were shared with members of Finance and Performance Committee, Executive Management Team and Board for comment.

3.6. Feedback from this consultation has now been reflected in an updated set of SFIs and Scheme of Delegation which were reviewed by the Group Audit Committee.

3.7. The material changes that have been made to the 2019 version of the SFIs and Scheme of Delegation within the Corporate Governance Manual are:

- Ensure reference to relevant documents are current
- Update of job titles and inclusion of Deputy CEO role where relevant
- Removal of reference to NHS Improvement
- Inclusion of reference to management of waste/cost reduction
- Strengthening of the budget virement process and its alignment to the scheme of delegation
- Strengthening of reference to capital, including separation of IT and non-IT
- Updating of delegated values
- Updating of public procurement thresholds

3.8. The Reservation of Powers and Scheme of Delegation section has been carefully cross-matched against the updated content of the Standing Orders and SFIs to ensure that key responsibilities and delegations are captured accurately and linked to these documents.

4. Solutions / recommendations

4.1. The Board of Directors is recommended to review, approve and adopt the Corporate Governance Manual and its component parts on the recommendation of the Group Audit Committee.

Corporate Governance Manual

- ***Standing Orders for the Practice and Procedure of the Board of Directors***
- ***Trust Standing Financial Instructions***
- ***Scheme of Delegation and Reservation of Powers to the Board of Directors***

Contents

Introduction

The Corporate Governance Manual brings together a number of core governance documents which outline the controls and governance in place within the Trust in respect of the Board and its committees, the financial framework and decision-making processes.

It is composed of:

- The Standing Orders for the Practice and Procedure of the Board of Directors;
- The Standing Financial Instructions (SFIs); and
- The Scheme of Delegation and Reservation of Powers to the Board of Directors.

All three documents are intrinsically linked and therefore together they form the Corporate Governance Manual.

Change control

Version	Date	Main changes
1.0	September 2019	• Full review of all three component elements of the Corporate Governance Manual. • Note that version numbers were not previously tracked and therefore this is considered to be version 1.0, but recognising that the documents were in existence prior to this time.
2.0.	March 2024	• Full review of all three component elements, including a significant number of changes to modernise the documents and ensure they are fit for purpose.

Standing Orders for the Practice and Procedure of the Board of Directors

1. Statutory Framework

1.1. Gateshead Health NHS Foundation Trust is a statutory body which became a public benefit corporation on 5 January 2005 following its approval as an NHS Foundation Trust by the independent regulator at the time (Monitor) pursuant to the Health and Social Care (Community Health and Standards) Act 2003 (the 2003 Act).

1.2. The Trust operates from a number of locations, but its principle place of business is at Queen Elizabeth Hospital, Sheriff Hill, Gateshead, NE9 6SX.

1.3. NHS Foundation Trusts are governed by Acts of Parliament, mainly the National Health Service Act 2003, the National Health Service Act 2006, the Health and Social Care Act 2012, the Health and Care Act 2022, by their constitutions and by the provider licence to operate granted by the regulator. The functions of the Trust are conferred by this legislation and authorisation.

1.4. As a public benefit corporation, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role, it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health and Social Care. The Trust also has a common law duty as a bailee (custodian) for property held by the Trust on behalf of patients.

1.5. Documents including the Standing Financial Instructions and the Scheme of Delegation and Reservation of Powers shall have effect as if incorporated into Standing Orders.

2. Interpretation

2.1. Save as otherwise permitted by law and subject to the Constitution, at any meeting the Chair of the Trust shall be the final authority on the interpretation of standing orders (on which they should be advised by the Company Secretary).

2.2. Any expression to which a meaning is given under the Health Service Acts, or in the regulations or orders made under the Acts shall have the same meaning in this interpretation.

2.3. Key definitions relevant to these Standing Orders are outlined below:

Term	Definition
Accounting Officer	The Accounting Officer has responsibility for the overall organisation, management and staffing of the NHS

Term	Definition
	foundation trust and for its procedures in financial and other matters. The NHS Act 2006 designates the Chief Executive as the Accounting Officer.
Accounting Officer's Memorandum	A document published by the regulator which outlines the responsibilities of the Accounting Officer
Board of Directors / the Board	The Chair, Chief Executive, Executive Directors and Non-Executive Directors collectively as a body.
Budget	A resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.
Chair of the Board	The person appointed by the Council of Governors to lead the Council of Governors and Board of Directors and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Deputy Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable.
Chief Executive	The Chief Executive Officer of the Trust
Commissioning	The process for determining the need for and for obtaining the supply of healthcare and related services by the Trust within available resources
Committee	A committee of the Board of Directors or sub-committee created and appointed by the Trust
Constitution	The constitution of the Trust approved by the Board of Directors and Council of Governors which describes the operation of the Foundation Trust
Committee members	The directors formally appointed by the Board to sit on or to chair specific committees
Company Secretary	A person who may be appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the Chair and monitor the Trust's compliance with the Regulatory Framework and these Standing Orders
Contracting and procuring	The systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets
Council of Governors (CoG)	The body of elected and appointed governors, authorised to be members of the Council of Governors and act in accordance with the constitution
Deputy Chair	The Non-Executive Director appointed from amongst the Non-Executive Directors as Deputy Chair by the Board to

Term	Definition
	take on the Chair's duties if the Chair is absent for any reason
Group Director of Finance	The Chief Financial Officer of the Trust
Executive Director	A Member of the Board of Directors who holds an executive office of the Trust
Member	Any person registered as a member of the Trust and authorised to vote in elections to select governors
Member of the Board	An Executive or Non-Executive Director, including the Chair.
NHS England	The regulator for NHS providers
Nominated Officer	An officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions
Non-Executive Director	A Member of the Board of Directors who does not hold an executive office of the Trust
Officer	An employee of the Trust or any other person holding a paid appointment or office with the Trust
Senior Independent Director	An independent Non-Executive Director who provides a sounding board for the Chair and serve as an intermediary for the other directors when necessary
Standing Financial Instructions	Core governance document designed to ensure that financial transactions are carried out in accordance with law and the governing framework set by the regulator and the Trust.
Standing Orders	Core governance document which outlines the practice and procedure for the Board of Directors, its members and its committees.
Trust / Foundation Trust	Refers to Gateshead Health NHS Foundation Trust

3. Board of Directors

3.1. All business shall be conducted in the name of the Trust. All decisions must be taken objectively and in the interests of the Trust.

3.2. All funds received in trust (Charitable funds) shall be held in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

3.3. Directors acting on behalf of the Trust as a corporate trustee are responsible for ensuring that the trustee duties of the Trust are complied with. Accountability for charitable funds held on trust is to the Charity Commission.

3.4. The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in Reservation of Powers to the Board and have effect as if incorporated into the Standing Orders.

4. The Role of the Board of Directors

4.1. The role of the Board of Directors is to provide active leadership of the NHS Foundation Trust within a framework of prudent and effective controls which enables risk to be assessed and managed. The Board of Directors and each Director individually, has a duty to promote the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

4.2. The Board as a whole is responsible for ensuring the quality and safety of services, setting the Trust's strategic aims, taking into consideration the views of the Council of Governors, ensuring that the necessary financial and human resources are in place and agreeing the Trust's values and standards of conduct and behaviour.

4.3. The Board of Directors is responsible for ensuring that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance. Where appropriate the Board will commission independent advice to provide an adequate and reliable level of assurance.

5. Composition of the Board

5.1. The composition of the Board will be in accordance with the Constitution of the Trust.

5.2. **Executive Directors** will exercise their authority within the terms of these Standing Orders and the Trust's Standing Financial Instructions and the Scheme of Delegation.

5.3. The **Chief Executive** is responsible for the overall performance of the executive functions of the Trust and is the Accounting Officer who shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the NHS Foundation Trust Accounting Officer Memorandum.

5.4. The **Group Director of Finance & Digital** shall be responsible for the provision of financial advice to the Trust for the supervision of financial control and accounting systems and will be responsible, along with the Chief Executive, for ensuring the discharge of obligations under relevant Financial Directions.

5.5. The **Non-Executive Directors** will not be granted nor will they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of, or when chairing, a committee of the Trust which has delegated powers.

5.6. Non-Executive Directors should receive the necessary information and feel able to raise appropriate challenge of recommendations or decisions of the Board, in particular making full use of their skills and experience gained both as a Director of the Foundation Trust and also in other leadership roles.

5.7. The **Chair** is responsible for the operation of the Board and will chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with their terms of appointment and with these Standing Orders.

5.8. The Chair will take responsibility either directly or indirectly for the induction of the Non-Executive Directors, their portfolios of interests and assignments, and their performance.

5.9. The Chair will work in close harmony with the Chief Executive and will ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

6. Appointment of Board Members

6.1. The Chair and Non-Executive Directors are appointed and removed by the Council of Governors in accordance with the Constitution. The Council of Governors will establish a committee, the Governor Remuneration Committee, whose function it will be to oversee the appointment process and make recommendations on suitable candidates to the Council of Governors.

6.2. The Chief Executive is appointed and removed by the Board of Directors' Remuneration Committee, subject to approval by the Council of Governors.

6.3. Executive Directors are appointed and removed by the Board of Directors' Remuneration Committee.

6.4. The Board can appoint one of the Non-Executive Directors to be Deputy Chair for a period of time not exceeding the remainder of their term. The Deputy Chair cannot be the Audit Committee Chair.

6.5. Where the Chair of the Trust has ceased to hold office or are unable to perform their duties due to illness or any other cause, the Deputy Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties. References to the Chair in these Standing Orders shall, so long as there is no Chair able to perform their duties, be taken to include references to the Deputy Chair.

6.6. The Board can appoint one of the Non-Executive Directors to be the Senior Independent Director for a period of time not exceeding the remainder of their term. The appointment must be made in consultation with the Council of Governors. The Senior Independent Director cannot be the Audit Committee Chair.

7. Terms of Office of Board Members

7.1. In accordance with the Code of Governance for NHS Provider Trusts, Non-Executive Directors, including the Chair, should be appointed by the Council of Governors for specified terms subject to re-appointment thereafter at intervals of no more than three years.

7.2. Any decision to extend a term beyond six years from the date of the first appointment to the Board is subject to rigorous review. The Chair and Non-Executive Directors should not remain in post beyond nine years. A Non-Executive Director becoming Chair after a three-year term as a Non-Executive Director would not trigger a review after three years in post as Chair.

7.3. All extensions and re-appointments must be considered in the context of the latest requirements of the Code of Governance.

8. Meetings of the Boad of Directors – Calling Meetings

8.1. The Chair of the Trust may call a meeting of the Board at any time.

8.2. If the Chair refuses to call a meeting after a requisition from at least one third of the Board of Directors, has been presented to them (with evidence of such support being recorded on paper or electronically), or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to them the Directors who supported the request may convene a meeting of the Board of Directors in default of the Chair. No business shall be transacted at the meeting other than that specified in the requisition.

8.3. Agendas will be sent to Members of the Board six days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear days before the meeting, save in emergency. Failure to serve such a notice on more than three Members of the

Board will invalidate the meeting. A notice shall be presumed to have been served once issued electronically.

8.4. Before each meeting of the Board of Directors a public notice of the time and place of the meeting shall be displayed on the Trust's website at least three clear days before the meeting.

8.5. At the discretion of the Chair meetings may be held in person, using virtual technology or in a hybrid format (a combination of the two). A Board meeting held in any of these formats constitutes a properly governed meeting to which these Standing Orders apply. This extends to all groups within the Board's governance structure. The same principles regarding voting rights and quorum will apply to virtual / hybrid meetings.

8.6. At the discretion of the Chair an extraordinary Board meeting may be called provided Board Members are given at least twenty-four hours notice, with best endeavours to provide as much notice as possible. No business shall be transacted at an exceptional meeting of the Board of Directors unless at least one-third of the whole number of the Directors appointed (including at least two Non-Executive Directors and two Executive Directors) are present.

8.7. The Board of Directors is divided into a public and private session. The Board of Directors recognises the need to be as open and transparent as possible and therefore the majority of its business will be conducted in public session. Provision is made for parts of the meeting to be held in closed session where items of a confidential nature are discussed. Such items may relate to personal data, commercial interests or issues which would prejudice the effective conduct of public affairs.

9. Meetings of the Board of Directors – Setting the Agenda

9.1. The Board may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.

9.2. A Member of the Board desiring a matter to be included on an agenda shall make his request in writing to the Chair at least 10 clear days before the meeting. The request should include appropriate supporting information. Requests made less than 10 clear days before a meeting may be included on the agenda at the discretion of the Chair.

9.3. Requests for agenda items should state whether the item of business is proposed to be transacted in the presence of the public or reserved for discussion in private session and should include appropriate supporting information.

10. Meetings of the Board of Directors – Petitions

10.1. Where a petition has been received by the Trust the Chair of the Board shall include the petition as an item for the agenda of the next Board meeting.

11. Meetings of the Board of Directors – Chair of the Meeting

11.1. At any meeting of the Board, the Chair of the Board, if present, shall preside. If the Chair is absent from the meeting the Deputy Chair shall preside. If the Chair and Deputy Chair are absent such Non-Executive Director as the Members of the Board present shall choose shall preside.

11.2. If the Chair is absent temporarily on the grounds of a declared conflict of interest the Deputy Chair, if present, shall preside. If the Chair and Deputy Chair are both disqualified from participating, such Non-Executive Director as the Members of the Board present shall choose shall preside.

12. Meetings of the Board of Directors – Chair's Ruling

12.1. Statements of Members of the Board made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

13. Meetings of the Board of Directors – Notices of a Motion

13.1. A Member of the Board desiring to move or amend a motion shall send a written notice (including by email) thereof at least 10 clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda.

13.2. A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.

13.3. Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Member of the Board who gives it and also the signature of four other Board Members. When any such motion has been disposed of by the Board, it shall not be competent for any Member other than the Chair to propose a motion to the same effect within six months, however the Chair may do so if they consider it appropriate.

13.4. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

13.5. When a motion is under discussion or immediately prior to discussion it shall be open to a Member of the Board to move:

- an amendment to the motion.
- the adjournment of the discussion or the meeting.
- that the meeting proceed to the next business (*)
- the appointment of an ad hoc committee to deal with a specific item of business.
- that the motion be now put (*)

*In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Member of the Board who has not previously taken part in the debate and who is eligible to vote.

13.6. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.

13.7. Subject to the agreement of the Chair, a Director may give notice of an emergency motion after the issue of the notice of the meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared at the commencement of the business of the meeting as an additional agenda item included in the agenda. The Chair's decision to include the item is final.

14. Meetings of the Board of Directors - Voting

14.1. A question at a meeting shall be determined by a majority of the votes of the Chair of the meeting and Members of the Board present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.

14.2. All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Members of the Board present so request.

14.3. If at least one-third of the Members of the Board present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Member of the Board present voted or abstained.

14.4. If a Member of the Board so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

14.5. In no circumstances may an absent Member of the Board vote by proxy. Absence is defined as being absent at the time of the vote.

14.6. An officer who has been appointed formally by the Board of Directors to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An officer attending the Board of Directors to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

15. Meetings of the Board of Directors – Minutes

15.1. The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.

15.2. The names of the Chair and Members of the Board present at the meeting shall be recorded in the minutes.

15.3. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

15.4. Minutes shall be circulated to all Board Members. Where providing a record of a public meeting, the minutes shall be made available to the public.

16. Meetings of the Board of Directors - Quorum

16.1. No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the Directors appointed, (including at least two Non-Executive Directors and two Executive Directors) are present.

16.2. An officer in attendance for an Executive Director but without formal acting- up status may not count towards the quorum.

16.3. If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest, he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

16.4. The above requirement for at least two Executive Director to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example if the Board were to approve a recommendation from the Remuneration Committee for which all Executive Directors were conflicted). The above requirement for at least two Non-Executive Director to form part of the

quorum shall not apply where the Non-Executive Directors are excluded from a meeting, recognising that this would be an unusual scenario.

17. Meetings of the Board of Directors – Observers at Board of Directors' Meetings

17.1. All Governors, staff members and members of the public may observe the Board of Directors when it meets in public. Observers of the meetings are permitted to speak only by invitation of the Chair at a specified point in the meeting and may not propose motions or vote. This reflects that the Board of Directors does not constitute a public meeting.

18. Meetings of the Board of Directors – Adjournment of Meetings

18.1. The Board of Directors may, by resolution, adjourn any meeting to some other specified date, place and time and such adjourned meeting shall be deemed a continuation of the original meeting. No business shall be transacted at any adjourned meeting which was not included in the agenda of the meeting of which it is an adjournment.

18.2. When any meeting is adjourned to another day, other than the following day, notice of the adjourned meeting shall be sent to each Director specifying the business to be transacted.

19. Arrangements for the Exercise of Functions by Delegation

19.1. Subject to the Regulatory Framework and such directions, if any, as may be given by NHS England, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee or sub-committee appointed by virtue of these Standing Orders, in each case subject to such restrictions and conditions as the Board thinks fit.

20. Exercise of Functions by Delegation – Emergency Powers

20.1. The powers which the Board has retained to itself within these Standing Orders, may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the Board for noting.

21. Exercise of Functions by Delegation – Delegation to Committees and Officers

21.1. The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board.

21.2. Those routine functions of the Trust which have not been retained as reserved to the Board of Directors or delegated to a committee, sub-committee or joint committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Board.

21.3. The Chief Executive shall prepare a Reservation and Delegation of Powers identifying proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendments to the Reservation and Delegation of Powers that shall be considered and approved by the Board as indicated above.

21.4. Nothing in the Scheme of Delegation by the Board shall impair the discharge of the direct accountability of the Executive Directors to the Board of the Directors to provide information and advise the Board in accordance with the Constitution, Authorisation, statutory provisions.

21.5. The arrangements made by the Board as set out in the Reservation and Delegation of Powers to the Board and Delegation of Powers document shall have effect as if incorporated in these Standing Orders.

22. Committees

22.1. Subject to the Constitution and any statutory provisions, the Board of Directors may and, if directed, shall appoint committees of the Trust, consisting wholly or partly of the Chair and Directors of the Board.

22.2. These committees may appoint sub-committees consisting wholly or partly of members of the committee, or wholly of persons who are not members of the committee.

22.3. The Standing Orders of the Board, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Board. In which case the term “Chair” is to be read as a reference to the Chair of the committee as the context permits, and the term “Member of the Board” is to be read as a reference to a member of the committee also as the context permits.

22.4. Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with the Regulatory Framework and any

direction or guidance issued by NHS England. Such terms of reference shall have effect as if incorporated into the Standing Orders.

22.5. Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board.

22.6. The Board shall approve the appointments to each of the committees which it has formally constituted.

22.7. Where the Trust is required to appoint persons to a committee and/or to undertake statutory functions as required by the Independent Regulator, and where such appointments are to operate independently of the Board of Directors, such appointments shall be made in accordance with the regulations and directions laid down by the Board of Directors.

22.8. The committees established by the Board of Directors are:

- Group Audit Committee
- Finance and Performance Committee
- Quality Governance Committee
- People and Organisational Development Committee
- Digital Committee
- Group Remuneration Committee

22.9. The Board of Directors may establish other committees, sub-committees and joint committees, including ad hoc committees, sub-committees and joint committees at its discretion without requirement to amend these standing orders.

22.10. A member of the Board of Directors or a member of a committee shall not disclose any matter reported to the Board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee shall resolve that it is confidential or embargoed.

22.11. Non-Executive Directors may attend any meeting of any committee by submitting prior notice to the Committee Chair. The Chair of the Group Audit Committee reserves the right to restrict attendance to all or part of any Group Audit Committee meeting according to the nature of the agenda.

23. Declaration of Interests and Register of Interests

23.1. In accordance with the Constitution, provider licence and regulatory framework all Board Members are required to declare interests which are relevant and material to the Board of which they are a Member. All existing Board members should

declare such interests. Any Board members appointed subsequently should do so on appointment.

23.2. This section of the Standing Orders should be read in conjunction with the Constitution and the Trust's policy on conflicts of interest.

23.3. Interests which are 'relevant and material' are to be interpreted in accordance with guidance issued by NHS England. This includes, but is not limited to:

(a) Directorships, including Non-Executive directorships held in private companies or public limited companies (with the exception of those of dormant companies).
(b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
(c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.
(d) A position of trust in a charity or voluntary organisation in the field of health and social care.
(e) Any connection with a voluntary or other organisation contracting for NHS services.
(f) To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.
(g) Any other commercial interest in the decision before the meeting.

23.4. If Board Members are in any doubt about the relevance of an interest, this should be discussed with the Chair or the Company Secretary.

23.5. At the time Board members' interests are declared; they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring.

23.6. Declared interests are maintained on a register by the Company Secretary, which is available for public inspection.

23.7. During the course of a Board meeting, if a conflict of interest is established, the Member of the Board concerned should play no part in the relevant discussion or decision and may be asked to withdraw from the meeting at the Chair's discretion.

23.8. The interests of Board members' spouses or cohabiting partners should be regarded as relevant and should be disclosed.

23.9. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

23.10. If the Chair or another Member of the Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

23.11. As well as declaring interests, all Board Members must also comply with the requirements of Regulation 5 (Fit and Proper Persons: Directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and associated regulatory requirements as set by NHS England. Board Members must demonstrate compliance upon appointment and annually.

24. Declarations of Interest – Appointments and Relations

24.1. A Member of the Board shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a Member of the Board from giving written or verbal testimonial of a candidate's ability, experience or character for submission to the Trust.

24.2. Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee by the Member of the Board who conducted the discussion.

24.3. Candidates for any Trust appointment shall be advised that, when making their application, they must disclose in writing to the Trust whether to their knowledge they are related to any Member of the Board or Director of the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.

24.4. The Chair and every Member of the Board and officer of the Trust shall disclose to the Chief Executive any relationship between themselves and a candidate of whose candidature that Member of the Board or officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

24.5. On appointment, members of the Board (and prior to acceptance of an appointment in the case of officer members) should disclose to the Board whether they are related to any other Member of the Board of Directors or holder of any office within the Trust.

25. Custody of the Seal and the Sealing of Documents

25.1. The Common Seal of the Trust shall be kept by the Chair or an officer authorised by them in a secure place.

25.2. In accordance with common law, all deeds should be executed under seal. A deed is a written document which is executed with the necessary formality (that is, more than a simple signature), and by which an interest, right or property passes or is confirmed.

25.3. The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a committee, thereof or where the Board has delegated its powers.

25.4. The seal shall be affixed in the presence of the Chair and Chief Executive or another Executive Director.

25.5. An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all these transactions shall be made to the Board annually. (The report shall contain details of the seal number, the description of the document and date of sealing).

26. Signature of Documents

26.1. Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, or in their absence, an Executive Director (to whom the Board and Chief Executive has granted the necessary authority), unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

26.2. The Chief Executive (or nominated officer) shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board of Directors or any committee, sub-committee or standing committee with delegated authority.

27. Waiver of Standing Orders

27.1. Except where this would contravene any statutory provision or any guidance issued by NHS England, any one or more of the Standing Orders may be waived at any meeting, provided that at least two-thirds of the Board are present, including two Executive Directors and two Non-Executive Directors, and that a majority of those present vote in favour of suspension.

27.2. A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

27.3. The Group Audit Committee shall review every decision to suspend Standing Orders. The Company Secretary shall notify the Committee of such decisions.

27.4. All Directors and officers have a duty to disclosure any non-compliance with these Standing Orders to the Chair and Chief Executive as soon as possible.

28. Variation and Amendment of the Standing Orders

28.1. These Standing Orders shall be amended by the Board of Directors only if:

- a notice of motion has been given; and
- no fewer than half the total of the Trust's Non-Executive Directors vote in favour of amendment; and
- at least two-thirds of the Board Members are present; and
- the variation proposed does not contravene a statutory provision or direction made by NHS England.

Standing Financial Instructions

29. General

29.1. These Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Reservation and Delegation of Powers adopted by the Trust.

29.2. These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Group Director of Finance & Digital.

29.3. Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Group Director of Finance & Digital or Deputy Director of Finance must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

29.4. The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.

29.5. **Overriding Standing Financial Instructions** – if for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Group Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Group Director of Finance & Digital as soon as possible.

29.6. Officers of the Trust should note that the Standing Orders, SFIs and the Reservation and Delegation of Powers, do not contain every legal obligation applicable to the Trust. The Trust and each officer of the Trust must comply with all requirements of legislation such as those contained in Health Service Acts and all guidance and directions binding on the Trust. Legislation, guidance and directions will impose requirements additional to standing orders, SFIs and the Reservation and Delegation of Powers. All such legislation and binding guidance and directions shall take precedence over standing orders, SFIs and the Reservation and Delegation of Powers, which shall be interpreted accordingly.

30. Responsibilities and delegation

30.1. The **Trust Board** exercises financial supervision and control by:

(a) formulating the financial strategy;
(b) requiring the submission and approval of budgets within approved allocations/overall income;
(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);
(d) defining specific responsibilities placed on members of the Board, Council of Governors and employees as indicated in the Reservation and Delegation of Powers document.

30.2. The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. All other powers have been delegated to such other committees or individuals as the Trust has established. See Reservation and Delegation of Powers for full details.

30.3. The **Chief Executive and Group Director of Finance & Digital** will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

30.4. Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accounting Officer, to Parliament for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

30.5. It is a duty of the Chief Executive to ensure that Members of the Board and, employees and all new appointees are notified of, and put in a position to understand their responsibilities within these Instructions.

30.6. The **Group Director of Finance & Digital** is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;
(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time, and, without prejudice to any other functions of the Trust, and employees of the Trust.

Without prejudice to the functions of Directors and employees of the Trust the duties of the Group Director of Finance & Digital include:

(d) the provision of financial advice to other members of the Board and employees;
(e) the design, implementation and supervision of systems of internal financial control;
(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

30.7. All Board Members and employees are responsible for:

(a) the security of the property of the Trust;
(b) avoiding loss;
(c) exercising economy and efficiency in the use of resources;
(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Reservation and Delegation of Powers.

30.8. Any **contractor or employee of a contractor** who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

30.9. For **all members of the Board and any employees who carry out a financial function**, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Group Director of Finance & Digital and must comply with issued financial policies and procedure notes.

31. Audit

31.1. In accordance with Standing Orders, the Board shall formally establish a **Group Audit Committee**, with clearly defined terms of reference.

31.2. The **Group Director of Finance & Digital** is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;
(b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards;
(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption
(d) ensuring that an annual audit report is prepared by Internal Audit, Counter Fraud and External Audit as required by the Committee and Board in

accordance with current NHS England and Department of Health and Social Care requirements.

31.3. The Group Director of Finance & Digital or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
(b) access at all reasonable times to any land, premises, member of the Board or employee of the Trust;
(c) the production of any cash, stores or other property of the Trust under a member of the Board or an employee's control; and
(d) explanations concerning any matter under investigation.

31.4. **Internal Audit** will review, appraise and report upon:

(a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
(b) the adequacy and application of financial and other related management controls;
(c) the suitability of financial and other related management data;
(d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) fraud and other offences;
(ii) waste, extravagance, inefficient administration;
(iii) poor value for money or other causes.

31.5. Whenever any matters arise which involve, or are thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Group Director of Finance & Digital must be notified immediately. The Group Director of Finance in conjunction with the Group Internal Audit Manager will determine if the Chief Executive is to be notified. The Chief Executive in discussion with the Group Director of Finance will determine if the Trust Chair is to be notified.

31.6. The Group Internal Audit Manager will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

31.7. The NHS Foundation Trust Accounting Officer Memorandum provides that Internal Audit should accord with the objectives standards and practices set out in the Public Sector Internal Audit Standards, which states that Internal Audit is an independent and objective appraisal service within an organisation.

31.8. Accordingly the Group Internal Audit Manager shall be accountable to the Group Director of Finance & Digital, and the Audit Committee. The reporting system for Internal Audit shall be agreed between, Internal Audit, the Group Director of Finance & Digital and the Audit Committee. The annual plan and contractual agreement will be approved by the Audit Committee and shall comply with the guidance on reporting and relationships contained in the Government Internal Audit Standards.

31.9. Managers in receipt of audit reports referred to them have a duty to take appropriate remedial actions within the agreed time-scales within the report. The Group Director of Finance shall identify a formal review process to monitor the extent of compliance with audit recommendations. Where appropriate remedial action has failed to take place within a reasonable period, the matter shall be reported by the Group Director of Finance and Group Internal Audit Manager to the Group Audit Committee.

31.10. The **External Auditor** is appointed by the Council of Governors on the recommendation of the Audit Committee. The Audit Committee should assess the annual effectiveness of the External Auditor and provide assurance to the Council of Governors. If there are any performance issues relating to the service provided by the External Auditor, then this will be addressed using the contractual mechanisms.

31.11. In auditing the accounts, the Auditor must comply with any directions given by NHS England and to the standards, procedures and techniques to be adopted, in particular the Audit Code for NHS Foundation Trusts.

31.12. **Fraud and Corruption** - in line with their responsibilities, the Chief Executive and Group Director of Finance & Digital shall monitor and ensure compliance with the requirements of the conditions included in the NHS Standard Contract for Providers in relation to counter fraud requirements.

31.13. The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Counter Fraud Authority and NHS Anti-Fraud Manual.

31.14. The Local Counter Fraud Specialist shall report to the Group Director of Finance & Digital and shall work with staff in NHS Counter Fraud Authority in accordance with the NHS Anti-Fraud Manual.

31.15. On becoming aware of any suspected or actual bribery, corruption or fraud involving NHS-funded services, the Group Director of Finance & Digital must promptly report the matter to its nominated Local Counter Fraud Specialist and to NHS Counter Fraud Authority.

31.16. The Local Counter Fraud Specialist will provide a written report, at least annually, on counter fraud work within the Trust and submit this to the Audit Committee.

31.17. **Security management** - in line with their responsibilities, the Chief Executive will monitor and ensure compliance with Directions issued by the NHS Counter Fraud Authority on NHS security management.

31.18. The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

31.19. The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

32. Business Planning, Budgets, Budgetary Control and Monitoring

32.1. Preparation and Approval of Plans and Budgets

32.1.1. The Chief Executive will compile and submit to the Board an Annual Plan which takes into account financial targets and forecast limits of available resources. The Plan will contain:

(a) a statement of the significant assumptions on which the plan is based;
(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

32.1.2. Prior to the start of the financial year, the Group Director of Finance & Digital will, on behalf of the Chief Executive, prepare and submit for approval by the Board of Directors, a revenue budget which may be subject to change as a result of concluding contracting discussions with commissioners. Such budgets will:

(a) contain a statement of the significant assumptions on which they are based;
(b) contain details of major changes in workload, delivery of services, or resources required:
(c) be produced following discussion with appropriate Budget Holders;
(d) be prepared within the limits of available funds; and
(e) identify potential risks

32.1.3. The Group Director of Finance & Digital shall monitor financial performance against budget and plan, periodically review them, and report to the Board as detailed in the Trust's Accountability Framework.

32.1.4. All budget holders must provide information as required by the Group Director of Finance & Digital to enable budgets to be compiled.

32.1.5. All budget holders will sign up to their allocated budgets at the commencement of each financial year and comply with the requirements of the Accountability Framework.

32.1.6. The Group Director of Finance & Digital has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

32.2. Budgetary Delegation

32.2.1. The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation will be in accordance with the Trusts' Business Unit Structure with a named Executive Director being responsible for the management of each Business Units budget. It will also be accompanied by a clear definition of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement; in accordance with budget virement process
(e) achievement of planned levels of service;
(f) the provision of regular reports.

32.2.2. The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

32.2.3. Any request to incur costs in excess of delegated budgets must be approved by the Chief Executive

32.2.4. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

32.2.5. Non-recurring budgets should not be used to finance recurring expenditure without the authority of the Chief Executive, as advised by the Group Director of Finance & Digital.

32.3. Budgetary Control and Reporting

32.3.1. The Group Director of Finance & Digital will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Finance & Performance Committee (and bi monthly reported to the Trust Board) in a form approved by the Board containing:
   i. income and expenditure to date showing trends and forecast year-end position;
   ii. movements in working capital;

iii. movements in cash and capital;
iv. capital project spend and projected outturn against plan;
v. explanations of any material variances from plan;
vi. achievement of waste reduction and financial sustainability programme
vii. details of any corrective action where necessary and the Chief Executive and/or Group Director of Finance & Digital view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
(c) investigation and reporting of variances from financial, workload and workforce budgets;
(d) monitoring of management action to correct variances; and
(e) arrangements for the authorisation of budget transfers via an approved budget virement process aligned to the scheme of delegation
(f) arrangements for the authorisation of skill mix changes to approved budgets via an approved budget virement process aligned to the scheme of delegation

32.3.2. Each Budget Holder is responsible for ensuring that:

(a) spending is in line with their delegated budget and virement controls;
(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;
(c) no permanent employees are appointed over and above those provided for within the available resources and funded workforce establishment as approved by the Board via the annual plan approval process, except for:
i. an increase to funded establishments as per the business case approval process
ii. an increase to funded establishments as approved by the Chief Executive

32.3.3. The Chief Executive is responsible for establishing processes and procedures for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the plan and a balanced budget.

32.4. Capital Expenditure

32.4.1. The Group Director of Finance & Digital will, on behalf of the Chief Executive, prepare and submit for approval by the Board of Directors, a capital spending plan.

32.4.2. The Group Director of Finance & Digital will, on behalf of the Chief Executive prepare and submit to the Executive Management Team in-year changes to the approved capital plan.

32.4.3. The Group Director of Finance & Digital will, on behalf of the Chief Executive prepare and submit to the Executive Management Team in year monitoring of

spend against the approved capital plan, including the risk of scheme over and under spends.

32.4.4. The general rules applying to delegation and reporting shall also apply to capital expenditure. The particular applications relating to capital are contained in SFI 41.

32.5. Financial Reporting to NHS England

32.5.1. The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the Integrated Care Board and NHS England.

32.5.2. The Group Director of Finance & Digital will, on behalf of the Chief Executive prepare and submit the appropriate monitoring forms to the Integrated Care Board and NHS England.

33. Annual Accounts and Reports

33.1. The Group Director of Finance & Digital, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by NHS England, the treasury, the Trust's accounting policies, and generally accepted accounting practice/International Financial Reporting Standards;
(b) prepare and submit annual financial reports to NHS England in accordance with current guidelines which are presented before Parliament for each financial year in accordance with the prescribed timetable; and
(c) submit financial returns to NHS England and the Department of Health and Social Care which are presented before Parliament for each financial year in accordance with the prescribed timetable.

33.2. The Trust's annual accounts must be audited by an auditor appointed by the Council of Governors.

33.3. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

33.3.1. The Trust will publish an annual report, in accordance with guidelines on local accountability, and the present it at a public meeting. The document will comply with NHS Foundation Trust Annual Reporting Manual.

34. Bank and Government Banking Services (GBS) Accounts

34.1. The Group Director of Finance & Digital is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance issued from time to time by NHS England.

34.2. The Trust Board has a duty to safeguard the use of public money and will approve all external credit and borrowing arrangements.

34.3. No member of staff should open any bank account for any Trust or Charitable fund purpose outside of the above arrangements.

34.4. The Group Director of Finance & Digital is responsible for:

(a) bank accounts and GBS accounts;
(b) establishing separate bank accounts for the Trust's non-exchequer funds;
(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;
(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

34.5. The Group Director of Finance & Digital will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated;
(b) the limit to be applied to any overdraft;
(c) those authorised to sign cheques or other orders drawn on the Trust's accounts;
(d) an Operating Treasury Management Policy

34.6. The Group Director of Finance & Digital must advise the Trust's bankers in writing of the conditions under which each account will be operated.

34.7. The Group Director of Finance & Digital will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

35. Income, Fees and Charges and the Security of Cash, Cheques and Other Negotiable Instruments

35.1. Income Systems

35.1.1. The Group Director of Finance & Digital is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

35.1.2. The Group Director of Finance & Digital is also responsible for the prompt banking of all monies received.

35.2. Fees and Charges

35.2.1. The Group Director of Finance & Digital is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the NHS or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

35.2.2. All employees must inform the Group Director of Finance & Digital of money due arising from transactions which they initiate with, including all contracts, leases, tenancy agreements, private patient undertakings, training events and other transactions.

35.2.3. The Trust must comply with any private charges regulations required under the Terms of Authorisation.

35.3. Debt Recovery

35.3.1. The Group Director of Finance & Digital is responsible for the appropriate recovery action on all outstanding debts.

35.3.2. Income not received should be dealt with in accordance with losses procedures.

35.3.3. Overpayments should be detected (or preferably prevented) and recovery initiated.

35.4. Security of Cash, Cheques and Other Negotiable Instruments

35.4.1. The Group Director of Finance & Digital is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
(b) ordering and securely controlling any such stationery
(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

35.4.2. Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

35.4.3. All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Group Director of Finance & Digital.

35.4.4. The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for

any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

36. Tendering and Contracting Procedure

36.1. The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where SO. 27 Waiver of Standing Orders is applied).

36.2. The Trust shall comply with the Public Contracts Regulations 2015, and all relevant EU Legislation. Such legislation shall be incorporated into the Trust's Standing Orders and SFIs.

36.3. **Reverse eAuctions** - The Trust should have policies and procedures in place for the control of all tendering activity carried out through Reverse eAuctions. The Trust will use, where appropriate, the eAuction facility to conduct e-auctions on its behalf and will determine throughout the year the most appropriate product areas that will achieve the best value by being managed through an eAuction.

36.4. The results of the eAuction will be made available in electronic format for scrutiny and ratification using a similar process to that of electronic tenders, and a record will be kept of the full submissions.

36.5. The Trust shall comply as far as is practicable with the requirements of the guidance published on Capital investment and Property Business Case Approval Guidance for NHS Foundation Trusts in respect of capital investment and estate and property transactions.

36.6. Formal Competitive Tendering: General Applicability

36.1.1. The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DHSC);
- for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and
- the disposals of any tangible or intangible property (including equipment, land and intellectual property).

36.7. Formal Competitive Tendering: Health Care Services

36.7.1. Where the Trust has a requirement to procure healthcare services (and/or other services classed as the “light touch” regime as part of Regulation 74 onwards of the Public Contracts Regulations 2015) (whether by way of sub-contract or otherwise), the Trust shall consider its duties under the EU Treaty and whether such service requirement should be advertised. A service contract will fall within the scope of the Light Touch regime if it is for the type of health, social and other services listed at Schedule 3 of the PCR2015. For these Light Touch regime contracts, a higher threshold than that for ordinary service contracts will apply, before the Light Touch regime is applicable. This threshold is set out at Article 4(d) of the Directive.

36.7.2. Where the Trust considers that the circumstances require it to advertise for the supply of healthcare services, Standing Orders and these SFIs shall apply, as far as they are applicable to the tendering procedure, although at all times the Trust should consider its duties under SFI 37.

36.8. Exceptions and Instances Where Formal Tendering Need Not Be Applied

36.8.1. Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the tender limit as specified in the Reservation and Delegation of Powers.

(b) where the supply is proposed under special arrangements negotiated by the DHSC in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in SFI 28.

Formal tendering procedures **may be waived** in the following circumstances:

(d) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(e) where the requirement is covered by an existing contract;

(f) where nationally negotiated agreements applicable to Foundation Trusts are in place;

(g) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(h) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(i) where specialist expertise is required and is available from only one source;

(j) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(k) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

(l) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Group Director of Finance & Digital will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

(m) where allowed and provided for in the Group Accounting Manual.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Board via the Finance and Performance Committee or as delegated to the Supply Procurement Committee.

36.9. Fair and Transparent Competition

36.9.1. Except where the exceptions set out in SFI 36.8.1. apply and permit the use of a single tender action, the Trust shall ensure that for all invitations to tender, whether regulated by the Public Contracts Regulations 2015 or not, the tender process adopted is fair and transparent and is considered in a fair and transparent manner.

36.10. Items Which Subsequently Breach Thresholds After Original Approval

36.10.1. Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

36.11. Contracting / Tendering Procedure

36.11.1. Electronic tendering procedure:

(a) Invitation to tender:

(i) All invitations to tender on a formal competitive basis shall state the date and time as being the latest time for the receipt of tenders and that no tender will be considered for acceptance unless submitted through the appropriate process, as instructed within the tender documentation electronically.

(ii) Every tender for goods and services shall embody the adopted contract terms and conditions as appropriate with the contract form required for the specific goods and services.

(b) Receipt, safe custody and record of formal tenders:

(i) An auditable date/time stamp of all actions must be automatically created through the eTendering service. This audit trail will be available for review in real-time

(ii) Tenders may not be ‘opened’ or supplier information viewed until the pre-defined time and date for opening has passed.

(c) Opening formal tenders:

(i) Electronic Tenders – The Chief Executive (or other officer) will designate and agree a list of officers who will be able to access the electronic tenders and release them once the time and date for opening has passed in accordance with financial procedure note.

(ii) An auditable log of actions, which may not be edited, will be created including, but not limited to:

Procurement actions:

- Time/date stamp of ‘publication’ of tender by buyer
- Time/date stamp of any amendments to a ‘published’ tender (eg if any buyer tender document attachments are added/amended during the process).

(d) Every tender for goods, materials, services or disposals for the Group shall contain and comprise appropriate terms and conditions regulating the conduct of the tender, shall contain appropriate terms and conditions on which the contract is to be awarded and shall be substantively based to regulate the provision of the goods, materials, services to be provided or in relation to the disposal.

(e) Every tender for building or engineering works (except for maintenance work, when *Estatecode* guidance shall be followed) for the Group shall contain terms and conditions on which the contract is to be awarded and shall be substantively based that shall embody or be in the terms of the current edition of a suitable and recognised industry form of contract, including but not limited to, one of the Joint Contracts Tribunal Standard Forms of Building Contract or the NEC standard forms of contract or Department of the Environment (GC/Wks) standard forms of contract; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A) or (in the case of civil engineering work) the General Conditions of Contract recommended by the institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents may be modified (in minor respects only), to cover special features of individual projects.

36.11.2. Invitation to tender – manual process:

If the mechanism for tendering through the electronic tender process as defined in 36.11.1 above fails then the following procedures must be adhered to

(a) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(b) All invitations to tender shall state that no tender will be accepted unless:

(i) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;

(ii) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

(c) Receipt and safe custody of tenders

The Chief Executive or their nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening in accordance with the financial procedure note.

The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

(d) **Opening tenders and register of tenders**

(e) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by one Executive Director and one Senior Manager, designated by the Chief Executive. These managers must not have been involved in the tender process or be from the originating department. The Trust Secretary on behalf of the Chief Executive shall maintain a list of designated officers to open tenders. A copy of this list will be held with the Register of Tenders.

(f) A member of the Trust Board will be required to be one of the two approved persons present for the opening of tenders estimated above the tender limit. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Reservation and Delegation of Powers. This applies to both paper and electronic tenders.

(g) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender. The tender process will include the preparation, specification and evaluation of the tender.

(h) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Group Director of Finance & Digital or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

(i) All Executive Directors/members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

(j) Every tender received shall be marked with the date of opening and initialled by those present at the opening.

(k) A register shall be maintained by the Chief Executive, or a person authorised by them, to show for each set of competitive tender invitations despatched:

- the subject of the tendering exercise;
- the name of all firms/individuals invited;
- the names of firms/individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(l) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon their own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (SFI 36.11.4).

36.11.3. Admissibility of tenders:

(a) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Trust Board or under delegated limits as set out in the Standard Operating Procedures for the Supply Procurement Group.

(b) Where only one tender is received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

36.11.4. Late tenders:

(a) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(b) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders, that, in the case of the manual procedure have been duly opened, have not left the custody of the Chief Executive or their nominated officer. In the case

of both the manual and electronic procedure, the process of evaluation and adjudication must not have been started.

(b) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or their nominated officer.

36.11.5. Acceptance of formal tenders:

(a) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender.

(b) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(i) experience and qualifications of team members;

(ii) understanding of client's needs;

(iii) feasibility and credibility of proposed approach;

(iv) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented by the Supplies Procurement Committee and the reason(s) for not accepting the lowest tender clearly stated.

(c) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(d) The use of these procedures must demonstrate that the award of the contract was:

(i) not in excess of the going market rate/price current at the time the contract was awarded;

(ii) that best value for money was achieved.

(e) All tenders should be treated as confidential and should be retained for inspection.

36.11.6. Tender reports to the Trust Board will be made on an exceptional circumstance basis only.

36.11.7. List of approved firms:

(a) **Responsibility for maintaining list**

(i) A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms where practicable from whom tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract.

(ii) A firm will only be included on an approved list of tenderers if it complies with current VAT registration and insurance, and has a track record of doing so.

(iii) The Trust is committed to ensuring that, as far as is reasonably practicable, the way we treat staff reflects their individual needs and does not unlawfully discriminate against individuals or groups on the grounds of any protected characteristic (Equality Act 2010). This policy aims to uphold the right of all staff to be treated fairly and consistently adopts a human rights approach.

(iv) Where a firm is included on an approved list of tenderers the Trust shall ensure that it is satisfied that such firm conforms with the requirements of the Health and Safety at Work Act 1974, the Monitory Reform (Fire Safety) Order 2005, and any amending and/or other related legislation concerned with fire, the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. As part of any process to identify or review firms for an approved list, firms must provide to the appropriate manager a copy of its health and safety policy, risk assessments, safe systems at work, together with any licences for other statutory authorities or approvals and evidence of the safety of plant and equipment, when requested.

(b) **Building and Engineering Construction Works**

Invitations to tender shall normally be made to firms included on the approved list of tenderers. This will include firms selected on the Department of Health & Social Care Procure 21 or the Construction Line Contractors list of primary supply chain partners.

(c) **Financial Standing and Technical Competence of Contractors**

The Group Director of Finance & Digital may make or institute any enquiries they deem appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical/medical competence.

36.11.8. Exceptions to using approved contractors:

If in the opinion of the Chief Executive and the Group Director of Finance & Digital or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list and notified to the Chief Executive in accordance with delegated limits.

36.12. Quotations: Competitive and Non-Competitive

36.12.1. General position on quotations: Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income is in line with the limits identified in the Scheme of Delegation.

36.12.2. Competitive quotations:

(a) Quotations should be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

(b) Quotations should be obtained using the electronic tendering portal or in writing to the Chief Executive or his nominated officer unless it is determines that it is impractical to do so in which case quotations may be obtained verbally. Confirmation of verbal quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

(c) All quotations should be treated as confidential and should be retained for inspection. The Chief executive or their nominated officer should evaluate the quotation and select the quote which gives the best value for money. If

this is not the lowest quotation , if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record, or in the electronic system.

36.12.3. Non-competitive quotations: non-competitive quotations in writing may be obtained in the following circumstances:

(a) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(b) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(c) miscellaneous services, supplies and disposals;

(d) single quotations may be obtained where the value of the goods or service is less than the quotation limit as stated in the Delegation of Powers.

(e) where goods or services are for building and engineering works the Director of Estates or nominated officer may approve single quotations where the value is between the quotation and tender limit as stated in the Standard Operating Procedures providing they certify that the first two conditions of this SFI (i.e. SFI 36.12.3 (a) and (b) apply).

36.12.4. Quotations to be within financial limits - no quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Group Director of Finance & Digital.

36.13. Authorisation of tenders and competitive quotations:

36.13.1. Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as set out in the schedule of reservation and delegation of powers.

36.13.2. Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in the minutes.

36.14. Private finance for capital procurement:

36.14.1. When the Board of Directors proposes, or is required to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
(b) The Trust must seek all applicable approvals and the requirements of all guidance by the NHS England.
(c) The proposal must be specifically agreed by the Board of the Trust.
(d) The selection of a contractor/finance company must be on the basis of competitive tendering.

36.15. Compliance requirements for all contracts

36.15.1. The Board may only enter into contracts which comply with:

(a) the Trust's Standing Orders and Standing Financial Instructions;
(b) EU Directives and other statutory provisions;
(c) any relevant directions including the Group Accounting Manual, Estatecode and guidance on the Procurement and Management of Consultants;
(d) the same terms and conditions of contract as was the basis on which tenders or quotations were invited;
(e) in all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

36.16. Personnel and agency or temporary staff contracts

36.16.1. The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

36.17. Disposals

36.17.1. Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer;
(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;
(c) items to be disposed of with an estimated sale value of less than £500 this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
(e) assets required for the provision of mandatory goods and services are protected. They may not be disposed of without the agreement of NHS England.

36.18. In-House Services

36.18.1. The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

36.18.2. In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.
(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.
(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Group Director of Finance & Digital representative. A non-officer member should be a member of the evaluation team.

36.18.3. All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

36.18.4. The evaluation team shall make recommendations to the Board of Directors following any benchmarking process or a market testing exercise carried out pursuant to SFI 36.2.

37. Contract for the Provision of Healthcare Services

37.1. The Board shall regularly review, and shall at all times maintain and ensure, the capacity and capability of the Trust to provide the mandatory goods and services referred to in the Trust's Licence, Terms of Authorisation and compliance with annual declarations as detailed in the NHS Foundation Trust Annual Reporting Manual.

37.2. The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the Annual Operational Plan. In carrying out these functions, the Chief Executive should take into account the advice of the Group Director of Finance & Digital regarding costing and pricing of services, payment terms and conditions and amendments to service agreements.

37.3. Contracts should be so devised as to achieve activity and performance targets, minimise risk, and maximise the Trust's opportunity to generate income. The Trust will produce a cost tariff in accordance with NHS guidelines.

37.4. The Group Director of Finance & Digital shall ensure that a summary of the Trust's new contracts is reported annually to the Board, in line with the Scheme of Delegation. The Group Director of Finance & Digital shall also produce regular reports to the Board detailing actual and forecast contract income with a detailed assessment of the variable elements of income.

37.5. Where the Trust enters into a relationship with another organisation for the supply or receipt of other services, whether clinical or non-clinical, the responsible officer should ensure that an appropriate contract is present and signed by both parties.

37.6. All contracts shall be legally binding, shall comply with best costing practice and shall be so devised as to manage contractual risk, in so far as is reasonably achievable in the circumstances of each contract, whilst optimising the Trust's opportunity to generate income.

37.7. The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable contracts with Commissioners for the provision of NHS services.

38. Terms of Service, Allowances and Payment of Directors and Employees

38.1. Remuneration and Terms of Service

38.1.1. In accordance with Standing Orders SO 6 the Board shall establish a **Group Remuneration Committee**: The committee shall have clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

38.1.2. The Group Remuneration Committee will:

(a) ensure an annual review of remuneration, allowances and terms of service is conducted to determine whether an uplift should be awarded and if so, the level of uplift for all employees which fall within its scope.
(b) monitor and evaluate the performance of such designated senior staff
(c) oversee and advise on any severance packages.
(d) review regularly the structure, size and composition (including the skills, knowledge and experience) required of the Board of Directors and agree any changes
(e) give full consideration to succession planning for senior Trust staff, taking into account the challenges and opportunities facing the Trust and what skills and expertise are therefore needed on the Board in the future.

(f) be responsible for identifying and nominating on behalf of the Board Directors candidates to fill Executive Director and Trust subsidiary Directors as and when they arise.

38.1.3. The **Council of Governors' Remuneration Committee** shall have clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

38.1.4. The Council of Governors' Remuneration Committee will:

(a) ensure an annual review of remuneration, allowances and terms of service of the Chair and Non-Executive Directors is conducted
(b) ensure evaluation of the performance of the Chair and Non-Executive Directors is undertaken in line with the agreed performance appraisal framework
(c) identify and nominate candidates to fill Chair and Non-Executive Director vacancies for approval by the Council of Governors

38.1.5. The Committee will submit the results of its deliberations to a general meeting of the Council of Governors for ratification of its recommendations.

38.2. Funded Establishment

38.2.1. The workforce plans incorporated within the Trust's annual budget will form the recurring funded establishment.

38.2.2. The recurring funded establishment of any department can be varied/skill mixed in accordance with the approved budget virement process and delegated limits providing the change remains within the total value of the delegated pay budgets.

38.2.3. The recurring funded establishment of any department may not be varied/skill mixed without the approval of the Chief Executive if the change exceeds the total value of the delegated pay budgets. See Reservation and Delegation of Powers for additional information.

38.2.4. The recurring funded establishment of any department should not be increased by the virement of non-pay budgets to pay unless approved by the Chief Executive.

38.2.5. The recurring funded establishment of any department should not be increased unless in accordance with a business case approved via the business case approval process.

38.2.6. The funded establishment informs the value of delegated pay budgets on an annual basis to be approved by the Board as part of the annual financial planning process. The Chief Executive will determine the level of delegation to budget managers. See Reservation and Delegation of Powers for additional information.

38.3. Staff Appointments and Regrading

38.3.1. No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless within the limit of their approved budget and funded establishment.

38.3.2. No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration above funded establishment

(a) unless authorised to do so by the Chief Executive.

38.4. Processing Payroll

38.4.1. The Group Director of Finance & Digital is responsible for arranging the provision of an appropriate payroll service. Together with the service provider, the Group Director of Finance & Digital is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;
(b) the final determination of pay and allowances;
(c) making payment on agreed dates;
(d) agreeing method of payment.

38.4.2. Together with the service provider the Group Director of Finance & Digital will issue instructions regarding:

(a) verification and documentation of data;
(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;
(c) maintenance of subsidiary records for pensions, income tax, social security and other authorised deductions from pay;
(d) security and confidentiality of payroll information;
(e) checks to be applied to completed payroll before and after payment;
(f) authority to release payroll data under the provisions of the GDPR;
(g) methods of payment available to various categories of employee and officers;
(h) procedures for payment by cheques or bank credit, to employees and officers;
(i) procedures for the recall of cheques and bank credits;
(j) pay advances and their recovery;
(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

38.4.3. Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;
(b) completing time records and other notifications in accordance with the Group Director of Finance & Digital's instructions and in the form prescribed by the Group Director of Finance & Digital;
(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Group Director of Finance & Digital must be informed immediately.

38.4.4. Regardless of the arrangements for providing the payroll service, the Group Director of Finance & Digital shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

38.5. Contracts of Employment

38.5.1. The Board shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a Contract of Employment and which complies with employment legislation;
(b) dealing with variations to, or termination of, contracts of employment.

39. Non-Pay Expenditure

39.1. Delegation of Authority

39.1.1. The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

39.1.2. The Chief Executive and Group Director of Finance & Digital will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;
(b) the maximum level of each requisition and the system for authorisation above that level.

39.1.3. The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

39.2. Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

39.2.1. The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Group Director of Finance & Digital (and/or the Chief Executive) shall be consulted.

39.2.2. The Group Director of Finance & Digital shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

39.2.3. The Group Director of Finance and Digital will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;
(b) prepare procedural instructions or guidance within the Reservation and Delegation of Powers on the obtaining of goods, works and services incorporating the thresholds;
(c) be responsible for the prompt payment of all properly authorised accounts and claims;
(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Trust employees (including specimens of their signatures) authorised to certify invoices.
(ii) Certification that:
- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the authorised time records, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iii) A timetable and system for submission to the Group Director of Finance & Digital of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.
(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI 39.2.4 below.

39.2.4. Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the current discount rate); or it is common business practice to pay in advance e.g. annual maintenance contracts, utilities, TV licence.
(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;
(c) The Group Director of Finance & Digital will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);
(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

39.2.5. Official orders must:

(a) be consecutively numbered;
(b) be in a form approved by the Group Director of Finance & Digital;
(c) state the Trust's terms and conditions of trade;
(d) only be issued to, and used by, those duly authorised by the Chief Executive.

39.2.6. **Duties of managers and officers** - Managers and officers must ensure that they comply fully with the guidance and limits specified by the Group Director of Finance & Digital and that:

(a) all contracts (except as otherwise provided for in the Reservation and Delegation of Powers), leases, tenancy agreements and other commitments which may result in a liability are notified to the Group Director of Finance & Digital in advance of any commitment being made;
(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(c) particular caution is exercised when hospitality and gifts are offered by actual or potential suppliers or contractors. The policy on Managing Conflicts of Policy (PP20) should be adhered to at all times with appropriate declarations made in line with these requirements.
(d) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Group Director of Finance & Digital on behalf of the Chief Executive;
(e) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;
(f) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";
(g) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;
(h) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;
(i) changes to the list of employees and officers authorised to certify invoices are notified to the Group Director of Finance & Digital;
(j) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Group Director of Finance & Digital;
(k) petty cash records are maintained in a form as determined by the Group Director of Finance & Digital.

39.2.7. The Chief Executive and Group Director of Finance & Digital shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

40. External Borrowing

40.1. The Group Director of Finance & Digital will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed commercial borrowing with the Foundation Trust Financing Facility or any commercial lender, within the limits set in the Foundation Trust's authorisation and reviewed annually by NHS England.

40.2. The Group Director of Finance & Digital is also responsible for reporting periodically to the Board concerning the PDC and all loans and overdrafts. These reports should include key balance sheet information showing changes to long term debt, PDC and other borrowings (i.e. prudential borrowing). Taken together with the Income & Expenditure report it will show the planned and projected position on interest and capital.

40.3. The Group Director of Finance & Digital will ensure that all loans negotiated with the Foundation Trust Financing Facility (FTFF) or any commercial lender are clearly documented and a nominated responsible officer will ensure that the terms of repayment are adhered to. All changes to the structure of any loan or a change in repayment terms will be reported by the Group Director of Finance & Digital to the Board.

40.4. Any application for a loan or overdraft will only be made by the Group Director of Finance & Digital or by an employee acting on his/her behalf, and in accordance with the Reservation and Delegation of Powers.

40.5. The Group Director of Finance & Digital must prepare detailed procedural instructions concerning applications for loans and overdrafts.

40.6. All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Group Director of Finance & Digital.

40.7. All long-term borrowing must be consistent with the Plan and be subject to the limits authorised by NHS England and approved by the Trust Board.

40.8. Investments

40.8.1. All cash surpluses must be held in safe harbour institutions in line with the guidance contained in NHS England “Managing Operating Cash in NHS Foundation Trusts”. The Group Director of Finance & Digital will prepare an Operating Treasury Management Policy which will be authorised by the Board.

40.8.2. The Group Director of Finance & Digital is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

40.8.3. The Group Director of Finance & Digital will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

41. Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

41.1. Capital Investment

41.1.1. The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;
(c) shall ensure that capital investment is not undertaken without confirmation on the availability of resources to finance all revenue consequences of the capital scheme;
(d) shall ensure that where applicable support for the scheme is confirmed from commissioners and or NHS England.

41.1.2. For capital expenditure proposals the Chief Executive shall ensure:

(a) that an appropriate business case is produced setting out:

(i) where possible an appropriate option appraisal has been undertaken comparing costs and benefits

(ii) the involvement of appropriate Trust personnel and external agencies, if appropriate

(ii) appropriate project management and control arrangements are in place

(b) that a Director or nominated officer has certified professionally to the costs and revenue consequences detailed in the business case.

41.1.3. For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of “Estatecode”.

41.1.4. The Group Director of Finance & Digital shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HMRC guidance.

41.1.5. The Group Director of Finance & Digital shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure, including scheme under and over spends.

41.1.6. The approval of the Trust’s capital programme will require specific additional approvals for each capital scheme to enable:

(a) authorisation to commit expenditure in accordance with these standing orders and within approved budget;
(b) approval to award a contract in accordance with these standing orders.

41.1.7. The Chief Executive will issue a Reservation and Delegation of Powers for capital investment management in accordance with "Estatecode" guidance, Procure 21+ and the Trust’s Standing Orders.

41.1.8. The Group Director of Finance & Digital shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

41.2. Asset Registers

41.2.1. The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Group Director of Finance & Digital concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

41.2.2. The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in 'The asset register and disposal of assets: guidance for providers of commissioner requested services (April 14)' guidance.

41.2.3. Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;
(c) lease agreements in respect of assets held under IFRS 16 and capitalised.

41.2.4. Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

41.2.5. The Group Director of Finance & Digital shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

41.2.6. The value of each asset shall be valued in accordance with methods specified in 'The asset register and disposal of assets: guidance for providers of commissioner requested services guidance.

41.2.7. The value of each asset shall be depreciated using methods and rates as specified in 'The asset register and disposal of assets: guidance for providers of commissioner requested services guidance.

41.2.8. The Group Director of Finance & Digital of the Trust shall calculate capital charges as specified in 'The asset register and disposal of assets: guidance for providers of commissioner requested services' guidance.

41.3. Security of Assets

41.3.1. The overall control of fixed assets is the responsibility of the Chief Executive.

41.3.2. Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Group Director of Finance & Digital. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;
(b) identification of additions and disposals;
(c) identification of all repairs and maintenance expenses;
(d) physical security of assets;
(e) periodic verification of the existence of, condition of, and title to, assets recorded;
(f) identification and reporting of all costs associated with the retention of an asset;
(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

41.3.3. All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Group Director of Finance & Digital.

41.3.4. Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedure.

41.3.5. Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

41.3.6. Where practical, assets should be marked as Trust property.

42. Stores and Receipt of Goods

42.1. Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;
(b) subjected to annual stock take;
(c) valued at the lower of cost or net realisable value.

42.2. Control of Stores, Stocktaking, Condemnations and Disposal

42.2.1. Subject to the responsibility of the Group Director of Finance & Digital for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by them to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Group Director of Finance & Digital. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

42.2.2. The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as Trust property.

42.2.3. The Group Director of Finance & Digital shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

42.2.4. Stocktaking arrangements shall be agreed with the Group Director of Finance & Digital and there shall be a physical check covering all items in store at least once a year.

42.2.5. Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Group Director of Finance & Digital.

42.2.6. The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Group Director of Finance & Digital for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Group Director of Finance & Digital any evidence of significant overstocking and of any negligence or malpractice (see also SFI 43 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

42.3. Goods Supplied by NHS Supply Chain

42.3.1. For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Group Director of Finance & Digital who shall satisfy himself that the goods have been received before accepting the recharge.

43. Disposals and Condemnations, Losses and Special Payments (see SFI 36.17)

43.1. Disposals and Condemnations

43.1.1. The Group Director of Finance & Digital must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

43.1.2. When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Group Director of Finance & Digital of the estimated market value of the item, taking account of professional advice where appropriate.

43.1.3. All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Group Director of Finance & Digital;
(b) recorded by the Condemning Officer in a form approved by the Group Director of Finance & Digital which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Group Director of Finance & Digital.

43.1.4. The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Group Director of Finance & Digital who will take the appropriate action.

43.2. Losses and Special Payments

43.2.1. The Group Director of Finance & Digital must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

43.2.2. Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Group Director of Finance & Digital or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Group Director of Finance & Digital and/or Chief Executive. Where a criminal offence is suspected, the Group Director of Finance & Digital must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Group Director of Finance & Digital must inform the NHS Counter Fraud Authority in accordance with Secretary of State for Health's Directions.

43.2.3. The Group Director of Finance & Digital must notify the NHS Counter Fraud Authority and the External Auditor of all frauds.

43.2.4. For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Group Director of Finance & Digital must immediately notify:

(a) the Board,
(b) the External Auditor.

43.2.5. The Board shall approve the writing-off of losses. In practice, this will be delegated to the Audit Committee.

43.2.6. The Group Director of Finance & Digital shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

43.2.7. For any loss, the Group Director of Finance & Digital should consider whether any insurance claim can be made.

43.2.8. The Group Director of Finance & Digital shall maintain a Losses and Special Payments Register in which write-off action is recorded.

43.2.9. All losses and special payments must be reported to the Audit Committee.

44. Information Technology

44.1. Responsibilities and Duties of the Chief Information Officer

44.1.1. The Chief Information Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018
(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

44.1.2. The Chief Information Officer shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

44.1.3. The Chief Information Officer with responsibility for Information Technology shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

44.2. Responsibilities and Duties of Other Directors and Officers in Relation to Computer Systems of a General Application

44.2.1. In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the Group Director of Finance & Digital:

(a) details of the outline design of the system;
(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

44.3. Contracts for Computer Services With Other Health Bodies and Outside Agencies

44.3.1. The Chief Information Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

44.3.2. Where another health organisation or any other agency provides a computer service for financial applications, the Chief Information Officer shall periodically seek assurances that adequate controls are in operation.

44.4. Risk Assessment

44.4.1. The Chief Information Officer shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

44.5. Requirements for Computer Systems Which Have an Impact on Corporate Financial Systems

44.5.1. Where computer systems have an impact on corporate financial systems the Chief Information Officer shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;
(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;
(c) Group Director of Finance & Digital staff have access to such data;
(d) such computer audit reviews as are considered necessary are being carried out.

45. Patients' Property

45.1. The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

45.2. The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets; (notices are subject to sensitivity guidance)
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

45.3. The Group Director of Finance & Digital must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

45.4. Separate accounts for patients' moneys, shall be opened and operated under arrangements agreed by the Group Director of Finance & Digital.

45.5. In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate

or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

45.6. Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

45.7. Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

46. Charitable Funds

46.1. Corporate Trustee

46.1.1. SO 1.4 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust.

46.1.2. The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety.

46.1.3. The Group Director of Finance & Digital shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

46.2. Accountability to Charity Commission

46.2.1. The trustee responsibilities must be discharged separately and full recognition given to the Trust's accountability to the Charity Commission for charitable funds held on trust.

46.2.2. The Reservation and Delegation of Powers make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

46.3. Applicability of Standing Financial Instructions to Charitable Funds

46.3.1. In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of charitable funds.

46.3.2. The over-riding principle is that the integrity of each charitable fund must be maintained in accordance with the Charities Acts and recommended practice and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

46.4. Charitable Funds Committee

46.4.1. The Trust shall establish a Charitable Funds Committee with clearly defined terms of reference which:

(a) shall ensure that the Trust's charitable funds are managed appropriately with regard to the declaration of trust and appropriate legislation, and
(b) have primary responsibility to the Board of Directors for ensuring that these SFIs are applied, and where appropriate, closely liaise with the Board of Directors' legal adviser.

46.4.2. SFI 46 shall be interpreted and applied in conjunction with the rest of these SFIs subject to modifications contained herein.

46.4.3. The Charitable Funds Committee is responsible for setting the boundary at which the Trust will accept responsibility for donated income.

46.5. Administration of the Charitable Fund

46.5.1. The Charitable Funds Committee will arrange for the proper administration of charitable funds in accordance with their respective terms of trust, and ensure that accounting records are kept in a way that identifies separately the different categories of fund between unrestricted funds, restricted funds and endowment funds, and complies with charities legislation.

46.5.2. The Charitable Funds Committee will produce detailed codes of procedure covering every aspect of the financial management of funds held on trust, for the guidance of Directors and employees.

46.5.3. The Charitable Funds Committee shall periodically review the funds in existence and shall make recommendations to the Charitable Trust regarding the potential for rationalisation of such funds as permitted by the declarations of trust and charities legislation.

46.5.4. The Charitable Funds Committee may recommend that additional funds be established where this is consistent with this body's policy for ensuring the safe and appropriate management of funds, eg designation for specific wards or departments, or the creation of restricted funds to meet the restricted purpose of a donation.

46.6. Income

46.6.1. In respect of donations, the Charitable Funds Committee shall provide guidelines to officers of this body as to how to proceed when offered funds. These to include:

(a) the identification of the donor's intentions;
(b) where possible, the avoidance of new restricted purpose funds;
(c) the avoidance of impossible, undesirable, or administratively difficult objects;
(d) sources of immediate further advice;
(e) treatment of offers for personal gifts; and
(f) provide secure and appropriate receipting arrangements which shall indicate the funds have been accepted directly into this body's charitable funds and that the donor's intentions have been noted and accepted.

46.6.2. In respect of legacies and bequests, the Charitable Funds Committee shall:

(a) provide guidelines to officers of the Trust regarding the receipt of funds/other assets from Executors;
(b) be empowered on behalf of the Trust to negotiate arrangements regarding the administration of a Will with Executors and to discharge them from their duty; and
(c) be directly responsible for the appropriate treatment of all legacies and bequests.

46.6.3. In respect of trading income, the Charitable Funds Committee shall;

(a) be primarily responsible, along with other designated officers, for any trading undertaken by the Trust as corporate trustee; and
(b) be primarily responsible for the appropriate treatment of all funds received from this source.

46.6.4. In respect of investment income, the Charitable Funds Committee shall be responsible for the appropriate treatment of all dividends, interest and other receipts associated with funds held on trust by the Trust as a corporate trustee.

46.7. Fundraising

46.7.1. The Charitable Funds Committee shall:

(a) in respect of legacies and bequests, provide guidelines to officers of the Trust covering any approach regarding the wording of Wills;
(b) after taking appropriate legal and tax advice, deal with all arrangements for fund raising by and/or on behalf of this body, and ensure compliance with all statutes and regulations;
(c) be empowered to liaise with other organisations/persons raising funds for this body, and provide them with an adequate discharge. The Chief Executive (acting under the instructions of the Charitable Funds Committee) shall be the only officer empowered to give approval for such fund raising subject to the over-riding direction of the Charitable Trust;

(d) be responsible for alerting the Charitable Trust to any irregularities regarding the use of the Trust's name or its registration numbers; and
(e) be required to advise the Charitable Trust on the financial implications of any proposal for fund raising activities which the Trust as corporate trustee may initiate, sponsor or approve.

46.7.2. The Trust's policy on fund raising requires that:

(a) all those involved in fund raising, whether members of the public or NHS staff, are clear about the implications of their activities and have agreed them with this body before they commence any appeal to the public, including the action to be taken should the appeal target not be reached;
(b) that the public are not misled about any aspect of an appeal; and
(c) that any appeal with which this body is in any way associated is conducted in conformity with all applicable standards.

46.8. Investment Management

46.8.1. The Charitable Funds Committee shall be responsible for all aspects of the management of the investment of charitable funds. The issues on which it shall be required to provide advice to the Charitable Trust shall include:

(a) the formulation of investment policy within the powers of the Trust under statute and within its governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;
(b) the appointment of advisers and fund managers. The Charitable Funds Committee will agree the terms of such appointments and the written agreements shall be signed by the Chief Executive;
(c) the use of Trust assets; which shall be appropriately authorised in writing;
(d) the review of the performance of fund managers and advisers; and
(e) the reporting of investment performance.

46.9. Use of Funds

46.9.1. Authorisation of expenditure from charitable funds will be laid down in the Reservation and Delegation of Powers.

46.9.2. The exercise of the Trust's discretion in the application of charitable funds shall be managed by the Charitable Funds Committee. In doing so, it shall be aware of the following:

(a) the objects of the charitable funds;
(b) the availability of liquid funds;
(c) the powers of delegation available to commit resources as detailed in the Reservation and Delegation of Powers;
(d) the avoidance of use of Exchequer funds to discharge charitable fund liabilities (except where administratively unavoidable), and to ensure that

any indebtedness to the Trustee Exchequer funds shall be discharged by charitable funds at the earliest possible time;

(e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the body and any reserved policy;

(f) the definitions of “charitable purposes” as determined by the charity commission and relevant legislation and case law; and

(g) any restrictions on spending capital.

46.10. Banking Services

46.10.1. The Charitable Funds Committee shall advise the Charitable Trust and, with its approval, shall ensure that appropriate banking services are available to this body as corporate trustee.

46.10.2. The Trust as corporate trustee shall approve the bank accounts to be used for charitable funds.

46.11. Reporting

46.11.1. The Charitable Funds Committee shall ensure that regular reports are made to the Charitable Trust with regard to, inter alia, the receipt of funds, investments and the disposition of resources.

46.11.2. The Charitable Funds Committee shall prepare annual accounts in the required manner that shall be submitted to the Charitable Trust within agreed timescales.

46.11.3. The Charitable Funds Committee shall prepare an annual trustee’s report and the required returns and to the Charity Commission for adoption by the Charitable Trust.

46.12. Accounting and Audit

46.12.1. The Charitable Funds Committee shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit;

46.12.2. The Charitable Funds Committee shall liaise with external audit and provide them will all necessary information.

46.13. Administration Costs

46.13.1. The Charitable Funds Committee shall identify all costs directly incurred in the administration of charitable funds and, in agreement with the Charitable Trust, shall charge such costs to the appropriate charitable fund.

46.14. Custody of Investment Certificates and the Deeds of Properties

46.14.1. The Group Director of Finance & Digital shall ensure that Investment certificate and deeds of properties are held in a safe and secure location.

46.15. Legacies

46.15.1. The Group Director of Finance & Digital shall be authorised to give executors good discharge from their duties.

46.15.2. The Group Director of Finance & Digital, shall be authorised to obtain a grant of probate or make application for letters of administration where the Trust is the beneficiary.

47. Managing Conflicts of Interest

47.1. The Group Director of Finance & Digital shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance from NHS England – “Managing Conflicts of Interest in the NHS” and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see SO 23 and SFI 47).

48. Retention of Records

48.1. The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health & Social Security guidelines.

48.2. The records held in archives shall be capable of retrieval by authorised persons.

48.3. Records held in accordance with latest NHS England guidance ie ”Records Management Code of Practice” Practice” shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed. Records Management Policy IG05 provides further information.

49. Risk Management and Insurance

49.1. Programme of Risk Management

49.1.1. The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with the Governance framework requirements, which must be approved and monitored by the Board.

49.1.2. The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;
(b) engendering among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
(d) contingency plans to offset the impact of adverse events;
(e) audit arrangements including; Internal Audit, clinical audit, health and safety review;
(f) a clear indication of which risks shall be insured;
(g) arrangements to review the Risk Management programme.

49.1.3. The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement within the Annual Report and Accounts as required by NHS England.

49.2. Insurance: Risk Pooling Schemes administered by NHS Resolution

49.2.1. The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

49.3. Arrangements to be followed by the Board in agreeing Insurance cover

49.3.1. Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Managing Director QEF shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Managing Director QEF shall ensure that documented procedures cover these arrangements.

49.3.2. Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for one or other of the risks covered by the schemes, the Managing Director QEF shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Managing Director will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

49.3.3. All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the ‘deductible’). The Managing Director QEF should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Scheme of Delegation and Reservation of Powers to the Board of Directors

Reservation of Powers to the Board of Directors

Reference		
Standing Orders		
SO	27.1	Waiver of standing orders
SO	21.3	Approval of scheme of delegation
SO	28.1	Approval of variations to the Standing Orders
Board Appointments		
SO	6.4	Appointment of Deputy Chair
SO	6.6	Appointment of Senior Independent Director
Committees		
SO	22.1	Appointment of committees/sub committees of the Board
SO	22.4	Approval of terms of reference of committees/sub committees of the Board
SO	22.6	Appointments to committees
SO	22.9	Establishment of appropriate sub-committees
SO	22.5	Delegation of powers to sub-committees
Use of Seal / Signature of Documents		
SO	25.3	Authorisation of the use of the seal
SO	26.1/2	Authorising the signature of legal documents in line with the scheme of delegation
Strategy		
SFI	30.1.a	Ensure Trust strategy is in place

Finance General		
SFI	30.1.b	Approval of revenue and capital plan
Audit		
SFI	31.1.	Establishment of an Audit Committee
Allocations, Planning, Budgets, Budgetary Control and Monitoring		
SFI	32.1.1.	Production of revenue plan
SFI	32.1.2.	Production of revenue budgets
SFI	32.3.1.	Maintain systems of budgetary control & reporting
SFI	32.3.2.	Budget holder responsibilities
SFI	32.4.1.	Production of capital plan
Financial Control and Reporting		
SFI	32.2.3.	Authorisation of budget overspend
SFI	32.1.3	Review financial performance against approved financial plans
Bank and GBS Accounts		
SFI	34	Approval of Banking arrangements
Remuneration		
SFI	38.1	Establishment of Remuneration Committee
Staff Appointments		
SFI	38.3	Approval of funded establishment
Non Pay Expenditure		
SFI	39.1.1.	Approval of level of annual non-pay spend
External Borrowing		
SFI	40	Approval of long term borrowing
Capital Investment		
SFI	41.1.	Approval of long term borrowing
Risk Management and Insurance		
SFI	49	Approval of Trust insurance Arrangements

Scheme of Delegation

		Delegation of Powers	Delegated to	Operational Responsibility
Standing Orders				
SO	2.1	Interpretation of standing orders	Chair	Company Secretary
SO	5.8	Induction of the Non-Executive Directors	Chair	Company Secretary
SO	6.1 / 7.1	Appointment and removal of the Chair and Non-Executive Directors	Council of Governors	-
SO	6.2	Appointment of the Chief Executive	Group Remuneration Committee	-
SO	6.3	Appointment of Executive Directors	Group Remuneration Committee	-
SO	6.5	Performance of Chair duties in the absence of the Chair	Deputy Chair	-
SO	8.1	Calling a Board Meeting	Chair	-
SO	9.2	Approval of Board Meeting agendas	Chair	
SO	12.1	Final decision on questions of order, relevancy and regularity	Chair	
SO	20.1	Exercise of emergency powers	Chief Executive and Chair (following consultation with at least two Non-Executive Directors)	
SO	21.2	Exercise of functions not reserved for the Board or delegated to a committee	Chief Executive	Executive Directors

SO	25.1	Secure storage of the seal	Chair	
SO	25.4	Oversight of the affixing of the seal	Chair and Chief Executive / Executive Directors	
SO	26.1/2	Signing of legal documents as approved by the Board	Chief Executive	Executive Directors
SO	3.28	Review suspension of standing orders	Group Audit Committee	Company Secretary
Interests				
SO	23.6	Establish register of interests	Company Secretary	
Strategy				
Digital Committee Terms of Reference		Ensure Trust-wide IT Strategy in place and monitor	Chief Executive	
		Delivery of Trust Strategy	Chief Executive	All Executive Directors
		Signing of leases	Group Director of Finance & Digital	
		Signing of documents in legal proceedings	Chief Executive/Deputy Chief Executive	
Finance and Performance Committee Terms of Reference		Seek assurance of effective arrangements for management of contracts and SLA's with Commissioners	Finance and Performance Committee	Group Director of Finance & Digital
SFI	37.2	Negotiation & approval of contracts for provision of healthcare services	Chief Executive	Group Director of Finance & Digital
SFI	37.3	Production of cost tariff in accordance with NHS guidelines	Chief Executive	Group Director of Finance & Digital

SFI	37.4	Reporting of contracts for goods to Board	Chief Executive	Group Director of Finance & Digital
SFI	37.4	Reporting of contracts for services to the Board	Chief Executive	Group Director of Finance & Digital
Finance General				
SFI	30.1.a	Formulating financial strategy	Group Director of Finance & Digital	Deputy Director of Finance & Digital
SFI	30.1.c	Defining essential features of procedures and systems	Group Director of Finance & Digital	Deputy Director of Finance
SFI	30.1.c.	Responsibility for ensuring the organisation delivers value for money	Chief Executive & Executive Directors	
SFI	30.1.c	Seek assurance of ensuring the organisation delivers value for money	Finance & Performance Committee	Chief Executive & Executive Directors
SFI	30.3	Responsibility for Financial Control	Chief Executive & Group Director of Finance & Digital	
SFI	30.6.a	Implementation of financial policies	Group Director of Finance & Digital	Deputy Director of Finance
SFI	30.6.b	Maintaining an effective system of financial control	Group Director of Finance & Digital	Deputy Director of Finance
SFI	30.6.c	Maintenance of financial records	Group Director of Finance & Digital	Deputy Director of Finance
SFI	30.6.d	Provision of financial advice to the board and employees	Group Director of Finance & Digital	Deputy Director of Finance
SFI	30.6.e	Design, implementation and supervision of systems of internal control	Group Director of Finance & Digital	Deputy Director of Finance
SFI	30.6.f	Preparation and maintenance of accounts etc	Group Director of Finance & Digital	Deputy Director of Finance
SFI	30.7.a	Security of the property of the Trust	All Staff	

SFI	30.7.b	Avoiding loss	All Staff	
SFI	30.7.c	Exercising economy and efficiency in the use of resources	All Staff	
SFI	30.7.d	Conforming with standing orders, standing financial instructions, financial procedures, and the scheme of delegation	All Staff	
Audit				
SFI	31.2.a	Ensuring adequate arrangements in place for the review of effectiveness of internal audit	Group Director of Finance & Digital	Deputy Director of Finance
SFI	31.2.b	Ensuring adequacy and effectiveness of internal audit	Group Director of Finance & Digital	Deputy Director of Finance
SFI	31.2.c	Decide stage to involve police in cases of misappropriation and other irregularities	Group Director of Finance & Digital	Deputy Director of Finance
SFI	31.2.d	Ensuring the preparation of an annual audit report by Internal Audit, External Audit & Counter Fraud as required.	Group Director of Finance & Digital	Deputy Director of Finance
SFI	31.8	Determining the audit system for Internal Audit	Group Audit Committee, Group Director of Finance & Digital & Internal Audit	Deputy Director of Finance
SFI	31.10	Appointment of External Auditor	Council of Governors	
SFI	31.12	Ensure compliance with the NHS standard contract in respect of fraud, bribery and corruption	Chief Executive & Group Director of Finance & Digital	
Group Audit Committee		Obtaining outside legal or independent advice on audit matters	Group Audit Committee	Group Director of Finance & Digital

Terms of Reference				
Group Audit Committee Terms of Reference		Review work and findings of External & Internal Audit, Internal including agreeing nature and scope of audit	Group Audit Committee	Group Director of Finance & Digital
Group Audit Committee Terms of Reference		Responsible for seeking assurance for all audit and counter fraud functions.	Group Audit Committee	Group Director of Finance & Digital
Group Audit Committee Terms of Reference		Agreement and implementation of action plans arising from audit reports	All Staff	
Security Management				
SFI	31.17	Monitoring compliance with SoS Directions	Chief Executive	Group Director of Finance & Digital
SFI	31.19	Controlling & Co-ordaining security	Chief Executive	Security Management Director & Local Security Management Specialist
Business Planning, Budgets, Budgetary Control and Monitoring				
SFI	32.1.1.	Preparation of Annual Plan	Chief Executive	Executive Directors
SFI	32.1.2	Preparation of annual budgets	Chief Executive	Group Director of Finance & Digital
SFI	32.1.2.	Approval of annual Income & expenditure spending plan	Board of Directors	
SFI	32.1.3.	Monitoring of financial performance against budget	Group Director of Finance & Digital	Deputy Director of Finance

SFI	32.1.4.	Provision of information to inform budget setting	Deputy Director of Finance	Assistant Finance Directors & All Budget Holders
SFI	32.1.5	Agree Business Unit revenue budgets for the year	Deputy Director of Finance	All Budget Holders
SFI	32.1.6	Provision of adequate training in budgetary control	Group Director of Finance & Digital	Deputy Director of Finance
Budget Delegation				
SFI	32.2.1.	Delegation of budgetary control	Chief Executive	Budget Holders
SFI	32.2.5.	Authorisation of use of non-recurrent funds for recurrent purposes	Chief Executive	Group Director of Finance & Digital
Financial Control and Reporting				
SFI	32.3.1.	Devise & maintain systems of budgetary control	Group Director of Finance & Digital	Deputy Director of Finance
SFI	32.3.1.a	Provision of monthly budget reports to the Finance & Performance Committee & bi monthly reports to Board	Group Director of Finance & Digital	Deputy Director of Finance
SFI	32.3.1.b	Provision of monthly budget information to budget holders	Group Director of Finance & Digital	Deputy Director of Finance
SFI	32.3.1.c	Investigation and reporting of variances from budgets	Group Director of Finance & Digital	Deputy Director of Finance
SFI	32.3.1.d	Monitoring of action to correct variances	Group Director of Finance & Digital	Deputy Director of Finance
SFI	32.3.1.e	Authorisation of budget transfers, outside of Trust virement process	Group Director of Finance & Digital	Deputy Director of Finance
SFI	32.3.2.a	Management of budget within allocation	Group Director of Finance & Digital	Budget Holders
SFI	32.3.2.b	Ensuring allocated funds are used for the purpose intended	Group Director of Finance & Digital	Budget Holders

SFI	32.3.2.c	Appointment of permanent employees within available resources	Operational Directors, Heads of Corporate Business Units	Budget Holders
SFI	32.3.2.c	Appointment of permanent employees outside of available resources	Chief Executive	
SFI	32.3.3.	Identification of cost improvements and income generation initiatives	Chief Executive	Group Director of Finance & Digital
SFI	32.5.1.	Submission of financial monitoring returns as required by appropriate bodies	Chief Executive	Group Director of Finance & Digital
SFI	33.1.	Preparation & submission of annual accounts and reports	Group Director of Finance & Digital	Deputy Director of Finance
Capital Expenditure				
SFI	32.4.1.	Preparation of capital spending plan	Chief Executive	Group Director of Finance & Digital
SFI	32.4.1.	Approval of capital spending plan	Board of Directors	
SFI	32.4.2.	Approval of in-year changes to the capital spending plan	Executive Management Team	
SFI	32.4.3	Notification of in-year spending against the approved capital spending plan	Group Director of Finance & Digital	Deputy Director of Finance
Bank and GBS Accounts				
SFI	34.1	Management of banking arrangements	Group Director of Finance & Digital	Deputy Director of Finance
SFI	34.2	Approval of all banking arrangements	Board of Directors	
SFI	34.5	Preparation of detailed instructions on the operation of bank and GBS accounts	Group Director of Finance & Digital	Deputy Director of Finance
SFI	34.7	Review of commercial banking arrangements	Group Director of Finance & Digital	Deputy Director of Finance
Income, Fees and Charges and Security of Cash, Cheques and other Negotiable Instruments				

SFI	35.1.1.	Designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due	Group Director of Finance & Digital	Deputy Director of Finance
SFI	35.1.2	Prompt banking of cash	Group Director of Finance & Digital	Deputy Director of Finance
SFI	35.2.1.	Approval and review of all local fees and charges	Group Director of Finance & Digital	Deputy Director of Finance
SFI	35.3.1.	Recovery of all outstanding debts	Group Director of Finance & Digital	Deputy Director of Finance
SFI	35.4.1	Security of cash, cheques and other negotiable instruments	Group Director of Finance & Digital	Deputy Director of Finance
Tendering and Contracting Procedures				
SFI	36.8.1	Waiving of formal tendering procedures	See Financial Delegation Limits	
SFI	36.8.1.m	Preparing a report on tender waivers for Board via Finance and Performance Committee and the Supply Procurement Committee	Group Director of Finance & Digital	Deputy Director of Finance
SFI	36.11.7.a	Maintenance of list of approved suppliers	Group Director of Finance & Digital	Director of Finance QEF Trust subsidiary
SFI	36.11.1	Receipt and safe custody of tenders	Electronic portal or Chief Executive	
SFI	36.11.1	Opening of tenders >£25K	Electronic portal or Chief Executive, Executive Director	Electronic portal or designated senior manager
SFI	36.11.4	Considering of late tenders	Chief Executive	

	36.11.5.c	Acceptance of tenders that commit to expenditure in excess of allocated budget	Chief Executive	
SFI	36.11.8	Use of contractors not on approved list	Chief Executive, Group Director of Finance & Digital	
SFI	36.12.2.	Competitive quotations	Group Director of Finance & Digital, Head of Procurement using the electronic portal	
SFI	36.12.4	Approval of quotations above budgetary limit	Chief Executive	Group Director of Finance & Digital
SFI	36.13	Authorisation of Tenders and Competitive Quotations	See Financial Delegation Limits – Orders	
SFI	36.14	Approval of proposals to utilise private finance for capital procurement	Board of Directors	
SFI	39.2.6.f	Issuing of verbal orders	Chief Executive	
In-House Services				
SFI	36.18.1	Ensuring value for money	Chief Executive Officer	Executive Director, Associate Director
Human Resources				
People and Organisational Development Committee Terms of Reference		Provide people-related advice to the Board	Director of People & OD	

People and Organisational Development Committee Terms of Reference		Seek assurance over the delivery of People and OD strategies, plans and initiatives covering culture, workforce development, workforce management, equality and diversity, health and wellbeing	POD Committee	Director of People & OD
SFI	32.1.2.	Approve spending plans for training & OD requirements	Board of Directors (via approval of annual spending plan)	
Terms of Service				
SFI	38.1.2.a	Review remuneration, allowances and terms of service annually for senior employees in its remit	Remuneration Committee	Chief Executive and Chair
SFI	38.1.2.b	Monitor and evaluate the performance of designated senior staff within its area of responsibility, its composition and its arrangements for reporting	Remuneration Committee	Chief Executive and Chair
SFI	38.1.2.d	Review the structure, size and composition of the Board	Remuneration Committee	Chief Executive and Chair
SFI	38.1.2.e	Review succession planning and assess the skills and expertise required for the Board	Remuneration Committee	Chief Executive and Chair
SFI	38.1.2.f	Identify and nominate candidates to fill Board vacancies within its remit	Remuneration Committee	Chief Executive and Chair
SFI	38.1.4.a	Review remuneration, allowances and terms of service annually for the Chair and Non-Executive Directors	Council of Governors	Council of Governors' Remuneration Committee
SFI	38.1.4.b	Seek assurance that the performance of the Chair and Non-Executive Directors is	Council of Governors	Council of Governors' Remuneration Committee

		evaluated in line with agreed performance frameworks		
SFI	38.1.4.c	Appoint candidates to fill Chair and Non-Executive Director vacancies	Council of Governors	Council of Governors' Remuneration Committee
Staff Appointments				
SFI	38.2.2.	Approval of variation of funded establishment within available budget	Operational Director, Head of Corporate Business Units	
SFI	38.2.3.	Approval of variation of funded establishment with a cost greater than available budget	Chief Executive	Group Director of Finance & Digital
SFI	38.2.4.	Increase to funded establishment via the virement of a non-pay budget	Chief Executive	Group Director of Finance & Digital
SFI	38.3.1.	Engagement, re-engagement, regrading of employees within available budget	Operational Director, Head of Corporate Business Units	
SFI	38.3.2.	Engagement, re-engagement, regarding of employees with a cost greater than available budget	Chief Executive	Group Director of Finance & Digital
SFI	38.3.2.	Approval of procedures for the determination of commencing pay rates, conditions of service etc	POD Committee	Director of People & OD
Processing of Payroll				
SFI	38.4.1.	Arranging the provision of an appropriate payroll service	Group Director of Finance & Digital	Deputy Director of Finance
SFI	38.4.1.a	Specifying timetables for submission of properly authorised time records and other notifications	Group Director of Finance & Digital	Deputy Director of Finance

SFI	38.4.1.b	Final determination of pay and allowances	Group Director of Finance & Digital	Deputy Director of Finance
SFI	38.4.1.c	Making payment on agreed dates	Group Director of Finance & Digital	Deputy Director of Finance
SFI	38.4.1.d	Agreeing method of payment	Group Director of Finance & Digital	Deputy Director of Finance
SFI	38.4.2.a	Issue of instructions around the use and verification of payroll data	Group Director of Finance & Digital	Deputy Director of Finance
SFI	38.5.1.a	Ensuring that all employees are issued with a contract of employment	Group Executive Director of People and OD	Deputy Director of People and OD
SFI	38.5.1.b	Addressing variations to or termination of contracts of employment	Group Executive Director of People and OD	Deputy Director of People and OD
Finance and Planning				
Finance and Performance Committee Terms of Reference		Oversight of annual financial planning both revenue, capital and cash and budget setting of the Trust	Finance & Performance Committee	Group Director of Finance & Digital
Finance and Performance Committee Terms of Reference		Seeking assurance over the delivery of key strategies within its remit	Finance & Performance Committee	
Finance and Performance Committee		Seeking assurance over commercial opportunities and contract delivery within its remit	Finance & Performance Committee	Director of Strategy, Planning & Partnerships

Terms of Reference				
Finance and Performance Committee Terms of Reference		Seeking assurance of performance against National and Local targets	Finance & Performance Committee	Group Director of Finance & Digital
Finance and Performance Committee Terms of Reference		Seeking assurance of performance against cost reduction programme, transformation and productivity targets	Finance & Performance Committee	
		Approval of budget virement	See financial delegation Limits	
		Approval of capital expenditure	See financial delegation Limits	
		Oversee the delivery of the capital financial plan	Group Director of Finance & Digital	Deputy Director of Finance
		Oversee the delivery of the revenue financial plan	Group Director of Finance & Digital	Deputy Director of Finance
Contracts of Employment				
SFI	38.5.1.a	Ensuring that all employees are issued with a contract of employment	Group Executive Director of People and OD	Deputy Director of People and OD
Non-Pay Expenditure				
SFI	39.1.1.	Approval of non-payment expenditure levels annually	Board of Directors	
SFI	39.1.1	Determine level of non-pay delegation to budget managers	Chief Executive	Group Director of Finance & Digital

SFI	39.2.4.	Authorisation of prepayments	Group Director of Finance & Digital	Deputy Director of Finance
SFI	39.2.5.	Authorisation of those who official orders can be issued to	Chief Executive	Group Director of Finance & Digital
SFI	39.2.6.j	Approval of petty cash limit	Group Director of Finance & Digital	Deputy Director of Finance
SFI	39.2.7	Ensuring that arrangements for the financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE	Group Director of Finance & Digital	Managing Director of QEF Subsidiary
External Borrowing				
SFI	40.1	Advise the Board on borrowing and payment of PDC	Group Director of Finance & Digital	Deputy Director of Finance
SFI	40.3	Ensure that all loans are clearly documented	Group Director of Finance & Digital	Deputy Director of Finance
SFI	40.2	Report to Board periodically on PDC, loans and overdrafts	Group Director of Finance & Digital	Deputy Director of Finance
SFI	40.4	Application for an external loan or overdraft	Group Director of Finance & Digital	Deputy Director of Finance
SFI	40.5	Preparation of procedural instructions on the application of loans and overdrafts	Group Director of Finance & Digital	Deputy Director of Finance
SFI	40.6	Approval of short term borrowing	Group Director of Finance & Digital	Deputy Director of Finance
Investments				
SFI	40.8.2	Advising the Board on investment strategy	Group Director of Finance & Digital	Deputy Director of Finance

SFI	40.8.3	Preparation of procedural instructions on the operation of investment accounts	Group Director of Finance & Digital	Deputy Director of Finance
Capital Investment				
SFI	41.1.1.a	Ensuring adequate approval process and investment appraisal systems for all capital projects	Chief Executive	Managing Director of QEF Subsidiary
SFI	41.1.1.b	Authority for the management of all capital schemes to be delivered on time and to cost	Chief Executive	Managing Director of QEF Subsidiary
SFI	41.1.1.d	Seeking support for schemes where required from commissioners or NHS England	Chief Executive	
SFI	41.1.5.	Issue procedures for the regular reporting of capital expenditure	Group Director of Finance & Digital	Deputy Director of Finance
SFI	41.1.6.c	Authority to commit capital expenditure in year (post approval of capital programme)	See Financial Delegation limits	
SFI	36.11.5	Approval to accept a successful tender	Chief Executive – see Financial Delegation limits	
Asset Registers				
SFI	41.2.1.	Responsible for maintenance of register of assets	Chief Executive	Group Director of Finance & Digital
SFI	41.2.5.	Approve procedures for reconciliation of fixed asset balances	Group Director of Finance & Digital	Deputy Director of Finance

SFI	41.2.8.	Calculation of capital charges	Group Director of Finance & Digital	Deputy Director of Finance
Security of Assets				
SFI	41.3.1.	Overall control of fixed assets	Chief Executive	Executive Directors
SFI	41.3.2.	Approval of asset control procedures	Group Director of Finance & Digital	Deputy Director of Finance
Stores and Receipt of Goods				
SFI	42.2.1	Systems of control	Chief Executive	Group Director of Finance & Digital
SFI	42.2.1.	Day to day responsibility for stores	Supplies Manager, Pharmacy Manager, Catering Manager, Pathology Manager.	
SFI	42.2.3.	Procedures and systems for regulation of stores	Group Director of Finance & Digital	Deputy Director of Finance
SFI	42.2.4	Stocktaking arrangements	Group Director of Finance & Digital	Deputy Director of Finance
SFI	42.2.5	Approval of alternative arrangements where a complete system of stores control is not justified	Group Director of Finance & Digital	Deputy Director of Finance
SFI	42.3.6	System of review of slow moving and obsolete items and their subsequent disposal / replacement	Delegated Manager	Group Director of Finance & Digital
SFI	42.3.1.	Identification of staff authorised to requisition and accept goods supplied via the NHS Supply Chain central warehouses	Chief Executive	Group Director of Finance & Digital
Disposals and Condemnations, Losses and Special Payments				

SFI	43.1.1.	Preparation of detailed procedures	Group Director of Finance & Digital	Deputy Director of Finance
SFI	43.1.3.a	Approval of condemnations/disposals	Group Director of Finance & Digital	Authorised condemning officer
SFI	43.2.1.	Preparation of procedural instructions on the recording and accounting for condemnations, losses and special payments.	Group Director of Finance & Digital	Deputy Director of Finance
SFI	43.2.2.	Duty to report actual and suspected losses to the head of department who will then inform the Chief Executive, Group Director of Finance or officer charged with responsibility for responding to concerns involving losses	All Staff	
SFI	43.2.2.	Notification to External Audit of frauds and the NHS Counter Fraud Authority	Group Director of Finance & Digital	Deputy Director of Finance
SFI	43.2.4.	Notification to the Board and External Audit of losses caused by theft, arson, neglect of duty or gross carelessness	Group Director of Finance & Digital	Deputy Director of Finance
SFI	43.2.5	Approval of losses	Group Audit Committee	
SFI	43.2.6.	Safeguarding of Trust assets in bankruptcies and liquidations	Group Director of Finance & Digital	Deputy Director of Finance
SFI	43.2.8.	Maintenance of losses register	Group Director of Finance & Digital	Deputy Director of Finance
SFI	43.2.9.	Receive reports on all losses and special payments	Group Audit Committee	
Information Technology				
SFI	44.1.1.	Responsibility for the accuracy and security of computerised data	Group Director of Finance & Digital	Chief Digital Information Officer

SFI	44.1.3.	Publication of Freedom of Information Publication Scheme	Group Director of Finance & Digital	Chief Digital Information Officer
SFI	44.3.	Responsibility for contracts for computer services with other health bodies or outside agencies	Group Director of Finance & Digital	Chief Digital Information Officer
SFI	44.4.1.	Identification of organisational risks arising from the use of IT	Group Director of Finance & Digital	Chief Digital Information Officer
Patients' Property				
SFI	45.2	Notification to patients/guardians prior to admission of Trust responsibilities and liabilities around patient's property	Chief Executive	Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals
SFI	45.3	Provision of detailed written instructions on the collection, custody, investment, recording, safekeeping and disposal of patients' property	Group Director of Finance & Digital	Deputy Director of Finance
SFI	45.4	Agreements for the provision of separate accounts for patients' monies	Group Director of Finance & Digital	Deputy Director of Finance
Charitable Funds				
SFI	46.1.3	Ensuring that each trust fund is appropriately managed	Group Director of Finance & Digital	Deputy Director of Finance
SFI	46.1 – 46.7	Ensuring charitable funds are managed and administered appropriately and in line with the SFIs	Charitable Funds Committee	Group Director of Finance & Digital
SFI	46.8	Responsible for all aspects of the management of the investment of charitable funds	Charitable Funds Committee	Group Director of Finance & Digital

SFI	46.9	Authorisation of expenditure from charitable funds	Charitable Funds Committee and as per delegated limits	
SFI	46.10	Approval of bank accounts for charitable funds	The Trust as corporate trustee (via the Board of Trustees)	
SFI	46.11	Preparation of annual accounts, returns and reports as required by the Charity Commission and Charitable Trust	Charitable Funds Committee	Group Director of Finance & Digital
SFI	46.14	Ensure that investment certificate and deeds of properties are held in a safe and secure location	Group Director of Finance & Digital	Deputy Director of Finance
SFI	46.15.1	Giving executors good discharge from their duties	Group Director of Finance & Digital	Deputy Director of Finance
SFI	46.15.2	Application to obtain grant of probate	Group Director of Finance & Digital	Deputy Director of Finance
Retention of Records				
SFI	48.1	Maintaining archives for all records required to be retained	Chief Executive	Group Director of Finance & Digital
SFI	48.3	Authorisation to destroy records	Chief Executive	Group Director of Finance & Digital
Risk Management and Insurance				
SFI	49.1.1.	Ensuring that the Trust has a programme of risk management	Chief Executive	Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals
SFI	49.1.1.	Programme of risk management approved and monitored	Board of Directors	Group Audit Committee

SFI	49.2.1.	Determine whether the Trust will insure through the risk pooling schemes administered by NHS Resolution	Board of Directors	
SFI	49.3	Ensuring insurance arrangements entered into are appropriate and complementary to the risk management programme and that the Board is informed of the nature and extent of the risks. Ensuring there are documented procedures to cover the management of claims and payments	Managing Director of QEF Subsidiary	

Financial delegation levels

Delegated area	Specifics / values	Authority delegated to:	Notes
2. Management of Budgets			
2.1 Annual Revenue Budgets	At Trust Level	Chief Executive (CEO) or Deputy Chief Executive	
	At Clinical Business Unit	Operational Director	
	At Corporate Departments	Corporate Departments Director	
	At Department Level	Nominated Budget Manager	
2.2 Annual Capital Budget	At Trust Level	Chief Executive or Deputy Chief	

Delegated area	Specifics / values	Authority delegated to:	Notes
	At Capital Scheme Level – Non IT	Executive Managing Director QEF	
	At Capital Scheme Level - IT	Chief Digital Information Officer	
2.3 Business Cases – Revenue	All Business Cases	Chief Executive via Senior Management Team	
	Over £1,000,000	Trust Board	
2.4 Business Cases – Capital	All Business Cases	Chief Executive via Executive Management Team	
	Over £1,000,000	Trust Board	
2.5 Patient & Non Patient Care Contracts (Income to the Trust)	Up to £250,000	Operational Director for Clinical Business Units, Relevant Director for Corporate Business Units	
	Up to £500,000	Executive Director	
	Over £500,000	Chief Executive or Deputy Chief Executive	
3. Non Pay Expenditure			
3.1 Revenue Expenditure Approval of orders for non-discretionary goods or services within delegated budgets	Up to £2,500	Band 6 or above	In the absence of the Chief Executive and Group Director of Finance & Digital delegated to Deputy Chief Executive and Deputy Director of Finance
	Up to £10,000	Band 8 or above	
	Up to £50,000	Operational Director, Head of Corporate Service	
	Up to £100,000	Executive Director	

Delegated area	Specifics / values	Authority delegated to:	Notes
	Over £100,000	Chief Executive, Group Director of Finance & Digital	
Approval of orders for discretionary goods or services within delegated budgets	Up to £50,000 Up to £100,000 Over £100,000	Operational Director, Head of Corporate Service Executive Director Chief Executive, Group Director of Finance & Digital	In the absence of the Chief Executive and Group Director of Finance delegated to Deputy Director of Finance
Invoice Verification	All - Where the charge forms part of a previously authorised contract e.g. Pharmacy/ Roche et	Band 6 or above	The placing of the order is the point at which expenditure is approved. All invoices should be supported by a purchase order except for agency and LET doctor invoices.
3.2 Capital Expenditure			
Individual Capital Project - Non IT Schemes Placing of contracts/orders for capital projects approved by Trust Board	Up to £50,000 Up to £100,000 Over £100,000 Over £1,000,000	Delegated to QEF Head of Estates Delegated to QEF Director of Finance QEF Managing Director QEF Chair	In the absence of the Chief Executive and Group Director of Finance delegated to Deputy Director of Finance
Individual Capital Project- IT Schemes	Up to £50,000 Up to £100,000	Chief Digital Information Officer Executive Director	In the absence of the Chief Executive and Group Director of

Delegated area	Specifics / values	Authority delegated to:	Notes
Placing of contracts/orders for capital projects approved by Trust Board	Over £100,000 Over £1,000,000	Chief Executive, Group Director of Finance & Digital Trust Board	Finance delegated to Deputy Director of Finance
In year changes to approved capital projects	Up to £1,000,000 Over £1,000,000	Chief Executive, via Executive Management Team Trust Board	
Land transactions	All	Trust Board	
4. Quotation and Tendering Recorded on the Tender registered held in the Procurement Department			
4.1 Expenditure	From £1,000 to £9,999 From £10,000 up to £49,999 From £50,000 up to Sterling thresholds (UK procurement thresholds) (for the application of the Public Contract Regulations) Public Procurement thresholds from 1st January 2024 inclusive of Value Added Tax: Supplies and services Central Government -	2 verbal quotes 3 quotations (electronic) Formal tender process (electronic) advertised on Contract finder Above thresholds are subject to Public Contract Regulations & relevant procurement process	All elements of expenditure refer to the cumulative cost over the whole life of the contract, and all limits are exclusive of VAT.

Delegated area	Specifics / values	Authority delegated to:	Notes
	£139,688 Supplies & services all other contracting authorities £214,904 Works - £5,372,609 Light Touch Regime - £663,540 Concession Contracts - £5,372,609		
4.2 Contract Awards			
The award of new contracts	Up to £50,000 Up to £100,000 Over £100,00 Over £1,000,000	Operational Director, Head of Corporate Service Executive Director Chief Executive, Group Director of Finance & Digital Trust Board	
4.2 Specific Circumstances In certain very specific circumstances (as stated in the Standing Financial Instructions) the Chief Executive, Director of Finance or nominated deputy may waive the quotation process and the CEO or D of F&D may waive the tender process.	Waiving of Standing Orders up to £150,000 per annum exclusive of VAT Waiving of Standing Orders Over £150,000 exclusive of	Supply and Procurement Committee Chief Executive< Deputy Chief Executive and Group Director of	Chair's action can be sought in exceptional circumstances between the meeting of the Supply and Procurement Committee To meet on a timely basis as a triumvirate.

Delegated area	Specifics / values	Authority delegated to:	Notes
	VAT	Finance and Digital	
5. Pay Expenditure **5.1 Substantive Staff**	Appointment to funded post Skill mix of existing funded posts within overall available pay budgets Appointment to unfunded post Skill mix of existing funded posts above available pay budgets	Vacancy Control Panel Operational Director or Head of Service via budget virement process Chief Executive or Deputy Chief Executive approval via Vacancy Control Panel Chief Executive or Deputy Chief Executive approval via budget virement process	
5.2 Packages	Special severance payments Removal Packages up to £8,000	Chief Executive, Group Director of Finance & Digital and subject to NHS England and HMT approval and ratification by Trust Board Deputy Director of POD and Deputy Director of Finance	

Delegated area	Specifics / values	Authority delegated to:	Notes
5.3 Lease Cars	Lease Car Application	Operational Director or Head of Service	
5.4 Agency Staff	Registered Nursing/AHP/Scientific & Professional Agency On Framework in hours 8am to 5pm	Operational Director via agency booking process	
	Registered Nursing/AHP/Scientific & Professional Agency On Framework out of hours	Strategic on Call via agency booking process	All agency requests only allowable in exceptional circumstances only necessitated by clinical risk.
	Registered Nursing/AHP/Scientific & Professional Agency Off Framework in hours 8am to 5pm	Chief Operating Officer, Other Executive Directors, via agency booking process	
	Registered Nursing/AHP/Scientific & Professional Agency Off Framework out of hours	Strategic on Call via agency booking process	
	Healthcare Assistant On Framework in hours 8am to 5pm	Chief Nurse, Deputy Chief Nurse via agency booking process	
	Healthcare Assistant On Framework out of hours	Strategic on Call via agency booking process	

Delegated area	Specifics / values	Authority delegated to:	Notes
	Healthcare Assistant Off Framework in hours 8am to 5pm	Chief Nurse, Deputy Chief Nurse via agency booking process	
	Healthcare Assistant Off Framework out of hours	Strategic on Call via agency booking process	
	Medical Staff On Framework below £100 or published price cap in hours 8am to 5pm	Executive Director via agency booking process	
	Medical Staff On Framework within price cap out of hours	Strategic on Call via agency booking process	In absence of Chief Executive delegated to Deputy Chief Executive
	Medical Staff Off Framework above £100 or published price cap 8am to 5pm	Chief Executive or Deputy Chief Executive via agency booking process	
	Medical Staff Off Framework above £100 per hour or price cap out of hours	Strategic on Call via agency booking process with retrospective approval by Chief Executive or Deputy Chief Executive	
	Any shift by individuals costing more than £100 per hour or above published price cap –see link in notes section	Executive Management Team and ICB as per published guidance	Agency-rules-changes-for-2023-to-2024.pdf (england.nhs.uk)

Delegated area	Specifics / values	Authority delegated to:	Notes
	Non Clinical Agency Staff including domestics and porters – see link in notes section		https://www.england.nhs.uk/wp-content/uploads/2023/04/Agency-rules-changes-for-2023-to-2024.pdf
5.5 Bank Staff	Medical Staff Bank - payment to cover vacant shift in funded establishment	Band 8 or above, example Service Line Manager	
	Nurse/AHP/Scientific & Therapeutic	Band 8 or above, example Service Line Manager	
5.6 Waiting List Initiatives	Waiting list initiative – payment of WLI to deliver additional activity in excess of core job plan.	Operational Director via waiting list approval process	
6. Losses and Special Payments Losses and Special Payments other than those settlements made on behalf of the Trust by the NHS Resolution under the Clinical Negligence Scheme for Trusts (CNST) and the Risk Sharing Pooling Scheme for Trust (PSPT):	All	Chief Executive, Group Director of Finance & Digital	
	Losses and gifts over £300,000	Approval by NHSE and HMT	
	Special payments of any kind over £95,000	Approval by NHSE and HMT	

Delegated area	Specifics / values	Authority delegated to:	Notes
7. Fee Setting	Agreeing Contract Prices with Commissioners Income Generation Scheme Prices Private Patient Fees Overseas Visitor Fees Trading Agencies Charges	Group Director Finance, Deputy Director of Finance	
8. Tenders for Services to be Provided Where tenders are prepared to bid for services these shall be approved prior to submission.	All	Group Director of Finance & Digital via, Senior Management Team	
9. Charitable Funds **9.1 Fund Expenditure** **9.2 Charitable Fund** **9.3 Investment**	 Up to £2,500 From £2,501 to £10,000 Over £10,000 Responsibility for the Investment Policy for Charitable Funds	 Funds Managers Charitable Funds Operational Group Charitable Fund Committee acting on behalf of the Corporate Trustee Charitable Fund Committee acting on behalf of the Corporate Trustee	Per item
10. Hospitality 10.1 Gift and Hospitality Register 10.2 Declarations 10.3 Authorisations	Keeping the register Declaring hospitality received over £25 Authorisation over £25	Trust Board Secretary All staff Chief Executive, Group Director of Finance & Digital	

Delegated area	Specifics / values	Authority delegated to:	Notes
11. Condemning Disposal All capital items that are obsolete, redundant, or beyond economic repair must be disposed of in accordance with the agreed procedure and reported to Associate Director of Financial Services for inclusion in the losses report. Disposal of assets with a net book value:	All	Delegated to QEF	
12. Banking Arrangements Signing of payable orders and cheques or other orders drawn on the Trust's commercial bank accounts and the Government Banking Service Accounts:	Up to £25,000 Over £25,000	1 x signatory nominated in writing by the Group Director of Finance & Digital 2 x signatories nominated in writing by the Group Director of Finance & Digital	
13. Virements All virements between non pay subjective codes. Virement to fund Category D requests	Up to £50,000 Up to £100,000 Over £100,000 Up to £5,000	Operational Director, Head of Corporate Service Executive Director Chief Executive, Group Director of Finance & Digital Operational Director, Head of Corporate Service	

Delegated area	Specifics / values	Authority delegated to:	Notes
All virements between pay and non-pay codes	All	Chief Executive, Group Director of Finance & Digital	Can only happen in exceptional circumstances

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 7ii

Report Title:	**QE Facilities' Standing Financial Instructions, and Scheme of Delegation**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 March 2024			
Author:	Philip Glasgow, QEF Director of Finance			
Executive Sponsor:	Gavin Evans, QEF Managing Director			
Report presented by:	Gavin Evans, QEF Managing Director			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To formally ratify the QEF Standing Financial Instructions and Scheme of Delegation			
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*	QEF Board – December 2023 Group Audit Committee – March 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 QEF Standing Financial Instructions, and Scheme of Delegation were approved by the QEF Board in December 2023. • For completeness they were presented to the Group Audit Committee in March 2024 for information and comparability with the Trust versions of these documents. There were no identified issues. • It is noted that the SFIs and Scheme of Delegation require formal ratification by the Group Board of Directors.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Group Audit Committee and QEF Board formally recommends that the Board of Directors ratify the QEF Standing Financial Instructions and Scheme of Delegation.			

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:	Having effective governance should support the Group in developing a strong control environment, which in turn supports the delivery of the strategic objectives.				
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** ☒		

The levels of authorisation summarised below should all be viewed in line with the specific policies and procedures that apply.

DELEGATED AREA	SPECIFICS/ VALUES	AUTHORITY DELEGATED TO	NOTES
1. General			
1.1 Appointment of Director Alternatives		Reserved to Shareholder	
1.2 Issuance of New Share Capital		Reserved to Shareholder	
1.3 Appointment of New Directors		Reserved to Shareholder	
1.4 Appointment of the Chair of the Company		Reserved to Shareholder	
1.5 Amendment to the Scheme of Delegation		Reserved to Shareholder	
1.6 Suspension of the Standing Orders		Reserved to Shareholder	
1.7 Act as Liaison Between the Shareholders and the Company. Represent Shareholder Interests at Board Meeting		Chairman	
1.8 Monthly Oversight Meeting	1.8.1 Monthly Meeting to Discuss a Report on Company Performance, Projects, Risks etc	QEF Managing Director QEF Finance Director Shareholder Representatives	
1.9 Related Party Transactions	1.9.1 Maintain Schedule of Related Parties and relevant interests, ensuring that at all times, transactions with related parties are clearly understood and specifically authorised as such	QEF Board	
1.10 Use of the Company Seal		QEF Board	
1.11 Appointment of Sub Committees	1.11.1 Approval of terms of reference for the sub committees and delegation of powers to sub committees.	QEF Board	
1.12 HR Support	1.12.1 Authorising access to specialist	QEF Board	

DELEGATED AREA	SPECIFICS/ VALUES	AUTHORITY DELEGATED TO	NOTES
	HR support via the outsourced service provision agreement.		
1.13Corporate Governance	1.13.1 Review of Overall Corporate Governance Arrangements	QEF Board	
1.14 Litigation	1.14.1 Prosecution, commencement, defence or settlement of litigation, or an alternative dispute resolution mechanism.	QEF Board/QEF Managing Director/QEF Finance Director	
2. Corporate Strategy			
2.1 Report Company's Performance, Risks and Activities	2.1.1 External to Shareholder Responsibility from Clause 1.8.	Chairman	
2.2 Internal Responsibility to the Chairman/Board for Day to Day Management of Company Operations		QEF Managing Director	
2.3 Setting Overall Governance	2.3.1 Within Group Governance Structure	QEF Board	
2.4 Setting Company Mission, Vision, Values and Standards	2.4.1 In line with over-arching Group Strategy	QEF Board	
2.5 Approval and Delivery of Company's Strategic Aims and Objectives		QEF Finance Director	
2.6 Delivery of Company's Strategic Aims and Objectives		Heads of Service, or authorised nominated deputy.	
2.7 Management of System of Internal Control	2.7.1 Management of System of Internal Control	Heads of Service, or authorised nominated deputy.	Leading to competent and prudent management, sound planning, adequate accounting and other records and compliance with statutory and regulatory obligations.
	2.7.2 Monitor compliance with the system of controls to ensure compliance with laws and regulations governing the retention of	QEF Board	

DELEGATED AREA	SPECIFICS/ VALUES	AUTHORITY DELEGATED TO	NOTES
	documentation.		
3. Articles of Association			
3.1 Articles of Association Amendments	3.1.1 Extension of the company's activities into significant new business or geographic areas. 3.1.2 Any decision to cease to operate all or any material part of the company's business.	Shareholder Chairman QEF Managing Director	
4. Financial Plans			
4.1 Annual Revenue Budgets	4.1.1 Preparation of Plan 4.1.2 Approval of Annual Plan 4.1.3 Approval of Variation to Plan 4.1.4 Agree Scheme of Budget Delegation 4.1.5 Communication of Budget to Budget Holders 4.1.6 Formally Accept Delegated Budgets	QEF Finance Director QEF Board QEF Board QEF Board QEF Finance Director Delegated Budget Holders	
4.2 Annual Financial Plan and Medium Term Financial Plan	4.2.1 Preparation of Plan 4.2.2 Approval of Plan 4.2.3 Approval of Variation to Plan	QEF Finance Director QEF Board QEF Board	
4.3 Budget Monitoring	4.3.1 Preparation of Budget Monitoring Reports 4.3.2 Monitoring of Performance Against Budget 4.3.3 Authorisation of Budget Overspend 4.3.4 Provision of Information to Support Effective Budget Monitoring	QEF Finance Director QEF Board QEF Board Delegated Budget Holders	Highlighting any overspend or irregular expenditure as soon as it becomes known or suspected.

DELEGATED AREA	SPECIFICS/ VALUES	AUTHORITY DELEGATED TO	NOTES
4.4 Statutory Accounts	4.4.1 Preparation of Directors Report	QEF Board	
	4.4.2 Preparation of Strategic Report	QEF Board	
	4.4.3 Receive, review and approve Annual Financial Statements	QEF Board	
	4.4.4 Preparation of Compliant Annual Financial Statements	QEF Finance Director	
	4.4.5 Uploading to Companies House within required timescale	QEF Finance Director	
	4.4.6 Monitoring that Books of Account are Being Appropriately Maintained	QEF Board	
	4.4.7 Ensuring Books of Account and Appropriately Maintained	QEF Finance Director	
	4.4.8 To comply with the arrangements for the audit of the Group financial statements	QEF Finance Director	
	4.4.9 To arrange external audit of the Annual Financial Statements as required by the Companies Act	QEF Board	
	4.4.10 To facilitate the effective completion of external audit where required	QEF Finance Director	
4.5 Books of Account and Accounting Policies	4.5.1 Selection of Accounting Policies	QEF Board	
	4.5.2 Recommendation of Accounting Policies	QEF Finance Director	
	4.5.3 Maintenance of a clear record of the assets of the company including physical verification	QEF Finance Director	
4.6 Business Cases – Capital	4.6.1 Recommendation of QEF Capital Programme to Support Annual and Medium Term Financial Plans	QEF Finance Director	
	4.6.2 Approval of QEF Capital Programme to annual value of £100,000	QEF Board	

DELEGATED AREA	SPECIFICS/ VALUES	AUTHORITY DELEGATED TO	NOTES
	4.6.3 Recommendation of QEF Capital Programme in Excess of £100,000 to Shareholder 4.6.4 Approval of QEF Capital Programme over £100,000 per annum	QEF Board Reserved to Shareholder	
5. Non Pay Expenditure 5.1 Departmental Revenue Expenditure Goods or services ordered 5.2 Capital Individual Capital Project	 Up to £5,000 Up to £10,000 Up to £25,000 Up to £50,000 Up to £100,000 Over £100,000 Within capital project budgetary limit Over capital budgetary limit (by scheme)	 Band 6 (or equivalent) or above Band 8 (or equivalent) or above Head of Service Associate Director QEF Finance Director QEF Managing Director Delegated to QEF nominated officer To be approved by Capital Steering Group and ratified by EMT	 Authorisation of invoices does not in itself commit as expenditure.
6. Quotation and Tendering Recorded on the Tender registered held in the Procurement Department 6**.1 Expenditure**	 6.1.1 Ensuring that all procurement and contracting is conducted in accordance with the Ultimate Parent Undertaking's standing instructions and orders governing this area. 6.1.2 Compliance with the terms of the outsourced service provision for non pay expenditure £1,000 to £9,999 From £10,000 up to £49,999 From £50,000 up to Sterling	 QEF Finance Director Budget Holders Heads of Service 2 verbal quotes 3 quotations (electronic) Formal tender process (electronic) advertised on	

DELEGATED AREA	SPECIFICS/ VALUES	AUTHORITY DELEGATED TO	NOTES
	thresholds (UK procurement thresholds) (for the application of the Public Contract Regulations) Public Procurement thresholds from 1st Jan 2022 (Inc. VAT): Supplies and services - £138,760 Works - £5,336,937 Light Touch Regime - £663,540 Concession Contracts - £5,336,937	Contract finder	All elements of expenditure refer to the cumulative cost over the whole life of the contract, and all limits are exclusive of VAT.
6.2 Contracts	6.2.1 Signing of Contracts	QEF Board/QEF Managing Director	
	6.2.2 Ensuring adherence to the Ultimate Parent tendering and contracting arrangements.	QEF Board	
6.3 Procurement Sign off	6.3.1 Expenditure on Contract with Gateshead Health Foundation Trust	Trust SPC	
	6.3.2 Expenditure on Contract with Third Party Organisations or QEF Standalone Expenditure	QEF SPC	
7. Pay Expenditure **7**.1 Posts	7.1.1 Establishment of post	QEF Managing Director via SLT VCF Process	Includes restructure within delegated budget.
	7.1.2 Appointment to funded post	QEF Managing Director via SLT VCF Process	
	7.1.3 Appointment to unfunded post	Trust EMT Approval after QEF Managing Director Approval	
	7.1.4 Amendment of an existing post	QEF Managing Director via SLT VCF Process	
	7.1.5 Propose Changes to Staff Remuneration	QEF Board	
	7.1.6 Approve Changes to Staff Remuneration	Reserved to Shareholder	

DELEGATED AREA	SPECIFICS/ VALUES	AUTHORITY DELEGATED TO	NOTES
7.2 Payroll Service	7.2.1 Ensuring Compliance with Requirements of Outsourced Payroll Service within area of Delegation	Delegated Budget Holders	
	7.2.2 Monitoring of Outsourced Service Provision	Heads of Service or authorised/nominated officer	QEF HR Lead
7.3 Staff Employment Contracts	7.3.1 Monitoring compliance with instruction to issue all staff with a contract of employment.	QEF Board	
7.4 Directors Remuneration	7.4.1 Agreeing remuneration of Directors	Reserved to Shareholder	
8. Losses and Special Payments Losses and Special Payments other than those settlements made on behalf of the Trust by the NHS Litigation Authority under the Clinical Negligence Scheme for Trusts (CNST) and the Risk Sharing Pooling Scheme for Trust (PSPT):			
8.1 Losses and Special Payments excluded from above	All	QEF Finance Director	
9. New Third Party Contracts			
9.1 Tender Documents	9.1.1 Approval of Tenders including Margin, Service Levels and Submission Up to £100,000 From £100,001 to £1,000,000 Over £1,000,000	 QEF Finance Director QEF Managing Director QEF Board	
9.2 New Business Approval	Up to £100,000 From £100,001 to £1,000,000 Over £1,000,000	QEF Managing Director QEF Board Trust Board	
10. Hospitality 10.1 Gift and Hospitality Register	Keeping the register	QEF Company Secretary	
10.2 Declarations	Declaring hospitality received over	All staff	

DELEGATED AREA	SPECIFICS/ VALUES	AUTHORITY DELEGATED TO	NOTES
	£25		
10.3 Authorisations	Authorisation over £25	QEF Managing Director/QEF Finance Director	
11. Asset Disposal			
11.1 Disposal of assets with a net book value:	Under £5,000 Between £5,001 and £20,000 Over £20,000	QEF Finance Director QEF Board Reserved to Shareholder	
12. Banking and Borrowing Arrangements			
12.1 Banking Arrangements	12.1.1 Recommendation of Banking Arrangements 12.1.2 Approval of Banking Arrangements	QEF Finance Director QEF Board	Subject to considerations of value for money.
12.2 Authorised Signatories	12.2.1 Recommend a scheme of authorised signatories for banking 12.2.2 Approve scheme of authorised signatories for banking	QEF Finance Director QEF Board	
12.3 Borrowing	12.3.1 Determine Borrowing Requirement to Fund Medium Term Financial Plan 12.3.2 Operate Short Term Funding Arrangements 12.3.3 Define and Delegate Short Term Funding Arrangements 12.3.4 Recommend Long Term Borrowing Proposals to Shareholder 12.3.5 Approve Long Term Borrowing	QEF Board QEF Finance Director QEF Board QEF Board Reserved to Shareholder	Recommend approval of such if judged necessary and affordable
12.4 Cash Management	12.4.1 Ensure an effective cash management system. 12.4.2 Monitoring of the system for the management of cash	QEF Finance Director QEF Board	

DELEGATED AREA	SPECIFICS/ VALUES	AUTHORITY DELEGATED TO	NOTES
13. IT Service Provision 13.1 Outsourced IT Contract	13.1.1 Ensuring compliance with the terms of the outsourced IT service provision 13.1.2 Ensuring the information security held on unsupported platforms and applications. 13.1.3 Approving arrangements to secure IT assets and data 13.1.4 Monitoring arrangements to ensure that core operational platforms and applications are adequately secured and maintained	Heads of Service QEF Board QEF Board QEF Board	
14. Risk Management 14.1 Risk Management	14.1.1 Responsibility for the organisations risk appetite as set out in its emerging, open, managed & Corporate risk registers aggregated with the risk profiles and tolerances set out on the in insurance pre-renewal profiles. 14.1.2 Identification, treatment and management of organisational and operational risk 14.1.3 To monitor the management of risk, including the efficacy of identified mitigations in sufficient detail to support the preparation of the Group Annual Governance Statement.	QEF Board Heads of Service QEF Board	
15. Insurance **15.1.1 Corporate and Top Up Insurances over the NHSLA**	15.1.1 Maintain and update cover details, comply with term of the insurance agree mitigation of the	Heads of Service Budget Holders Delegated Individuals	

DELEGATED AREA	SPECIFICS/ VALUES	AUTHORITY DELEGATED TO	NOTES
	policies by sound management, training, reporting, advising of changes in limits and liabilities, policy and compliant processors.		
	15.1.2 Preparation and sourcing of the appropriate corporate Insurance's to mitigate business risk and contingency	QEF Board	
	15.1.3 Approval of the appropriate corporate Insurance's to mitigate business risk and contingency	QEF Managing Director	

A limited company, part of the
Gateshead Health NHS
Foundation Trust Group

QEF Standing Financial Instructions

Issue number	Review date	QEF approval	Shareholder approval	Revision details
1.0	01/02/2017			New document
1.1	19/02/2018		Audit committee	Procurement elements of the SFI's updated
1.2	02/07/2021	SMT	Audit Committee	Revision updating formal tender process 1.Opening of formal tenders (i) page 19 of 28 2. Opening and register of tenders 20,21 of 28 Amendments to authorised officers to include board members in this process

Contents

1. Introduction

1.1. These standing financial instructions should be read in conjunction with the [approved] articles of association and [approved] scheme of reservations and Delegation for the company which define the role, remit and function of the board of directors.

1.2. Notwithstanding the specific clauses set out below the board of directors and employees of the company are responsible for the security of the property of the company, avoiding loss, achieving economy and effectiveness in the use of resources and complying with these standing financial instructions.

1.3. These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the company and its constituent departments including seconded or sub contracted individuals. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Finance Director.

1.4. Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Finance Director must be sought before acting.

1.5. Officers of the company should note that the SFI's and the Scheme of Delegation do not contain every legal obligation applicable to the company. The company and each officer of the company must comply with all requirements of legislation (which shall mean any statute, subordinate or secondary legislation, any enforceable community right within the meaning of section 2(1) of the European Community Act 1972 and any applicable judgement of a relevant court of law which is a binding precedent in England), and all guidance and directions binding on the company. Legislation, guidance and directions will impose requirements additional to SFI's and the Scheme of Delegation of Powers. All such legislation and binding guidance and directions shall take precedence over standing orders, SFI's and the Scheme of Delegation, which shall be interpreted accordingly.

2. Committees and Scheme of Delegation

2.1. Under the powers of clause 11 (1) the board of directors shall appoint a Remuneration committee if it is considered necessary. The Board of directors will agree a proposal for an Internal Audit provision and will ensure that the company reports to the Group Audit Committee and ensures that third party assurance reports are made. An audit charter will govern the company and included will be the right of the Finance Director to bypass reporting lines and report directly to the Group Audit Committee if he/she consider it necessary.

2.2. The board of directors shall agree terms of reference for any committee establishing the role, remit and authority of the committee, with such terms being taken to, and approved by, a properly convened meeting of the board of directors.

2.3. Revisions to the terms of reference for the sub committees can only be considered and approved by a further properly convened meeting of the board of directors.

3. Business Plan, Budgets and Estimates

3.1. The Finance Director will prepare and submit to the board of directors an annual financial plan which will set out as a minimum

3.1.1. A projected profit and loss account for the period profiled by [month/quarter]

3.1.2. A projected balance sheet for each [month/quarter] of the plan

3.1.3. A cashflow projection for each [month/quarter]

3.1.4. A summary of the significant assumptions and estimates upon which the plan is based

3.1.5. A narrative summary of the underlying work stream assumptions

3.1.6. A summary of the demand for, sources of and application of capital throughout the lifetime of the plan

3.1.7. An analysis of the critical risks to the plan and proposed mitigations of these risks

3.2. The annual plan referred to in 3.1.1.1. will be presented alongside a medium term financial plan which will comprise an annual projected profit and loss account, balance sheet and cashflow statement covering a period of not less than 3 full financial periods.

3.3. The annual financial plans, once approved by the board of directors, shall form the basis of the annual budgets for the company.

3.4. The annual financial plan shall be prepared and presented to the board of directors no later than February to ensure that the company is able to present an approved budget to the ultimate parent undertaking by March so that the board of the ultimate parent undertaking can properly form a view of the overall activities of the group.

3.5. The board of directors shall provide any and all information required by the board of the ultimate parent undertaking to all that board to reach a full understanding of the plans for the company

3.6. Not withstanding the requirements of clause 3.1.5 the subsidiaries annual plan, medium term financial plan and annual budgets remain at all times the responsibility of the board of directors of the company; this responsibility cannot

be delegated by the board of directors nor can accountability for the plan or underlying assumptions be assumed by the ultimate parent undertaking or any committee of that undertaking.

3.7. The Finance Director will prepare and present a report in sufficient detail and in a format agreed by the board of directors to allow the board of directors to monitor performance against the plan and trading accounts of the operating segments of the company. These reports will be presented not less than 6 times per year at intervals of not more than 2 months.

3.8. Whilst the Finance Director may rely upon the outsourced finance function for the preparation of the monitoring reports responsibility of such reports remains with the Finance Director who must take such steps as they judge fit to satisfy themselves as to the reliability of the report presented.

3.9. The board of directors may, at any time during the year, at their discretion vary the annual financial plan so long as such a variation is agreed upon at a properly convened meeting of the board of directors. In this event it is the responsibility of the Finance Director to ensure that such variations, and the implications for the annual and medium term financial plans, are communicated to the budget holders and the board of the ultimate parent undertaking.

3.10. Whilst the responsibility for the delivery of the annual financial plan, the resulting budget and the medium term financial plan rests with the board of directors the board of directors may, at their discretion, delegate the day to day management of any or all of the budget to such persons within the company as they judge fit and competent to perform such a task.

3.11. Such delegation as set out at 3.2.1 does not reduce or diminish the board of directors' accountability for the delivery of the annual plan, the budget or the medium term financial plan and, therefore, the board of directors must implement such training, monitoring and performance management processes as they judge necessary to satisfy themselves that the day to day management of the budget does not jeopardise delivery of the plans.

3.12. The board of directors shall, when agreeing the annual budget as set out in clause [3.1.3] also agree a formal scheme of budgetary delegation which will stipulate;

3.12.1. To whom elements of the budget are to be delegated,

3.12.2. The precise value of the budget delegated,

3.12.3. the delegated authority to vire between budgets where multiple elements of the budget are delegated to a single individual

3.12.4. the purpose and intention for which the budgets are delegated

3.13. All budget holders approved within clause [3.2.3] will be required to formally acknowledge and accept the annual budget as approved by the board of directors.

3.14. All budget holders are required to provide all information and explanations as required by [who] in support of effective management of the budgets.

3.15. The Finance Director is responsible to ensuring that budget holders are provided with sufficient detailed and timely information to allow them to effectively manage the budget properly delegated to them. This information may be provided by the outsourced financial services provider however the Finance Director remains responsible for ensuring that the service and information provided is fit for purpose and in line with the agreed terms of that service.

3.16. Any budget holder who becomes aware of the existence of circumstances set out in clauses 3.2.7.1 to 3.2.7.4 has a duty and an obligation to notify the Finance Director and to make sufficient enquiries and investigations so as to allow a clear statement of the quantum, circumstances and mitigating actions to be taken.

3.16.1. of a risk of an overspend against the delegated budget

3.16.2. of an actual overspend against the budget

3.16.3. that delegated funds have been used for a purpose other than that intended

3.16.4. that delegate funds have been lost due to perpetration of fraud against the company

4. Financial Statements and Books of Account

4.1. The board of directors shall be responsible for preparing the Board of directors Report, Strategic Report and Financial Statements and for maintaining the books of account of the Company in accordance with the requirements of the Companies Act 2006.

4.2. Where employees are engaged in the business of maintaining these records it is for the board of directors to judge whether the manner of discharge is to their satisfaction.

4.3. The board of directors shall ensure that the books of account are maintained to a sufficient standard to support fully the preparation of group consolidation financial statements in line with the deadline set by NHSI, the NHS FT Regulator, for the year of account.

4.4. The board of directors are responsible for the selection of accounting policies and estimation techniques (including asset lives and depreciation methods) which are appropriate to the company.

4.5. The company’s accounts must be audited by an auditor appointed by the board of directors. The companies audited annual accounts must be consolidated and presented at a public meeting as part of the group accounts of the parent company.

5. Banking

5.1. The board of directors are responsible for approving the banking arrangements of the company

5.2. The board of directors will review the commercial banking arrangements of the company at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the company's commercial banking business.

5.3. The day to day operational management of the banking facility will be provided by the company's finance function however the board of directors are responsible for ensuring that an appropriate scheme of authorisation and approved signatories is agreed and maintained.

6. Borrowing

6.1. The board of directors are responsible for reviewing the capital requirements of the company and determining what borrowing levels are required to support the business plan.

6.2. The board of directors are responsible for reviewing the affordability of any borrowing or other financing proposal.

6.3. The board of directors may, at their discretion, delegate authority to the Finance Director to operate a short term financing facility so as to manage working capital within the limits of the annual plan agreed by the board of directors. Any such delegation should be confined to the quantum and duration set out in the plan as approved by the board of directors.

6.4. All long term borrowing must be explicitly approved by the board of directors at the point of contractual agreement.

6.5. The board of directors must notify the ultimate parent undertaking of any intention to seek long or short term borrowing so that the ultimate parent undertaking can understand the implications for the financial regulation of that undertaking. In the event that, in the opinion of the board of directors of the ultimate parent undertaking, the implications for the financial regulation of that undertaking is unacceptable the ultimate parent undertaking may, at its discretion, direct the board of directors of the company not to enter into the borrowing arrangement.

6.6. The Finance Director must prepare detailed procedural instructions concerning applications for loans and overdrafts if/when these are utilised by the Company.

7. Cash

7.1. The board of directors are responsible for:

7.1.1. approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
7.1.2. ordering and securely controlling any such stationery;
7.1.3. the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
7.1.4. prescribing systems and procedures for handling cash and negotiable securities on behalf of the company.
7.1.5. Where the above are carried out by means of a service level agreement with the parent company the board of directors must ensure that the systems and practices are subject to internal and external assurance.

7.2. Company monies shall not under any circumstances be used for the encashment of private cheques or IOUs.
7.3. All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the board of directors.
7.4. The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the company or any superior undertaking is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the company and group from responsibility for any loss.

8. Assets

8.1. The board of directors are responsible for ensuring that

8.1.1. any QEF specific capital expenditure is subject to an appropriate investment appraisal process including the production of a detailed business case which is commensurate with the extent of investment proposed prior to any contractual commitment being entered into
8.1.2. any capital expenditure is entered into only where it is supported by the annual financial plan and medium term financial plan including consideration of any borrowing or financing implications
8.1.3. any programme of capital expenditure is appropriately monitored by the board of directors so as to ensure that programmes are delivered on time and within the agreed cost envelope
8.1.4. where the capital programme requires interim stage payments that the cashflow projection supports the making of these stage payments.

8.1.5. That the project is undertaken in full compliance with relevant taxation schemes and guidance

8.1.6. where capital expenditure is incurred in connection with services rendered to a third party the nature of the relationship between the company and the third party the responsibility for the resulting asset and any indemnities or warranties is clearly understood. When acting as an agent of the parent company the subsidiary will act in accordance with the Standing Financial Instructions and scheme of delegation of the parent at all times.

8.2. The board of directors are responsible for maintaining a clear and accurate record of the assets held by the company and for taking such steps as are necessary to ensure the security of these assets and for ensuring that they remain in a useable condition. Securing the assets shall include

8.2.1. recording managerial responsibility for each asset;

8.2.2. identification of additions and disposals;

8.2.3. identification of all repairs and maintenance expenses;

8.2.4. physical security of assets;

8.2.5. periodic verification of the existence of, condition of, and title to, assets recorded;

8.2.6. identification and reporting of all costs associated with the retention of an asset;

8.2.7. reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

9. Stocks

9.1. Subject to the responsibility of the Finance Director for the systems of control, overall responsibility for the control of stores shall be delegated to the Head of Procurement by the Managing Director. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Finance Director. The control of the company Pharmacy stocks shall be the responsibility of the superintendent pharmacist; the control of any fuel oil of a designated estates manager.

9.2. The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by a designated manager / superintendent pharmacist. Wherever practicable, stocks should be marked as company property.

9.3. The Finance Director or nominated officer shall set out procedures and systems to regulate all stores (and storage systems / devices) including records for receipt of goods, issues, and returns to stores, and losses.

9.4. Stocktaking arrangements shall be agreed with the Finance Director and there shall be a physical check covering all items in store at least once a year.

9.5. Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

9.6. The designated Manager/ superintendent pharmacist shall be responsible for a system approved by the Finance Director for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Finance Director any evidence of significant overstocking and of any negligence or malpractice (see also article 10 Disposals and Condemnations and article 15 Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

10. Disposals and Condemnation

10.1. The Finance Director shall prepare a procedure for the disposal and condemnation of assets under the control of the company.

10.2. When it is decided to dispose of a company asset, the business manager or authorised deputy will determine and advise the Finance Director of the estimated market value of the item, taking account of professional advice where appropriate.

All unserviceable articles shall be:

10.3. condemned or otherwise disposed of by an employee authorised for that purpose by the Finance Director;

10.4. recorded by the Condemning Officer in a form approved by the Finance Director which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Finance Director.

10.5. The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Finance Director who will take the appropriate action.

10.6. Where capital assets are lost, scrapped, otherwise disposed of the board of directors are responsible for authorising this event.

10.7. The board of directors are responsible for ensuing proper conduct in connection with any asset disposals including taking sufficient steps to ensure that any related party transactions are clearly understood and authorised in advance by the board of directors

10.8. Any disposal of assets must have appropriate approval. If the value of the disposal exceeds the agreed deminimus level then it will require approval of the parent company board and any such disposal must be reported to the parent company accordingly. All disposals of assets must comply with the company procedure.

11. Terms of Service, Allowance and Payment of Staff

11.1. The Board of directors shall

11.1.1. Ensure an annual review of remuneration, allowances and terms of service is conducted to determine whether an uplift should be awarded and, if so, the level of uplift to all employees [excluding the board of directors]

11.1.2. Oversee and advise on any severance packages

11.1.3. Give full consideration to succession planning for the senior employees of the company taking into account the challenges and opportunities facing the company and the planned future developments as set out in the business plan developed in accordance with clause [3] of this orders and instructions.

11.1.4. The manpower plans incorporated within the budget described in Section 3, once approved by the Board, shall form the funded establishment.

11.2. The funded establishment may not be varied without approval of the Board of Directors.

11.3. No director or employee of the Company may engage, re-engage or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to any changes in any aspect of remuneration

11.3.1. Unless authorised to do by authority of the Board; or

11.3.2. Unless within the limit of their delegated budget and funded establishment.

11.4. The Head of Estates will be responsible for monitoring the provision of service against the terms of the Service Level Agreement

11.5. Appropriately nominated managers have delegated authority for:

11.5.1. Completing time records and other notifications in accordance with the Service Level Agreement and in the form stipulated by that agreement

11.5.2. Submitting time records and other notifications in accordance with the agreed timetables as set out in the Service Level Agreement

11.5.3. Submitting termination forms in the form and manner prescribed by the Service Level Agreement immediately upon knowing the effective date of an employee’s resignation, termination or retirement

11.6. The board of directors shall ensure that:

11.6.1. All employees are issued with a contract of employment in a form approved by the Board and which complies with employment legislation; and

11.6.2. Variations to and termination of contracts of employment are dealt with.

The board of directors may elect, by decision of the Board, to delegate this responsibility

11.7. Expert support in matters of Human Resource Management will be conducted by the company's HR manager

11.8. Clauses related to the remuneration of the board of directors are addressed in the Article 19 of the Articles of Association.

12. Non-Pay Expenditure

12.1. The approved level of non pay expenditure and delegated responsibility shall be set through the budget setting process set out at clause 3.

12.2. The procurement of non pay expenditure shall be carried out by the procurement department of the company. Budget holders are required to comply with the procurement processes of the company.

13. Information Technology and information governance.

13.1. Information technology services shall be provided by the outsourced provider and the terms of this service will be governed by an SLA to be agreed by the board of directors. The Managing Director is responsible for managing the provision of this service to the terms set out in the SLA.

13.2. The outsourced provider shall be responsible for the security of computerised financial data relating to the company so long as it is stored in an agreed manner on supported assets and platforms.

13.3. The board of directors are responsible for the security of any financial data relating to the company not held on agreed supported assets and platforms.

13.4. The board of directors are responsible for agreeing any necessary procedures to ensure adequate (reasonable) protection of the company's data, programs and computer hardware for which the board of directors are responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998.

13.5. The board of directors are responsible for the maintenance and updating of all known software systems used by the company. This responsibility will extend to the following.

13.5.1. Devising and implementing any necessary procedures to ensure adequate (reasonable) protection of the company's data and programmes from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998

13.5.2. Ensuring that adequate (reasonable) controls exist over data entry, processing, server storage and output to ensure security, privacy, accuracy, completeness and timeliness of the data, as well as the efficient and effective operation of the system. Server storage must be contained within the service level agreement setting out the limits required.

13.5.3. Ensuring that adequate controls exist such that the compute operation is separated from development, maintenance and amendment.

13.5.4. Ensuring that an adequate management (audit) trail exists through the computerised system

13.5.5. Ensuring that new system amendments are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

13.5.6. Ensuring that any system acquisition, development and maintenance are in line with the medium term plan.

13.5.7. Ensuring that the data produced for use with financial systems is adequate, complete and timely and that a management (audit) trail exists

13.5.8. Ensuring that the board of directors have ready access to the data

13.5.9. Ensuring that such computer audit reviews as the board of directors may consider necessary are carried out

13.6. The board of directors shall ensure that risks to the company arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk.

14. Internal Audit

14.1. The QEF board of directors shall comply with the reasonable requests of the Internal Auditors to Gateshead Health NHS FT who may, from time to time and in accordance with the agreed audit plan and scope of work, require access to Company staff and documentation. (See Appendix 1 INTERNAL AUDIT PROVISION TO QE FACILTIES AND SUBSEQUENT REPORTING TO TRUST AUDIT COMMITTEE)

15. Losses and Special Payments

15.1. The board of directors are responsible for recording and communicating any losses to the ultimate parent undertaking to assist the board of directors of that

entity in forming a view of the governance arrangements throughout the group. In discharging this responsibility the board of directors of the company should have regard to the arrangements and requirements set out in the corporate governance manual of the ultimate parent undertaking. The formation of a Losses and Special payments system will be provided by the outsourced finance function who will apply the same rules and regulations as per the parent company. Any diversion must be agreed by the Board of Board of directors and reported to the Audit Committee of the parent.

15.2. All staff and board of directors of the company have a duty to prevent loss due to fraud. Where such a loss is known or suspected to have occurred the board of directors should be notified immediately unless it is suspected that the board of directors are implicated in the loss, in which case the director of finance of the ultimate controlling entity should be notified.

16. Counter Fraud

16.1. The board of directors shall co-operate with the local counter fraud specialist appointed by the ultimate parent undertaking providing all information and explanations required upon request

16.2. The board of directors shall co-operate with NHS Protect (and / or any prevailing Internal Audit function) providing all information and explanations required upon request.

16.3 all reports of fraud are to be escalated to the QEF MD and or Finance director in the fist instance.

17. External Audit

17.1. The board of directors shall make available all books and records, information and explanations to the auditors of the Group Financial statements as the auditor judges necessary to form an opinion on the financial statements of the Group

17.2. The board of directors shall, at all times, comply with Companies Act 2006 requirements to subject the financial statements of the Company to external audit.

17.3. [where the company meets the criteria for exemption from audit the board of directors may, at their discretion, take such exemptions]

17.4. The board of directors shall be responsible for the appointment of an external auditor where appropriate in conjunction with the parent company.

18. Risk Management

18.1. The board of directors shall use the Group system of risk management which is commensurate with the risks faced and sufficient to allow them to make a clear

statement of assurance to the ultimate parent undertaking in support of the group wide Annual Governance Statement

18.2. The board of directors shall determine the appropriate form and content of the risk management process and shall be responsible for communicating the requirements to the staff of the company.

18.3. The ultimate parent undertaking may, at its discretion, and solely in connection with its duty to prepare a group wide Annual Governance Statement, require the board of directors to amend, enhance or otherwise adapt their process for the recording and management of risk.

19. Retention of Documentation

19.1. The board of directors shall be responsible for maintaining archives for all records required to be retained in accordance with the department of health guidance, the limitation act 1980 and any contractual warranties or commitments entered into in the normal course of business.

19.2. The records held in archives shall be capable of retrieval by authorised persons.

19.3. Records held in accordance with the latest Department of Health guidance shall only be destroyed at the express instigation of the board of directors. Detail shall be maintained of records destroyed.

20. Gifts, Hospitality, Related Parties and Interests.

20.1. Having due regard to relevant legislation such as the Bribery Act 2012 the board of directors shall implement a clear policy on the acceptance and offering of gifts and hospitality howsoever made.

20.2. The board of directors shall maintain a current and complete record of all such gifts and hospitality offered and received.

20.3. For the purposes of providing assurance to the parent undertaking the board of directors shall also have regard to relevant department of health guidance such as HSG (93) 5 “Standards of Business Conduct for NHS Staff”.

20.4. The board of directors shall ensure that a current register of all relevant related parties to and interests of the board of directors and employees of the company is maintained at all times and in such a way as to be available for inspection upon request.

20.5. Canvassing of the board of directors or senior officers directly or indirectly for any appointment with the company shall disqualify the candidate for such an appointment.

20.6. Candidates for any company appointment are to be notified that, when making their application, they must disclose in writing whether to their knowledge they are related to any director or senior employee of the company.

Failure to disclose such a relationship shall disqualify a candidate and, if appointment, render them liable to instant dismissal.

20.7. The board of directors and senior officers of the company shall disclosure to the board of directors the existence of any relationship, contact or canvassing, whether formal or informal, as soon as they become aware that the counterparty has begun to seek an appointment with the company.

21. Tendering and Contracting.

21.1.1 These clauses shall apply to all expenditure proposed in connection with all equipment, consumables, materials, services, acquisition or other major works to capital assets carried out in respect of the company assets or on behalf of third parties or otherwise connected to the principle purpose of the company. Where doubt exists as to whether an element of expenditure should be covered by clause 11 or clause 12 guidance should be sought from the Head of Estates, Head of Procurement or the Director of Finance.

21.1.2 Tendering and Contracting will be in line with the parent company tendering and contracting arrangements. Public procurement regulations will apply and be adhered to.

21.2 Duty to comply with Standing Orders and Standing Financial Instructions.

The procedure for making all contracts by or on behalf of the QEF shall comply with these Standing Orders and Standing Financial Instructions (except where SO. 3.26 Suspension of Standing Orders is applied).

21.3 Legislation and Guidance Governing Public Procurement.

QEF shall comply with the Public Contracts Regulations 2015, and all relevant EC Directives. Such legislation shall be incorporated into the QEF Standing Orders and SFI's.

21.4 Capital Investment.

QEF shall comply as far as is practicable with the requirements of the guidance published on capital investment and Protection of Assets – Guidance for NHS Foundation Trusts in respect of capital investment and estate and property transactions.

21.5 Formal Competitive Tendering.

21.5.1 General Applicability.

QEF as a subcontractor to the trust shall ensure that competitive tenders are invited for:

• the supply of goods, equipment, consumables, materials and manufactured articles services (other than specialised services sought from or provided by the DH);
• for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens);
• the disposals of any tangible or intangible property (including equipment, land and intellectual property).

21.5.2 **Exceptions and instances where formal tendering need not be applied.**

Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the tender limits as specified in the Scheme of Delegation.
(b) where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with;
(c) regarding disposals
Formal tendering procedures **may be waived** in the following circumstances:
(d) in very exceptional circumstances where the Managing Director or Director of Finance decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate record;
(e) where the requirement is covered by an existing contract;
(f) where nationally negotiated agreements applicable to Foundation Trusts are in place, and have been approved by the Board;
(g) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;
(h) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;
(i) where specialist expertise is required and is available from only one source;
(j) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;
(k) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;
(l) for the provision of legal advice and services providing that any legal firm or partnership commissioned by QEF is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for

England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.
The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.
(m) where allowed and provided for in the Capital Accounting Manual. The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate QEF record and reported to the Board or as delegated to the Supply Procurement Committee.

21.6 **Fair and Transparent Competition.**

Except where the exceptions set out in SFI 21.5.3 apply and permit the use of a single tender action, QEF shall ensure that for all invitations to tender, whether regulated by the Public Contracts Regulations 2015 or not, the tender process adopted is fair and transparent and is considered in a fair and transparent manner.

21.7 **Items which subsequently breach thresholds after original approval.**

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Managing Director or Director of Finance, and be recorded in an appropriate QEF record.

21.8 . **Contracting/Tendering Procedure**

21.8.1 **Electronic Tendering Procedure**

(a) **Invitation to tender**

(i) All invitations to tender on a formal competitive basis shall state the date and time as being the latest time for the receipt of tenders and that no tender will be considered for acceptance unless submitted through the appropriate process, as instructed within the tender documentation electronically.
(ii) Every tender for goods and services shall embody the adopted contract terms and conditions as appropriate with the contract form required for the specific goods and services.

(b) **Receipt, Safe Custody and Record of Formal Tenders**

(i) An auditable date/time stamp of all actions must be automatically created

through the eTendering service. This audit trail will be available for review in real-time
(ii) Tenders may not be 'opened' or supplier information viewed until the predefined time and date for opening has passed.

(c) **Opening Formal Tenders**

(i) Electronic Tenders – A QE Facilities Board Member who has declared no conflict of interest in regards the current tender will be able to access the electronic tenders and release them once the time and date for opening has passed.
(ii) An auditable log of actions, which may not be edited, will be created including, but not limited to:

- Time/date stamp of 'publication' of tender by buyer
- Time/date stamp of any amendments to a 'published' tender and or response to a tender (eg if any buyer tender document attachments are added/amended during the process).

(d) Every tender for goods, materials, services or disposals shall contain and comprise appropriate terms and conditions regulating the conduct of the tender, shall contain appropriate terms and conditions on which the contract is to be awarded and shall be substantively based to regulate the provision of the goods, materials, services to be provided or in relation to the disposal.
(e) Every tender for building or engineering works (except for maintenance work, when *Estatecode* guidance shall be followed) shall contain terms and conditions on which the contract to be awarded and shall be substantively based that shall embody or be in the terms of the current edition of a suitable and recognised industry form of contract, including but not limited to, one of the Joint Contracts Tribunal Standard Forms of Building Contract or the NEC standard forms of contract or Department of the Environment (GC/Wks) standard forms of contract; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A) or (in the case of civil engineering work) the General Conditions of Contract recommended by the institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents may be modified (in minor respects only), to cover special features of individual projects.

21.9 **Invitation to tender – Manual Process.**

If the mechanism for tendering through the electronic tender process as defined in

21.9.1 Above fails then the following procedures must be adhered to
(a) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(b) All invitations to tender shall state that no tender will be accepted unless:

(i) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Manging Director or nominated Manager;
(ii) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

(c) **Receipt and safe custody of tenders.**

The Managing Director or his nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening. The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

(d) **Opening tenders and Register of tenders**

(e) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by one Board Member whom has declared no conflict of interest in any element of that tender exercise. Tenders will be opened in a single process in the presence of an authorised and independent witness who will have the responsibility to record the event. These Individuals must not have been involved in the tender process or be from the originating department. The head of Procurement on behalf of the Manging Director shall maintain a list of designated officers to open tenders. A copy of this list will be held with the Register of Tenders.

(f) A member of the QEF Board will be required to be one of the two approved persons present for the opening of tenders estimated above the tender limit.
The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority This applies to both paper and electronic tenders.

(g) The ‘originating’ Department will be taken to mean the Department sponsoring or commissioning the tender. The tender process will include the preparation, specification and evaluation of the tender.

(h) The involvement of QEF Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance or any approved Senior Manager from the Finance Directorate from serving as one of the two Independent officers appointed to open tenders.

(i) All Executive Directors/members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

(j) Every tender received shall be marked with the date of opening and initialled by those present at the opening.

(k) A register shall be maintained by the Managing Director or a person authorised by him, to show for each set of competitive tender invitations despatched:

- the subject of the tendering exercise;
- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present.
A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (SFI 22.6.4).

Board members are required to raise with the Managing Director, QEF Chairperson or Company Secretary as soon as a conflict of interest arises.

21.10 **Admissibility of Tenders.**

(a) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the QEF Board or under delegated limits as set out by the QEF Board.

(b) Where only one tender is received, the Manging Director and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

21.11 **Late tenders**

(a) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Managing Director or Director of Finance decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(b) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders, that, in the case of the manual procedure have been duly opened, have not left the custody of the Managing Director or his nominated officer. In the case of both the manual and electronic procedure, the process of evaluation and adjudication must not have been started.

(c) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Manging Director or his nominated officer.

21.16 **Acceptance of formal tenders.**

(a) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

(b) The lowest tender, if payment is to be made by QEF, or the highest, if payment is to be received by QEF, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(i) experience and qualifications of team members;
(ii) understanding of client's needs;
(iii) feasibility and credibility of proposed approach;
(iv) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the by the Supplies Procurement Committee and the reason(s) for not accepting the lowest tender clearly stated.

(c) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by QEF and which is not in accordance with these Instructions except with the authorisation of the Managing Director or the Director of finance.

(d) The use of these procedures must demonstrate that the award of the contract was:

(i) not in excess of the going market rate / price current at the time the contract was awarded;
(ii) that best value for money was achieved.
(e) All tenders should be treated as confidential and should be retained for inspection.

21.13 **Tender reports to the Trust Board**

Reports to the QEF Board will be made on an exceptional circumstance basis only.

21.14 **List of approved firms.**

(a) **Responsibility for maintaining list**

(i) A manager nominated by the Managing Director or Director of finance, shall on behalf of QEF maintain lists of approved firms where practicable from whom tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence QEF is satisfied. All suppliers must be made aware of the QEF terms and conditions of contract.

(ii) A firm will only be included on an approved list of tenderers if it complies with current VAT registration and insurance, and has a track record of doing so.

(iii) Where a firm is included on an approved list of tenderers, the Trust shall as a condition for inclusion ensure that it is satisfied that when engaging, training, promoting or dismissing employees or in any conditions of employment, that such firm shall not discriminate against any person because of colour, race, ethnic or national origins, religion or belief, age, disability, marital status or sex, and will comply with all relevant legislation including but not limited to,

- *the provisions of the Equal Pay Act 1970*
- *(Amendment) Regulations 2003, the Sex Discrimination Act 1975*
- *(Amendment Regulations 2008, the Race Relations Act 1976*
- *(Amendment) Regulations 2003, the Disability Discrimination Act 2005,*
- *the Employment Equality (Age) Regulations 2006, the Race Relations*
- *(Amendment) Act 2000, and any amending and/or related legislation or*
- *binding guidance.*

(iv) Where a firm is included on an approved list of tenderers QEF shall ensure that it is satisfied that such firm conforms with the requirements of the Health and Safety at Work et Act 1974, the Regulatory Reform (Fire

Safety) Order 2005, and any amending and/or other related legislation concerned with fire, the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution.

As part of any process to identify or review firms for an approved list, firms must provide to the appropriate manager a copy of its health and safety policy, risk assessments, safe systems at work, together with any licences for other statutory authorities or approvals and evidence of the safety of plant and equipment, when requested.

(b) **Building and Engineering Construction Works**

Invitations to tender shall normally be made to firms included on the approved list of tenderers. This will include firms selected on the Department of Health Procure 21 or the Construction Line Contractors list of primary supply chain partners.

(c) **Financial Standing and Technical Competence of Contractors.**

The Director of Finance may make or institute any enquiries he/she deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

(d) **Exceptions to using approved contractors.**

If in the opinion of the Manging Director and the Director of Finance or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Managing Director should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote. An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

21.14 **Quotations: Competitive and non-competitive.**

21.14.1 **General Position on quotations**

Quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income is in line with the limits identified in the Scheme of Delegation.

21.14.2 **Competitive Quotations**

(a) Quotations should be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of QEF Board.
(b) Quotations should be obtained using the electronic tendering portal or in writing to the Manging Director or his nominated officer unless it is determines that it is impractical to do so in which case quotations may be obtained verbally.
Confirmation of verbal quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.
(c) All quotations should be treated as confidential and should be retained for inspection. The Managing Director or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation , if payment is to be made by QEF, or the highest if payment is to be received by QEF, then the choice made and the reasons why should be recorded in a permanent record, or in the electronic system.

21.14.3 **Non-Competitive Quotations**

Non-competitive quotations in writing may be obtained in the following circumstances:

(a) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(b) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(c) miscellaneous services, supplies and disposals;

(d) single quotations may be obtained where the value of the goods or service is less than the quotation limit as stated in the Delegation of Powers.

(e) where goods or services are for building and engineering works the Director of Estates or nominated officer may approve single quotations where the value is between the quotation and tender limit as stated in the Standard Operating Procedures providing they certify that the first two conditions of this SFI (ie SFI 21.7.3 (a) and (b) apply).

21.14.4 **Quotations to be within Financial Limits**

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the managing Director.

21.15 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as set out in the schedule of reservation and delegation of powers.

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in the minutes.

21.16 Private Finance for Capital Procurement.

When the Board of Directors proposes, or is required to use finance provided by the private sector the following should apply:

(a) The Managing Director shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
(b) The Trust must seek all applicable approvals and the requirements of all guidance by the Independent Regulator including *Risk Evaluation for Investment Decisions by NHS Foundation Trusts.*
(c) The proposal must be specifically agreed by the Board of QEF .
(d) The selection of a contractor/finance company must be on the basis of competitive tendering.

21.17 Compliance requirements for all contracts.

The Board may only enter into contracts which comply with:

(a) the QEF Standing Orders and Standing Financial Instructions;
(b) EU Directives and other statutory provisions;
(c) any relevant directions including the Capital Accounting Manual, Estatecode and guidance on the Procurement and Management of Consultants;
(d) the same terms and conditions of contract as was the basis on which tenders or quotations were invited;
(e) in all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Managing Director shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

21.18 Personnel and Agency or Temporary Staff Contracts.

The Managing Director shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts. SEE Chris

21.19 Disposals

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Manging Director or his nominated officer;
(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;
(c) items to be disposed of with an estimated sale value of less than £500 this figure to be reviewed on a periodic basis;
(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
(e) assets required for the provision of mandatory goods and services are protected. They may not be disposed of without the agreement of Monitor.

21.20 **In-house Services.**

21.20.1 The Manging Director shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. QEF may also determine from time to time that in-house services should be market tested by competitive tendering.

21.20.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.
(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.
(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Director of Finance representative. A non-officer member should be a member of the evaluation team.

21.20.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

21.20.4 The evaluation team shall make recommendations to the Board of Directors following any benchmarking process or a market testing exercise carried out pursuant to SFI 21.2.

21.21 **Above Threshold of Procurement regulations 2015.**

When expenditure exceeds Public Procurement thresholds the Regulations a take president over QEF SFI's

22. Review and Revision to this document

24.1 This document shall judge to have effect until such time as it is replaced

24.2 This document may only be replaced following review by the QEF board of directors and acceptance of amendments at a properly convened meeting of the board of directors

24.3 Any changes to this document should be communicated to the Audit committee of the parent undertaking for the purposes of informing the group wide Annual Governance Statement

24.4 This document shall be reviewed by the QEF Company Secretary and Director of Finance, reviewed by the QEF board of directors at intervals of not less than 2 years.

24.5 This document should be approved by Trust board before adoption.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 8

Report Title:	**Deputy Chair and Senior Independent Director Roles**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 March 2024			
Author:	Jennifer Boyle, Company Secretary			
Sponsor:	Alison Marshall, Chair			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To seek Board approval for the appointment process for the Deputy Chair and Senior Independent Director roles			
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*	Role descriptions and remuneration proposals reviewed by the Council of Governors and Governor Remuneration 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*
	• The Deputy Chair and Senior Independent Director (SID) positions are important roles on the Board of Directors.
	• To support succession planning, personal development and good governance, the roles have been reviewed and a new approach is proposed, which enables two different Non-Executive Directors to undertake these additional responsibilities.
	• Both positions are appointments to be made by the Board (with consultation with the Council of Governors required in relation to the SID).
	• Key consideration for the Board in respect of this paper is:
	  • Whether the proposed role descriptions are reflective of good governance; and
	  • Whether the proposed appointment process is robust, fair and proportionate.
	• There are no additional financial implications associated with this paper.			

<table>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The Board of Directors is requested to:
Approve the overall plan to formally separate the Deputy Chair and SID roles;
Review and approve the role descriptions; and
Review and approve the proposed appointment processes for both contested and uncontested scenarios, providing the Chair and Chief Executive with delegated authority to make the appointments.</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">An effective and unitary Board is integral to the delivery of all strategic objectives.</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">None directly noted.</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>

Deputy Chair and Senior Independent Director

1. Executive Summary

1.1. In accordance with the Provider Code of Governance the Deputy Chair and Senior Independent Director (SID) positions are appointments to be made by the Board of Directors, with the requirement to consult with the Council of Governors on the appointment of the SID.

1.2. Recognising the differing (albeit complementary) roles of the Deputy Chair and SID it is proposed to formally split the roles and enable these roles to be held by two different Non-Executive Directors.

1.3. The remuneration for these roles is a matter reserved for the Council of Governors and the Council has approved an enhancement of £1,583 per annum for each role (equal to the total enhancement currently paid for the joint SID and Deputy Chair post, therefore no additional financial impact).

1.4. Formal role descriptions have been drafted for approval by the Board of Directors.

1.5. It is proposed that expressions of interest will be sought from Non-Executive Directors (noting that in accordance with the Provider Code of Governance the Audit Committee Chair is ineligible to apply).

1.6. Should more than one candidate express an interest in each post, then a formal process of appointment will be undertaken, with delegated authority sought from the Board to enable the Chair and Chief Executive to oversee the process and make the appointment.

1.7. The appointments will be effective from 1 July 2024.

2. Introduction

2.1. Mike Robson is the current Deputy Chair and SID. He will commence his final year as a Non-Executive Director on 1 July 2024.

2.2. Recognising that any potential re-appointment to the Deputy Chair and SID roles for Mike Robson would be for a maximum of one year, it would be prudent for the positions to be opened up for expressions of interest from other Non-Executive Directors. This would allow Mike Robson to support the transition of these roles to colleagues, providing opportunities for a comprehensive handover whilst being on hand to support and advise new postholders as they settle into the roles. The Chair has discussed the proposal with Mike Robson, who is supportive of the planned approach.

2.3. This paper sets out a proposed approach to the appointment of the Deputy Chair and SID for approval by the Board of Directors.

3. Key issues

3.1. As outlined in the introduction, at present the roles of Senior Independent Director and Deputy Chair have been held by the same individual, which remains a permitted route under the Code of Governance.

3.2. Given that the two roles have different responsibilities (albeit complementary at times), it is proposed to formally split these out with the potential for the roles to be held by two different Non-Executive Directors. This also provides more developmental opportunities for Non-Executive Directors and shares the workload more evenly.

3.3. Role descriptions have been drafted for both positions and are included for information at Appendix 1 (Senior Independent Director) and Appendix 2 (Deputy Chair).

3.4. The role descriptions have been developed to reflect the responsibilities of the positions in accordance with the Code of Governance and with reference to benchmarking across other trusts.

3.5. It is noted that the Code stipulates that the appointment of the Deputy Chair is a Board appointment. The appointment of the Senior Independent Director is also a Board appointment, but in consultation with the Council. The Code prohibits the Audit Committee Chair from occupying either position.

3.6. As both roles have close links to the Council of Governors, views of the Council and the Governor Remuneration Committee on the plans and role descriptions were sought. The Council and Committee expressed support for both role descriptions and proposed plans.

3.7. Should the Board of Director approve the enclosed job descriptions, the Chair will seek expressions of interest from Non-Executive Directors (excluding Mike Robson and Andrew Moffat as Group Audit Committee Chair). The appointment term would be for a period of 3 years, or until the end of the current / confirmed term of the successful Non-Executive Director (whichever comes soonest).

3.8. Previously, the additional remuneration for the joint role was £3,165. The remuneration of Non-Executive Directors, including enhancements, is a matter for the Council of Governors. On the recommendation of the Governor Remuneration Committee the Council approved a proposal to equally split the current enhancement between the Senior Independent Director role and the Deputy Chair, with each attracting remuneration of £1,583 per annum.

3.9. The following process is proposed, should the Board approve the delegation of authority to deliver the process to the Chair and Chief Executive:

- Early-April - Chair invites Non-Executive Directors to formally express an interest in the positions of Deputy Chair and SID with a 2 week period for the expressions of interest to be made.
- If there is only one expression of interest in either or both roles:
    - If there is only one expression of interest per position, then the Chair has delegated authority to confirm the appointments, with formal reporting back to the next Board in early June to ratify the appointments ahead of the start date of 1 July 2024. Given that all Non-Executive Directors have had positive appraisals (as well as fit and proper person compliance) and demonstrated strong commitment, it is not proposed that any further process would be required.
- If there are multiple expressions of interest in either or both roles:

- In late April each candidate for the contested role(s) will be invited to meet informally to discuss the role with the Chair, Chief Executive, a senior clinical colleague and the Chair of the Governor Remuneration Committee.
    - The clinical colleague would act as an independent advisor, ensuring that there is clinical input into the process, in line with our clinically-led principles.
    - The Chair of the Governor Remuneration Committee will also act as an independent advisor, bringing the Governor voice into the process. The Chair of the Governor Remuneration Committee will then be able to report to the Council of Governors on the fairness of the process and the outcome.
- Once the Chair and Chief Executive form a recommendation, taking into account the views of the independent advisors, the appointments can be formally ratified by the Board of Directors in early June 2024.

4. Solutions / recommendations

4.1. The Board of Directors is requested to:

- Approve the overall plan to formally separate the Deputy Chair and SID roles;
- Review and approve the role descriptions; and
- Review and approve the proposed appointment processes for both contested and uncontested scenarios, providing the Chair and Chief Executive with delegated authority to make the appointments.

Senior Independent Director – Role Description

Background

Section B of the Code of Governance for NHS Provider Trusts stipulates the following:

> 2.11. *In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders.*

The Code also states that:

> 2.13. *The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available.*

Appointment

The Senior Independent Director (SID) is a Non-Executive Director appointed by the Board of Directors in consultation with the Council of Governors.

The SID will be appointed for a period of three years, or until the end of their term of office, whichever is soonest.

The SID role will receive remuneration of £1,583 per annum in addition to the standard Non-Executive Director remuneration.

In accordance with the provisions of the Code of Governance the SID should not be the chair of the Audit Committee.

The SID should undertake that they will have sufficient time to meet the rigours of the role and the additional responsibilities.

In addition to the duties described here the SID has the same duties as the other Non-Executive Directors.

The Role of the SID in Relation to the Chair and Non-Executive Directors

As outlined in the Code of Governance the SID has a key role in supporting the Chair, acting as a sounding board.

The SID is responsible for leading the appraisal of the Chair. In accordance with the Code, as part of this role the SID should hold a meeting with the Non-Executive Directors in the absence of the Chair at least annually to inform the appraisal process.

There may be other circumstances where such meetings are appropriate. Examples include informing the re-appointment process for the Chair, where Governors have expressed concerns about the Chair or when the Board of Directors is experiencing a period of stress (as outlined in more detail in the section on the Board of Directors).

The Role of the SID and the Council of Governors

As previously outlined, the SID is responsible for conducting the Chair's appraisal. The SID must agree the process for conducting the Chair's appraisal with the Council of Governors, ensuring compliance with national directives which may be issued by regulators in relation to this.

As part of the process the SID will seek the views of the Council of Governors on the performance of the Chair to inform the appraisal and objectives.

The SID will be responsible for leading the succession process for the Chair, including where re-appointment is proposed and where a new appointment is sought. The SID will make recommendations to the Council of Governors and its Governor Remuneration Committee in this regard and be a source of advice to the Council on the process to be followed.

The SID is expected to attend meetings of the Council of Governors and maintain regular contact with the Council in order to obtain a clear understanding of Governors' views on key strategic issues facing the Trust. This is in accordance with Appendix B of the Code (paragraph 2.13).

The SID should make themselves available to Governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the Chair.

In rare cases where there are performance concerns about the Chair, the SID should provide support and guidance to the Council of Governors in seeking to resolve concerns, or in the absence of a resolution, taking formal action. The SID should liaise with the Lead Governor and Deputy Lead Governor in such circumstances.

The SID has a responsibility to act as the lead Board Member in engaging with the Council of Governors should the Council have significant concerns about the performance of the Board, compliance with regulatory requirements or the welfare of the Trust.

The SID also has a responsibility to form part of an appeal panel in the event that there is a potential instance of non-compliance with the Governor Code of Conduct, in which the outcome of an investigation or review has been appealed by either a complainant or respondent.

The Role of the SID and the Board of Directors

The SID is responsible for chairing the Group Remuneration Committee.

The SID should meet with the other members of the Board as and when deemed appropriate and act as an alternative point of contact for Executive Directors, if required, in addition to the normal channels of the Chair and Chief Executive.

In circumstances where the Board of Directors is undergoing a period of stress the SID has a vital role in intervening to resolve issues of concern. These might include unresolved concerns on the part of the Council of Governors regarding the Chair's performance; where the relationship between the Chair and Chief Executive is either too close or not sufficiently harmonious; where the Trust's strategy is not supported by the whole Board of Directors; or where key decisions are being made without reference to the Board or where succession planning is being ignored.

In the circumstances outlined above the SID will work with the Chair, other Directors and / or Governors, to resolve significant issues.

The Board of Directors and Council of Governors need to have a clear understanding of the circumstances when the SID might intervene so that the SID's intervention is not sought in respect of trivial or inappropriate matters.

Deputy Chair – Role Description

Background

Section B of the Code of Governance for NHS Provider Trusts stipulates the following:

> *2.5. The board should identify a deputy or vice chair who could be the senior independent director.*

Appointment

The Deputy Chair is a Non-Executive Director appointed by the Board of Directors.

The Deputy Chair will be appointed for a period of three years, or until the end of their term of office, whichever is soonest.

The Deputy Chair role will receive remuneration of £1,583 per annum in addition to the standard Non-Executive Director remuneration.

In accordance with the provisions of the Code of Governance the Deputy Chair should not be the chair of the Audit Committee.

The Deputy Chair should undertake that they will have sufficient time to meet the rigours of the role and the additional responsibilities.

In addition to the duties described here the Deputy Chair has the same duties as the other Non-Executive Directors.

General Duties

The Deputy Chair should play an important role to supporting the Chair particularly in undertaking the informal aspects of their role including attendance at meetings with external organisations (representing the Chair), stakeholder engagement, undertaking visits to services and making awards.

The Deputy Chair acts as a source of advice to the Chair as and when required.

The Deputy Chair shall chair meetings of the Board of Directors in the following circumstances:

- When the Chair of the Trust is unavailable to chair the meeting
- On occasions when the Chair of the Trust declares an interest that prevents them from taking part in the consideration or discussion

The Deputy Chair shall chair meetings of the Council of Governors in the following circumstances:

- When the Chair of the Trust is unavailable to chair the meeting
- On occasions when the Chair of the Trust declares an interest that prevents them from taking part in the consideration or discussion

The Deputy Chair shall deputise for the Chair at internal and external meetings and events when the Chair is unavailable.

The Deputy Chair shall act as a point of contact and liaison for Board Members, colleagues and stakeholders in the absence of the Chair.

If the Chair of the Trust is unable to discharge their functions for a period of time (for example due to long-term absence), the Deputy Chair will be the Acting Chair of the Trust until such time as the Chair is able to discharge their duties, or a new Chair is appointed by the Council of Governors.

Item 9

2024-2025
Strategic Objectives Leading Indicators

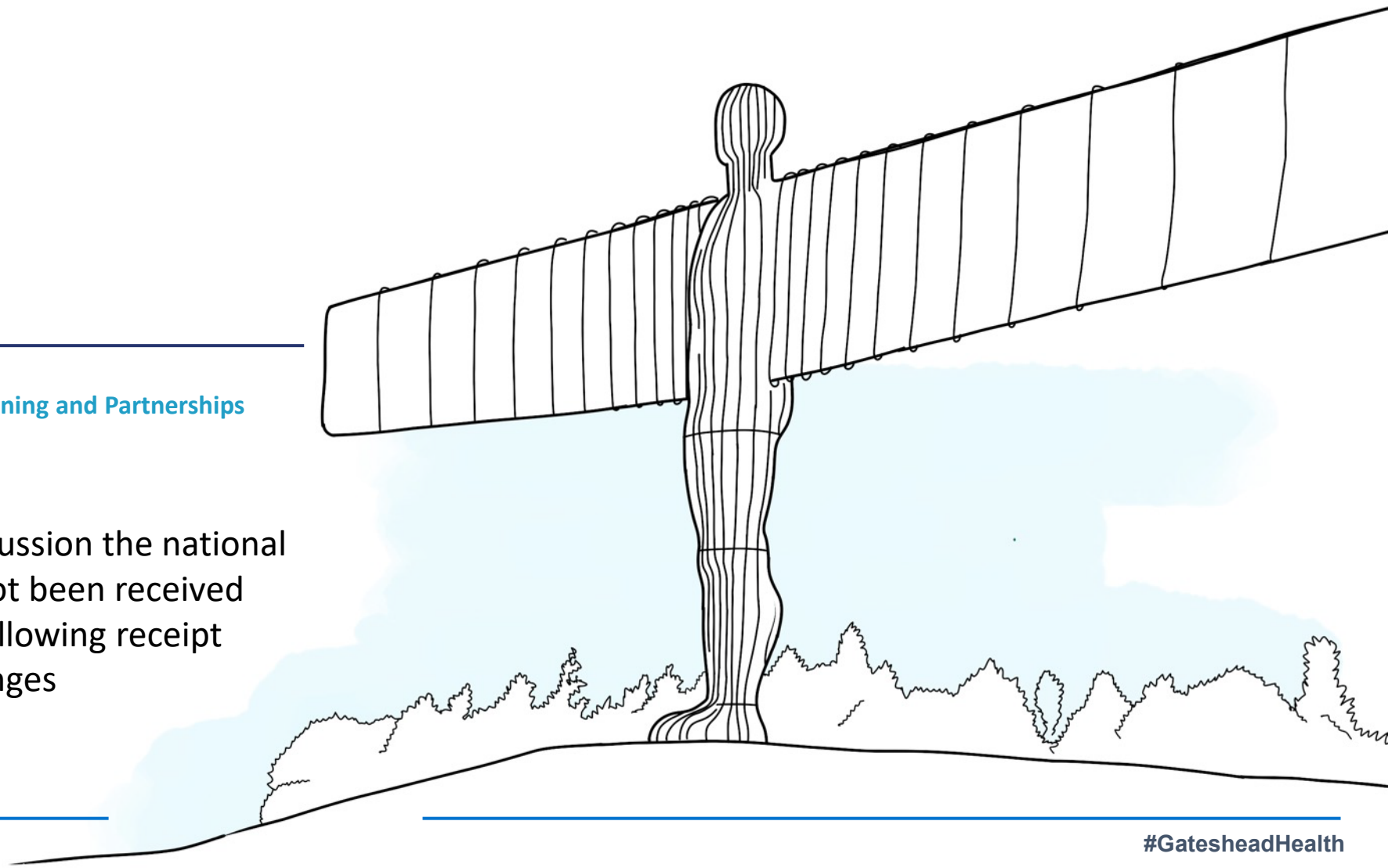
Jo Halliwell – Group Chief Operating Officer

Nicola Bruce – Interim Director of Strategy, Planning and Partnerships

Final draft version

Please note that at the time of discussion the national operating planning guidance has not been received therefore these will be reviewed following receipt which may inform subsequent changes

27 March 2024



Gateshead Health

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

2024/25 Strategic objectives to be agreed (1/5)

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

Current Objectives 23-24	Proposed Objectives 24-25
SA1.1 Continue to improve our maternity services in order to improve performance against key indicators and ensure improved patient outcomes by March 2024	Evidence full compliance with the Maternity Incentive Scheme (MIS) and the Ockenden actions
SA1.2 Develop and implement a continuous Quality improvement plan that enables the delivery of improved performance against key indicators by March 2024	Full delivery of the actions within the Quality Improvement Plan leading to improved outcomes and patient experience with particular focus on improvements relating to mental health, learning disabilities and cancer.
SA1.3 Ensure that there is a digital first and data led approach to transformation and improvement across all domains of activity in order to contribute to delivery of the key indicators by March 2024	Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.
	Agreement of an Estates strategy that provides a 3 year capital plan to address the key critical infrastructure and estates functional risks across the organisation

2024/25 Strategic objectives to be agreed (2/5)

2) We will be a great organisation with a highly engaged workforce	
Current Objectives 23-24	**Proposed Objectives 24-25**
SA2.1 Caring for our people in order to achieve improved compliance of key indicators by March 2024	Caring for our people in order to achieve the sickness absence and turnover standards by March 2025
SA2.2 Growing and developing our people in order to improve patient outcomes and reduce reliance on high cost agency staff by March 2024	Growing and developing our people in order to improve patient outcomes, reduce reliance on temporary staff and deliver the 24-25 workforce plan
SA2.3 Being a great place to work in order to improve staff survey outcomes and impact upon patient outcomes within 2-years	Evidence an improvement in the staff survey outcomes and increase staff engagement score

2024/25 Strategic objectives to be agreed (3/5)

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

Current Objectives 23-24	Proposed Objectives 24-25
SA3.1 Ensure that there is a strong focus on improving productivity and efficiency and best use of resources in everything that we do to meet the required performance standards/recovery requirements by March 2024.	Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025.
SA3.2 Achieve financial sustainability by in-year delivery of Trust CRP plan and development of robust sustainability plan for delivery within 3-years	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.

2024/25 Strategic objectives to be agreed (4/5)

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

Current Objectives 23-24	Proposed Objectives 24-25
SA4.1 Identify key local health inequalities challenges and ensure improvement plans are in place by March 2024	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
SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population	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'

2024/25 Strategic objectives to be agreed (5/5)

5) We will look to utilise our skills and expertise beyond Gateshead

Current Objectives 23-24	Proposed Objectives 24-25
SA5.1 We will look to utilise our skills and expertise beyond Gateshead in order to ensure organisational sustainability and contribute towards innovative care and provision within 23/24	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

2023/24 Leading indicators

Strategic Aims /Objectives	Lead Indicators (9)	Breakthrough Objectives (14)
Improve Productivity & Efficiency of our Services	Timely access to a bed, 60% within 1 hour of decision to admit (DTA)	Increase volumes of patients in the right bed
		Reduce Ave. ward moves per patient
	Zero Trolley Waits > 12 hours for admission	Improve ambulance handover times 65% within 15 mins
	Improved Length of stay ≤ 4 days	Reduce Time from Medically Optimised to Discharge
		Improve Readmission Rates
	Zero 52 week waiters by year end	Reduction in outpatient Waiting List
		Increase new outpatient Appointments
Continuously Improve Quality & Safety of our services for our patients	CQC Improvement Plan	Mortality within expected range HSMR
	C.Diff reductions per 100,000 bed days	Mortality within expected range SHMI
	Reduction n Harm from Falls	
We will be a great organisation with a highly engaged workforce	Maintain or improve on Staff Survey Staff Engagement Score 6.9	Vacancy Rate <5%
		Absence reduction< 5%
We will achieve financial sustainability	CRP Actioned (£15,900k)	Pay Spend (£249,822k)
		Non pay Spend (£132,424k)
		Achieve Plan

2024/25 Leading indicators - proposed

Strategic Aim	Lead Indicators	Breakthrough Indicators
We will continuously improve the quality and safety of our services for our patients	• Reduction in patient safety incidents linked to estate issues • Compliance with the Ockenden recommendations and Midwifery Incentive Scheme • Compliance with the quality improvement plan indicated by the % of actions on track	• *To be determined from the 12 patient safety indicators and 6 PSIRF strategic themes with a focus on Mental Health, Cancer and Learning Disabilities* • 25% reduction in critical infrastructure risk score • Achievement of a combined organisation PLACE score >95%
We will be a great organisation with a highly engaged workforce	• Improve the staff engagement score to 7.3 • Maintain the vacancy rate at <=2.5%	• Achievement of the internal turnover standard of 9.7% • Achievement of the internal sickness absence standard of 4.9% • Reduction in temporary staffing spend
We will enhance our productivity and efficiency to make the best use of our resources	• Non elective length of stay <4 days • Achievement of the four hour trajectory • Achievement of the 52 week standard by end Q1 and delivery of the trajectory for 40 weeks • Evidence achievement of the 24-25 financial plan	• Achievement of the trajectory to reduce >12 hour total time in department • Achievement of the trajectory to achieve RTA to bed within 1 hour • Increase in new outpatient activity • Reduce the number of patients with no criteria to reside • Forecast Outturn achievement • Reduction in run rate • CRP delivery

2024/25 Leading indicators - proposed

Strategic Aim	Lead Indicators	Breakthrough Indicators
We will be an effective partner and be ambitious in our commitment to improving health outcomes	• Evidence a reduction in the number of 'fragile' and 'vulnerable' services as a direct outcome of Alliance working • Evidence in an improvement in health inequalities in the key focus areas linked to the determinants of Health for Gateshead	• Improvements in smoking cessation rates • Reduction in the waiting times for paediatric autism pathway referrals • Reduction in the wait for gynaecology outpatients to no more than 26 weeks • Increase in the number of digital devices repurposed to the local community
We will develop and expand our services within and beyond Gateshead	• 0.5% increase in QEF externally generated turnover	

Next Steps

- Finalise the objectives and the leading indicators in line with national guidance where applicable
- Define the breakthrough indicators for clinical quality linked to the 12 patient safety indicators and 6 PSIRF strategic themes
- Revise the Board Assurance Framework for 24-25 taking the new strategic objectives into account
- Develop and implement a leading indicators dashboard
- Embed delivery and monitor performance / progress through the new governance arrangements
- Assured through Finance and Performance Committee to Trust Board

Gateshead Health NHS Foundation Trust

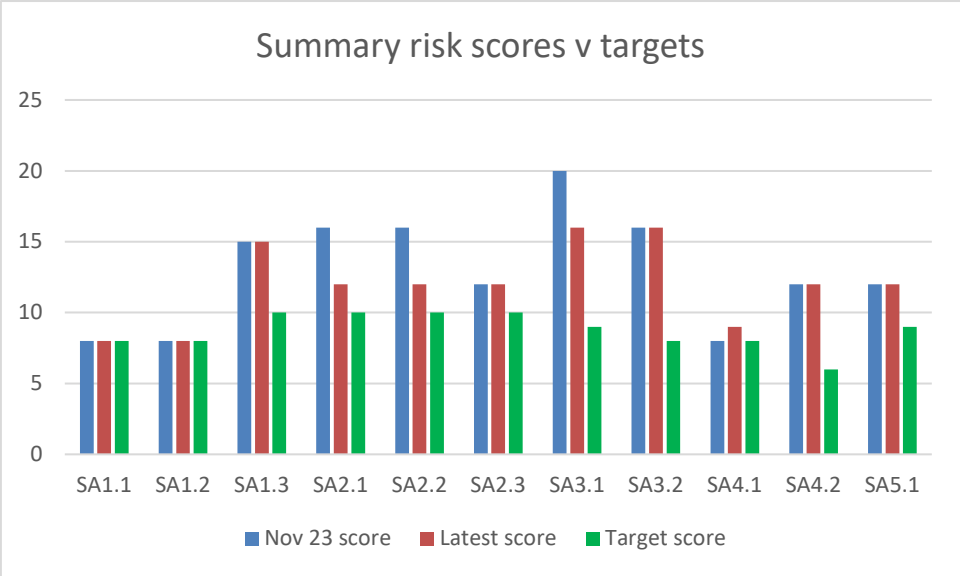
Report Cover Sheet Agenda Item: 10

<table>
<tr><td>Report Title:</td><td colspan="4">Board Assurance Framework Closure Report 2023/24</td></tr>
<tr><td>Name of Meeting:</td><td colspan="4">Board of Directors</td></tr>
<tr><td>Date of Meeting:</td><td colspan="4">27 March 2024</td></tr>
<tr><td>Author:</td><td colspan="4">Jennifer Boyle, Company Secretary</td></tr>
<tr><td>Executive Sponsor:</td><td colspan="4">Dr Gillian Findley, Chief Nurse and Deputy Chief Executive</td></tr>
<tr><td>Report presented by:</td><td colspan="4">Dr Gillian Findley, Chief Nurse and Deputy Chief Executive</td></tr>
<tr><td rowspan="2">Purpose of Report
Briefly describe why this report is being presented at this meeting</td><td>Decision:
☐</td><td>Discussion:
☐</td><td>Assurance:
☒</td><td>Information:
☐</td></tr>
<tr><td colspan="4">This report provides the Board with the closing position of the Board Assurance Framework for 2023/24.</td></tr>
<tr><td>Proposed level of assurance – to be completed by paper sponsor:</td><td>Fully assured
☐
No gaps in assurance</td><td>Partially assured
☒
Some gaps identified</td><td>Not assured
☐
Significant assurance gaps</td><td>Not applicable
☐</td></tr>
<tr><td>Paper previously considered by:
State where this paper (or a version of it) has been considered prior to this point if applicable</td><td colspan="4">Board Committees
Note that the Finance and Performance Committee will consider its relevant BAF extracts on 26 March 2024 and verbally update the Board if there are any material changes to note.</td></tr>
<tr><td>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</td><td colspan="4">• Extracts of the BAF have been reviewed and updated at each Board committee meeting since the full BAF was presented to Board in November 2023.
• The BAF key is as follows:

<table><tr><th>Key</th><th>Description</th></tr><tr><td></td><td>Not yet started</td></tr><tr><td></td><td>Started and on track no risks to delivery</td></tr><tr><td></td><td>Plan in place with some risks to delivery</td></tr><tr><td></td><td>Off track, risks to delivery and or no plan/timescales and or objective not achievable</td></tr><tr><td></td><td>Complete</td></tr></table>
The BAF demonstrates that active updates have been made to the BAF at each committee to reflect to identification of new controls or assurances and any gaps.</td></tr>
</table>

Current risk scores compared to target are as follows (with the scores as at the last Board update in November 2023 included so movement can be seen at a glance):



This demonstrates that 2 risks have been managed effectively to achieve the target risk score as the year-end approaches – the summary risks linked to improving our maternity services (SA1.1) and implementing a continuous quality improvement plan (SA1.2). This provides good assurance over the control environment in place in respect of quality of care, with external third line of defence assurance such as the CQC maternity services report supporting this assertion.

Since November 2023 there have also been reductions in the summary risk scores relating to the following objectives: caring for our people (SA2.1), growing and developing our people (SA2.2) and productivity and efficiency (SA3.1) when compared to the previous position reported to Board in November 2023. The reduction in risk scores reflect the work undertaken in respect of recruitment and retention (SA2.1 and SA2.2) and the improvements in performance and productivity which are showing through our leading indicators (SA3.1). The level of risk remains high in relation to performance and efficiency, although sustained improvements have been seen within quarter four (for example ambulance handovers and reductions in long waits).

Areas with the highest current scores relate to digital (SA1.3), productivity and efficiency (SA3.1) and financial sustainability (SA3.2). This triangulates with the information reported to Board as part of other formal reports on the agenda, including the Organisational Risk Register.

The individual summary risk score graphs contained within the BAF demonstrate the active review of the risks during the year. This includes the dynamic updates of risks such as SA3.1 and SA3.2 which have both increased and decreased during the year, reflecting the changing operating environment.

	A score which has remained static during the year relates to the risk of missing opportunities to innovate and generate additional income for reinvestment in patient staff and staff wellbeing (SA5.1). This has remained at a score of 12 throughout the year. Much work has been undertaken between the Trust and QE Facilities to enhance the governance during the year in order to support appropriate income general and strategic delivery as we move into the new financial year. **Next steps** The BAF is built around understanding the potential strategic risks which may prevent the achievement of the strategic objectives and the controls and assurances (or gaps) which link to these objectives and risks. The Board is considering the proposed new objectives as part of this Board meeting (March 2024). In addition, the Board will be considering and reviewing its risk appetite as part of a Board development session in April 2024. This will help to inform the setting of the target risk levels on the BAF. These are both important steps which will assist in the development of the BAF for 2024/25. Assurance is provided that should any remaining gaps in control or assurance not neatly align to a strategic objective and associated risk area in 2024/25, then they will be transferred to the action logs of the respective Committee to ensure that the gaps are closed out.
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is requested to review the closing position of the BAF (noting that there may be a verbal update in respect of the elements mapped to the Finance and Performance Committee should any changes arise from the meeting the day before the Board), taking assurance that this has been actively utilised to seek assurance over the control and assurance environment during the year.
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:	This relates to all corporate objectives, assisting in the management and mitigation of risks which may pose a risk to delivery.

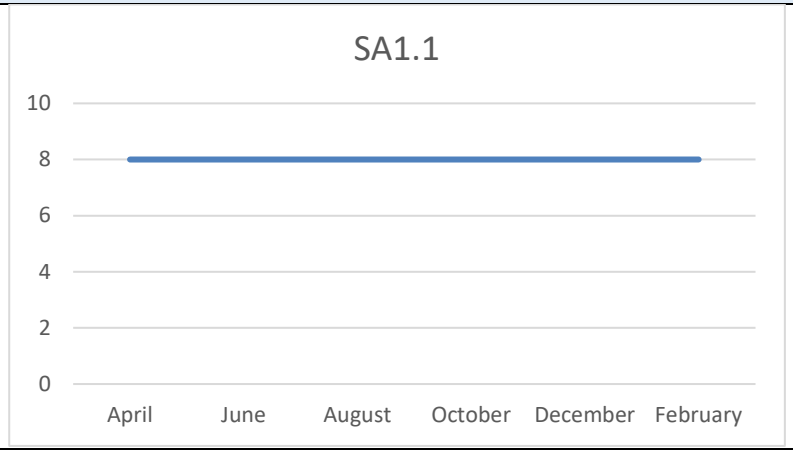
Links to CQC Key Lines of Enquiry	Caring	Responsive	Well-led	Effective	Safe
			☒		

(KLOE):	☐	☐		☐	☐
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):	Risks identified on the BAF itself.				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐		**No** ☐		**Not applicable** ☒

Quality Governance Committee BAF (SA1.1, SA1.2, SA4.1, SA4.2)

Strategic objective:	SA1.1 Continue to improve our maternity services in order to improve performance against key indicators and ensure improved patient outcomes by March 2024.
Executive Owner:	Chief Nurse
Board Committee Oversight:	**Quality Governance Committee**
Date of Last Review:	February 24 Quality Governance Committee
Summary risk	

This is a risk that the Trust is unable to maintain the level of improvements required to enhance maternity services due to resource capacity (finance, staffing and estates for example), impacting upon the quality of maternity services and a decline in performance against the maternity metrics and patient outcomes.



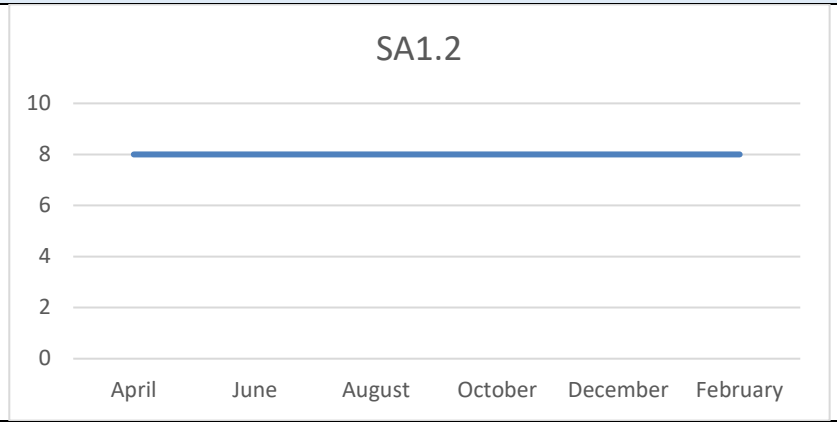
CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
2	4	8	2	4	8

Links to risks on the ORR (scores as at June 23):	POD 2764 - Workforce - Risk of not having a clearly agreed workforce plan for the next 3, 5 and 10 years. (16) SURGE 2398 - Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings (15) ESTFAC 3186 - There is a risk to ongoing business continuity of service provision due to ageing trust estate (12)

Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Maternity workforce plans developed, with some specialist roles already appointed to	The listening event held with SCBU staff identified a need to undertake a staffing review to determine whether an uplift of staff is required. Staffing review to be supported by the Neonatal Network with an update planned for one month's time.	KP	August 23	Aug – staffing review completed (transferred to controls)	
Face to face training in place	Maternity and neonatal delivery plan gap analysis	KP	End of September 23	Gap analysis completed	

Estates strategy in place and work commenced on maternity estates improvements						
Action plans in place for Maternity Incentive Scheme and Ockenden have been developed						
Gap analysis undertaken against Ockenden reports						
Neonatal Badger implementation complete resulting in improved integrated and digitisation of records.						
Maternity Birth Rate Plus assessment scheduled for Oct 23						
Special Care Baby Unit listening and engagement event held						
SCBU staffing review completed						
Substantive Head of Midwifery commenced in post on 1 January 2024						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Performance is monitored within the department at governance meetings						
Maternity forms part of the Surgery Quality Oversight Meetings where performance is overseen by the exec team						
Action plan for Ockenden monitored at Maternity and SBU Safecare						
Action plan completed for Maternity Incentive Scheme						
Fully recruited to midwife posts						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Ockenden assurance report to Board in March – Ockenden one year on						
Maternity Integrated Oversight Report now in place and presented to the Quality Governance Committee and the Board of						

Directors. It will continue to evolve.						
Maternity assurance report presented at every Quality Governance Committee meeting						
Ockenden assurance report to Board in May 2022						
Patient safety walkabouts with Executive Directors and Non- Executive Director held monthly						
Assurance (Level 3 – external)						
Feedback received from regional team regarding Ockenden evidence submission						
Maternity Voices Partnership provide regular feedback to the unit on patient experience						
Friends and Family test score results are positive and provide good assurance over the quality of care						
Chief Midwifery Officer visit to the Trust. Awards presented to colleagues in Maternity for the provision of excellent care, leadership and inspiration to colleagues and patients.						
CQC maternity survey ranked the Trust as 5th best out of 61 units in England						
Internal audit report for the maternity incentive scheme received and shows reasonable assurance						
CQC report received – 'good' rating for maternity						

Strategic objective:	SA1.2 Develop and implement a continuous Quality improvement plan that enables the delivery of improved performance against key indicators by March 2024
Executive Owner:	Chief Nurse
Board Committee Oversight:	Quality Governance Committee
Date of Last Review:	February 24 Quality Governance Committee
Summary risk	
Pressures on performance, people and finance coupled with external influences may place significant risk on the ability of the Trust to achieve national quality standards and deliver the quality improvement plan	

CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
2	4	8	2	4	8

Links to risks on the ORR (scores as at June 23):	MEDIC 2982 - Risk of delayed transfers of care and increased hospital lengths of stay (was 16 now 8) POD 2764 - Workforce - Risk of not having a clearly agreed workforce plan for the next 3, 5 and 10 years. (16) NMQ 3089 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures. (was 12 now 8) POD 3095 - Risk of Significant, unprecedented service disruption due to industrial action (16)

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Gap analysis undertaken against CQC standards	Query raised regarding whether health and safety inspections are taking place in line with requirements	GF	Oct 23	Dec 23 – H&S inspections reinstated. Feb 24 – Committee agreed action as complete.	
Core standards action plan has been developed					
Clinical audit programme in place					

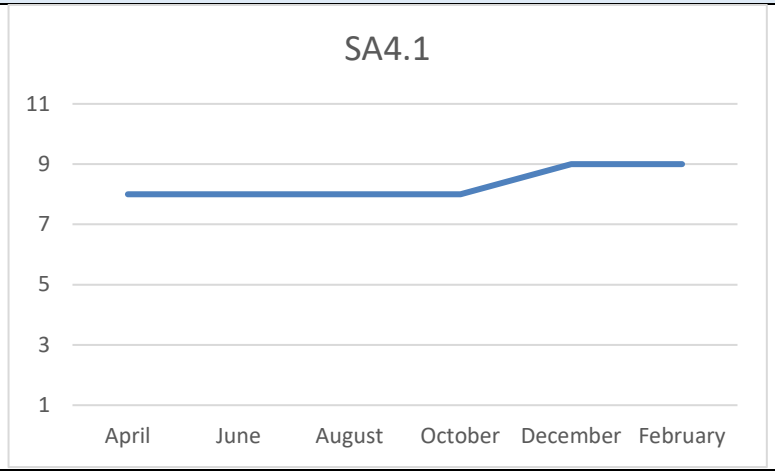
Quality Governance Committee and sub-groups in place						
Equality and Quality Impact Assessment (EQIA) programme in place						
Transformation and Quality Improvement Programme in place						
Datix and incident reporting systems in place to record risks and incidents and capture learnings						
Nursing strategy in place						
Good Governance Institute work completed re: assessment of compliance and controls regarding well-led.						
CQC task and finish group established						
New Compliance Group established						
Quality Strategy ratified at Board in March 2023 and now live						
Good Governance Institute undertaking a review of meetings to ensure appropriate coverage, escalation, assurance etc.						
Continuous improvement framework in development						
PSIRF plan and policy developed						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
SafeCare meetings in each operational business unit		Leading indicator report continues to develop and training planned for the Board.	Exec Directors	December 2023	Oct – Scheduled for Board development in December Feb 24 - First training date now completed. Second is due to take place 23rd Feb 24. Further training dates planned.	

Quality is a key component of the Quarterly Oversight meetings		Gap in assurance relating to the quality and safety aspects of QEF's work outside of the core contract with the Trust. A report is being developed by QEF for presentation to QGC.	SH (QEF)	December 2023	Feb – assurance report was presented at the December 23 meeting. Committee to consider whether action can be closed and transferred to assurance level 2. Feb 24 – Committee agreed that this gap had been addressed.	
Compliance Manager is in post and has action plan for compliance		Northern Trauma Network Peer Review completed and identified some priority actions, particularly tracking trauma patients and meeting the rehabilitation standards. Plans are being developed to address the findings.	AB	February 24	Report to be presented at Feb. Feb 24 – Committee agreed to keep this action open until a data analyst is in post to support this tracking work.	
CQC task and finish group in place to provide oversight of CQC action plan						
SafeCare meeting has been re-established in Medicine. Safecare lead appointed for medicine						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
IOR includes quality metrics mapped to the key lines of enquiry – reviewed by the Quality Governance Committee and Board bi-monthly						
Patient and staff stories presented to Board at every meeting						
Clinical audit outcomes reported to Quality Governance Committee						
Complaint triangulation report presented to Quality Governance Committee						
Safer staffing report now including red flag data						

Cancer services annual report received	[redacted]					
Quality and safety reporting on QEF non-core contract now in place						
Assurance (Level 3 – external)						
CQC process audit by AuditOne – outcome awaited						
AuditOne audits from 2021/22 – NICE Guidance (good) and Duty of Candour (good)						
Medicines optimisation service received 'good' rating from CQC						
Screening Quality Assurance Service (SQAS) visit to colposcopy with positive feedback						
GGI well-led governance report completed						
Northern Trauma Network Peer Review (note that this has identified some gaps in assurance)						

Strategic objective:	SA4.1 Identify key local health inequalities challenges and ensure improvement plans are in place by March 2024
Executive Owner:	Medical Director
Board Committee Oversight:	Quality Governance Committee
Date of Last Review:	February 24 Quality Governance Committee
Summary risk	

There is a risk that due to competing pressures (such as financial constraints and the need to meet national operational targets) the Trust does not deliver on its health inequalities action plan, resulting in continued decline in health within the local population



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
3	3	9	4	2	8

Links to risks on the ORR (scores as at June 23):	COO 2945 - Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI. (12)

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Health Inequalities Lead and SRO identified	Lack of knowledge and expertise – resource to be identified internally. Maintain strong links with ICS team and Gateshead Director of Public Health	Medical Director	December 22	June 23 – dedicated resource not yet identified. Agreed to ensure operational oversight at divisional level with reporting to the Inequalities Board and SMT.	

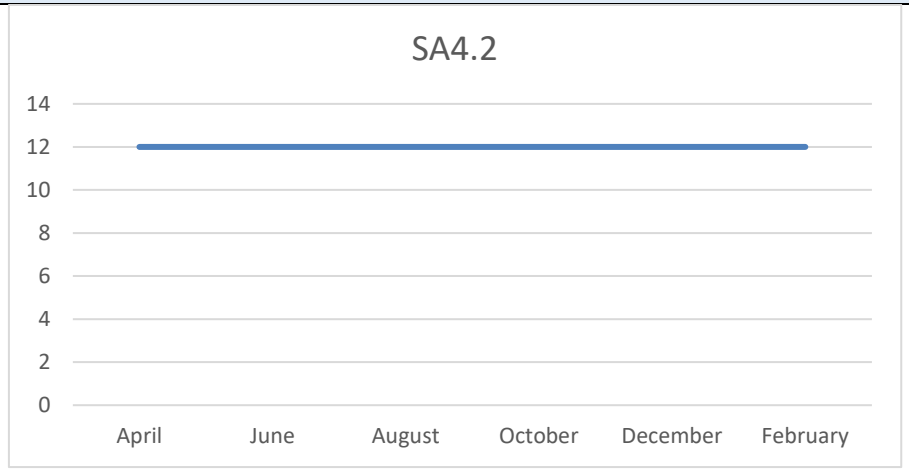
					Consideration to be made to adding health inequalities to the cover sheets. Feb 24 – committee to consider whether the gap in resource has been addressed Feb 24 – Committee asked that EMT consider this in light of the focus on health inequalities and provide feedback to the Committee.	
Health Inequalities Board established with members including the Director of Public Health for Gateshead		No defined ongoing resource for central oversight of inequalities work across the Trust.	Medical Director	June 24	Feb 24 – as above – EMT to consider and feed back to the Committee.	
Waiting lists record deprivation score index and data sets also record ethnicity						
Trust engagement in Making Every Contact Count						
Engagement in Gateshead Cares System Board						
Engagement with Gateshead Citizens' Advice to provide support to patients and staff						
Quality Governance Committee established as the reporting line for Health Inequalities Board						
Health Inequalities action plan in place						
Increased capacity to develop strategic relationships at pace due to the appointment of the Medical Director of Operations freeing up capacity for the Medical Director to						

lead in this with the CEO						
Medical Director in attendance at new ICB committee relating to health inequalities						
Survey of all ongoing work linked to inequalities across the Trust completed						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
		Gap in assurance linked to lack of dedicated resource, meaning assurance flows are not functioning as effectively as they should	Medical Director	June 24	Feb 24 no ongoing dedicated resource identified	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Presentations to the Board of Directors on health inequalities by the Trust lead, ICS lead and Director of Public Health for Gateshead – provides assurance over commitment and progress to-date						
Reports to Board on the Citizens' Advice collaboration and outcomes – last report November 2021						
Health inequalities metrics included in the IOR.						
Board consideration of place-based governance and working arrangements proposal which outlines proposed next steps for Gateshead Cares.						
Quarterly reporting on health inequalities presented to Quality Governance Committee.						

Health inequalities action plan monitored at the Health Inequalities Board meeting	[redacted]					
Assurance (Level 3 – external)	[redacted]					
Feedback from ICB and Place Based Partners on Health Inequalities work and outcomes	[redacted]					

Strategic objective:	SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population
Executive Owner:	Chief Operating Officer
Board Committee Oversight:	Quality Governance Committee
Date of Last Review:	February 24 Quality Governance Committee
Summary risk	

There is a risk that health and care outcomes for the population of Gateshead are not improved, so the Gateshead Care priorities and action plan fail to collectively deliver and the health and care outcomes at place-level are not delivered



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
4	3	12	2	3	6

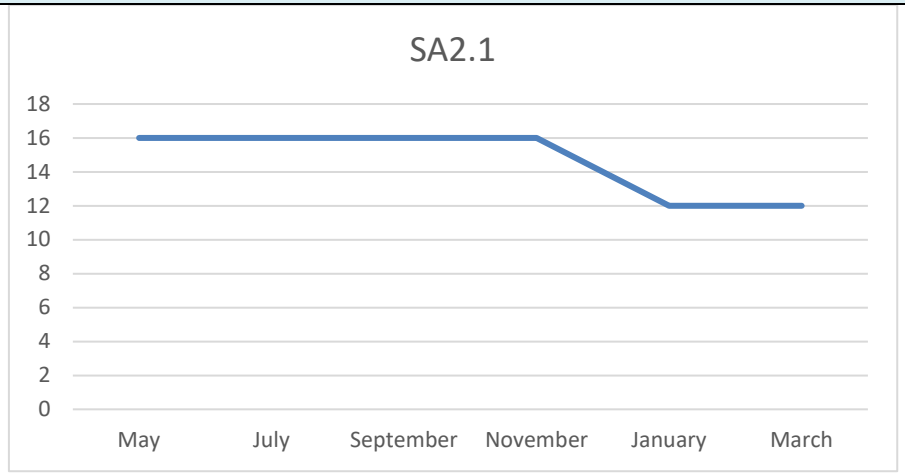
Links to risks on the ORR (as at April 23):	MEDIC 2982 - Risk of delayed transfers of care and increased hospital lengths of stay (was 16 now 8) NMQ 3089 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures. (was 12 now 8)

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Joint session planned with the system to review priorities and set objectives for 22/23	Membership of Gateshead Cares Board does not include representatives from areas such as education and housing, which contribute towards health outcomes. Note this is not in control of the Trust	N/a	N/a	N/a	N/a
Senior representation secured at Gateshead Cares meetings					
Trust developed strong relationships with key stakeholders and can influence the agenda					

New strategy shared at Health and Wellbeing Board in September 2022 to help support alignment across Gateshead system.						
Increased capacity to develop strategic relationships at pace due to the appointment of the Medical Director of Operations freeing up capacity for the Medical Director to lead in this with the CEO						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
		To identify reports to include health outcomes to go to committee and Board	Medical Director	~~October 2022~~ ~~November 2022~~ August 2023	Working to include patient outcomes in the IOR. November 2022 is a more realistic target as this is a significant piece of work June 23 – J Halliwell agreed to revisit and provide an update at the next meeting	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Partnership working updates on cycle of business for SMT and EMT.						
Assurance (Level 3 – external)						

	[redacted]					

People and OD Committee BAF (SA2.1, SA2.2, SA2.3)

Strategic objective:	**SA2.1 Caring for our people in order to achieve improved compliance to leading indicators by March 2024**
Executive Owner:	Executive Director of People and OD
Board Committee Oversight:	People and OD Committee
Date of Last Review:	March 2024 POD Committee
Summary risk	
There is a risk that the Trust is unable to provide appropriate levels of support to staff from a health and wellbeing perspective due to resource and capacity constraints and an increase in activity as part of our operational recovery. This may result in increases in sickness, reductions in morale, reduced retention rates and ultimately impact negatively on our ability to deliver high quality care to our patients.	

CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
3	4	12	2	5	10

Links to risks on the ORR:	POD 3095 - Risk of significant, unprecedented service disruption due to industrial action (16) POD 2373 - Exposure to incidents of violence and aggression in ECC (15) POD 3298 - Increase in incivility and disrespectful behaviours being reported (12)

Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Health and wellbeing funding secured for 23/24 in form of B7 role, 12m Band 5 and B3 for 3 months.	Delivery of the HWB Strategy.	AV	Mar 23	Complete and added to controls	**Complete**
Health and wellbeing team established (funding expires June 23).	Deliver a sustainable annual vaccination campaign that improves vaccination uptake, ensuring 85% of staff are vaccinated.	LF	~~January~~ February 24	July 23 – planning for this has commenced Campaign underway	**Ongoing**

					although compliance rates well below 85%	
Clear progress in reducing outstanding historic DBS		Reduction in sickness absence – training to be rolled out and new absence management approach embedded.	DB	Oct 23	Professional Absence Management training remains ongoing, robust absence management process embedding, focused approach reviewed and well received by SMT, further focused approached required and to be reviewed in 6 months. This is now BAU, with absence rates monitored closely across the Trust. Agreed to close action in Jan 24.	**Complete**
Partnership with Gateshead Citizen's Advice to provide additional support to staff.		Health and wellbeing team funding due to expire in June 23 and finance to extend not yet agreed. Charitable funds currently explored.	LF	Jun 23	Funding has been secured for a B7 Health & Wellbeing Manager role, which will go out to advert this month. Charitable Funds request submitted to fund B5 for another 12 months and work underway to scope options around B3 position. July 23 – B7 successfully appointed. Charitable Funds were secured	**Complete**

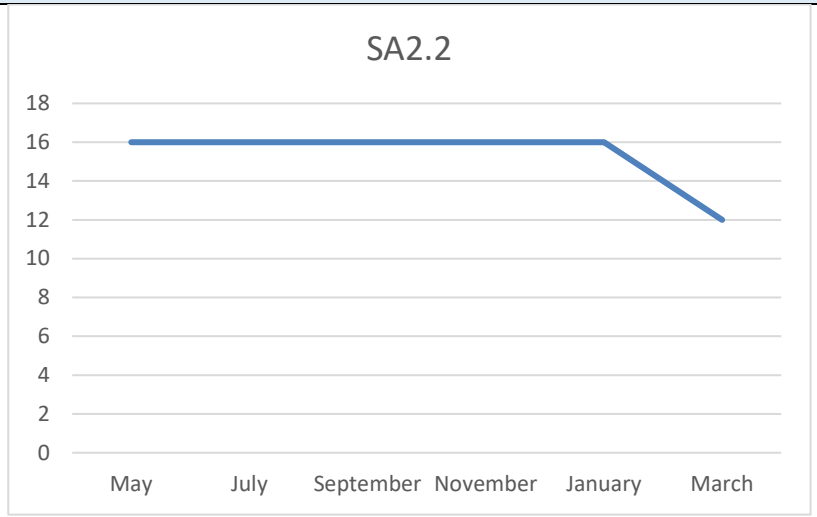
	[redacted]				to extend the Band 5 Health & Wellbeing Advisor position for a further 12 months. The B3 role has been extended for 3 months to cover a planned Occupational Health & Wellbeing Team restructure.	
Listening Space now launched and in operation.	[redacted]	Implementation of DBS update programme to be implemented.	DB	June 24	July 23 – this work has commenced Jan 24 – Group DBS policy reviewed and revised to take into account rolling DBS programme. This has been approved by the Trust and is passing through the QEF approval process. March 24 – In place for new staff and working with staffside on implementation plan for existing staff	**Ongoing**
Plans in place to prepare and mitigate risks as much as possible in respect of forthcoming industrial action.	[redacted]	To oversee the harmonisation of the three relevant policies relating to Violence and Aggression, as part of the Zero Tolerance work, with accompanying protocols.	LF	~~March 24~~ July 24	Jan 24 – this work has commenced with relevant stakeholders. Mar 24 – Violence & Aggression policy updated and circulated for initial feedback. This will be reviewed by the reformed Violence Reduction Group	**On track with some risks to delivery**

					before going through full sign-off process.	
Flu and Covid vaccination programme delivered to colleagues.						
Health and Wellbeing ambassador network established.						
Improved catering provision in place, with medium term actions on track.						
Positive impact of focused sickness absence management approach from both management and POD teams.						
HWB strategy in place						
Planning in place for Covid, flu, whooping cough vaccinations						
Progress being made to close any gaps in recruitment check documentation						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
POD Quality Meeting, Management Meeting People and OD Steering Group to be set up in Q1		Compliance with health and wellbeing conversations unknown.	DJ	Dec 22 To be reviewed Feb 23	Reportable from ESR from appraisals completed since November 22	**Complete**
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Health and wellbeing metrics reported to POD Committee, including vaccination uptake and actions to support financial wellbeing						
Health and wellbeing metrics reported in IOR at Board.						

Corporate objective update reported for Q1 and Q2	[redacted]					
Equality Delivery System EDI report	[redacted]					
Assurance (Level 3 – external)	[redacted]					
Staff feedback on HWB in 2022 and 2023 survey results.	[redacted]					
International recruitment team has been awarded the NHS Pastoral Care Quality Award - recognises commitment to providing high-quality pastoral care and the positive impact this has on staff wellbeing.	[redacted]					
Staff survey results provide good assurance compared to national average	[redacted]					

Strategic objective:	SA2.2 Growing and developing our people in order to improve patient outcomes and reduce reliance on high cost agency staff by March 2024
Executive Owner:	Executive Director of People and OD
Board Committee Oversight:	People and OD Committee
Date of Last Review:	March 2024 POD Committee
Summary risk	

Risk of not having the right people in the right place at the right time with the right skills due to lack of workforce capacity, resources and expertise across the organisation, ultimately impacting negatively on our patient outcomes and financial outcomes.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
3	4	12	2	5	10

Links to risks on the ORR:	2764 - Risk of not having clearly agreed workforce plans for the next 3, 5 and 10 years (16) score to be reviewed following ERMG on 04/03/24 POD 3095 - Risk of significant, unprecedented service disruption due to industrial action (16)

Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Planning and co-ordination process in place for industrial action	People Strategy has been developed and is due to be presented at March Board.	AV	New approved timescale – March 23	People Strategy timeline in Trac. Jan 23 – People Strategy to be presented at 9 Feb Board strategy day with ratification planned for March	Complete

					Board. April 23 - People Strategy signed off and agreed at March 2023 Board. Verbal update to be given and final version shared at PODC in May 2023.	
International recruitment – programme well established.		Further development of people metrics; nursing dashboard further developed, medical staffing and AHP designed and tested. People Analyst to look to triangulate bank and agency spend, sickness absence and vacancy rates and include in the narrative.	LH	Feb 23	April 23 - AHP dashboard developed and updated monthly. Initial Medical Dashboard developed – pending feedback from Medical Workforce Group. Nursing Dashboard not yet developed and reached a position where it was agreed with the Head of Nursing that the Nursing workforce information (whilst in various places) was sufficient. Bank, agency, sickness and vacancy rates triangulated via the inpatient workforce report summary with has been developed.	**Complete**
Recruitment process streamlined		Comprehensive Workforce Plans – paper to be brought back to May Committee, writing up work to date, next actions and potential risks.	NB	Mar 23	Meetings scheduled throughout January 2023 with Business	**Complete**

(RPIW).					units and The Whole System Partnership to gather intelligence to support workforce planning looking at skill requirements. April 23 - Paper listed to be presented at PODC in May 2023.	
Managing Well and Leading Well programmes fully operational.		E-Rostering for Medical Workforce. Medical staffing task and finish group agreeing future medical staffing service with scoping of potential new e-rostering system to follow given the current system has expired. Current controls in place to effectively manage the rostering in the interim, and good clinical engagement.	BO	~~Feb 24~~ July 24	Zebra Project manager in post regular meetings in diary with Medical Staffing Manager. Implementation plan under review. New system to be scoped Zebra system not renewed at contract end date so work to commence on agreeing new system about to start. Task and finish group final meeting on 20.01.24 with proposals to go back to EMT. March 24 – working group set up to look at system requirements and procurement	**On track with some risk**
New absence management policy in place.		Securing funding to progress the RNDA apprenticeship programme – Gateshead Apprenticeship into Nursing GAiN	SN	Proposed new date June 23	Presented to SMT but further work required. April 23 - Agreed in principle at SMT with	**Complete**

					planning to commence. As investment needed exceeds £1m in total, this requires board approval. July 23 – on July 23 Board agenda for decision Aug 23 – approved at July Board – recommend the closure of this gap.	
People analyst in post and initial reports developed; nursing dashboard in place with benchmarking and trajectories.		Exit interview process to be embedded and work to be undertaken to increase completion rates	NB	~~Feb 24~~ May 2024	April 23 - Exit interview process reviewed and revisions suggested, however still requires roll out, comms and embedding. July 23 – agreed to review as part of wider retention work – to be considered at Sept POD Committee. Nov 23- Lack of capacity to progress this work. Discussed at Nov committee with revised date proposed February 24 – Exit interviews are being completed, work has been done to analyse the feedback from this to date. Reminder to managers went out re: importance of	**On track with some risk**

					timely ESR completions to allow these invites to be sent. Further work to be picked up as part of the people promise exemplar programme.	
Retention initiatives in place to support and encourage colleagues to remain with the Trust.		NHS Long Term Workforce Plan released – internal scoping for the Trust and wider ICS to be undertaken	AV / GR	Jan 24	Aug 23 – briefing delivered to Board as part of Board development Regional work ongoing as we await the national implementation plan.	**Complete**
School and local community supply initiatives in place to attract the Trust's future workforce.		Medical Staffing task and finish group actions to be formulated into an action plan with target dates identified.	AV / GR	~~Jan 24~~ May 24	As per the update above. Feb 24 – action plan developed alongside closure report, although recognising that there is more work to do to address this risk. Specific resource needed to work in the team and recruitment plans underway March 24 – Committee agreed a new date of May 24 recognising that there had been delays due to resource challenges	
Agency group in place to provide greater controls over the usage of						

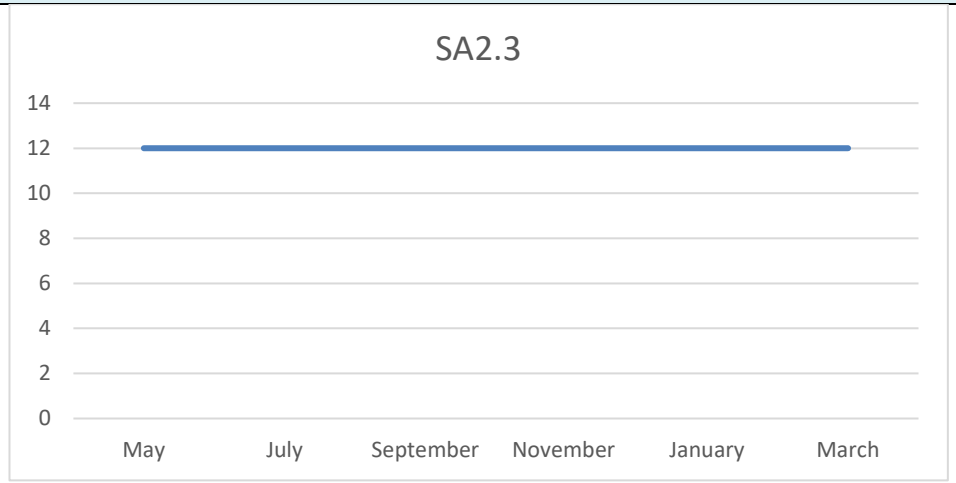
agency staff.						
Healthcare Academy Approach in Development supporting Health Care Careers across Gateshead.						
KPI report developed around Theatre's initiatives and progress reports provided.						
Workforce plan in place						
People Strategy 2023-25 in place						
GAiN apprenticeship programme approved by Board						
Medical Staffing task and finish group has been set up, good progress being made						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Staffing Task and Finish Group.		BU Dashboard.	LH	~~Feb 23~~ Proposed new date July 23	April 23 - Business unit level workforce information is available via BI reporting but is currently being redeveloped by the BI team, co-ordinated by the People & Information Systems	**Complete**

					Manager.	
Nursing Workforce Group		Medical Staffing Dashboard.	LH	Feb 23	April 23 - Initial Medical Dashboard developed – pending feedback from Medical Workforce Group.	**Complete**
POD Management Meeting and SMT.		Further POD metrics being developed.	LH	Mar 23	April 23 - our People Analyst is always looking at ways to analyse and present current metrics differently. Looking at change over time, variations and data points that stand out.	**Complete**
Medical staffing dashboard developed in draft		Consideration how we are able to report on the overall medical training picture for the Trust bringing in the ADQM feedback and GMC survey feedback, along with staff survey feedback.	NH/CB	September 24	Data to be triangulated and taken to medical workforce group for discussion	**Ongoing**
Strategic objective update reported for Q1.						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
POD Metrics to POD Committee.						
Nurse/HCSW Dashboard now in place to monitor vacancies and presented to formal groups for assurance and						

review.	[redacted]					
Assurance (Level 3 – external)	[redacted]					
Returns to NHSE.	[redacted]					

Strategic objective:	**SA2.3 Being a great place to work in order to improve staff survey outcomes and impact upon patient outcomes within 2 years.**
Executive Owner:	Executive Director of People and OD
Board Committee Oversight:	People and OD Committee
Date of Last Review:	March 2024 POD Committee
Summary risk	

There is a risk that the Trust's culture does not reflect the organisational values due to resourcing pressures and a lack of focus on organisational development, training and development, resulting in reduced retention, vacancies, poor staff survey results and ultimately impacting on patient outcomes.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
3	4	12	2	5	10

Links to risks on the ORR:	2764 -Risk of not having clearly agreed workforce plans for the next 3, 5 and 10 years (16) score to be reviewed following ERMG on 04/03/24 POD 3095 - Risk of significant, unprecedented service disruption due to industrial action (16) POD 2373 - Exposure to incidents of violence and aggression in ECC (15) POD 3298 - Increase in incivility and disrespectful behaviours being reported (12)

Controls		**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Trust-wide engagement programme that resulted in the launch of a new vision and behaviour framework.		Engagement approach for the culture programme not yet fully defined.	LF	~~March 23~~ ~~June 2023~~	April 23 - Culture Programme launched w/c 24 April 2023, with initial communications underway. Culture Board to be	**Complete**

				September 24	established May 2023, with a programme scoping session to follow, when a full engagement approach will be agreed. Engagement approach agreed and work ongoing on the priority areas of Zero Tolerance, Psychological Safety, FTSU and staff experience March 24 – Committee assurance that an engagement plan for the culture programme is now in place. Action closed.	
Trust values have been reviewed as part of the wider engagement programme and remain the same.		Culture Programme approach agreed, with a structure built around 6 workstream SRO's and supporting Programme Managers.	LF	March 2023	April 23 - 6 SROs and 6 Programme Managers confirmed.	**Complete**
Culture Programme has been established overseen by the Transformation Board and sponsored by the CEO.		Engagement plan for EDS2.	KS	~~May 2023~~ Nov 23	April 23 - Verbal update to be given at PODC in May 2023. July 23 – written update requested for Sept 23 Nov 23- agreed T&F group to be set up reporting to the HREDI group Jan 24 - Not in place yet Mar 24 – EDS submitted at end of	**Complete**

	[redacted]				Feb 24 and on agenda for March committee Proposal to close this action – agreed at Committee.	
Overarching Programme SRO agreed and confirmed.		Freedom to Speak Up – more information to be included on themes, trends and closing dates. People analyst to support future developments of the report.	GR	July 2023	April 23 – action plan in place to review Freedom to Speak Up more widely. Included in thematic review. June 23 – interviews scheduled for a dedicated FTSU Guardian role. Nov 23- Complete, new Guardian in post and data reporting confirmed	**Complete**
Freedom to Speak Up report received for Q1		Low completion rates for Pulse survey – action to increase the Pulse survey rates in line with the leading indicator work	LF	Jan 2024	Communications increased around the Pulse survey March 24 – National Quarterly Pulse Survey (Q4) closed 31 January 2024 with 110 (3%) colleagues taking part, which saw a 30-respondent increase on the previous Pulse Survey take-up rate. The focus was 'We Work Flexibly'. Capacity issues within OD has impacted level of targeted engagement but plans in development as we	**Complete (albeit target not achieved for 23/24)**

					enter the 2024-25 survey window. March 24 – Committee agreed to close this gap and add a new action re: increasing engagement with the Pulse Survey in 2024/25.	
Existing team of Cultural Ambassadors that can support the programme.		Increase Board-level compliance for FTSU training	AV / SN / JB	Sept 23	July 23 – reminder sent to Board August 23 reminder sent to Board 12/13 completed all staff mandated training. 5/13 have completed the board level training. Jan 24 compliance rates are 9 out of 13 Board members have completed training March 24 – confirmed that the Board training has been completed and agreed to close out this action.	**Complete**
2022 Annual Staff Survey results received, analysed and communication campaign underway.		Develop zero-tolerance time to stop campaign Good engagement with staffside and networks	AV/LF	~~Nov 23~~ ~~March 24~~	Nov 23- Launch date of 24th November with team working on intranet site and support materials Feedback from engagement in Nov being incorporated and materials being	**Complete**

	[redacted]			June 2024	finalised for managers Feb 24 –training (SRTRC) has been arranged for all managers as part of the campaign and a soft launch of 'its not ok' took place on 29/02. March – Committee agreed to close this action as the campaign has been developed. A new action to be raised re: engagement with staffside and the networks.	
EDS2 update received.		Work on robust comms and engagement on the 2023 staff survey	LF	Nov 23	Nov 23- campaign launched and current response rate is 35.1% Jan – survey results are to be shared this month and a programme of engagement has been developed to support this. Feb – wide engagement taken place March – Committee assured engagement has taken place / plans are in place and agreed to close.	**Complete**
Culture programme resource and staffing now in place		Staff networks to be 're-launched' along with Zero tolerance campaign	AV/KS	~~Nov 23~~	Jan 24 – Staff networks presented to Board in Dec 23 as	**On track with some risk**

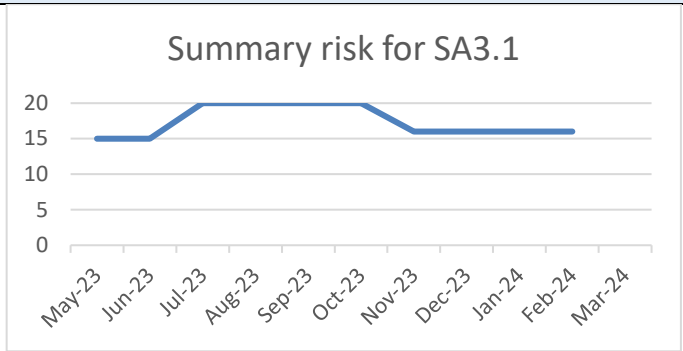
				April 24	part of this work. KS to conduct a review of the networks following EMT discussion in Jan 24	
Professional Nurse Advocates in place		Improve engagement with the Pulse Survey for 2024/25	LF	March 25		Not yet started
Legacy Nurses recruited		Increase engagement with staffside and the staff networks as part of the Zero Tolerance campaign	LF	September 24		Not yet started
Staff survey launched for 2023						
9 FTSU Champions and full-time Guardian appointed						
Corporate induction programme in place						
Anti-racism charter signed with Unison						
Engagement plan in place for the culture programme delivery						
Engagement plan for the Equality Delivery System now in place						
Board Members fully trained in FTSU						
Zero tolerance programme launched and in place						
Engagement plan in place re: staff survey results						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
POD Management Team.						

Assurance (Level 2: Reports / metrics seen by Board / committee etc)	[redacted]					
Transformation Board.						
POD Committee in place with regular reporting						
Corporate objective update for Q1 to POD						
Assurance (Level 3 – external)						
Staff survey 2022 provides good assurance						

Finance and Performance Committee BAF (SA3.1, SA3.2, SA5.1)

Strategic objective:	SA3.1 Ensure that there is a strong focus on improving productivity and efficiency and best use of resources in everything that we do to meet the required performance standards/recovery requirements by March 2024.
Executive Owner:	Chief Operating Officer
Board Committee Oversight:	Finance and Performance Committee
Date of Last Review:	February 2024 – F&P Committee
Summary risk	

There is a risk that the Trust is unable to deliver the required productivity and efficiency to support the trust to meet the required performance standards, due to ongoing operational pressures and workforce gaps.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	3	3	9

Links to risks on the ORR:	MEDIC 2982 – risk of delayed transfers of care and increased hospital lengths of stay (was 16 now 8) POD 2764 - Workforce - Risk of not having clearly agreed workforce plans for the next 3, 5 and 10 years. (16) POD 3095 - Risk of significant, unprecedented service disruption due to industrial action (16) FIN 3102 - Activity is not delivered in line with planned trajectories, leading to reduction in income (16)

Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
PMO team in place and supporting operational business units in the delivery of the transformation projects	Further work required to develop robust workforce plans to address vacancies in Business units	Executive Director of People and OD	March 2023	March 23 – business units engaged in the annual planning process to develop the workforce plans. May 23 – recruited to 95% of NOM plan. Workforce plan submitted as part of annual plan.	Complete

as above	[redacted]	Clinically led estates strategy to be developed to inform 23-25 estates plans	QEF MD / Chief Operating Officer	~~December 22~~ Proposed: ~~March 22~~ ~~May 2023~~ March 24	March 23 – recognition that this needs to be informed by the work to scope Bensham and the operational services review and therefore more work needs to be completed in due course May 23 – estates strategy work incorporated into the thematic review with deadline of 30/06 for initial assessment and 31/03/24 for overall delivery. Sept 23 – estates update to be provided to September 23 Board meeting. Nov 23 – further update scheduled for Nov Board. Dec 23 – update presented at Nov 23 Board with further updates to future meetings. Workstream now includes Chief Nurse, Medical Director and Chief Operating Officer. Jan 24 – further update due at January's Board	**On track**

					meeting Feb 24 – Board received an update in January. A delivery plan is now in development. March 24 – update scheduled for March Board of Directors	
New operating model (NOM) programme board in place to oversee the delivery and benefits realisation of the NOM delivery – receives updates from Elective and planned care project board and Unscheduled Care project board – The NOM board reports into the Trusts Transformation board and Executive Capital group		In respect of discharges there remains a gap in respect of LA capacity plans which are outstanding and the joint meeting scheduled for December was stood down. There are also issues in respect of digital capacity to deliver to required data. Collaborative work continues with the goal of presenting to the Board strategy session in February 2023.	Chief Operating Officer	February 23	COO and LA meeting is being scheduled. Digital issues escalated. March 23 – joint session delivered as part of Board strategy day. Work continues. May 23 – collaborative work will continue, but the specific work referenced here is complete. Discharges currently within tolerable limits.	**Complete**
Winter Plan in place and signed off by Board and submitted to ICB for winter 22/23		A need to develop a collective understanding of the sustainability, vulnerabilities and strengths of our service offering. The Trust Board has commissioned a review to inform this.	Executive Directors	~~September 2023~~ March 24	May 23 – incorporated into thematic review delivery plan. Engagement underway with full review expected to be completed by September 23. Sept 23 – an update is included on the Sept	**Complete**

	[redacted]				Board agenda. Oct 23 – follow-up discussion scheduled for Oct Board development. Proposal to revise deadline date in line with financial year. Proposal for target date change approved at F&P Committee. Dec 23 – sustainable services update scheduled for January Board. Feb 24 – Board received a comprehensive report which identified the priority areas. This now becomes business as usual in respect of being incorporated into the planning process. Recommend the gap is closed and a corresponding control added re: the completion of the review. March 24 – Committee approved the closure of this gap at the February meeting, noting that the outputs wouldn't necessarily flow	

					directly through this Committee as part of the governance structure.	
Estates plan for the New Operating Model in place and being delivered						
Productive relationship with local authority on discharges – collaboration will continue as business as usual						
Development of a focussed length of stay project to support a reduction in the duration of hospital stays						
Annual plan submitted for 23/24 covering operational delivery, finance and workforce						
Delivery Oversight Group established to oversee the delivery of the sustainability workstreams.						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Chief Operating Officer meets with senior team on a weekly basis to oversee performance delivery		NO workforce or Quality data in the IOR that enables triangulation with performance information	~~Chief Operating Officer~~ Group Director of Finance and Digital	March 23	March 23 – work being undertaken to refine the IOR with exception reporting at Board and increased granularity at operational tiers May 23 – this work is now complete and changes have been made to the IOR.	**Complete**

Escalation into BU monthly monitoring outcome of Q2 QOM re: Assurance Framework.	[redacted]	Benefits realisation process for elective and scheduled care transformation programmes not clear. Outcomes to be clearly defined so that they can be measured.	Chief Operating Officer	~~December 2022~~ April 2023	March 23 – action reopened to reflect benefits realisation exercise reporting to April F&P Committee. May 23 – paper was presented to April's meeting in line with timescale. Follow-up paper presented to the May 23 meeting. Action considered complete.	**Complete**
Elective and Planned Care Recovery project Board in place to monitor delivery of the transformation programme		Committee not sighted on the themes and trends from the weekly performance clinics – identified as a gap in assurance. Agreed to bring a summary back to the Committee along with the impact on the activity trajectory	Deputy Director of Planning and Performance	August 2023	Oct – note these are now entitled the Access and Performance Clinics. Elective Recovery Board Assessment presented and agreed action to bring to the Committee a single elective recovery report. On agenda for Oct meeting. Confirmed that this addresses gap in assurance and agreed to close.	
Unscheduled Care Programme Board in place to monitor oversight and delivery of the transformation programme		Gap in assurance relating to understanding the impact of the New Operating Model. A further report to come back to Committee to articulate performance metrics and mitigations.	Group Director of Finance / Deputy Director of Planning and Performance	July 2023	July 23 – on agenda Oct 23 – learning report is included on the agenda. Review and determine whether this address the gap in assurance here. Nov 23 – note that	

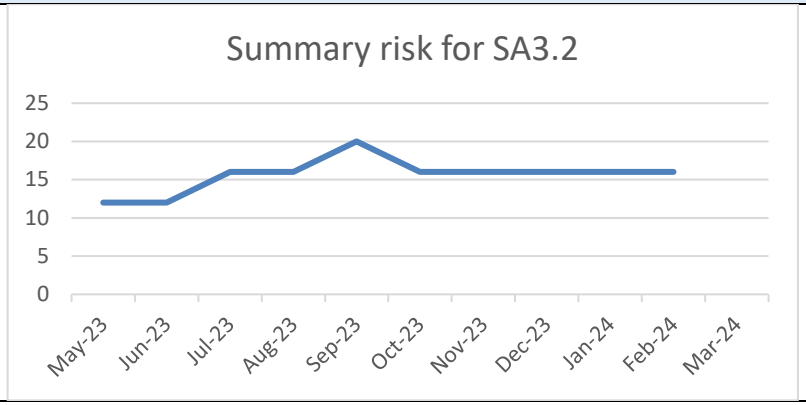
					the paper was deferred to the Nov F&P meeting and therefore will be considered this month to determine if the report closes the gap in assurance Dec 23 – Committee to consider whether this gap in assurance is closed. Jan 24 – Committee determined further assurance was needed and a report is on Jan agenda. Feb 24 – report received at the previous meeting and the programme confirmed as closed.	
Weekly performance clinics in place		Gaps identified in relation to leading indicator report – to add in mutual aid slide, breakthrough indicators, amendments to leading indicators and SPC chart for ambulance handovers	Group Chief Operating Officer	March 24	March 24 – Feb Committee agreed to leave open as work still being undertaken on the report in line with deadline. Mutual aid slide to be replaced with narrative as per Committee discussion.	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Quarterly Oversight Meetings in place -Executive led to meet on performance of all business units						

chaired by the CEO						
Integrated Oversight Report reviewed at Board and Board committees, and undertaking deep dives where required for extra assurance e.g. discharges.						
Operational Business Unit governance review completed and shared with the OBUs and Chief Operating Officer. Model documents developed to aid implementation.						
Quarterly Oversight meeting outputs on F&P cycle of business to provide assurance bi-monthly						
IOR contains quality and workforce data to support triangulation with operational performance						
Elective recovery report now presented regularly at F&P Committee.						
Leading indicators developed and reported to F&P Committee for assurance						
New Operating Model closure report provided assurance over lessons learned						
Assurance (Level 3 – external)						
External review of discharges underway – outcome not yet available						
ECIST review undertaken – confirmed all transformation plans appropriate and identified areas of good practice						

External review of waiting list integrity provided good assurance	[redacted]					
Monthly regional performance report – benchmarking provided as part of IOR	[redacted]					
	[redacted]					

Strategic objective:	SA3.2 Achieve financial sustainability by in-year delivery of Trust CRP plan and development of robust sustainability plan for delivery within 3-years
Executive Owner:	Group Director of Finance and Digital
Board Committee Oversight:	Finance and Performance Committee
Date of Last Review:	February 2024 F&P Committee
Summary risk	

There is a risk that the Trust does not achieve its financial and capital plans due to the challenging level of CRP, rising costs of living and under-delivery of activity trajectories impacting upon the future ability of the Trust to deliver high quality services and innovation for our patients.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	2	4	8

Links to risks on the ORR:	FIN 3103 - operational pressures result in non-achievement of CRP (16) ~~FIN 3127 - There is a considerable risk that the Trust is unable to meet the financial projections included in its plan. (16)~~ Risk closed as this has been managed given the Trust's projected financial outturn for the year. FIN 3102 - Activity is not delivered in line with planned trajectories, leading to reduction in income (16)

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Agreed budgets in place for each business unit reconciled to balanced position and agreed financial plan, inclusive of CRP targets	Finance team not yet fully established and therefore support is prioritised to 'core business' – recruitment underway	Group Director of Finance	~~December 2022~~ March 2023	March 23 – the team are now more established and no longer focussed on core business only. Two key posts will be recruited to in late March 2023. May 23 – new	**Complete**

					structures are now in place and all core roles recruited to.	
Financial accountability framework in place		SFIs and scheme of delegation require updating to reflect changes in the governance structure and decision-making	Group Director of Finance / Company Secretary	2023/24	March 23 – note this work will now take place in 23/24. May 23 – Deloitte review due for completion end of June with delivery plan to be agreed once findings known July 23 – Deloitte report anticipated by the end of the month August 23 – report received and to be considered at an extraordinary Board. Sept 23 – this features as part of the actions agreed at the extraordinary Board in Sept. Agreed as a priority action with a confirmed deadline of December 2023. Jan 24 – drafted reviewed by the Committee in December. Scheduled for review at January's Board.	**On track**

					Feb 24 – deferred from Jan Board but scheduled for March Audit Co and Board for final sign off. March 24 – Audit Committee reviewed these documents and recommend them to Board in March. Action recommended for closure on this basis.	
Regular meetings with ICS to discuss system position, required actions and inflationary pressures		Trust moved into SOF Segment 3. Immediate actions to be identified and developed with reporting to the Delivery Oversight Group.	Group Director of Finance	Sept 23	Oct 23 – DOG report on the agenda. Review and determine whether this closes gap in control. Jan 24 – Committee to determine whether gap is closed. Feb 24 – Committee confirmed closure in Jan given that the actions have been identified and the DOG stood down.	
New business case process launched in April 22.		Business planning process for the Trust to be fully reviewed and refreshed to strengthen the controls in place and bring forward the planning to commence earlier and encompass a longer time period	Interim Director of Strategy, Planning and Partnerships	Oct 23	Sept 23 – update paper provided to SMT to outline proposed process. Jan 24 – Committee to determine whether gap is closed. Feb 24 – Jan meeting – agreed to remain	

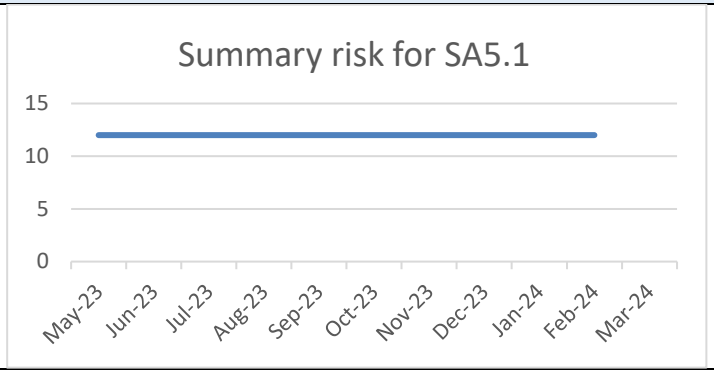
					open as business planning is being developed. March 24 – planning process is underway with an outline delivery plan currently being drafted.	
Oversight meetings in place with each business unit to hold to account, CRP and accountability framework key item						
Capital plan in place with monthly reporting to F&P						
Close monitoring of the Elective recovery programme to ensure delivery of ERF						
CRP framework in place for 23/24						
Core finance roles recruited to, strengthening the capability and capacity of the team						
Delivery Oversight Group closed as sustainability actions have been identified and progress made.						
Minuted meetings with NHS England regarding System Oversight Framework levels						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Month end finance closure and related procedures		System Oversight Framework external monitoring and assurance arrangements not yet defined	Group Director of Finance	March 23	Dependent upon external developments – will be kept under review Jan – the forecasting protocol document has previously been presented to	**Complete**

					committee. SOF reporting and monitoring still to be confirmed. Feb 23 – no change March 23 – monitoring by NHSE has not yet restarted. The monitoring arrangements for 23/24 are yet to be communicated. May 23 – ICB meeting held to confirm SOF rating with further meeting in June. June 23 – meeting arranged for 21 June.	
Monthly budget meetings held between business units and assigned financial management support leads						
Oversight / hold to account meetings						
Regional DoF ICS meetings now happening 4 times per month, accompanied by a monthly triangulation meeting between the Trust, the ICB and NHSE.						
SMT planning sessions held to develop a robust and realistic CRP plan for 23/24						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Achievement against revenue and capital plan reviewed for assurance at Finance and Performance Committee, including agency spend, CRP detail and forecasting.						

Revenue and capital report received for assurance at Board of Directors						
HFMA action plan in place and presented to the Committee.						
Assurance paper received on CRP plans and delivery						
CRP reporting and assurance defined as via SMT, Transformation Board and then Finance and Performance Committee.						
Supply and Procurement Committee oversight routinely reported to Finance and Performance Committee						
QEF Finance Report routinely presented to Finance and Performance Committee for assurance						
Leading indicators developed and reported to F&P Committee for assurance						
Assurance (Level 3 – external)						
Internal audits provide assurance over financial systems and controls – accounts receivable (good), accounts payable (reasonable), capital planning and monitoring (good), waivers (reasonable).						
ICB oversight meetings in place						
Unqualified audit opinion issued for 22/23						
'Good' Head of Internal Audit opinion issued for 22/23 – provides external assurance over control environment						

Strategic objective:	SA5.1 We will look to utilise our skills and expertise beyond Gateshead in order to ensure organisational sustainability and contribute towards innovative care and provision within 23/24
Executive Owner:	QEF Managing Director
Board Committee Oversight:	Finance and Performance Committee
Date of Last Review:	February 2024 – F&P Committee
Summary risk	

There is a risk that the Group will miss opportunities to utilise skills and expertise to generate income for reinvestment in patient care and staff wellbeing, resulting in increased pressures on existing funding.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
4	3	12	3	3	9

Links to risks on the ORR:	~~FIN 3127 - There is a considerable risk that the Trust is unable to meet the financial projections included in its plan. (16)~~ Risk closed as this has been managed given the Trust's projected financial outturn for the year.

Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Regular meetings in place with external partners to discuss opportunities	Trust commercial strategy in development	QEF MD	~~October 2022~~ ~~Jan 2023~~ Dec 2023	March 23 – this work will now take place in 23/24 due to capacity May 23 – new strategic objective resets delivery date of Dec 23.	**Overdue**
Monthly strategy meeting in place in QEF to discuss opportunities	Lack of clarity re: QEF strategy and how this links to the Trust's overall strategy. Collaborative session with the Board and QEF colleagues planned for April.	Board of Directors	June 2023	May 23 – collaborative session held and work underway to review the governance to support delivery of the aims	**Complete**

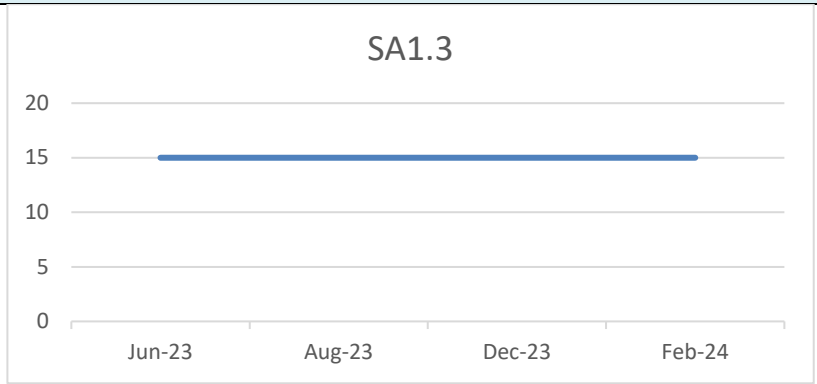
QEF commercial strategy in place		A need to ensure the appropriate governance structure is in place to support the delivery of the collective vision for QEF and provide assurances back to the Trust Board and F&P Committee. Independent governance review to be commissioned to inform this.	CEO	~~June 2023~~ July 2023 December 2023	May 23 – review commenced and due to report at the end of June 23. June 23 – verbal feedback to be provided 28 June with the written report to follow in July 23. Oct 23 - action log developed following time-out session and consideration of report. Priority actions identified. Proposed date for completion of priority actions Dec 23 – date change requested. Jan 24 – most priority actions have been completed. The remainder were reported to Nov Board with a further update due in March 24.	**Overdue**
Strategy session between the Board and QEF held – shared vision now in place.						
QEF Strategy agreed at extraordinary Board – 4 Sept						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Weekly senior management meetings in QEF with reporting to QEF Board						
Commercial divisions within QEF report to QEF Board on progress made						

Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
QEF quarterly reporting to F&P Committee						
QEF reporting to Board twice per year						
Assurance (Level 3 – external)						

Digital Committee (SA1.3)

Strategic objective:	SA1.3 Ensure that there is a Digital first and data led approach to transformation and improvement across all domains of activity in order to contribute to delivery of the key indicators by March 2024
Executive Owner:	Group Director of Finance and Digital
Board Committee Oversight:	Digital Committee
Date of Last Review:	February 24 Digital Committee
Summary risk	

There is a risk that the Trust is not able to access / utilise digital technologies to greatest effect, impacting upon the ability to drive improvements in service provision and deliver against the leading indicators as well as increasing the risk of critical system failure.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
3	5	15	2	5	10

Links to risks on the ORR (as at June 23):	COO 2945 - Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI. (12) IMT 3310 - Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure. (16) *New risk added to ORR* IMT 3313 - Inability to support legislation and best practice associated with records management (16)

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Digital re-prioritisation and engagement exercise completed to ensure digital delivery plan is realistic based on current resource.	Digital Strategy delivery plan to be developed.	Nick Black, CIO	~~Sep 23~~ Mar 24	Partially complete - digital maturity assessment has been completed, with key target areas identified as part of the gap analysis. System Exploitation Fraework has been established and core systems are prioritised	**Partially complete**

					for developments. Full delivery is dependent on the outcome of the EPR discussions. Feb 24 – Committee discussed that the digital strategy delivery plan is dependent on the outcome of the EPR procurement.	
Digital Transformation and Digital Assurance Groups in place.		Agree OBC for Electronic Patient Record system	Nick Black, CIO	~~Oct 23~~ Mar 24	OBC for EPR agreed by Execs in February 23. Asked to be re-validated following market engagement. Nov 23 – new market engagement event arranged for 13 Dec. Revised deadline required to be agreed for closure of this gap. Jan 24 – engagement event held in Dec 23 with clinicians and managers. This represents a 3 month delay to the target date which has previously been reported and approved by board. Feb 24 – OBC created for the EPR system and revalidated following the marketing engagement exercise.	**Ongoing**
Significant stakeholder engagement to seek views on digital aspirations and challenges within the Trust to inform future developments.		Agree FBC for Electronic Patient Record system	Nick Black, CIO	~~Oct 24~~ Mar 24	Follows OBC review Nov 23 – as above. A revised deadline will need to be agreed here	**Ongoing**

					to enable appropriate monitoring. Jan 24 – as previously reported the date for this is dependent on the outcome of the EPR discussions. This has previously been reported to board. Feb 24 – the FBC is dependent on the outcome of the EPR procurement process and therefore remains outstanding at this stage.	
Engagement of Channel 3 Consulting to lead options appraisal, outline business case development and requirements specification work on the electronic patient record (EPR) plan.		Implementation of additional layer of project governance to provide control, ownership and assurance on the delivery of digital programmes.	Adam Charlton	Jun 23	Nov 23 – update to be provided at the December meeting. Dec 23 – Complete. Programme board has been established with core controls in place. Reporting and escalation routes are in place and utilised. A programme delivery framework will be developed 23/34	**Complete**
Systems management audit programme.						
Structured project management and change control procedures						
Clinical Safety resource in place to oversee and manage best practice process.						
Board approved Digital strategy in place						

Qualified Cyber security specialist in place						
Prioritisation matrix in place to support the management of risks to the digital delivery plan						
Programme delivery board in place						

Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Approval to proceed with development of Electronic Patient Record FBC – Feb 23.		Identification of EPR solution in place, but its method of procurement has changed. This modification has been communicated with Clinical Stakeholders who participated in the Channel 3 option appraisal work. Source of funding for the EPR project unclear. Full business case including fully costed benefits for the identified EPR solution is required to ensure the Trust is ready to benefit from funding should / when it becomes available.	Group Director of Finance & Digital/ Chief Digital Information Officer	~~Oct 22~~ *Dec 23*	Apr 23 Update – Approval given at Feb Exec, Digital Committee and CSG to move to FBC. Draft procurement proposal on requirements/procurement approach received from Channel 3 and is currently with key stakeholders for review. Meeting held with CEO and Group Director of Finance & Digital to verify approach 4th May Next steps - develop RFI/market engagement document and have a showcasing day to view the possibilities of the suppliers on the patch (ICS/national requirement) It has been confirmed regionally that no known funding is available. June 23 – EPR outline business case approval now anticipated for Nov 23 following clinical review.	

				Nov 23 – new market engagement event arranged for 13 Dec. Revised deadline required to be agreed for closure of this gap. Jan 24 – as outlined above an engagement event was held in Dec 23. Delivery of the FBC is dependent on the outcome of the EPR discussions. Dates will need to be re-aligned to the procurement timeline for the preferred solution. Procurement to be stood up as a project in the next reporting period.	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Digital delivery plan reviewed by Digital Committee at each meeting	Committee identified that greater assurance over data quality would be beneficial to see at Digital Committee. Work is being progressed through the Digital Assurance Group to expand the data quality reporting and will be reported to Digital Committee following this.	Chief Digital Information Officer	Jun 23	Nov 23 – update to be provided at the December meeting. Dec 23 – Complete, delivery plan is a regular item with a new reporting format which has been accepted by the committee.	**Complete**
Digital & Data Strategic objectives update report reviewed by Digital Committee	KPIs: Committee requests further assurance in the form of narrative explanations for the items RAG-rated as red in the Digital Service KPI report	Chief Digital Information Officer	Feb 23	Apr 23 – this remains a work in progress, linked to action below regarding 'leading indicators' Nov 23 – as required, the KPIs were escalated to Board in September 23 as part of the Digital Committee reporting. An action plan has been developed and escalation	**Complete**

					processes are in place. Jan 24 – Digital Service KPI report presented at the Dec 23 meeting following significant work to refine the KPIs and narrative. Committee to consider whether the new report provides closure on this identified gap in assurance. Feb 24 – Committee confirmed that the reporting around KPIs is providing the assurance information required and therefore agreed to close out this action.	
Digital & Data KPIs reported to Digital Committee		KPIs: Risk Management Programme with IAOs at 22% compliance vs 100% target. Improvement plan and interim targets requested.	SIRO	Jun 23	Apr 23 – compliance routinely reported to SMT for management action. June 23 – issue identified by the Committee for Board escalation Nov 23 – confirmed that this has been escalated to Board and to Audit Committee. Dec 23 – limited progress had been made by the December meeting. The Executive lead would provide the Chair with an informal update prior to the next meeting in Feb 24. Feb 24 – some improvement has been seen here but this needs to be sustained in order to demonstrate that the gap in assurance has been addressed.	**Overdue**
AuditOne outstanding actions – progress report presented to Digital Committee		KPIs: Review of digital KPIs is taking place with high level indicators to be developed and aligned to the emerging 'leading' indicators.	Head of Digital Transformation and Assurance	Jun 23	Apr 23 – commenced June 23 – lack of progress on delivery of some KPIs to be	**Complete**

					escalated to Board. Nov 23 – as required, the KPIs were escalated to Board in September 23 as part of the Digital Committee reporting. An action plan has been developed and escalation processes are in place. Jan 24 – Digital Service KPI report presented at the Dec 23 meeting following significant work to refine the KPIs and narrative. Committee to consider whether the new report provides closure on this identified gap in assurance. Feb 24 – Committee confirmed that the reporting around KPIs is providing the assurance information required and therefore agreed to close out this action.	
Digital workforce capacity tracker reviewed at Digital Transformation Group		Open and closed audit action report doesn't provide details on how actions have been closed.	Head of Digital Transformation and Assurance	Feb 24	Jan 24 – report and governance process around closure of audit actions has been updated to ensure that this narrative is provided. Committee to consider closing this gap in assurance at the next meeting.	
Digital Committee receives tracking report on open audit actions to monitor implementation						
Assurance (Level 3 – external)						
AuditOne reports – Docstore IT General Controls (reasonable), Cyber Incident Response Planning (reasonable), Health Information Exchange (good), Outpatient		Complete Peer Review and submit National Digital Maturity Assessment return	Chief Digital Information Officer	Jun 23	June 23 – peer review was completed in May 23 and submitted to NHSE. The results will be considered in a	**Complete**

Digital Programme (substantial), DSP Toolkit follow-up (moderate), IT Change Management (limited), IT Asset Management (limited), ICE system audit (reasonable)	[redacted]				follow-up piece of work to understand development opportunities.	
Global Digital Exemplar Fast Follower accreditation	[redacted]					
Digital Maturity Assessment and peer review completed	[redacted]					

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 11

Report Title:	**Constitutional Amendment**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 March 2024			
Author:	Jennifer Boyle, Company Secretary			
Sponsor:	Alison Marshall, Chair			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☐	**Information:** ☐
	To seek approval for proposed changes to the Constitution.			
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*	Governance and Development Committee – August 2023 and January 2024 Council of Governors – February 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*	• There are a number of vacant appointed Governor positions on the Council, which in part reflect changes that have impacted on local partner organisations. • This paper proposes a change to the make-up of the appointed Governor positions on the Council to ensure that key partners are represented. • The paper also proposes to remove the Governor Code of Conduct and Council of Governors' Standing Orders as appendices to the Constitution, as they are separate and distinct documents with their own review and approval processes. • The Council of Governors approved the proposed changes to the Constitution in February 2024 (except the change relating to the Standing Orders, as the paper was deferred due to quorum requirements).			
Recommended actions for this meeting:	The Board of Directors is requested approve the proposal to amend the Constitution as follows:			

<table>
<tr><td>Outline what the meeting is expected to do with this paper</td><td colspan="5">• Replace the Gateshead Diversity Forum with Healthwatch Gateshead;
• Remove the CCG seat from the composition of the Council; and
• Formally separate the Governor Code of Conduct and Council of Governors' Standing Orders from the Constitution so they are no longer appendices.</td></tr>
<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="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">Representing the views of key partners at the Council should support the achievement of objectives aligned to Aim 4 and 5.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☐</td><td>Responsive
☐</td><td>Well-led
☒</td><td>Effective
☐</td><td>Safe
☐</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">-</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

Constitution Review – Appointed Governors

1. Introduction

1.1. Paragraphs 6.3, 6.6 and 6.7 of the Constitution define the following appointed / partnership Governor positions on the Council of Governors:

> 6.3 The specified partnership organisations below may appoint one Member of the Council of Governors:
>
> (a) Newcastle University
> (b) Northumbria University
> (c) Gateshead College
> (e) Gateshead Jewish Community Council
> (f) Gateshead Diversity Forum
> (g) Gateshead Youth Assembly
>
> In addition one member of the Council of Governors will be appointed from a voluntary organisation working within the community.
>
> 6.6 **Clinical Commissioning Group Governors**
>
> 6.6.1 Newcastle Gateshead Clinical Commissioning Group is authorised to appoint one Clinical Commissioning Group Governor pursuant to a process agreed by the Clinical Commissioning Group and the Trust. Where a Clinical Commissioning Group Governor post falls vacant, the CCG will appoint another Governor within three months of the Trust Secretary having received notification that the post is vacant.
>
> 6.7 **Local Authority Governors**
>
> 6.7.1 Gateshead Council are authorised to appoint one Local Authority Governor pursuant to a process agreed by that Local Authority and the Trust. Where a Local Authority Governor post falls vacant, the Local Authority will appoint another Governor within three months of the Trust Secretary having received notification that the post is vacant.

1.2. Recognising that a number of these partner organisations have not existed for some time or have held long-standing vacant positions on the Council of Governors, the Council of Governors and its Governance and Development Committee have considered, discussed and approved proposals to change the composition of this element of the Council.

1.3. The proposal outlined in this paper was approved by the Council of Governors in February 2024 (except the proposal relating to the Standing Orders due to the deferral of the agenda item).

1.4. Constitutional amendments require approval by both the Council of Governors and the Board of Directors, and therefore the proposals are presented to the Board for decision.

2. Appointed Governor Composition

2.1. There are a number of longstanding vacancies amongst our appointed Governors as shown in the following table:

Appointing organisation / group	Appointee
Newcastle University	New appointee Sasha Ban commencing in post shortly
Northumbria University	Dr Gemma Francis Spiers
Gateshead College	Chris Toon
Gateshead Jewish Community Council	Aron Sandler
Voluntary Organisation in the Community / Gateshead Voluntary Organisation Council	New vacancy which arose in January 2024 following the resignation of Douglas Hunter from Equal Arts
Gateshead Diversity Forum	Longstanding vacancy
Gateshead Youth Assembly	Longstanding vacancy
CCG Governor	Longstanding vacancy
Local Authority Governor	New appointee Cllr Dot Burnett commencing in post shortly

2.2. During the year the Governance and Development Committee focussed attention on the following longstanding vacant positions:

- Gateshead Youth Assembly;
- Clinical Commissioning Group;
- Gateshead Diversity Forum; and
- Local authority.

2.3. The Committee felt that the seat for Gateshead Youth Assembly should be maintained and the Company Secretary has contacted the Chief Executive of Gateshead Youth Council (of which the Assembly is part of) to discuss whether they have any interested young people who would like to take up the vacant seat.

2.4. The Gateshead Diversity Forum no longer exists and a constitutional change would be required to amend this to another named organisation. Research did not identify an alternative umbrella diversity group which represents equality and diversity in the community in the widest sense (i.e. across multiple protected characteristics).

2.5. When this was discussed at the Committee, a suggestion was made regarding seeking representation from Healthwatch Gateshead. As Healthwatch represents the interests of all members of the community in having a voice and input into health and social care services, this would be good alternative to a dedicated diversity group (recognising that aspects of diversity are represented by other appointed Governors – through the Jewish Community Council for example). It is also noted that other local Councils include Healthwatch representation, so this would not be unusual.

2.6. The Company Secretary reached out to Healthwatch to ensure that should the constitutional change be approved they would be able and willing to put forward a representative. A positive meeting was held with the Chair and Chief Executive of Healthwatch Gateshead, who will put forward the proposal to their own Board in March 2024.

2.7. As previously discussed the CCG no longer exists and therefore the seat should be removed or replaced. At present no other trust in the region has replaced their CCG seat with a seat for the ICB. As the Trust has many contact

points with the ICB, it is not proposed that this would add anything additional to the representation and accountability structures already in place.

2.8. The benchmarking shared with the Committee earlier in the year demonstrated that our Trust has comparatively more appointed Governors than our peers when compared to the total size of the Council. As such, it is proposed to remove the CCG seat entirely and not seek a replacement. It is noted that South Tyneside and Sunderland NHS FT recently implemented the same constitutional change. The Council of Governors were supportive of this proposal and approved it in February 2024.

2.9. With regards to the vacant local authority seat, the Chair raised this at a meeting with the Leader and the Chief Executive of Gateshead Council, and we are pleased to be welcoming Cllr Dot Burnett to the Council of Governors shortly.

3. Other aspects of the Constitution

3.1. A number of core governance documents have been subject to recent review, including the Governor Code of Conduct and the Council of Governors' Standing Orders. Both are standalone documents, but are also appended to the Constitution.

3.2. The Code of Conduct was approved at the Council of Governors, but the quorum requirements were not reached for the Standing Orders.

3.3. As both documents are separate and distinct from the Constitution with their own processes for approval, it is recommended that they are both removed as appendices from the Constitution.

3.4. The Council formally approved the separation of the new Code of Conduct from the Constitution. As the Standing Orders agenda item was deferred, this will be reconsidered at the next Council of Governors.

3.5. It is recommended that the Board of Directors formally approves the removal of the Code of Conduct and Council of Governors' Standing Orders as appendices of the Constitution (noting the Standing Orders will remain until this is also approved by the Council). This includes approval to adjust references to these appendices in the Constitution to signpost readers to the standalone documents.

4. Solutions / recommendations

4.1. In summary, the Council is requested to approve Constitutional amendments to:

- Replace the Gateshead Diversity Forum with Gateshead Healthwatch (subject to confirmation that Gateshead Healthwatch has approved the proposal for a representative to take up this position);
- Remove the CCG seat from the composition of the Council;
- Formally separate the Governor Code of Conduct and Council of Governors' Standing Orders from the Constitution so they are no longer appendices and amend the references in the Constitution accordingly.

4.2. The actual proposed changes to the text of the Constitution in relation to the appointed Governors can be seen in Appendix 1.

4.3. Constitutional amendments can only be passed as follows:

> 18. **Amendment of the Constitution**
>
> 18.1 (1) The Trust may make amendments to this Constitution only if –
>
> (a) more than half of the members of the council of governors of the Trust voting approve the amendments, and
>
> (b) more than half of the members of the Board of Directors of the Trust voting approve the amendments.
>
> (2) Amendments made under this section take effect as soon as the conditions in subsection 18.1 (1) (a) and (b) are satisfied

4.4. As the Council of Governors has already approved the changes (except the separation of the Standing Orders), the changes can be enacted if Board approval is granted. Confirmation on the outcome of the Gateshead Healthwatch Board discussions is expected prior to the Trust Board meeting and a verbal update will be provided should the outcome change the proposals in this paper.

4.5. As the changes relate to the powers of Governors, it will also be presented to the next Annual Members' Meeting in September 2024. The amendment can be enacted before this time, but would cease to have effort should it be rejected by Members at this time.

Appendix 1 – Proposed Changes to the Constitution

Removal and amendments of the definitions as follows:

"other partnership Governor"	means a Member of the Council of Governors appointed by a partnership organisation other than a ~~Clinical Commissioning Group or~~ university providing a medical or dental school to the Trust specified in paragraph 6.3;
~~"CCG Governor"~~	~~means a Member of the Council of Governors appointed by a Clinical Commissioning Group for which the Trust provides goods or services;~~

Other amendments to the main body of the Constitution:

6. Council of Governors

6.1 The Trust is to have a Council of Governors. It is to consist of Public Governors, Staff Governors, ~~Clinical Commissioning Group Governors~~, Local Authority Governors, Patient & Out of Area Governors, and other Partnership Governors.

6.2 The Council of Governors of the Trust is to include:

(a) 17 Public Governors

(b) 6 Staff Governors

~~(C) 1 Clinical Commissioning Group Governor~~

(c~~d~~) 1 Local Authority Governor

(de) 7 Partnership Governors

The number of Public Governors comprise more than half the total Membership of the Council.

Partnership Governors

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

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

In addition one member of the Council of Governors will be appointed from a voluntary organisation working within the community.

~~6.6 Clinical Commissioning Group Governors~~

~~6.6.1 Newcastle Gateshead Clinical Commissioning Group is authorised to appoint one Clinical Commissioning Group Governor pursuant to a process agreed by the Clinical Commissioning Group and the Trust. Where a Clinical Commissioning Group Governor post falls vacant, the CCG will appoint another Governor within three months of the Trust Secretary having received notification that the post is vacant.~~

6.~~6~~7 **Local Authority Governors**

6.~~6~~7.1 Gateshead Council are authorised to appoint one Local Authority Governor pursuant to a process agreed by that Local Authority and the Trust. Where a Local Authority Governor post falls vacant, the Local Authority will appoint another Governor within three months of the Trust Secretary having received notification that the post is vacant.

6.~~7~~8 **Other Partnership Governors:**

6.~~7~~8.1 Newcastle University, Northumbria University, Gateshead College and Gateshead Voluntary Organisation Council, Gateshead Jewish Community Council, Gateshead ~~Diversity Council~~Healthwatch, and Gateshead Youth Assembly are authorised to appoint one Governor each pursuant to a process agreed by those organisations and the Trust. Where a Partnership Governor post falls vacant, the relevant organisation will appoint another Governor within three months of the Trust Secretary having received notification that the post is vacant.

~~6.9.3 Clinical Commissioning Group Governors:~~

~~(a) may hold office for a period of three years;~~

~~(b) are eligible for reappointment at the end of that period;~~

~~(c) cease to hold office if the sponsoring Clinical Commissioning Group withdraws its sponsorship of them.~~

6.13 **Vacancies:**

6.13.1 Where membership of the Council of Governors ceases for one of the reasons set out in paragraphs 6.10 or 6.11 or through death in service:

(a) public and staff Governors shall be replaced at the next annual election in accordance with the relevant Electoral Scheme set out in Annex 3.

(b) should the vacancy affect the quorum or representation of a constituency for a period exceeding six months, a by-election shall be held in accordance with the relevant Electoral Scheme set out in Annex 3.

(c) ~~Clinical Commissioning Group~~, Local Authority and Partnership Governors shall be replaced in accordance with the processes agreed pursuant to paragraphs 6.6 to 6.~~7~~8.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 12

Report Title:	**Annual Declaration of Board Members Interests, Gifts and Hospitality**			
Name of Meeting:	Board of Directors			
Date of Meeting:	Wednesday 27th March 2024			
Author:	Diane Waites, Corporate Services Assistant			
Executive Sponsor:	Alison Marshall, Chair of the Board of Directors 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:** ☐
	In accordance with section 20 of Schedule 1 of the Health & Social Care (Community Health and Standards) Act 2003 NHS Foundation Trusts are required to maintain a register of Directors' and Governors' interests. This requirement is also enshrined in section 10 of the Trust's Constitution. The register for Gateshead Health NHS Foundation Trust is held at Trust Headquarters and is available to the public through the Company Secretary.			
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*	• Interests have been declared in accordance with the Trust's Managing Conflicts of Interest Policy. • This is aligned to the model policy issued by NHS England. • All Board Members must make an annual declaration and are required to make subsequent in-year declarations to record any changes in interests.			

<table>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The Board is asked to:
• Approve and record in the Board minutes the declared interests
• Note that the next annual review of the declaration of Board members' interests will take place in March 2025.</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>
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<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">Declarations of interests enable the early identification of any potential conflicts which may in turn impact upon the ability to achieve the strategic aims and 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
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<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">-</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

Forename	Surname	Position	Interest	From	To	Comments
Adam	Crampsie	Non-Executive Director	Chief Executive - Everyturn Mental Health	01/12/2020	present	Provider to Trust
			Chair - North East & North Cumbria VCSE Forum and Mental Health Lead	01/05/2023	present	
			Non-Executive Director - XR Therapeutics	01/01/2024	present	
			Trustee - Terrence Higgins Trust	01/05/2023	present	
Trudie	Davies	Chief Executive	None	01/03/2023	present	Started in post on 1 March 2023
Gavin	Evans	QEF Managing Director	None			
Gill	Findley	Chief Nurse/Deputy Chief Executive	None			
Neil	Halford	Medical Director of Operations	None			
Joanne	Halliwell	Group Chief Operating Officer	None	01/09/2023	present	Started in post on 1 September 2023
Martin	Hedley	Non-Executive Director	Non-Executive Director - Royal Surrey NHS Foundation Trust	01/03/2016	present	
			Chair & Non-Executive Director - RSCH Pharmacy Limited	01/11/2019	present	
			Governor - Gateshead College	01/03/2019	present	
			Managing Director/Recruiting/Coaching - Vision Achievement Limited	01/02/2013	present	
Kris	Mackenzie	Group Director of Finance and Digital	None			
Alison	Marshall	Chair	Non-Executive Director of Northern Powergrid plc (North East and Yorkshire)	2014	present	
			Ambassador for North Northumberland Hospice Care	2015	present	
			Spouse - NED of North East Ambulance Service NHSFT	2017	present	
			Spouse - NED of North East Ambulance Service Unified Solutions Ltd	2019	present	
			Spouse - Chair of Newcastle Gateshead Initiative	2016	present	
			Spouse - Chair of North East England Chamber of Commerce	2020	present	
			Spouse - Director of Newcastle United Foundation Projects Ltd			
			Spouse - NED of Believe Housing Ltd	2019	present	
			Spouse - Chair of Trustees for Newcastle United Foundation			
			Spouse - Ambassador of North Northumberland Hospice Care	2015	present	
			Spouse - Chair of Regional Development Committee, Prince's Trust			
Andrew	Moffat	Non-Executive Director	Non-Executive Director of Advanced Northumberland	24/04/2023	present	
Hilary	Parker	Non-Executive Director	Non-Executive Director of Kingston Properties Ltd (wholly owned subsidiary of Bernicia Housing)	2019	present	Registered housing association
			Trustee - Newcastle University Development Trust	2016	present	Charitable Trust
			Non-Executive Director of QE Facilities Ltd (wholly owned subsidiary of GHNHSFT)	01/10/2023	present	
			Chair of QE Facilities Ltd (wholly owned subsidiary of GHNHSFT)	2020	30/09/2023	
			Consultant - Sintons LLP Law Firm	2016	present	
Mike	Robson	Vice Chair/Non-Executive Director	None	01/04/2023	31/03/2024	
Anna	Stabler	Non-Executive Director	JP - Durham and Cleveland Bench	01/07/2021		Note - this will exclude any public law cases in relation to the Trust
Maggie	Pavlou	Non-Executive Director	Owner / Director - People Gauge (software business)	2011		
			Trustee - The People's Kitchen (charitable organisation)	2020		
			Trustee - The Chronicle Sunshine Fund (charitable organisation)	2020		
			Trustee - York Theatre Royal (arts)	2022		
			Chair of QE Facilities Ltd (wholly owned subsidiary of GHNHSFT)	01/10/2023	present	
			Non-Executive Director of QE Facilities Ltd (wholly owned subsidiary of GHNHSFT)	2022	30/09/2023	
			Spouse - Harlow Printing (printing firm)	2022		
Amanda	Venner	Group Director of People and Organisational Development	None			

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 13

Report Title:	**CQC Statement of Purpose**			
Name of Meeting:	Trust Board of Directors			
Date of Meeting:	27 March 2024			
Author:	Mrs Lindsay Grieves, CQC Compliance Manager Mrs Jane Conroy, Head of Quality and Patient Experience			
Executive Sponsor:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals			
Report presented by:	Mrs Jane Conroy, Head of Quality and Patient Experience			
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*	This paper has been considered by EMT.			

<table>
<tr><td>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</td><td colspan="6">The Statement of Purpose identifies five Locations which will appear on the Trust’s CQC Registration Certification:

• Queen Elizabeth Hospital
• Blaydon Primary Care Centre
• Cleadon Park Primary Care Centre
• Grindon Lane Primary Care Centre
• Breast Screening Unit at Sunderland Royal Hospital

All locations have previously appeared on the Trust’s CQC registration certification.

The Queen Elizabeth Hospital also has 85 satellite sites as detailed within, where Regulated activities may be delivered at or from. This includes AAA Screening provided within 11 HM Prisons.

This document includes the ‘Good’ outcome from the 2023 Maternity focussed inspection and updated bed numbers, WTE staff and annual revenue figures.</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:	

Statement of purpose

Health and Social Care Act 2008

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.

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**.

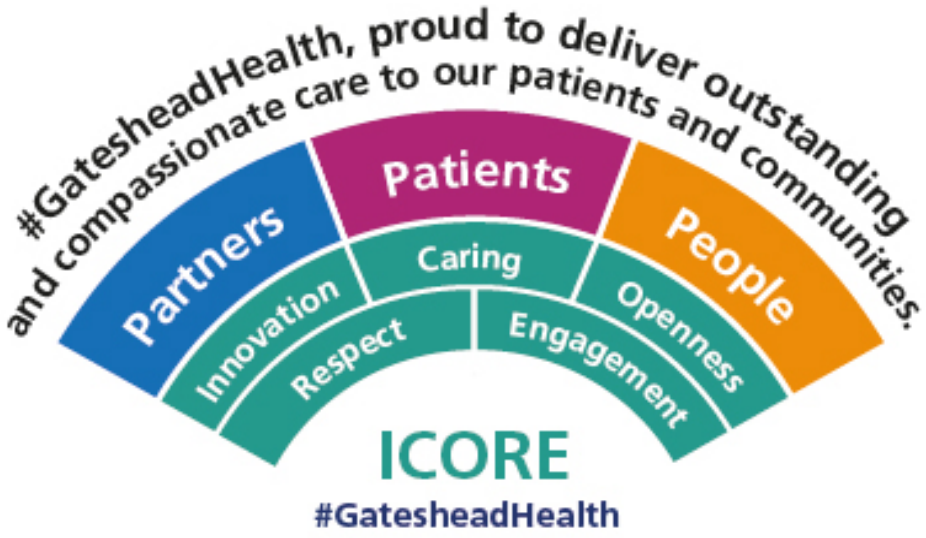
Through engagement with our people and partners, we have recognised how important it is that we use the title 'Gateshead Health' to be inclusive to all of the people who work for and represent the Trust.

- 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 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,	• AAA Screening

	Northumberland, TD15 1LT	
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 Tyne and Wear, NE40 4US	• Anticoagulation/Warfarin Clinics
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, Northumberland, NE46 1QJ	• AAA Screening
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 as well as CDC which includes CT, MRI, Ultrasound and Echo.

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 Neil Halford

2. Manager's contact details	
Business address	Acting 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]	
Neil.halford@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.

Gateshead Health NHS Foundation Trust

Chair's Report

Alison Marshall, Chair of the Board of Directors

27 March 2024

Announcements

We start this month's report with the sad news of the loss of two valued colleagues.

Joanne Donnelly, a Sister in our Emergency Department for many years, passed away last month.

Alison Sidebotham, a member of our finance team, sadly and unexpectedly passed away earlier this month.

Our thoughts are with the family and friends of both Alison and Joanne at this time.

Colleagues have been paying their respects and sharing their memories through books of condolence, which will be shared with the families.

Governor and Member Updates

- On 14 February we held our Council of Governors meeting. Key decisions included:
  - The reappointment of Mike Robson, Non-Executive Director (NED), for an additional year (to 30 June 2025);
  - The reappointment of Non-Executive Directors Anna Stabler (to 30 June 2027) and Maggie Pavlou (to 30 September 2027) for a second three-year term;
  - Approval of a new Governor Code of Conduct, a new Governor Handbook and a new Membership Strategy 2024 – 2027; and
  - Approval of proposed constitutional changes, in line with the paper on today's Board agenda.
- We held a Medicine for Members' event on 11 March. The event showcased the fantastic work of our community teams in caring for our patients. This included a marketplace event with stalls hosted by different community services to provide members, our Governors and the public with opportunities to learn more about how different elements of community services operate. This was followed by an informative presentation from the teams in our lecture theatre.
- On 20 March we held a workshop with Governor colleagues to engage and consult on the priorities for inclusion in the Quality Account.
- We will shortly be welcoming two new appointed Governors to the Council – Sasha Ban (Assistant Professor of Nursing, Midwifery and Head) representing Northumbria University and Councillor Dot Burnett representing Gateshead Council.




Stakeholder Engagement

Gateshead Health NHS Foundation Trust

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

- Visit to theatres
- Meeting with North East and North Cumbria Integrated Care System (NENC ICS) provider chairs
- North ICP Chairs, LA leaders and primary care leads
- Medical Director Andy Beeby's retirement celebrations hosted by the Jewish community
- Clinical Strategy Group away day
- Attending Gateshead Health and Wellbeing Board
- Visit to the Community Diagnostic Centre at the MetroCentre
- Consultant interviews across a number of specialties
- Great North Healthcare Alliance meetings
- Lead and Deputy Lead Governor monthly meetings
- Attending Urgent and Emergency Care Great North Healthcare Alliance conference

Partnership working

Gateshead Health NHS Foundation Trust

Great North Healthcare Alliance

- Ongoing discussions between Chairs and CEOs progressing well
- Key principles - first and foremost of which is improved patient outcomes and reduced inequalities
- Each Trust will retain its independent identity and integrity as a separate entity
- Principal focus has been to prioritise alliance working on shared areas of interest
- Identified areas of work progressing with CEO leads
- Input from Governors and Non Executive Directors
- Executives and Non Executives from across the Trust's are meeting to determine the workplan
- Emergency care conference 22nd March

Centre of Excellence for Women's Health inc. Women's Health Hub at Gateshead Place

- Excellent engagement across the Trust and wider system
- Attended Health and Wellbeing Board
- Trust representation at Overview and Scrutiny Committee and Primary Care Development session
- GP survey on services identified for the health hub to better understand current provision
- Service user survey in partnership with Healthwatch, GPs and Involve North East (791 responses so far)
- Discussions with primary care about pathways of care

Star of the Month Nominations

January

- Kelly Riley – Maternity
- Tracey Stead – Facilities
- Lois Brown – Medical Staffing
- Lisa Hall – POD

February

- Sue Bunting – A&E
- Ross Peddie – Surgery
- Katie Forester - InPhase
- Drew Griffiths - POD
- Ashleigh Frame - POD

Kelly Riley

You're a Star Winners

Sue Bunting

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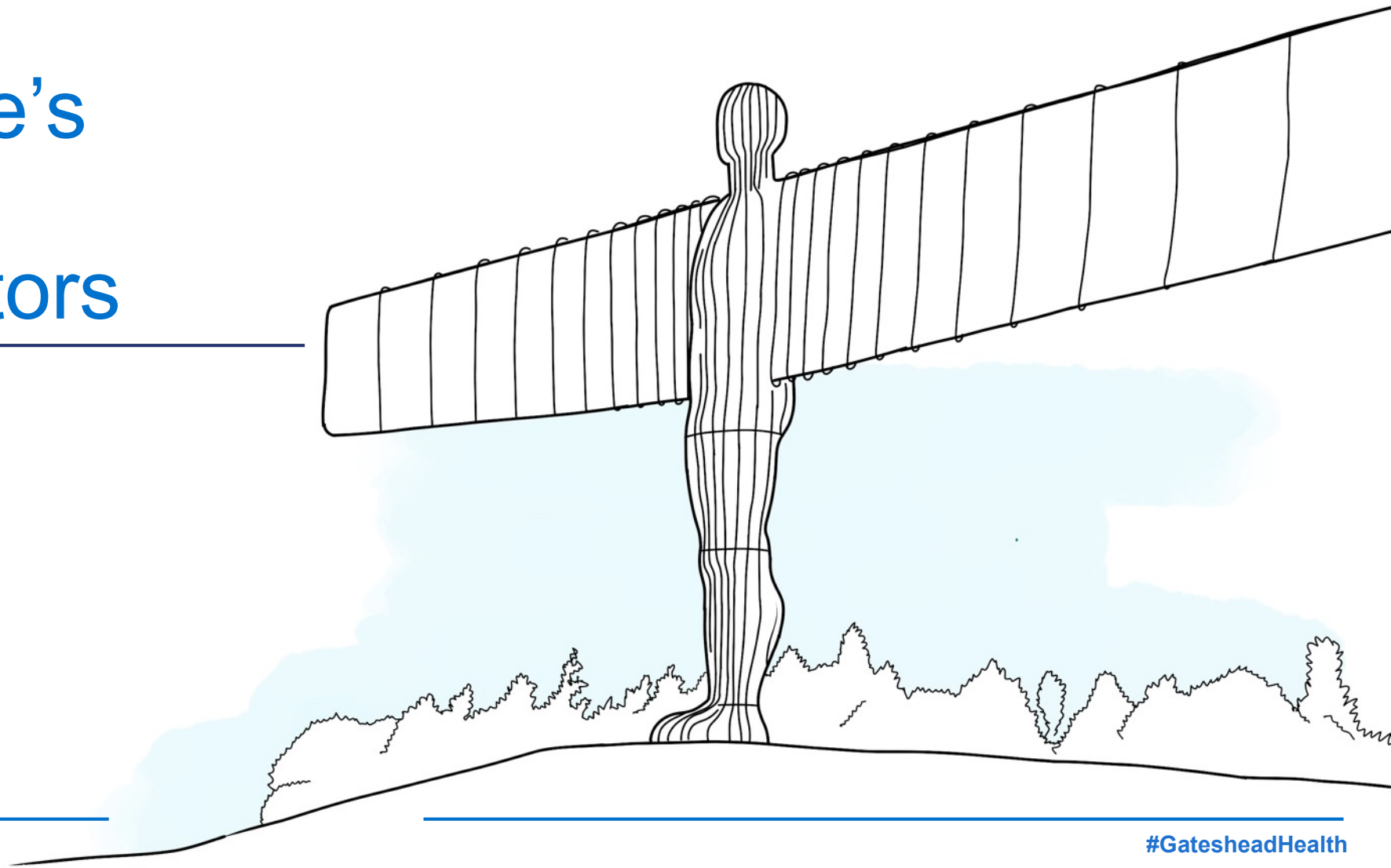
NHS Foundation Trust

Chief Executive's Update to the Board of Directors

Trudie Davies, Chief Executive

31 January 2024



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

Gateshead Health NHS Foundation Trust

- Our **maternity care** was ranked 5th out of 61 providers across the country in the annual Care Quality Commission (CQC) maternity survey. Our team achieved outstanding scores in relation to antenatal support, labour and birth and postnatal care.
- Development of our **Quality Account** for 2023/24 is underway. This has included consultation on the 2024/25 Quality Account priorities with colleagues and our Council of Governors. Consultation with Gateshead Healthwatch and the Joint Consultative Committee is also scheduled.
- We are seeking to recruit additional **Freedom to Speak Up Champions** to support the work of the Freedom to Speak Up Guardian and provide colleagues with the confidence to raise concerns, helping us to continue to improve our services to patients and working environment for colleagues.
- The Fuller Enquiry Phase 1 report was published in November 2023. This is an independent enquiry into the issues raised by the actions of David Fuller who abused the bodies of patients in hospital mortuaries. We have responded to the wider NHS Phase 2 enquiry through completion of a return. This will help to determine whether practices and procedures in place in NHS hospitals are sufficient to safeguard the security and dignity of the deceased. We strengthened our access controls to the mortuary as part of the initial response to the Fuller conviction in 2021.

Engagement, involvement and visits:

- Visit to theatres
- Meeting with our matrons
- Metastatic breast cancer event

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

Gateshead Health NHS Foundation Trust

- We shared our latest **NHS Staff Survey** results. We scored better than the national average in a number of areas, including care of patients being our top priority (79%), recommending the Trust as a place to work (68%) and colleagues being happy for a friend or relative to receive care at our Trust (75%). We are not complacent and will use the survey results to help inform future improvements.
- We have continued our work on the **Healthcare Assistant re-banding process** and shared our proposal and implementation plan with Unison and colleagues, providing a number of engagement opportunities to address queries and provide feedback.
- Our Medical Director, **Andy Beeby**, retired earlier this month after almost 30 years with the Trust and over 7 years as Medical Director. Colleagues past and present gathered to thank Andy for his service to the Trust and our patients and wish him well for his retirement. Mr Neil Halford is the Interim Medical Director until the recruitment to the substantive post is completed.
- We have welcomed **Gavin Evans** as our new Managing Director for QE Facilities, our subsidiary company. Gavin brings a wealth of experience and we look forward to working with him and our colleagues in QEF.
- We held a soft launch for our '**It's Not OK' campaign**, which represents our organisational zero tolerance work. This is an important piece of work for our cultural development alongside inclusivity training for all of our people managers.
- We celebrated **National Apprenticeship Week** in February, with 187 colleagues currently on an apprenticeship programmes. We also hosted our annual Apprenticeship Awards. Congratulations to all winners and nominees!
- Over the last few months we have worked with our **staff networks** to celebrate LBGT+ History Month in February and women's health month in March.

Engagement, involvement and visits:

- Apprenticeship Awards
- Consultant interviews across a number of specialities
- Loyalty and Motivation Awards
- Meetings with consultants

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

NHS Gateshead Health NHS Foundation Trust

- A significant amount of work has been undertaken on the development of our **annual plan**, including the development of underlying financial, workforce and operational plans for 2024/25. This has included engagement with our Governors, business units and corporate teams. Initial submissions have been made ahead of the final submission in early May.
- We continue to see improvements in our performance against key metrics. This included being recognised in a BBC article as one of the top ten trusts nationally with the shortest waits for routine treatment in January 2024 (the **18 weeks target**).
- We have maintained the improvements made in relation to **ambulance handovers**, with all handovers being completed within 30 minutes since 19 January 2024. This has been recognised by North East Ambulance Service and other local providers. This is a reflection not just on the work of the Emergency Department but on many other teams across the Trust who have worked together to achieve and maintain this standard, which is critically important for ensuring that our patients and those in the community receive timely and appropriate care.
- Building on the success of this and in line with our strategic aim to be an outstanding District General Hospital, we aim to deliver the NHS England standard that **76% of patients presenting to our Emergency Department will be admitted, transferred or discharged within four hours**. We believe that we can realise this through a whole Trust approach, working with partner agencies externally and demonstrating a collective responsibility to each other and our patients for whom long waits in the Emergency Department come with risks.
- We remain on track to achieve zero 65 week waits by the year-end, although we have identified a risk to achieving zero 52-week waits across certain specialties.

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

- We have continued to work with colleagues at place, ICB level and also within the Great North Healthcare Alliance as this begins to develop further.
- Our teams have been delivering **breast, bowel and abdominal aortic aneurysm (AAA) screening roadshows** to enhance community health awareness and facilitate early detection of potential health issues. The roadshows will continue throughout April, empowering our community to prioritise health and take proactive steps towards a healthier future.
- Work has commenced on the **Jubilee Courtyard Garden** which will provide a safe and supportive outside space for our patients, including critical care patients, stroke rehabilitation patients and dementia patients. It will also provide families of organ donors with a memorial space and provide a quiet and tranquil environment for visitors and colleagues. This has been made possible through our Gateshead Health Charity.
- Consultant and Staff Governor, Dr Andy Lowes, has been working with schools in our community to produce **artwork promoting organ donation**. In February we unveiled an incredible bespoke piece of artwork created by XP Gateshead school. ‘Being Human’ is displayed near the Windy Nook entrance.

Engagement, involvement and visits:

- Provider Collaborative workforce meetings
- Meeting with the Director of Public Health
- Great North Healthcare Alliance meetings
- Provider Collaborative and ICS meetings
- Place-based meetings

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

- Building work is now underway for the new MetroCentre **Community Diagnostic Centre (CDC)** in partnership with Newcastle Hospitals. The CDC will provide imaging, respiratory investigations and cardiac investigations with the centre designed to create capacity for these services that are seeing increased referrals. Faster access to crucial diagnostic tests like MRIs, ultrasounds, and heart function tests will have a really positive impact on patients from both Trusts.
- The CDC will offer 145,000 appointments per year and create 134 jobs when it opens in October 2024.

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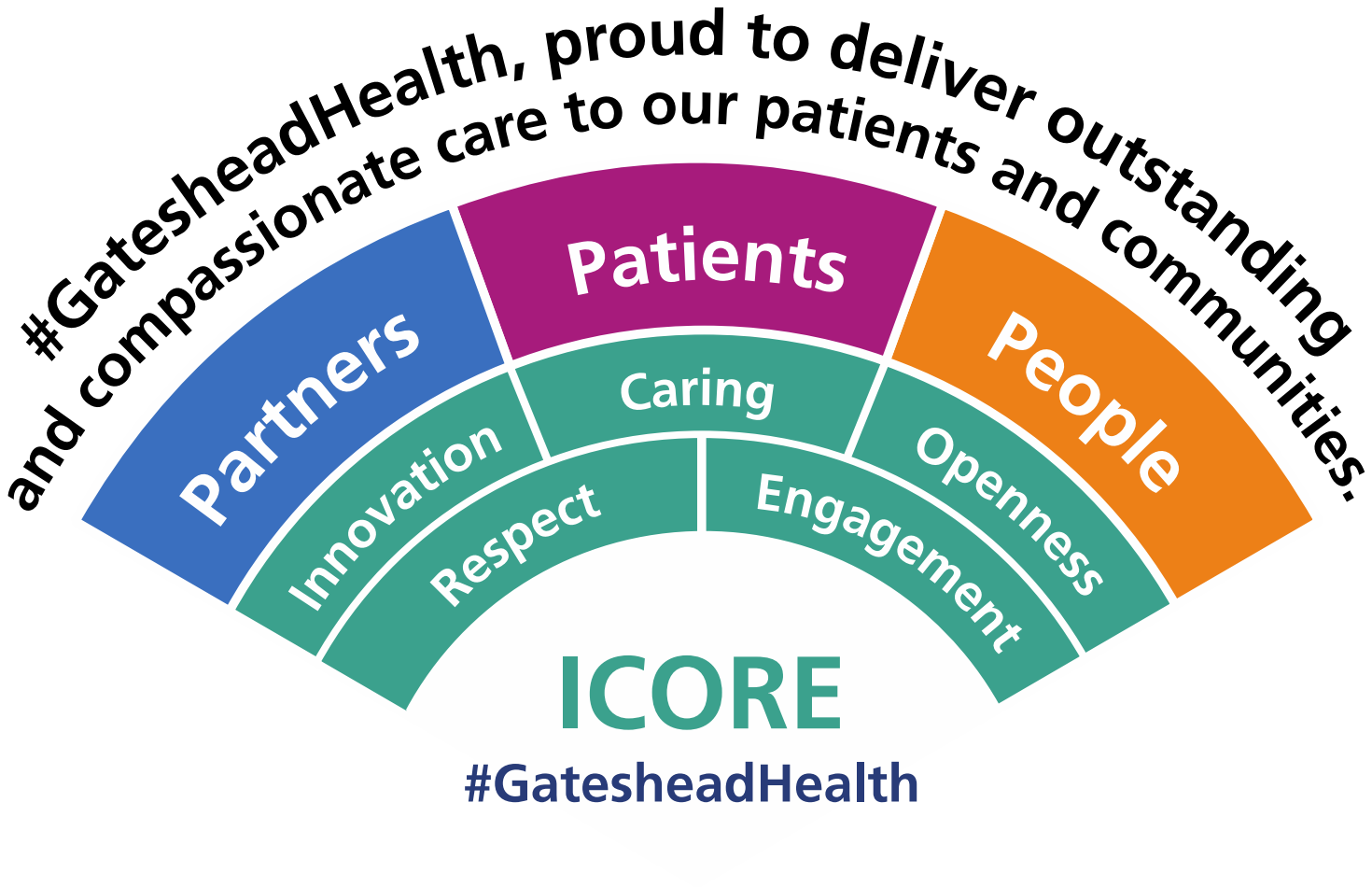


Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 16i

Report Title:	**Quarterly Strategic Aims and Objectives Q4 Update**			
Name of Meeting:	Trust Board			
Date of Meeting:	27 March 2024			
Author:	Executive Directors Nicola Bruce, Interim Director of Strategy, Planning and Partnerships			
Executive Sponsor:	Executive Directors			
Report presented by:	Nicola Bruce, Interim Director of Strategy, Planning and Partnerships			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To provide assurance over progress made towards the delivery of the strategic objectives for 2023/24.			
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*	Board committees have considered the objectives which have been mapped to them.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• The Board of Directors approved the strategic objectives for 2023/24 at their meeting in May 2023. • Strategic objective delivery action plans have been developed by Executive Director owners of each of the objectives since this time. • They have been reviewed by the relevant Board Committee. • This report presents a year end, Quarter4 update on the delivery of the strategic objectives for 2023/24.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is requested to: • review the accompanying action plan summary contained within this report • note progress towards delivery of the strategic objectives in 2023/24.			

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

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)	Risks which may pose a threat to the delivery of the corporate objectives are recognised via the Board Assurance Framework.		
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

					Quantity			11	32	6			
Strategic Aim	Strategic Objective	Summary of Actions	How	Action Owner	Start Date	End Date	Overdue	Some Risk	Work in Progress	Action Complete	Completion Date	Expected Outcomes/measures	Comments/progress
1) We will continuously improve the quality and safety of our services for our patients	SA1.1 Continue to improve our maternity services in order to improve performance against key indicators and ensure improved patient outcomes by March 2024. Executive Lead - Chief Nurse Assurance Committee: Quality Governance Committee	Assess and benchmark performance against key national inquiry reports in order to assure safety and promote learning	Action plan to be developed and implemented according to findings and monitor impact via quality committee.	KP	Apr-23	Mar-24						Delivery of the 19 safety priorities and improvement in the maternity metrics outlined and reported in the IOP	National maternity and neonatal plan has now been published. Gap analysis has been completed and we have joined with the regional team to agree how we implement some of the actions. We are linking this year 5 maternity incentive scheme. Concerns remain about our ability to achieve safety action 8 because of the significant cost of training and backfill. Options are being considered
		Assess and Implement the agreed plan for maternity Continuity of Carer and seek to measure improved outcomes according to expected benefits aligned to leading indicators.	Maternity team to be reconfigured to meet actions outlined in the MCOC plan	KP	Apr-23	Dec-23					Jun-23		We have met with staff and consulted on a range of options. The option chosen was to continue with one team and some enhanced support for the most vulnerable women. This has been implemented and is being evaluated. No further changes will be made at this stage.
		Implement any actions from the maternity CQC inspection 2023	Develop and implement action plan once final report is received and measure the impact, reporting via quality committee	GF/KP	Apr-23	Mar-24							The final CQC report has been received and actions have been added to the Trust wide CQC plan
	SA1.2 Develop and implement a continuous Quality improvement plan that enables the delivery of improved performance against key indicators by March 2024 Executive Lead - Chief Nurse Assurance Committee: Quality Governance Committee	Review, refresh and implement Quality Account Priorities to ensure that they align with Trust core goals and contribute to the agenda of reducing LOS	Implement the actions within the Quality Account and monitor the progress and impact on a monthly basis via divisional performance and quality governance meetings	GF	Apr-23	Mar-24						Quality Account Priorities achieved	Quality account actions have been presented to Quality Governance Committee and agreed. Actions will be monitored via the safecare risk and patient safety
		Monitor Quality Account Priorities implementation	Monitor the implementation plan for the Quality Account Priorities at SafeCare, Risk and Patient Safety Council	GF	Apr-23	Mar-24							Action plan is on the cycle of business for the safecare, risk and patient safety council.
	SA1.3 Ensure that there is a Digital first and data led approach to transformation and improvement across all domains of activity in order to contribute to delivery of the key indicators by March 2024 Group Director Finance and Digital Assurance Committee: Digital Committee	Enhance the basics - We will provide fast, modern, safe technology and services that users want and can rely on	Undertake the national Digital Maturity Assessment. Undertake user experience surveys and develop an improvement plan.	KM	Feb-23	Mar 24						Agreed Electronic Patient Record plan Improved data quality and data driven decision making Improved patient outcomes and staff experience	Q4 update - Complete. DMA completed and peer reviewed, gap analysis complete. Q4 Update: Complete. Several User Surveys have been conducted that will feed into the development of the EPR business case; ongoing schedule of user surveys to be developed as BaU. Gap analysis to feed into specification for Electronic Patient Record. Q2 Update: Partially complete - DMA completed and peer reviewed, gap analysis complete. User surveys complete/ongoing. Outstanding - Development of the improvement plan is linked to the completion of the EPR OBS and sue to delays in the supplier engagement and therefore collating stakeholder feedback this has been delayed. The date has been amended to reflect the current/revised date aligned to the EPR OBS. Q1 Update: Digital Maturity Assessment completed in draft; gap analysis currently taking place and will inform the specification for the EPR proposal.
			Implement the data quality strategy and develop indicators that provide assurance on clinical systems use and clinical coding depth.	KM	Dec-23	Mar-24							Q4 Update - Complete. Regular KPI reporting to DDAG, SMT and Digital Committee now includes Data Quality reports aligned to the DQ Strategy. Clinical Coding Workstream activity will continue into the new year. Q3 Update - partially complete. Digital KPIs are embedded, ownership outside of digital teams have been identified. A clinical coding workstream has been established. Q2 Update - Unable to progress KPIs specifically linked to the data quality strategy as this is outstanding. The initial draft was rejected in Oct 23 and information & performance team are progressing. Digital KPI reporting is established and under review, cross service working with performance and information is required to deliver and ensure integration with cross trust performance reporting. Kick off session to be arranged. Q1 Update - Some digital indicators developed and built into DAG reporting. This will be shared with service representatives to support an increase in this area. Looking at KPIs to track both digital performance and trust compliance with the ability to drill down to business units/service level.
		Deliver Improvements - We will provide technology to reduce inefficiencies, poor processes and duplicate records	Develop and agree the electronic patient record outline business case with full clinical ownership.	CB	Dec-21	TBC							Q4 Update: IN PROGRESS. Options appraisal paper currently in draft and will be taken through appropriate governance in April 24; it is recognised that this objective has been severely impacted by the delays in procurement. Propose that this objective is carried forward to 24/25 - Delivery timescales will be dependent on the procurement route agreed. Q3 Update - following the market engagement event, feedback has been collated and strategic direction sought regarding the direction of travel. This is required to complete the OBS. Alternative procurement routes are currently being investigated. Q2 Update - The market engagement event for the EPR had to be rescheduled due to industrial action, this represents a 3 month delay in the proposed procurement timeline; the date has been updated accordingly. There are 4 EPR suppliers scheduled to join the trust to present their EPR offering at the CSG away day in December. Feedback from this event will be used to enhance the draft specification and develop the supporting business case. Q1 Update - Outline business case agreed in February 23. Checkpoint requested to ensure full clinical ownership. Market engagement sessions to be arranged Autumn 2023 to agree the right strategic direction for the Trust.

					Quantity			11	32	6			
Strategic Aim	**Strategic Objective**	**Summary of Actions**	**How**	**Action Owner**	**Start Date**	**End Date**	**Overdue**	**Some Risk**	**Work in Progress**	**Action Complete**	**Completion Date**	**Expected Outcomes/measures**	**Comments/progress**
			Develop a systems and data exploitation plan that supports the delivery of leading indicators, supporting safe and efficient patient care.	DT/DR	Apr-23	Mar-24							Q4 Update: IN PROGRESS. Matrix of systems and compliance against Framework and whether they will be replaced by an EPR is currently in draft and will be presented to the next DTG and digital committee. A work programme led by the CNIO and Digital Nurses has commenced to support the development of a baseline utilisation standard of key systems within the trust. Q3 Update: Framework has been developed and approved; roadmaps for exploitation are currently being developed for the business critical systems initially focussing on enhancing our current provision and ensuring we are maximising the use of what we have already invested in. Longer term development and onward investment would be dependent on the EPR decision. Procedure for system exploitation management currently being developed. Initial roadmap to focus on agreed activity for 23/24. Longer term developments not started - longer term plan linked to the outcome/discussions regarding EPR.
		Open, share and transform - We will focus on joining up the needs of the user across the whole patient pathway	Expand access to patient record, results and images from across the region; sharing our data to support patient care cross the ICS.	CB	Dec-22	Mar-24							Q4 - UPDATE: ON HOLD. Key project delivery issues continue surrounding current Virgin link between Gateshead and North Tees and clinical safety impact on the Global Work List surrounding linking of patients with no matching demographics. The regional team are working with the supplier to resolve the issues but as yet no further delivery schedules are agreed. This is the GHFT workstream of a regional programme, GHFT are constrained by the regional delivery, Q3 - progress against this is restricted as it is a regional programme which dictates the delivery plan. Q2 Update - this is a regional programme led by the ICB's PMO. There has been delays in the programme relating to the technical processes which have now been resolved and ongoing delays with clinical sign off across all engaged trusts. GHFT continue to support the project and progress locally. Q1 Update - Global worklist testing completing, awaiting neighbouring Trusts. Delays in project due to regional timescale and cross organisational clinical sign off.
			Implement a patient portal to empower patients to manage their own health and care, and enable services to interact digitally with the patient.	CB	Mar-23	Dec-23							Q3 - Complete. The PEP is now live; rollout continues to additional services and phase 2 enhanced functionality is currently being planned. Q2 Update - Partially complete - The Health Call Patient Engagement Portal is the patient portal linked to the Great North Care Record. GHFT completed a successful pilot with the breast screening service, bringing together the PEP and the trusts hybrid mail solution meaning that patients at Gateshead were the first to go live with enhanced functionality - accessing both appointment information and supporting correspondence within the PEP. The trust continue to rollout the PEP to services according to the project timeline. Services live include •Symptomatic Breast •Trauma & Orthopaedics •Audiology •Dietetics & Nutrition Next services to go live: •Rheumatology •Gastroenterology •General Surgery Q1 Update - Contract in place, project work underway. Pilot clinic (breast) to go live July 23 with other areas to follow. GHFT to be the first trust to go live with supporting correspondence (linked to hybrid mail solution)
		Invest in people - We will focus on enhancing the skills and knowledge of the user involving them in digital	Implement the digital skills and inclusion plan for staff and patients; undertaking a workforce survey, completing a business case if required.	CB	Nov-22	TBC							A baseline assessment of current digital skills across our workforce will be undertaken to support the development of the EPR business case and will form the foundation of the training strategy for any subsequent deployment. Q2 Update - Patients, Citizens and Staff GHFT are a key contributing member of the Gateshead Digital Inclusion Group. This group is led by the local authority and comprises of health, social care, education, and charitable organisations at a Gateshead Place level. The group are collaborating to develop a Gateshead Digital Inclusion/equality strategy with a target date of December. The intention is that this will further be refined to a supporting organisation level action/delivery plan. Current activities of this group include a organisational skills survey which will also feed into the identification of the needs of our employees. The Group were shortlisted for a 'Dynamite Award' in the category "Equality, Diversity, and Inclusion" with the ceremony taking place 16/11. Staff Specific n addition to the activity above, a baseline assessment of current digital skills across our workforce will be undertaken to support the development of the EPR business case and will form the foundation of the training strategy for any subsequent deployment. It is suggested that this objective is split into two to allow for appropriate tracking of the two workstreams. Q1 Update - Talent management discussions have started in Dec 22, with a view to implement Scope for Growth talent management. Action plan currently being developed with the support of OD. Digital inclusion for patients - linked in to discussions at a place level.
	SA2.1 Caring for our people in order to achieve improved compliance of key indicators by March 2024 **Executive Lead - Executive Director of People and OD** **Assurance Committee: People and OD Committee**	Getting the basics right and looking after you in every way we can.	Providing a working environment where all basic needs are met for all colleagues working within the organisation.	LF	Apr-23	Mar-24						**Key Indicator: Absence rate reduction to 5% by March 2024** **Even better if target of 4.8% by March 2024**	Vending machines have been changed across the site to enable card payment. Out of hours catering offer continues. During strike action, free catering provision continues to be provided as part of the standard response. Work underway to place coffee machines in the Surgery Centre and on the Bensham site. Two junior doctor messes that have been renewed, refreshed and are accessible across the QE site. All existing offers remain and in addition, a review of out of hours catering has been completed in partnership with QEF, with a number of different options scoped. The option currently leading is the introduction of a new 24-hour vending machine that would replace the current vending machine and offer more cost-friendly and diverse meal options. Contract termination implications are being explored and a proposal paper is currently being developed by Associate Director of Estates and Facilities, ready for presentation to SMT. Q4 - Estates work underway and staff experience considered as part of this along with areas such as the Jnr Drs mess.
			Working in partnership with managers to support the needs of our people.	CO	Apr-23	Mar-24							Managing Well and Leading Well embedded as part of the development offer for people managers and leaders across the organisation, with QEF colleagues now invited to attend. New induction for line managers now in place to help build awareness of the expectations on managers. Professional policy training has been commissioned by Capsticks to provide a legal lens in addition to internal training supporting key policies including Grievance, Investigation/Disciplinary and Promoting and Supporting Attendance. Matrix approach and model of working across POD is well embedded, provides the foundations for supporting managers and providing access to specialist skills and expertise to support them in meeting the needs of their people. Policy Training has now moved back to internal delivery. Q4 - LTS Clinics are creating capacity and building managers capability in the delivery of procedural excellence. Matrix Approach continues. and renewed focus on sickness absence to commence in Q1.
			Embedding an organisational wellbeing culture embedded and aligned to the national Health & Wellbeing Framework.	LF	Apr-23	Mar-24							Continue to deliver against the three workstreams set out in the HWB strategy. The HWB Manager position has now been permanently recruited too. The Trust have also been awarded Gold Status for the Better Health at Work Award - which measures our activity against nationally recognised benchmark standards. The Health & Wellbeing Board is now closed and is succeeded by a bi-monthly engagement forum. Work continues on the delivery of the HWB Strategy and funds were secured to extend the Health & Wellbeing Facilitator role for another 12 months, to support the Health & Wellbeing Manager in delivery against objectives. Q4 - HWB is always being assessed against need and staff survey feedback will inform the 24/25 priorities

					Quantity			11	32	6			
Strategic Aim	Strategic Objective	Summary of Actions	How	Action Owner	Start Date	End Date	Overdue	Some Risk	Work in Progress	Action Complete	Completion Date	Expected Outcomes/measures	Comments/progress
2) We will be a great organisation with a highly engaged workforce			Target driven, efficient and effective approach to promoting and supporting attendance and a coaching approach to supporting managers.	CO	Apr-23	Mar-24							A collective leadership approach has been taken between POD team and operational around short term absence in addition to a target setting approach via case conferences having being introduced for long term absence. Professional training for managers has been designed and delivered by Capsticks, going forward this training will be carried out locally with our POD Advisory and L&D Teams. Although absence % has increased, we have grip and control through the robust LTS oversight, monthly clinics and target yet compassionate approach to absence management. Management capacity and capability has increased through dedicated support and focused approach to absence management. Each business unit receives monthly Short Term and Long Term absence reports and analysis of the attendance position in their area. Q4 - Improved reporting is enabling the identification of areas that need support . Coaching offer is well received and capacity is being increased.
	SA2.2 Growing and developing our people in order to improve patient outcomes and reduce reliance on high cost agency staff by March 2024 Executive Lead - Executive Director of People and OD Assurance Committee: People and OD Committee	Building our workforce and helping you be the best you can be.	Providing a professional and comprehensive customer focused Education, Learning and Development service to the organisation, working with services to ensure our people have the appropriate learning and professional development alongside a well-established core skills training programme.	SN	Apr-23	Mar-24						Key Indicator: Vacancy rate reduction to 5% by March 2024 Even better if target of 4% by March 2024	The Trust's first Learning at Work week was launched and ran in May 2023. L&D Facilitators have been working in partnership with business units to identify performance and development gaps and undertaking a comprehensive gap analysis. The Learning Needs Analysis is an embedded system of the Trust enabling leads, managers and individuals to highlight training and development requirements. Each entry is reviewed and action taken. As a Trust we have also developed a key partnership with CBC, the voluntary sector and the local authority to run place based joint workforce development offer and approach through the Gateshead Health and Care Academy. Q4 - Work is finalising on the review of core skills requirements, with all areas identifying a Statutory and Mandatory Training Link. A pilot of the revised process is underway.
			Develop a Trust wide strategic approach to workforce planning that is informed by population health needs, local and national strategy. With an ability to forecast and horizon scan.	SG	Apr-23	Mar-24							Work completed with Whole Systems Partnership to lead us through a process to explore and adopt a strategic approach to workforce planning. Final report received, which has been developed into a draft action plan. To be discussed with Trust management to then operationalise and ensure integration and alignment. Although the work undertaken to date contains both the approach and essential data and tools to enable a plan to be generated, it does not constitute a workforce plan it its current form as workforce plans require connection with the Trust Boards strategic goals, financial constraints and an assessment of opportunities. Delays in progressing this since last PODC due to capacity issues. Ability to progress will depend on dedicated resource to be able to progress and being able to put a formalised, structured approach in place that involves multiple stakeholders. Q4 - A session on the NHS Long Term Workforce Plan was delivered at Trust Board Development Day on 23 August 2023 and we will work closely across the region to ensure a consistent approach. GGI review of meetings implementation will see the re-instatement of the Trustwide education, learning and workforce development group to oversee and drive this work
			Have an agreed Trust wide retention strategy which includes a customisable range of high impact, effective tools that are deployed at a local level, depending on service need.	SG	Apr-23	Mar-24							A focus on retention paper has been drafted to present at November POD Committee to provide an overview of what our leavers data is telling us, review our position against the NHS Employers retention standards that form part of the national retention programme and provide recognition of what we are doing well and what future action needs to be taken. Q4 - Some positive steps towards this action have been taken through the introduction of legacy mentors supporting N&M colleagues - turnover has reduced since its peak in summer 2023. The Trust has been accepted onto the second cohort of the People Promise Exemplar Programme and this will allow further work to happen within 24/25.
	SA2.3 Being a great place to work in order to improve staff survey outcomes and impact upon patient outcomes within 2-years. Executive Lead - Executive Director of People and OD Assurance Committee: People and OD Committee	Being a values led organisation with compassionate and inclusive leadership, where you have a long, lasting and valuable career.	Leaders will role model compassionate, inclusive and collective leadership in all of their interactions, aligning with our ICORE Values and the national Our Leadership Way Framework.	LF	Apr-23	Mar-24						Leading Indicator: Maintain a target engagement score of 6.9 by March 2025. Even better if target of 7.5 by March 2025.	Both Managing Well and Leading Well are successful, well embedded development programmes across the Trust but as part of POD's commitment to continuous improvement are due a review to ensure that these are still current and reflecting our direction of travel as an organisation under new leadership to best support the organisation to be clinically led and managerially supported. The Learning & Development team have also recently launched a New Managers Induction, to support those moving into management positions within the Trust, ensuring there is consistency in message around expectations and behaviours. Q4 - Work is underway on the zero tolerance campaign, with a focus on irradicating bullying, harassment, discrimination and abuse from all colleague, patient and service user interactions.
			Flexible working practices will be commonplace across all staffing groups.	AV	Apr-23	Mar-24							The Trust's Flexible Working Policy has been updated to reflect changes to Section 33 of the national terms and conditions and also the NHS People Promise. Comms has started around this including why flexible working matters and that it is for everyone regardless of role, grade, or the reasons for wanting to work flexibly, with further communication and access to information planned. Q4 - The Trust's Homeworking policy is due to be updated and this will consider Agile Working more broadly that just home working. However a true cultural shift is required to make this common place moving forward, with role modelling at all levels of the organisation. Flexible working workshop planned for Q1
			Continue to work closely with our Freedom to Speak up Guardian, enabling and supporting colleagues to Raise Concerns where they need to, encouraging and facilitating a working environment where we can all speak up and speak out about issues that concern us.	AV	Apr-23	Mar-24							The Trust has an up to date FTSU policy which is accessible to all staff. The FTSU Guardian was recruited through an open and inclusive recruitment process and since being in post has received training for the role and is also registered with NGO as the Trust FTSUG. Board papers on findings are produced twice a year and quarterly presentations are delivered to POD committee and QOC. There has been a number of cases with positive outcomes and work is also currently being undertaken by the culture board regarding zero tolerance, specifically show racism the red card. Q4 - FTSU roadshows were undertaken in Oct 23 with the theme of barriers to speaking up. A staff was carried looking at barriers to speaking up and findings shared with the Board. A Board Development Day was also held looking at progressing a more open culture to support FTSU. A Facebook live session with CEO was also carried out and the next stage is to get a social platform set up for FTSU
			Work closely with the Trust EDI and engagement lead to provide support, experience and opportunities to promote, embed and champion the Inclusion agenda and Trust strategy.	AV	Apr-23	Mar-24							The Trust's EDI and Engagement Manager joined the POD Directorate at the beginning of July 2023. The Trust's EDI strategy has been approved by SMT and the HREDI Programme board have deliberated the strategy and incorporated this into the overarching EDI action plan. The EDI Workforce plan outlines 6 high impact actions the Trust is required to achieve in the next 12 - 18 months and a task and finish group has been set up to ensure work commences against high impact action 2. Q4 - Work on an EDI dashboard is in progress to enable easier reporting on progress across this broad agenda along with a review of the staff networks
	SA3.1 Ensure that there is a strong focus on improving productivity and efficiency and best use of resources in everything that we do to meet the required performance standards/recovery requirements by March 2024	Assess and benchmark services using tools including Model Hospital, GIRFT, the national cost index and other datasets to understand our position and opportunities to improve. Returning to the delivery of constitutional standards (egg zero >52 week waiters)	Via the Sustainability Programme and in particular Making Services Sustainable, Productivity and Planning workstreams.	JH	Apr-23	Mar-24						Monitored via the Integrated Oversight Report and Leading Indicators. Achieved	Plans in place to focus on increasing productivity through a variety of workstreams and will be monitored through the Delivery Oversight Group. Access & Performance meeting were refreshed in October 2023 under the Interim Chief Operating Officer to review activity recovery plans in depth by specialty. A dedicated Strategic Finance Business Partner for Costing and Transformation is now in post to support with Model Hospital and other benchmarking tools and analysis.

					Quantity			11	32	6			
Strategic Aim	Strategic Objective	Summary of Actions	How	Action Owner	Start Date	End Date	Overdue	Some Risk	Work in Progress	Action Complete	Completion Date	Expected Outcomes/measures	Comments/progress
	2024. Executive Lead - Chief Operating Officer Assurance Committee: Finance and Performance Committee	Ensure we monitor the return on investment of all business cases relating to operational performance.	Via the business case review group.	JH	Apr-23	Mar-24						through Delivery Oversight board, Performance Clinics and Monthly Oversight meetings	Return on investment of the New Operating Model (NOM) linked to performance is subject to ongoing review inc. as part of 24/25 operational plan delivery. Estates work associated with the NOM are due to complete in November 2023. The Trust's Business Case Review Group (BCRG) are reviewing the process to measure return on investments.
3) We will enhance our productivity and efficiency to make the best use of our resources	SA3.2 Achieve financial sustainability by in-year delivery of Trust CRP plan and development of robust sustainability plan for delivery within 3-years Executive Lead - Group Director of Finance and Digital Assurance Committee: Finance and Performance Committee	In year activity to deliver against the financial plan through the development, implementation and monitoring of clinically led CRP plans	Use of financial accountability framework and internal focus on delivery of cost improvement programme. Supported by robust budget monitoring and reporting to F&PC - capital and revenue. Establish a monitoring forum to manage and report in month variance to plans.	KM	Apr-23	Mar-24						Delivery of the financial projections as per submitted phased plan. Production of robust and achievable financial sustainability/recovery plan that returns the organisation to financial balance.	The forecast is now to better the original planned financial position. There has been some additional funding made available to the organisation, but the organisation has delivered the majority of its CRP plan this year. There has been a reliance on non-recurrent programmes and so there is sustainability work underway to convert this to recurrent improvements in the financial position.
		Ongoing focus on financial sustainability to improve the underlying financial position through assessment of service vulnerability and sustainability and using benchmarking tools to robustly assess efficiency at scale.	Ongoing assessment of underlying run rate, increase in effective organisational communication and engagement, use of benchmarking information and HFMA checklist. Continually horizon scan for developments and opportunities. Optimise estate strategy to reduce estate and seek to increase home working to optimise recruitment and minimise costs.	KM	Apr-23	Mar-24							The business intelligence arm of the finance function has produced some key benchmarking information that helps to inform areas of focus in addressing the underlying deficit of the organisation. This is an ongoing piece of work which is currently developing a delivery plan against the key areas of focus to lead to underlying sustainability.
		Automation of transactional processes optimising digital impact and reducing cost.	Work collaboratively with digital and transformation teams to utilise RPA function.	KM	Apr-23	Mar-24							Digital service have requested services propose further projects that virtual workers could be deployed to support. Michael Smith, Assistant Director of Finance for Governance and Control is leading on automation within the finance function. Key projects are being identified and scoped.
		Enhance capacity and capability of the finance team.	Complete recruitment to new structure and supporting organisational development programme of work.	KM	Apr-23	Mar-24					Jul-23		Organisational development work is underway with the finance team. Commencing with clarity in roles and responsibilities and ensuring tasks are allocated appropriately. Operational workplan is aligned to delivery of priorities and Trust Strategic objectives. New Assistant Director of Finance for Strategic Finance is in post and has an overriding objective to support cultural development and improved reporting.
	SA4.1 Identify key local health inequalities challenges and ensure improvement plans are in place by March 2024 Executive Lead - Medical Director Assurance Committee: Quality Governance Committee	Mitigating against 'digital exclusion' ensuring providers offer face to face care to patients who cannot use remote services and ensure more complete data collection to identify who is accessing face to face /telephone/video consultations is broken down by patient age, ethnicity, disability status	Included in the data scoping will be to review DNA and link with the learning disability team and also the MECC community teams.	NH	Apr-23	Mar-24						The delivery of an agreed health inequalities action plan and implementation of the Health Inequalities Strategy	Work in progress around outpatient transformation
		A framework for action across the NHS: Core20plus5 is NHS England's new approach to tackling health inequalities. It focuses on improvements for the most deprived 20 per cent of the population (core20), reducing inequalities for population groups identified locally (plus) and accelerating improvements in five clinical areas (5).	A gap analysis to be completed across the 5 clinical areas. Maternity, severe mental health, chronic respiratory disease, early detection of cancer and hypertension.	NH	Apr-23	Mar-24							Work is underway - we have recruited an individual on secondment to collate the work already underway which will allow us to identify were we have gaps Trust has completed the NHS health inequality toolkit to help further identify gaps and allow population of an action plan (7 themes)
4) We will be an effective partner and be ambitious in our commitment to improving health outcomes	SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population Executive Lead - Chief Operating Officer Assurance Committee: Quality Governance Committee	Work in partnership to influence and shape the place based vision. Increase clinical visibility within place	Map out meetings to ensure appropriate representation from the trust and carry out engagement by CEO & MD with key stakeholders	NH	Apr-23	Mar-24						Secure our alignment to Gateshead Place to achieve best outcomes for residents closer to home and reduce the reliance on the acute Trust. Develop strategic partnerships to ensure we are the delivery partner of choice within Gateshead.	Gateshead Health continue to be an active partner within Gateshead Cares System Board. Focus has been on health, housing and safety with all staff within Community Division now aware of recent guidance to improve this and referral routes to LA. Worked with LA to develop and submit the Better Care Fund submission focusing on improving and expanding health and social care services outside hospital to reduce admissions and improve health. Working with partners to develop a system level winter plan Support to Health and Wellbeing Board to review and agree the "Gateshead Plan" relating to ICB metrics. Increased clinical presence in place based discussions following re-direction of MD job plan and introduction of MD of Operations. MD is deputy chair for IPC Committee at (Gateshead) Place
5) We will look to utilise our skills and expertise beyond Gateshead	SA5.1 We will look to utilise our skills and expertise beyond Gateshead in order to ensure organisational sustainability and contribute towards innovative care and provision within 23/24 Executive Lead - QE	Undertake SWOT analysis of future commercial opportunities for the trust and QEF in order to prioritise and establish commercial strategy for delivery.	Stakeholder engagement internal and external	GE	Apr-23	Dec-23						Development of a commercial Strategy	Presentation by QEF shared at Trust Strategy session held on 26/4/23 which included a SWOT analysis and areas of potential growth. This was further shared at the Medical Staff Committee held on 20/6/23 to understand the aspirations of clinicians and how QEF can help realise these linked to work being undertaken on sustainable services and Trust strategy. Trust Board Development session held on 18th October included SWOT and PESTEL and strategic positioning. Director of Strategy, Planning and Partnerships met with Commercial Director at Health Innovation Network (prev. Academic Health Science Network (AHSN)) to explore opportunities for development. This includes the potential to join the Health and Life Sciences Pledge. New MD of QEF reviewing business development strategy.

					Quantity			11	32	6			
Strategic Aim	Strategic Objective	Summary of Actions	How	Action Owner	Start Date	End Date	Overdue	Some Risk	Work in Progress	Action Complete	Completion Date	Expected Outcomes/measures	Comments/progress
	Executive Lead - QE Facilities Director Assurance Committee: Finance and Performance Committee	Identify through the Making Services Sustainable work which services we can grow and develop	Engage with CSG. Clinical services to complete a review making recommendations for consideration;	NBr/KR	May-23	Dec-23						Service Sustainability Plan developed for board approval by December 2023	Work shared with CSG 10/5/23 followed by the development of a template for completion by teams to determine the clinical assessment of services - fragile, vulnerable or exceptional (phase 1). Numerous returns received that are being worked through to determine any gaps or immediate vulnerabilities. Corporate working group established and met 13/6/23 with clinical leadership from the Medical Director of Operations. Clinical assessment complete. Business / economic viability assessment underway. Needs to link to 2024/25 planning and strategic positioning discussions. Outputs shared at CSG in February with ongoing work feeding into 24/25 operational plan delivery.

Board of Directors

Gateshead Health NHS Foundation Trust

Agenda Item: 16ii

Report Title:	Organisational Risk Register (ORR)			
Name of Meeting:	Board of Directors			
Date of Meeting:	27th March 2024			
Author:	Marie Malone, Corporate and Clinical Risk Lead.			
Executive Sponsor:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals/Deputy CEO			
Report presented by:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals/Deputy CEO			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	To ensure the Board and Committees are clearly sighted on those risks that have an organisational -wide impact, the organisational risk register is compiled by the Executive Risk Management Group (ERMG) of those risks that impact on the delivery of strategic aims and objectives. This includes risks included within the Board Assurance Framework (BAF) as well as risks identified by the Group for inclusion as having an organisational impact and impact on delivery of strategic aims and objectives. The supporting report shows the risk profile of the ORR, includes a full register, and provides details of review compliance, and risk movements.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	The attached report is now received in the Executive Team Meeting each week, and at the Executive Risk Management Group meeting every month.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience*	Risks on the ORR were comprehensively discussed at previous ERMG meeting in March, and the following updates and movements agreed. Accompanying Report shows the following changes and is detailed within this report.			

<table>
<tr><td>

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

</td><td colspan="6">-There were 0 risks added, 2 risks removed and 3 risks reduced, demonstrating active mitigation of organisational risks as part of risk management framework.

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

-Risks are actively being reviewed and managed as per risk management framework timeframes.
Compliance with risks reviews 75%.
Compliance with actions reviews 100%

-Formal Findings from Internal Audit report Assurance Framework and Risk Management was published and a high level of compliance with the control framework was noted, with remedial action required.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">The Board are asked to:

• Review the risks and actions on the attached report and discuss and seek further information relating to risks as appropriate.
• Take assurance over the ongoing management of risks on the ORR.
• Be clearly sighted on the top 3 risks for the organisation.
• Be sighted on findings from internal audit (Audit one) for 2023.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="6">Each risk is linked to a corporate objective, see report.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Safe
☒</td><td>Effective
☒</td><td>Caring
☒</td><td>Responsive
☒</td><td colspan="2">Well-led
☒</td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
</table>

Links to risks (identify significant risks and DATIX reference)	Included in report		
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

Organisational Risk Register

Executive Summary

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

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

The Internal Audit of Risk Management and the Board Assurance Framework that was undertaken in November 2023 published its findings in February 2024. The report concluded that: "*Governance, risk management and control arrangements provide a good level of assurance that the risks identified are managed effectively. A high level of compliance with the control framework was found to be taking place."*

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

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

This report covers the period 18th January-18th March 2024 (extraction date for this report).

Organisational Risk Register – Movements

Following ERMG meeting in March 2024, there have been no additions to the ORR, 3 reductions and 2 removals.
There are currently 16 risks on the ORR, agreed by the group as per enclosed report.

New additions:
There have been no additions to the ORR in March

3 Risks reduced:
Risk reduced from 16 to 8

- **2982 (Medicine)** Risk of delay in transfer to community due to lack of social care provision and intermediate care beds, due to increased numbers of patients awaiting POC in medical wards (8)

-significant improvement in capacity demonstrated
-internal escalation routes in place

Risk reduced from 12 to 8

- **3089 (NMQ)** Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures (8)

-Overall position within Gateshead has improved.

Risk reduced from 16 to 12

- **3277 (CSS)** Risk of losing MRI provision due to temporary closure of department for essential refurbishment. This could result in reduced capacity and productivity (12)

-mobile scanner on site

-Contractor plans updated to ensure scanning can continue.

Risks removed and closed in period:

2 Risks closed:

- **1636 (Digital)** Risk of potential exposure to published critical cyber vulnerabilities. Resulting in potential harm to patients, data leaks, impacts on service delivery. (10)

-Historical risk to be replaced with new, dynamic risk

- **3127 (Finance)** There is a considerable risk that the trust will not be able to meet the planned trajectory of £12.588m adjusted deficit (4)

-Risk relating to 2023/24 financial situation and therefore no longer relevant.

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

Finance - 2 significant financial risks on the ORR.
Performance – Risk of delivery of performance targets (collective activity)
Workforce – Continued and prolonged industrial action could lead to harm.

1. **Finance:**

- **3102 (Finance)**. Activity is not delivered in line with planned trajectories, resulting in the Trust having reduced access to core funding. (16)
- **3103 (Finance)** Efficiency requirements are not achieved. (16)

-With 2 financial risks on the ORR with high scores of 16, there is significant emphasis on financial implications as an organisation.

2. **Performance:**

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

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

3. **Workforce:**

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

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

Current compliance with Risk reviews:

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

Risk and action review compliance is currently at 75% and 100% consecutively. This is an improvement on last reporting period.
Actions are assigned to all risks.
Support with reviews continue to be offered by Corporate and Clinical Risk Lead where able.

Recommendations

The Board of Directors are asked to:

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

Organisational Risk Register Report

Reporting Period: 18-Jan-2024 to 18-Mar-2024

Gateshead Health NHS Foundation Trust

Risk Profile (Current/Managed)

Resources - 1

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

Staff Safety - 1

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

Wellbeing - 1

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

Business Continuity - 1

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

Digital - 1

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

Finance - 2

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

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

No Risks

Effectiveness - 1

MEDIC 2982 - Risk of delayed transfers of care and increased hospital lengths of stay (8)

Experience - 1

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

Safety - 4

CSS 3277 - Risk of no MRI facility in the hospital (12)

NMQ 3089 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures. (8)

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

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

Compliance - 1

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

Information Governance - 2

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

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

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

Organisational Risk Register Report

Reporting Period: 18-Jan-2024 to 18-Mar-2024

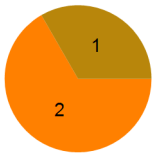
Gateshead Health NHS Foundation Trust

People & Resources

Sub Category

Resources
Staff Safety
Wellbeing

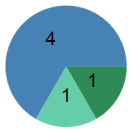
Cause



Resources/Skills
Systems/Processes

Quality Outcomes

Sub Category



Effectiveness
Experience
Safety

Cause

Environment/Equipment
External/Partnership
Resources/Skills

Finance & Efficiency

Sub Category

Business Continuity
Digital
Finance

Cause

Environment/Equipment
Finance
Resources/Skills
Systems/Processes

Regulation & Compliance

Sub Category

No Data Available

Cause

No Data Available

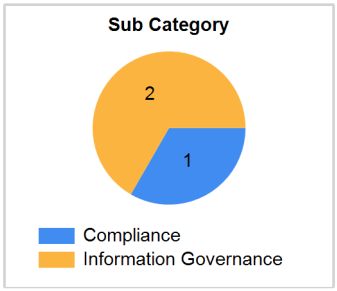
Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
IRR - Initial Risk Rating **TRR** - Target Risk Rating

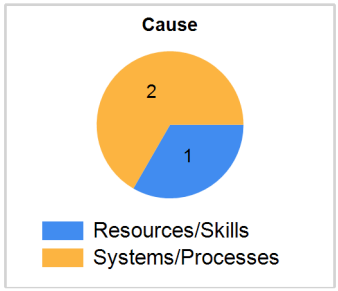
Organisational Risk Register Report

Reporting Period: 18-Jan-2024 to 18-Mar-2024

Gateshead Health NHS Foundation Trust

Reputation





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

Organisational Risk Register Report

Reporting Period: 18-Jan-2024 to 18-Mar-2024

Gateshead Health NHS Foundation Trust

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

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

Organisational Risk Register Report

Reporting Period: 18-Jan-2024 to 18-Mar-2024

Gateshead Health NHS Foundation Trust

2764 17/11/2020 Sophia Grainger People and OD Human Resources 06/03/2024 BAF ORG HRC QGC SA1.1 Continue to improve our maternity services in line with the wider learning from the Ockenden review, SA1.2 Continuous Quality improvement plan, SA2.2 Growing and developing our workforce	Risk that not having a clearly agreed workforce plans for the next 3, 5 and 10 years as a result of a lack of a robust workforce planning framework and agreed approach could result in a lack of a sustainable workforce model that is fit to meet future service needs.	20	International recruitment team established and well embed within the organisation, providing a regular supply pipeline. Domestic recruitment actively pursued and monitored. Strategy to over recruit to HCSW position. Registered Nurse Degree apprenticeship programme agreed. School and local community supply initiatives in place to attract the Trust's future workforce. Refreshed absence management policy and focused support absence management rolled out across the Trust to ensure we maximise the availability of our current workforce. Local pay arrangements agreed during times of pressure/areas where we struggle to recruit and retain. Consideration given to a strategic workforce planning approach as part of the work that was undertaken with the Whole Systems Partnership. Operational workforce plan submitted as part of the 2023-24 Operating Planning submission. Focus on growing and developing our workforce in the Trust's People Strategy and in the Trust's Strategic Aim 2.2, with associated actions. NHS Long Term Workforce Plan published to set a direction of travel and commit to an ongoing programme of strategic workforce planning. November 2023- AV- Trust Interim Director of Strategy and Planning appointed and working closely to agree an integrated Trustwide approach to planning, including finance and performance	16	Develop systems, processes and comms to support increasing exit interview completion rates across the Trust	Sophia Grainger 31/03/2024	8	Risk reallocated to Sophia Grainger, interim Head of People Planning, Peformance and Quality when Natasha Botto is on maternity leave.
					Transfer Window - establish as is position and action required to progress and operationalise	Sarah Neilson 31/03/2024		
					Review current retention offer and scope retention offer moving forward.	Sophia Grainger 31/03/2024		
					Education, learning and Workforce development group to continue work on the implications of the LTWFP and share proposals.	Sarah Neilson 31/03/2024		
					Work with Director of Strategy, Planning and Partnerships to explore broader approach to planning Trust wide and how we align the workforce planning approach to this	Sophia Grainger 30/04/2024		

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

Organisational Risk Register Report

Reporting Period: 18-Jan-2024 to 18-Mar-2024

Gateshead Health NHS Foundation Trust

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

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
3095 26/07/2022 Amanda Venner People and OD Workforce Development 01/04/2024 BU_DIR ORG HRC QGC SA1.2 Continuous Quality improvement plan, SA2.1 Protect and understand the health and well-being of our staff by looking after our workforce, SA2.2 Growing and developing our workforce	Risk to quality of care and service disruption due to Industrial Action of various trade unions across various sectors affecting staffing levels and potential impact on patient care, safety and quality.	**20**	Industrial action working group established and meeting regularly. Focused planning sessions have taken place to explore the planning, response and recovery elements of industrial action with reasonable worse case scenarios considered. A detailed work plan has been produced with a number of actions, lead officers and timescales. Set up of command and control and coordination (wef 12/12/2022). Local strike committee in place (wef 09/05/2022). Citrep position updated daily during period of IA. Business continuity planning, including an EPRR work place that runs along each period of IA. Command and control structure standards up in the event of IA. Close partnership working and regular local discussions with staff-side and respective trade union representatives as part of the IA Internal Working Group and the Sub-group of the JCC. Cancellation of some elective services to reduce need for junior medical staff. Consideration of utilisation of other staffing sources- consultants and/or specialist nurses and pharmacy support. Review of on call teams.	**16**	Support twice weekly co-ordination cell and fortnightly industrial action Trust wide working group.	Amanda Venner 01/05/2024	**8**	reviewed with AV. no change

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

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
3102 22/08/2022 Kris MacKenzie Finance Finance 06/04/2024 BU_DIR FPC ORG SA3.2 Achieving financial sustainability	Activity is not delivered in line with planned trajectories, resulting in the Trust having reduced access to core funding.	20	Active and in depth monitoring of activity information underway. Review of business units plans to deliver activity trajectories reviewed as part of monthly oveersight meetings. Activity achievement to be reviewed fortnightly at performance focussed SMT meeting. CRP project in development to strengthen counting and coding. november 2023- access and performance clinic work underway.	16	Timley and detailed reporting information Counting and Coding Review	Jane Fay 31/03/2024 Nick Black 31/03/2024	6	discussed at ERMG. No change to score or profile. To remain on ORR
3103 22/08/2022 Kris MacKenzie Finance Finance 04/04/2024 BU_DIR COO FPC ORG SA3.2 Achieving financial sustainability	Efficiency requirements are not achieved.	20	Efficiency delivery closely monitored as part of month end reporting. Weekly CRP working group in place to ensure traction, delivery and ongoing engagement. SMT meeting to focus on performance on a fortnightly basis.	16	delivery oversight group and finance focus sessions	Kris MacKenzie 01/04/2024	9	Discussed at ERMG. No changes to score or profile. To remain on the ORR

Key: **CRR** - Current Risk Rating **PRR** - Previous Risk Rating
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3310 21/11/2023 Dianne Ridsdale Digital Digital Transformation and Assurance 01/04/2024 BAF BU_DIR DIGC ORG SA1.3 Digital where it makes a difference	Risk of data mismanagement, leading to inappropriate access, misuse or inappropriate disclosures. Due to failure to incorporate best practices in the management of information across the organisation. Resulting in patient harm and/or failure to comply with UK law, national standards and contractual requirements.	20	Trust Policies, procedures, guides, materials and tools. Staff training, awareness and communication programmes Internal and external auditing and IG spot check programme	16	Development of role of IAO/IAA	Catherine Bright 29/03/2024	4	actions reviewed and updated
					Esablish IAO network with link to SIRO	Catherine Bright 29/03/2024		
					Support the trust to identify appropriate Information Asset Owners	Catherine Bright 31/03/2024		
					Review process by which the asset registers and data flows are managed - investigate options for simplification	Dianne Ridsdale 31/01/2025		
					Provide compliance reporting to business units	Catherine Bright (Completed 16/02/2024)		
					Identify and bring resources in to support the services to complete their IARs/DFMs	Dianne Ridsdale (Completed 01/03/2024)		

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3313 24/11/2023 Catherine Bright Digital Digital Transformation and Assurance 02/03/2024 BU_DIR DIGC ORG SA1.3 Digital where it makes a difference	Risk of breaching legislative requirements due to lack of long term strategic approach to the management and storage of health records [both digital and paper]. This could lead to regulatory and reputational harm.	20	Action to scope and procure an EPR to support robust record management requirements [Record Lifecycle - creation to destruction]	16	map out current health record sources	Mark Smith 31/03/2024	8	Work ongoing in relation to EPR to support management of clinical records and N365 to support corporate records.
					Establish the scope and procurement options for an EPR	Catherine Bright 30/04/2024		
					implement single document store	Adam Charlton 30/04/2024		
					develop FBC for integrated EPR	Catherine Bright 30/04/2025		
2373 01/08/2018 Laura Farrington People and OD Workforce Development 01/04/2024 BU_DIR HSC ORG HRC QGC SA2.1 Protect and understand the health and well-being of our staff by looking after our workforce	Staff exposure to incidents of violence and aggression from patients and visitors. Risk of harm to staff, risk to staff well-being through challenging behaviour demonstrated by some patients and/or visitors to ECC resulting in injury, increased absence from work, potential effect on recruitment and retention of staff, staff morale and confidence	20	policies in place to support staff training available reporting tools available forums for debrief/discussion and support available	15	Policy review -to include clinical teams, group policy	Lee Taylor 30/04/2024	6	updated following DW AV. action extended. Work is ongoing and has needed a wider group of stakeholders to be involved.

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

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2398 28/12/2018 Kate Hewitson Surgical Services Obstetrics 01/04/2024 BAF BU_DIR COO ORG QGC SA1.1 Continue to improve our maternity services in line with the wider learning from the Ockenden review, SA1.2 Continuous Quality improvement plan	There is a risk of delayed treatment due to maternity estate being a separate building resulting in the potential for severe harm to mothers and babies. Rising acuity of maternity patients and more frequent use of CCU, theatre staff and Paediatric teams creates additional likelihood of the need for these teams to attend the maternity department and delays to be incurred.	20	Pre-assessment - Women deemed likely to require critical care after elective procedures have their operation in main theatre to allow swift access to critical care. This only applies to elective patients and not emergency procedures or those in spontaneous labour. Any incidents are investigated to identify potential learning. major haemorrhage protocols in place	15	2861 action re looking into estate options	Kate Hewitson 03/06/2024	5	D/W RP no change.

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Gateshead Health NHS Foundation Trust

2945 14/09/2021 Debbie Renwick Chief Operating Officer Planning & Performance 23/02/2024 BU_DIR FPC ORG SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans	Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely business intelligence to deliver and improve services	15	Programme of work established to work on improving access to BI and improve board reporting along with service line access to quality performance and workforce data Project Manager appointed to lead on this work with support from NECS. Programme involves 3 projects Static reporting – Look back - this is what we achieved 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	12	• Work with the BU managers looking at what is available and start to build what is needed and get rid of what is not used/helpful	Debbie Renwick 31/03/2024	3	Additional capacity: Recruitment Process Underway: New JD created Re: Associate Director of BI. 7 candidates shortlisted. Interviews in for 23/1

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			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					
3186 07/02/2023 Philip Glasgow QE Facilities 04/04/2024 BU_DIR COO FPC ORG HSC SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans, SA3.2 Achieving financial sustainability	There is a risk to maintaining business continuity of services and recovery plans due to the estate infrastructure, age and backlog maintenance requirements which exceed the Trusts capital allocation.	**16**	Clinically led estates strategy developed and prioritsied on priority versus affordability	**12**	commission full estates review as part of Bensham retraction programme	Anthony Pratt 30/04/2024	**6**	No change - progressing with capital programme in 2023-24 and looking at requirements for 2024-25 programme.
3255 27/06/2023 Gillian Findley Chief Executive Office Chief Executive Office 23/03/2024 BU_DIR ORG QGC	There is a potential for people to lose trust and confidence in our services as a result of recent reports and incidents.	**20**	ICB have been notified and a risk escalation meeting was enacted. The Trust has included these concerns in a thematic review and a delivery plan has been developed. Plan is for enhanced surveillance to be stood down after next meeting.	**12**	monitor implementation of thematic review delivery plan	Gillian Findley 30/04/2024	**8**	Work has progressed and a culture review has been commissioned that will inform improvement plans
					complete thematic review actions	Gillian Findley (Completed 27/12/2023)		

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Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
3261 05/07/2023 Debbie Renwick Chief Operating Officer Planning & Performance 25/02/2024 BU_DIR FPC ORG QGC SA1.2 Continuous Quality improvement plan, SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans	Risk that the Trust will not achieve zero > 52 week waiters by March 2024. There are a number of services projecting long waiters over planned levels for multiple reasons Industrial Action, capacity deficits, workforce issues. This could result in patients waiting too long for treatment (potential for harm and litigation claims) and potential reputational damage for the Trust.	20	Performance clinics established to support overall delivery plans, recovery actions and future projections. Weekly Access & Performance Meetings: Progressing actions with relevant Service Lines at Risk.	12	Theatre roadmap aligning capacity and productivity to delivery plan	Debbie Renwick (Completed 29/12/2023)	8	Weekly A&P meeting managing risk of 52's and lost capacity IA Current forecasts included in A&P Output files to expedite risks. Current Forecast Risks are: Urology:20 Gynae:40 General Surgery: 22 T&O: 30 Current Risks and forecasts are include in A&P output files to manage and expedite risk: A range of options in place including IS/mutual aid & realigning DCC in job plans, Partial Booking and running super clinics in areas where there are high conversions of clock-stops on first OP attendances. Validation work continues: to ensure a clean PTL & maximised focus.
					Support BU in identifying risk of >52 ww	Debbie Renwick (Completed 25/01/2024)		

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

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note
3277 14/08/2023 Katy-Jo Wilkinson Clinical Support & Screening Diagnostics 14/04/2024 BU_DIR COO FPC HSC ORG QGC SA1.2 Continuous Quality improvement plan, SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population, SA5.1 We will look to utilise our skills and expertise beyond Gateshead	Risk of losing MRI provision due to temporary closure of department for essential refurbishment. This will result in reduced capacity and productivity. This could have significant consequences for inpatients requiring an MRI scan, and will increase waiting times for outpatient scans. This could have consequences for a number of patient pathways,including FDS pathways.	**20**	Recovering scanning capacity from NuTH on the mobile provision at BPCC. Negotiating reducing onsite scanner downtime with contractors. Mobile scanner will be on site for 19 weeks. Tunnel erected by QEF to connect Mobile unit to hospital. full assessment by engineer underway 16/01/2024	**12**	Identify contractor to complete works	Anthony Pratt (Completed 15/12/2023)	**8**	No change to score or status, however, dynamic risk may increase at next review given current provision of mobile scanner, and the need to temporarily close department in the near future.
					Check pad	Phil Davidson (Completed 15/12/2023)		
					Finalised plans	Anthony Pratt (Completed 22/01/2024)		

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3298 24/10/2023 Amanda Venner People and OD Workforce Development 01/04/2024 BU_DIR ORG HRC SA2.1 Protect and understand the health and well-being of our staff by looking after our workforce	There is a risk that promoting an environment that encourages speaking out and creating a psychologically safe culture may lead to increased reports of poor behaviour. This could have a negative impact on staff and require addiitional time and capacity to appropriately address the concerns. This could result in further health and well being concerns and staff absence.	15	Zero-Tolerance Campaign underway, focusing on clarifying expectations and providing training and support for colleagues in identifying and responding to bullying, harassment and discrimination from colleagues, patients or service users. Establishment of a full time, permanent Freedom to Speak Up Guardian and increasing number of FTSU Champions, creating an increasing number of avenues for colleagues to report incidents.	12	Deliver training for managers	Laura Farrington 31/03/2024	6	reviewed with AV. no change
					Review existing Bullying & Harassment policy	Laura Farrington 31/03/2024		
					EDI strategy to be developed	Amanda Venner 31/03/2024		
					ICS EDI programme to be fully scoped and network chairs supported	Amanda Venner 31/03/2024		
					Embed FTSU Champions within the Organisation	Tracy Healy 01/04/2024		
					Create a zero-tolerance campaign	Laura Farrington 01/04/2024		

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2982 06/12/2021 Mark Dale Medical Services Medical Services - Divisional Management 29/03/2024 BAF BU_DIR COO FPC ORG SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans, SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population	Risk of delay in transfer to community due to lack of social care provision and intermediate care beds, due to increased numbers of patients awaiting POC up to 30 patients in medical wards. This delay adds significant pressures to acute bed availability, escalation beds being required and significant risk of problems with flow through hospital impacting A&E breach standards and risk of patients being delayed within ambulances. This could result in patients remaining in hospital when medically optimised creating risk to these patients as well as other patients as bed capacity not able to meet demand. There is also a risk of patients deconditioning, resulting in failed discharge secondary to this. This could lead to increased pressures on nursing teams as well as poor patient experience and quality.	20	Daily meeting with LA to examine capacity in out of hospital system and match with demand for discharges. Target discharges of 40 per week to keep pace with demand. Monitoring of Delayed transfers of care twice weekly meeting Escalation of delays of care to the community BU and social services at twice weekly meetings. Monitoring of Breach levels and times. Monitoring of Ambulance delays. Monitoring increased LOS of medically optimised patients. Escalation of patients requiring social services support raised weekly at Discharge Systems group which includes Social services management and ICB representative. Medically Optimised meeting 2x week, passed to IPC/ICB Pilot on 2 wards re improving discharges.	8	Weekly stranded patient meeting	Rachel Thompson (Completed 29/02/2024)	4	following ERMG, agreed to remain as current risk as further work required to mitigate. Discharge processes work to commence.
3089 25/07/2022 Gillian Findley Nursing, Midwifery & Quality Quality Governance 23/05/2024 BAF BU_DIR ORG QGC SA1.2 Continuous Quality improvement plan	Quality - There is a risk of quality failures in patient care (patient safety, patient experience and effectiveness) due to external causes such as delayed discharges and pressures from other Trusts resulting in patient harm, regulatory action, and reputational impact	15	Daily report provided detailing all delayed discharges within the Trust. regular meetings now established with social care. Discharge liaison staff available to support wards and facilitate earlier discharge. surge plan is in place and is being managed	8	implementation of winter plan	Jo Halliwell (Completed 28/12/2023)	6	risk reduced as overall position within Gateshead has improved. there is still a risk of harm from delays in other Local Authority areas, which is being managed by the discharge teams.

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Reporting Period: 18-Jan-2024 to 18-Mar-2024

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Changes to CRR in Period - Current/Managed Risks

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

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note	PRR
2982 06/12/2021 Mark Dale Medical Services Medical Services - Divisional Management 29/03/2024 BAF BU_DIR COO FPC ORG SA3.1 Improve the productivity and efficiency of our operational services through the delivery of the New Operating Model and associated transformation plans, SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population	Risk of delayed transfers of care and increased hospital lengths of stay	20	Daily meeting with LA to examine capacity in out of hospital system and match with demand for discharges. Target discharges of 40 per week to keep pace with demand. Monitoring of Delayed transfers of care twice weekly meeting Escalation of delays of care to the community BU and social services at twice weekly meetings. Monitoring of Breach levels and times. Monitoring of Ambulance delays. Monitoring increased LOS of medically optimised patients. Escalation of patients requiring social services support raised weekly at Discharge Systems group which includes Social services management and ICB representative. Medically Optimised meeting 2x week, passed to IPC/ICB Pilot on 2 wards re improving discharges.	8	Weekly stranded patient meeting	Rachel Thompson (Completed 29/02/2024)	4	following ERMG, agreed to remain as current risk as further work required to mitigate. Discharge processes work to commence.	16 9
3089 25/07/2022 Gillian Findley Nursing, Midwifery & Quality Quality Governance 23/05/2024 BAF BU_DIR ORG QGC SA1.2 Continuous Quality improvement plan	Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures.	15	Daily report provided detailing all delayed discharges within the Trust. regular meetings now established with social care. Discharge liaison staff available to support wards and facilitate earlier discharge. surge plan is in place and is being managed	8	implementation of winter plan	Jo Halliwell (Completed 28/12/2023)	6	risk reduced as overall position within Gateshead has improved. there is still a risk of harm from delays in other Local Authority areas, which is being managed by the discharge teams.	12

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Reporting Period: 18-Jan-2024 to 18-Mar-2024

Gateshead Health NHS Foundation Trust

Changes to CRR in Period - Current/Managed Risks

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

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register / Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note	PRR
3277 14/08/2023 Katy-Jo Wilkinson Clinical Support & Screening Diagnostics 02/03/2024 BU_DIR COO FPC HSC ORG QGC SA1.2 Continuous Quality improvement plan, SA4.2 Work collaboratively as part of Gateshead Cares system to improve health and care outcomes to the Gateshead population, SA5.1 We will look to utilise our skills and expertise beyond Gateshead	Risk of no MRI facility in the hospital	20	Recovering scanning capacity from NuTH on the mobile provision at BPCC. Negotiating reducing onsite scanner downtime with contractors. Mobile scanner will be on site for 19 weeks. Tunnel erected by QEF to connect Mobile unit to hospital. full assessment by engineer underway 16/01/2024	12	Identify contractor to complete works Check pad Finalised plans	Anthony Pratt (Completed 15/12/2023) Phil Davidson (Completed 15/12/2023) Anthony Pratt (Completed 22/01/2024)	8	reviewed today with MG- likelihood increased to 3 due to ongoing issues with electrics and estates/facilities. Risk to remain dynamic and likely to evolve continuously until further notice.	16 1 8

3

Risks Moved to Managed in Period

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

0

Risks Closed in Period

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

Risks Added in Period

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

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Risks Removed in Period

Risk ID / Date Identified / Handler / BU / Service Line / Next Review Date / BAF / Risk Register Objectives	Risk Description	IRR	Current Controls	CRR	Action	Action Owner / Action Due	TRR	Latest Progress Note / Date Removed from ORR
1636 10/11/2014 Dianne Ridsdale Digital Digital Transformation and Assurance 25/10/2024 BU_DIR MDMG SA1.3 Digital where it makes a difference	Risk of potential exposure to published critical cyber vulnerabilities. Laptops, workstations and medical devices compromised by ransomware or botnets, due to endpoints being susceptible to compromise through the use of obsolete, old, or unpatched operating systems and third party software, including Java. Servers compromised by ransomware, due to servers susceptible to compromise through the use of obsolete, old, or unpatched operating systems and software. Due to failure to maintain all Digital assets, including installing Operating system patches, AV patches or other software and hardware updates across the IT estate, including network equipment and medical devices. Resulting in potential harm to patients, data leaks, impacts on service delivery.	**15**	AV on all end points AV up to date ATP in place site wide NHSD & Microsoft group policy templates Ongoing updates routinely planned as they are released Patching regime Network fully supported and maintained	**10**			**5**	formal agreement at ERMG to remove from the ORR and close. Historical risk no longer relevant to todays climate. New risk to be added based on todays landscape and following discussion of cyber vulnerabilities at board. 04-03-2024
3127 17/10/2022 Kris MacKenzie Finance Finance 20/01/2024 BU_DIR FPC SA3.2 Achieving financial sustainability	There is a considerable risk that the trust will not be able to meet the planned trajectory of £12.588m adjusted deficit. Contributory risks include delivery of planned elective activity limiting access to income, delivery of CRP, impact of inflation, realisation of mitigations and cost of ongoing service pressures resulting from unscheduled care activity and further periods of industrial action.	**20**	Financial performance being managed in line with the financial accountability framework. Accountability for performance part of the divisional oversight meetings discussions.	**4**	Delivery of financial mitigations inherent in plan	Jane Fay (Completed 04/03/2024)	**4**	formal agreement at ERMG to remove from the ORR and reduce likelihood (score of 1- rare). risk was specific to financial year 23/24. new risk to be raised for finaicail year 24/25. 04-03-2024
					Monitoring and modelling of impact of industrial action	Jane Fay (Completed 04/03/2024)		
					Comprehensive cost analysis	Jane Fay (Completed 04/03/2024)		
								2

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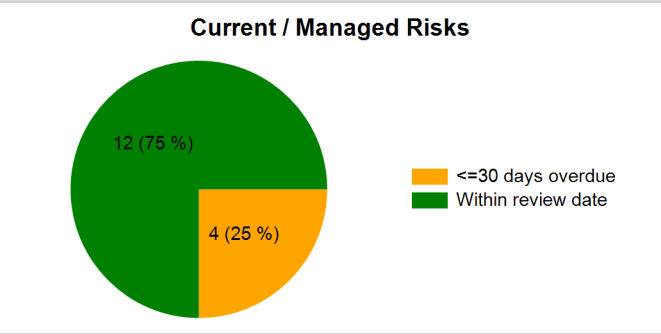
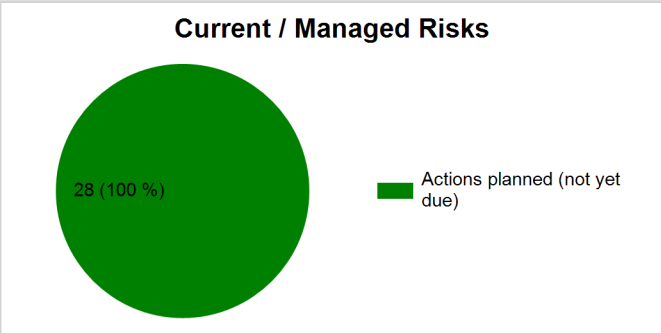
Reporting Period: 18-Jan-2024 to 18-Mar-2024

Gateshead Health NHS Foundation Trust

Risk Review Compliance



Risk Action Compliance



Movements in CRR

				CRR		
BU	Service Line	ID	Risk Description	Jan-2024	Feb-2024	Today
Chief Executive Office	Chief Executive Office	3255	People may lose trust an confidence in our services	12	12	12
Chief Operating Officer	Planning & Performance	2945	Risk of ineffective and inefficient management of services due to availability and access to appropriate and timely BI.	12	12	12
		3261	Failure to Deliver Operational Plan of Zero > 52 week waits by March 2024	12	12	12
Clinical Support & Screening	Diagnostics	3277	Risk of no MRI facility in the hospital	8	12	12
Digital	Digital Transformation and Assurance	3310	Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure.	16	16	16
		3313	Inability to support legislation and best practice associated with records management	16	16	16
Finance	Finance	3102	Activity is not deliverved in line with planned trajectories, leading to reduction in income	16	16	16
		3103	Risk that efficiency requirements are not met.	16	16	16

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IRR - Initial Risk Rating **TRR** - Target Risk Rating

Organisational Risk Register Report

Reporting Period: 18-Jan-2024 to 18-Mar-2024

Gateshead Health NHS Foundation Trust

Movements in CRR

				CRR		
BU	Service Line	ID	Risk Description	Jan-2024	Feb-2024	Today
Medical Services	Medical Services - Divisional Management	2982	Risk of delayed transfers of care and increased hospital lengths of stay	16	9	8
Nursing, Midwifery & Quality	Quality Governance	3089	Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures.	12	8	8
People and OD	Human Resources	2764	Risk of not having clearly agreed workforce plans for the next 3, 5 and 10 years.	16	16	16
	Workforce Development	2373	Exposure to incidents of violence and aggression in ECC	15	15	15
		3095	Risk of Significant, unprecidented service disruption due to industrial action	16	16	16
		3298	Increase in incivility and disrespectful behaviours being reported	12	12	12
QE Facilities		3186	There is a risk to ongoing business continuity of service provision due to ageing trust estate	12	12	12
Surgical Services	Obstetrics	2398	Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings	15	15	15

Committee Escalation and Assurance Report

Name of Board Committee	Finance and Performance Committee
Date of Board Committee:	27 February 2024
Chair of Board Committee:	Mr Mike Robson

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

- There were no issues identified as requiring escalation to the Board for further action.

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)

- Referral to the Digital Committee

  An action was agreed to cross-refer an issue identified by the Committee in relation to a delay with digital-related updates to the Digital Committee.

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

- The Committee agreed positive assurances had been received in relation to:
  - QEF Finance Report for January 2024 outturn– The Committee was assured that QEF are on track to achieve their financial plan for the year.
  - Integrated Performance Report – The committee commented positively on the report which is now focussing on key areas and summary information. Going forward it will also include narrative information on Mutual Aid.
  - Month 10 Financial Report – The Committee noted that the report was largely positive and were assured over the ability to meet the year-end deficit.
  - Progress with the Community Diagnostic Centre – The Committee took assurances from the report that the project is on track and the Committee is clearer about responsibilities and governance arrangements. There are

some issues to resolve with the contractor in relation to contracted completion dates and an approach has been agreed with QEF.
Risks (any new risks / proposed changes to risk scores)
• The Committee noted that planning is an area of concern due to delays in publishing the national guidance.

Gateshead Health NHS Foundation Trust

Assurance Report

Agenda Item: 17ii

Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☒
Committee Reporting Assurance:	Quality Governance Committee February 2024			
Name of Meeting:	Trust Board			
Date of Meeting:	February 2024			
Author:	Mrs A Stabler, Non-Executive Director			
Executive Lead:	Dr G Findley, Chief Nurse			
Report presented by:	Mrs A Stabler, Non-Executive Director			
Matters to be escalated to the Board:	For information only: The Committee noted that the Lead Nurse for Learning Disabilities is on long term sick and agreed to receive an update at the next meeting regarding any key risks and mitigations.			
Executive Summary:	**Items received for assurance:** **Medicines Quarterly Report** The report was presented informing that the omitted medicine is reported as a percentage that are within target range and the prescription turnaround times are spilt into 2 work streams with just over an hour turnaround. The Committee acknowledged the amount of green ratings in the targets and asked that targets be reviewed to drive further improvements in the service. This will be reviewed in the next report. **Paediatric Hearing Service Improvement Plan** The report was presented informing that the national review raised significant concerns and as a result we have established monthly oversight meetings with the ICB to undertake a detailed review to understand if the concerns have impacted on patient outcomes and to arrange a visit by subject matter experts for further investigation. The Committee acknowledged that one of the issues highlighted is the Audiology assessment rooms do not meet the required standards for Paediatric testing and Audiology are prioritisation for the relocation of services as part of the Trust estates plan with an initial meeting on 1 March 2024. The Committee agreed to receive an update in June 2024 regarding assurance that we have delivered on completing the actions required.			

Maternity Oversight Report
The report was presented informing there were 174 births, 0 serious incidents, 0 HSIB cases and 1 perinatal loss. The birth rate remains high with overall births for 2023/24 are 8.5% higher than the same point last year. The CQC Maternity Patient Survey was rated fifth in the country and a LMNS evidence review meeting was held on 18 January 2024 in which we have met the criteria for 6 of those elements with a requirement of full compliance by 31 March 2024.

Freedom to Speak Up (FTSU) Report
The report was presented informing in quarter 2 there were 7 cases reported of culture and in quarter 3 there were 18 cases reported of bullying and harassment. We have undertaken a review of service as requested by NHSE/I following the Lucy Letby case and there are currently 8 FTSU Champions in post with a plan to relaunch to recruit further due to leavers.

The Committee received the report for assurance noting that some of the cases have not been resolved due to the complexities.

Health and Safety Assurance Plan
The report was presented following on from the discussion at the last meeting where concerns were expressed regarding a number of areas of concern were highlighted arising from the Group Health and Safety Assurance Report. Issues included the lack of Health and Safety meetings in July and September 2023. Assurance was provided via a robust action plan that is being monitored via the executives. Of note there have been new additions to the structure of a Head of Safety, Health, Environment and Quality (SHEQ) and Health and Safety Officer that have both been appointed to. It was agreed that the next update would be via the regular report to the committee.

Quality Account Quarter 2&3 Progress Update
The report was presented informing that the Medical Examiner (ME) work is expanding into 13 GP practices; who will refer community deaths into the ME Office.
The Committee noted that the Lead Nurse for Learning Disabilities is on long term sick and agreed to receive an update at the next meeting or key risks and mitigations.

Complaints Update
The report was presented informing there were 8 overdue complaints of 6 within the Medical Business Unit and 2 within Surgery. One complaint response is written and we have received comments from Newcastle Hospital NHS Foundation Trust today. Additional support is being provided to Divisions to reduce the backlog further.

	Additionally a new process has been developed using previous engagement work of surveys, focus groups and one to ones to go as a proposal. **Learning Indicators Report** The report was presented informing that C Diff is over the trajectory however this is improving and if continues then we will end the year of less than 40 cases which is in line with last year. It was recommended that going forward that C Diff should be replace with safe staffing final agreement to this change will be via the Board Development Day. **Assurances from SafeCare Risk and Safety Council** The report was presented informing that meetings were held on 25 January and 20 February 2024 with items identified to highlight to the Committee as follows: • Closure of Datix and transition to InPhase • Enhanced PSIRF Reporting for Improved Learning • Clinical Audits and Legacy Action Closure The Committee acknowledged with regards to the concerns in relation to PSIRF, there are staff members in the team who are on sick and PSIRF was launched on 31 October 2023 with further training for Executive Directors, Trust Board and Senior Members of the Trust have been launched. **Serious Incidents Report** The report was presented updating on the implementation of PSIRF noting there is no longer a requirement to report on serious incidents moving forward. In quarter 2 and 3 there were 10 serious incidents opened with a number of outstanding reports. It was noted there are currently 247 actions requiring closure by 31 March 2024, we have transitioned across the majority of the actions and 46 relate to duty of candour that were concluded but not closed on the system. There were also 21 serious incidents closed by the ICB in this quarter. **Safer Staffing Report** The report was presented informing the average fill rates reported were 93.7% for registered nurses / midwives in the day and night were 103.5%. The average fill rates were for 126% for care staff in the day and night were 112.3%. The Committee noted that the sickness and absence is high amongst the Health Care Support Workers which is being picked up by the People and OD Committee to look into this further. The Committee asked for a deep dive over the past 12 months. **ICB Update** A verbal update was provided informing that the ICB is in the final stages of the restructure process that has been

<table>
<tr><td></td><td colspan="6">complex with uncertainty. There were discussions of the role and attendance at the Committee as the ICB have not got a describable service where the information flows from the Committee to the ICB in terms of escalation and assurance.

Internal Audit Reports Update
<u>WHO Surgical Checklist</u>
A verbal update was provided informing that the deadline for outstanding actions is the end of February 2024 and have received assurance from the teams that this will be delivered but have not been submitted. The Committee asked to receive a summarised paper at the next meeting and a noted a WHO user group will monitor this moving forward.

<u>DNACPR</u>
A verbal update was provided informing that the position has improved and the results will be presented at the next meeting via a paper.
It was acknowledged a summary overview of Internal Audit actions will be brought to every meeting.

Items received by the Committee for information:
• Mental Health Act Compliance Minutes – October 2023 and January 2024
• Cycle of Business</td></tr>
<tr><td>Recommended actions for Board</td><td colspan="6">Board are asked to note the work of the Committee and the assurances received and note the areas of risk identified but note the actions in place to resolve.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to: (Including reference to any specific risk)</td><td>Aim 1
☒</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☐</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☐</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
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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>Financial Implications:</td><td colspan="6">None to Note</td></tr>
<tr><td>Links to Risks (identify significant risks and DATIX reference)</td><td colspan="6">ORR Risks, 2879 – Maternity, 2779 CQC Compliance/ Improvement, 2868 – Further wave of Covid, 2880</td></tr>
<tr><td>People and OD Implications:</td><td colspan="6">Gaps in workforce in nursing, midwifery and mental health.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td colspan="2">Safe
☒</td></tr>
</table>

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

Committee Escalation and Assurance Report

Name of Board Committee	Digital Committee
Date of Board Committee:	7 February 2024
Chair of Board Committee:	Mr A Moffat

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

- There were no items requiring escalation to the Board.

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

- At the previous meeting in December 2023 it was agreed to see if recent actions had a material effect on the Information Asset Owner (IAO) KPIs before escalating. At this meeting it was noted there has been some improvement and several initiatives will be actioned over the next reporting period so it was agreed that this did not need escalating at this time, although it was noted that this area is still underperforming.

- The uncertainty around the integrated Electronic Patient Record procurement (EPR) is an area of concern and has an impact on other areas of work. An engagement event had been held in December with staff and potential suppliers which was a success. Action will be taken forward with digital leaders and the Executives to develop a decision making timeline around procurement.

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

- The Committee noted the range of work taking place in relation to addressing health inequalities through digital exclusion and the need for this to be tied into a visible work strand across the Trust on reducing health inequalities, rather than generically about digital exclusion.

- The Committee noted updates on:
  - Organisational Strategic Objectives
  - The overall digital programme plan
  - Digital strategy delivery update
  - System Exploitation Plan

- Digital Service KPIs
Risks (any new risks / proposed changes to risk scores)
• There were no changes to risk scores.

Committee Escalation and Assurance Report

Name of Board Committee	People and OD Committee
Date of Board Committee:	12 March 2024
Chair of Board Committee:	Mrs Maggie Pavlou

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

- There were no issues for escalation to the Board.

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

- Staff Survey - the Committee had concerns about the number of GEM colleagues experiencing bullying and harassment including of a sexual nature. It was noted that the questions around unwanted behaviour of a sexual nature were new to the survey this year. The Committee noted that a programme of work is underway on zero tolerance and that new national guidance in relation to a Sexual Safey Policy will form part of a wider piece of work being taken forward with staff networks on this issue.

  The Committee recognised that work is underway but they are not currently assured on this issue.

- Gender Pay Gap – the committee was not fully assured due to the way the information had been presented in the report and felt the direction of travel was not clear. The report will be reviewed and amended before the submission deadline at the end of March 2024.

- Guardian of Safe Working – the Committee had some concerns about the level of support provided by the medical staffing team due to concerns raised by junior doctors.

- EDI – the Committee noted that there are a lot of statutory returns in this area that they have oversight of, but would like to see this work brought together in an overarching approach and covering the whole organisation.

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

- ADQM – the Committee retrospectively approved the submission.

Risks (any new risks / proposed changes to risk scores)
• BAF – SA2.2 – Growing and developing our people - it was agreed that the likelihood score should be moved to 3, moving the current risk score down from 16 to 12. This is based on the planning and actions that are in place to address this risk and that we are moving in the right direction towards strategic objectives. • There were no changes to the ORR.

Committee Escalation and Assurance Report

Name of Board Committee	Group Audit Committee
Date of Board Committee:	5 March 2024
Chair of Board Committee:	Mr A Moffat

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

- There were no issues for escalation to the Board

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

- Internal Audit Recommendations – the Board were pleased to see an improvement in the response to internal audit recommendations following the matter being raised with the CEO by the Audit Committee following the last meeting, but this improved performance needs to be sustained.

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

- The Board's Standing Orders, as well as the Standing Financial Instructions for the Trust and for QEF were reviewed by the Committee and are to be recommended to the Board for approval and adoption.

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

- There is a risk of a possible reduction in performance in relation to risk compliance following the move over to the InPhase system.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 18

Report Title:	**2023 Staff Survey Results**			
Name of Meeting:	Board of Directors (Public Board)			
Date of Meeting:	27 March 2024			
Author:	Laura Farrington, Head of Leadership, OD & Staff Experience			
Executive Sponsor:	Amanda Venner, Executive Director of People and OD			
Report presented by:	Amanda Venner, Executive Director of People and OD			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	To provide insight into the 2023 staff survey results and share plans for the year ahead in response to the feedback received.			
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*	The 2023 staff survey was completed by 50% of colleagues and the results provide a positive picture of engagement with less than 5% of questions for both the Trust and QE Facilities significantly declining compared to the 2022 responses. The results show that various people promise themes are improving and the general trend for questions is positive. This is also evident in the regional comparison, which highlights Gateshead's strong position. Questions that have had a significant improvement are in the areas of **burnout and appraisals**, along with **bullying and harassment** when compared with others however, the results highlight that the experience of our GEM colleagues and those who have a long-lasting health condition or illness, is not as favourable. Of note are the results showing bullying, harassment, discrimination and abuse from colleagues and managers towards these colleague groups, which requires immediate attention. Recommended actions following the survey include using the culture programme as a key vehicle for improving behaviours			

<table>
<tr><td></td><td colspan="6">surrounding bullying, harassment, discrimination, and abuse, with a key focus on civility and respect. We will maintain a continued focus on freedom to speak up, flexible working and the NHS Equality, Diversity, and Inclusion Improvement Plan.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">For review, consideration, and discussion.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☐</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
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☐</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">SA2.1: Protect and understand the health and well-being of our staff by looking after our workforce

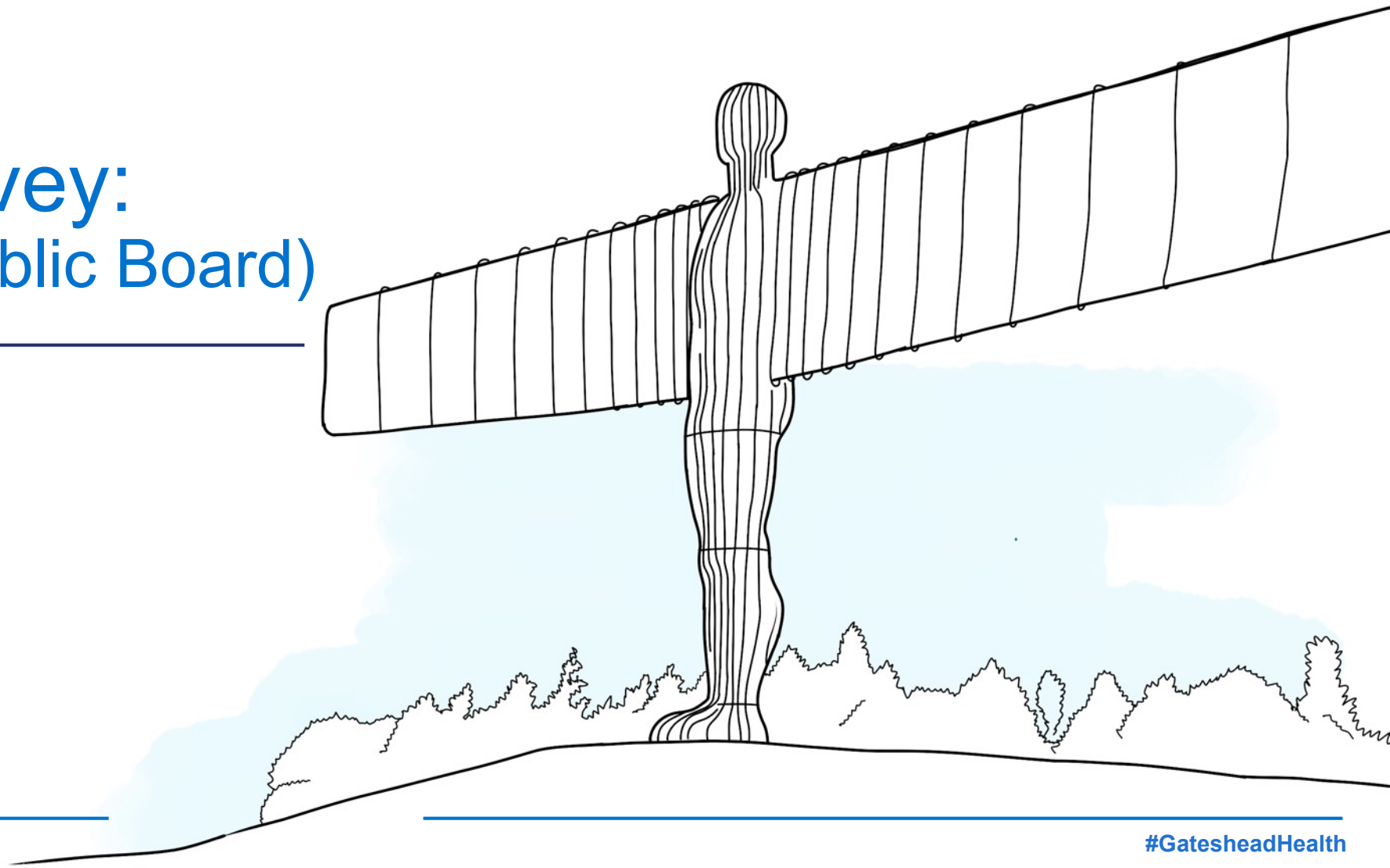
SA2.2: Growing and developing our workforce
SA2.3: Development and Implementation of a Culture Programme (2–3-year Programme)</td></tr>
<tr><td>Links to CQC Key Lines of Enquiry (KLOE):</td><td>Caring
☐</td><td>Responsive
☐</td><td>Well-led
☒</td><td>Effective
☐</td><td colspan="2">Safe
☐</td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):</td><td colspan="6"></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

2023 Staff Survey:
Group Results (Public Board)

Amanda Venner

27 March 2024



Group Staff Survey Actions following last year's survey

NHS Gateshead Health NHS Foundation Trust

Appointment of a full time Freedom to Speak Up Guardian

A new Trust prospectus to support personal development

Trust-wide learning needs analysis undertaken to better understand the development needs of teams and individuals

Appointment of a permanent Health and Wellbeing Manager

Culture programme launched with key workstreams focused on enhancing the culture at Gateshead including zero tolerance programme

More opportunities for colleagues to meet with the executive team in informal ways

Increased clinical input in decision making across the Trust

Introduction of a new appraisal form to improve the process

Increased communications around speaking up

Increased communications about discriminatory behaviour

Range of retention initiatives such as Legacy Nurses

Catering provision enhanced:

- Out of hours
- Fruit & Veg stall

Introduction to 2023 Staff Survey

The NHS People Promise sets out what NHS colleagues can expect from their leaders and from each other, and how we should all be able to describe working in the NHS, by 2024.

A total of 118 questions were asked in the 2023 survey, of these, 112 can be compared to 2022.

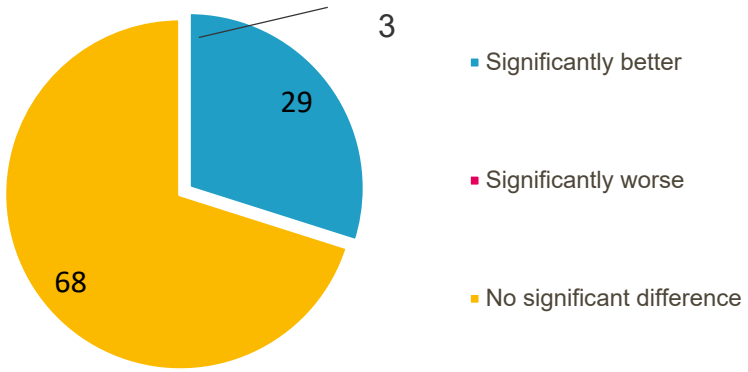
50% Group Completion Rate

49% Trust
59% QE Facilities
17% Bank

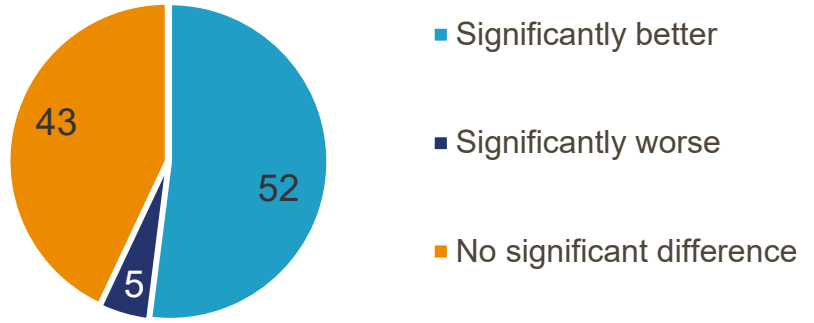
Group: Executive Summary

Gateshead Health NHS Foundation Trust

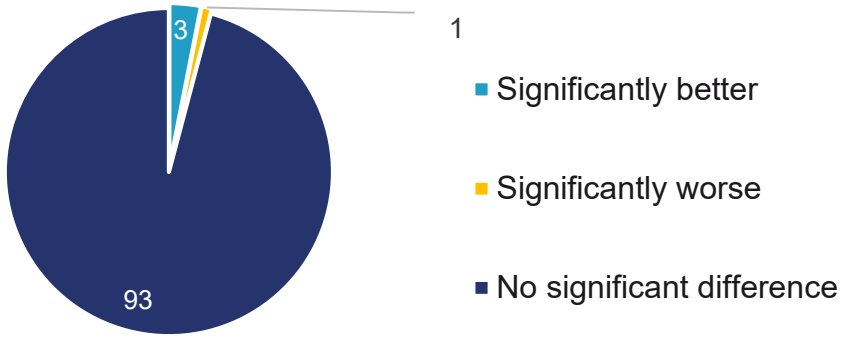
Comparison to 2022



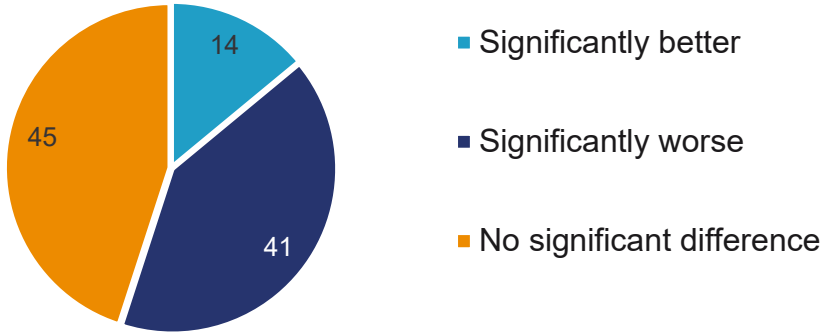
Trust Comparison with Picker average



QE Facilities Comparison to 2022



QE Facilities Comparison with average



Trust: Executive summary

Gateshead Health NHS Foundation Trust

Top 5 scores vs Organisation Average	Org	Picker Avg
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	75%	63%
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	83%	74%
q15. Organisation acts fairly: career progression	65%	57%
q25c. Would recommend organisation as place to work	68%	60%
q25e. Feel safe to speak up about anything that concerns me in this organisation	67%	61%

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q14d. Last experience of harassment/bullying/abuse reported	47%	51%
q2a. Often/always look forward to going to work	52%	56%
q22. I can eat nutritious and affordable food at work	53%	55%
q11d. In last 3 months, have not come to work when not feeling well enough to perform duties	44%	46%
q13d. Last experience of physical violence reported	69%	71%

Most improved scores	Org 2023	Org 2022	Picker Avg
q3i. Enough staff at organisation to do my job properly	32%	23%	32%
q23a. Received appraisal in the past 12 months	88%	80%	89%
q4c. Satisfied with level of pay	35%	28%	35%
q12b. Never/rarely feel burnt out because of work	33%	27%	33%
q6c. Achieve a good balance between work and home life	56%	51%	57%

Most declined scores	Org 2023	Org 2022	Picker Avg
q2c. Time often/always passes quickly when I am working	73%	75%	73%
q9e. Immediate manager values my work	73%	75%	72%
q24b. There are opportunities for me to develop my career in this organisation	56%	57%	56%
q7h. Feel valued by my team	70%	71%	70%
q3b. Feel trusted to do my job	90%	92%	90%

Tables are based on absolute % differences, not statistical significance

QE Facilities: Executive summary

Gateshead Health NHS Foundation Trust

Top 5 scores vs Organisation Average	Org	Picker Avg
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	78%	49%
q3g. Able to meet conflicting demands on my time at work	64%	51%
q12a. Never/rarely find work emotionally exhausting	44%	31%
q11c. In last 12 months, have not felt unwell due to work related stress	75%	66%
q23b. Appraisal helped me improve how I do my job	33%	24%

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	56%	76%
q7b. Team members often meet to discuss the team's effectiveness	53%	68%
q14d. Last experience of harassment/bullying/abuse reported	43%	57%
q24a. Organisation offers me challenging work	55%	69%
q11e. Not felt pressure from manager to come to work when not feeling well enough	69%	81%

Most improved scores	Org 2023	Org 2022
q23a. Received appraisal in the past 12 months	81%	69%
q4a. Satisfied with recognition for good work	60%	52%
q12e. Never/rarely worn out at the end of work	32%	25%
q12g. Never/rarely lack energy for family and friends	47%	40%
q12d. Never/rarely exhausted by the thought of another day/shift at work	54%	47%

Most declined scores	Org 2023	Org 2022
q13d. Last experience of physical violence reported	68%	82%
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	56%	65%
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	70%	76%
q2a. Often/always look forward to going to work	53%	59%
q3i. Enough staff at organisation to do my job properly	44%	50%

Tables are based on absolute % differences, not statistical significance

Group Improvement: Burnout

Gateshead Health NHS Foundation Trust

q12a	Never/rarely find work emotionally exhausting
q12b	Never/rarely feel burnt out because of work
q12c	Never/rarely frustrated by work
q12d	Never/rarely exhausted by the thought of another day/shift at work
q12e	Never/rarely worn out at the end of work
q12f	Never/rarely feel every working hour is tiring
q12g	Never/rarely lack energy for family and friends

Trust

Historical			External	
2021	2022	2023	Average	Organisation
22%	21%	**23%**	23%	23%
29%	27%	**33%**	31%	**33%**
19%	19%	**22%**	22%	22%
33%	33%	**38%**	37%	38%
14%	15%	**19%**	19%	19%
51%	51%	**54%**	51%	**54%**
33%	31%	**36%**	35%	36%

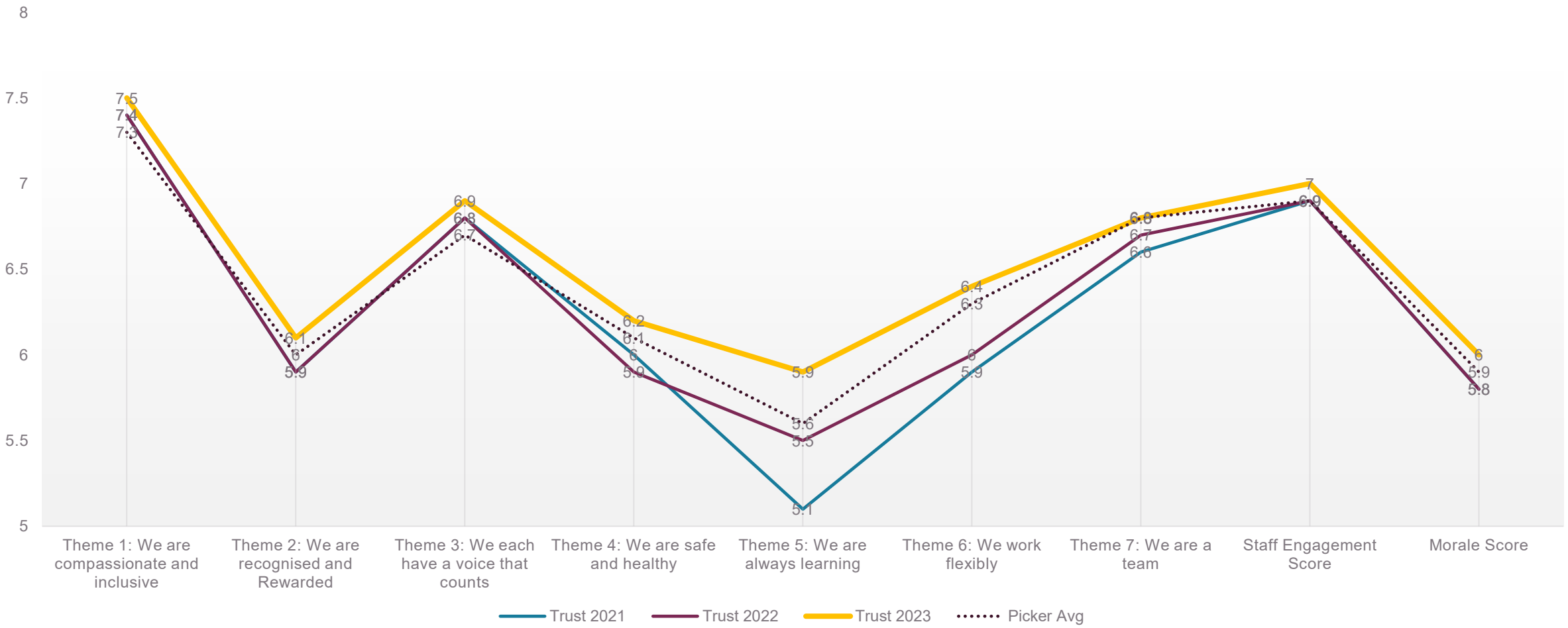
QE Facilities

Historical			External	
2021	2022	2023	Average	Organisation
	41%	44%	31%	**44%**
	41%	44%	39%	**44%**
	34%	33%	26%	**33%**
	47%	54%	47%	**54%**
	25%	**32%**	25%	**32%**
	60%	59%	60%	59%
	40%	47%	43%	47%

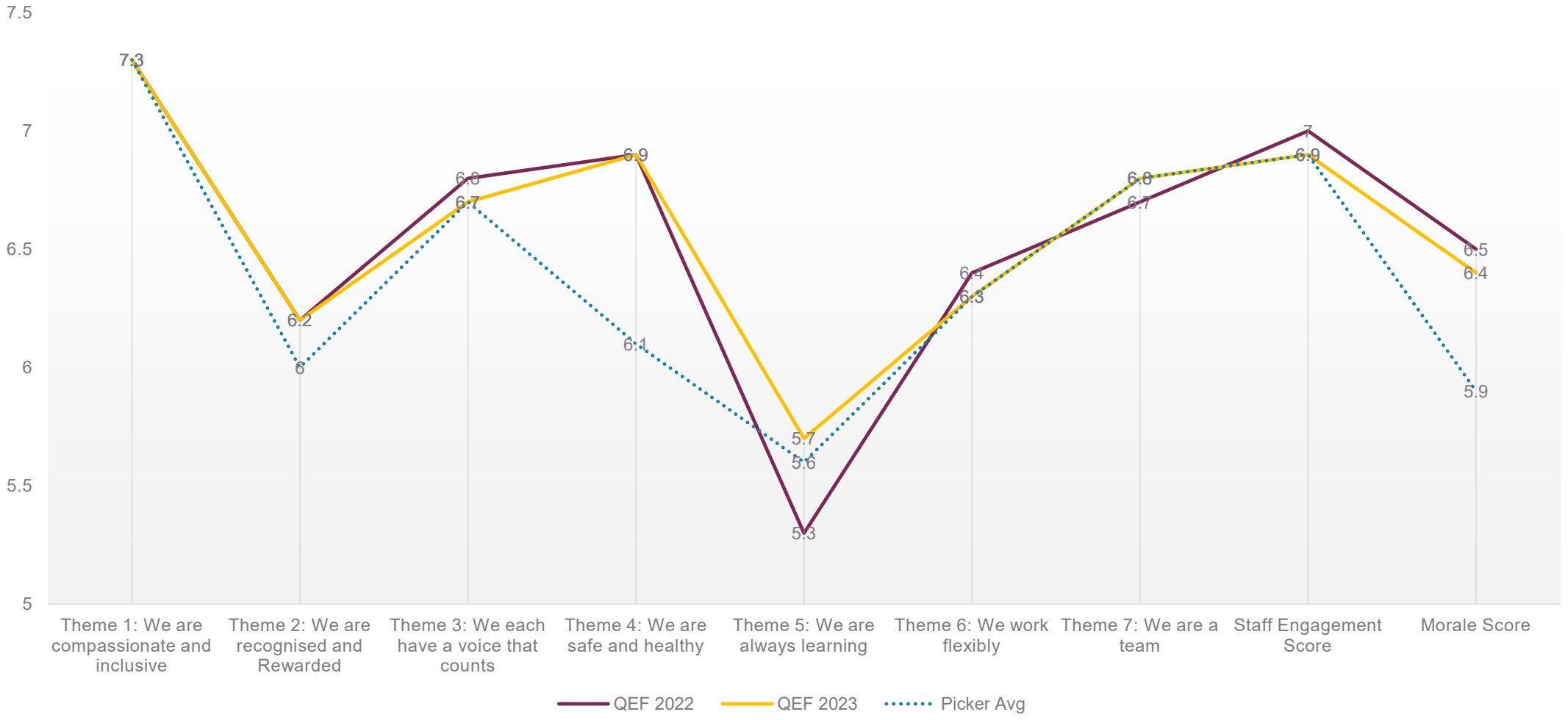
Green shoots of progress across the group but still further progress to be made

Trust: People Promise 3-year Trend

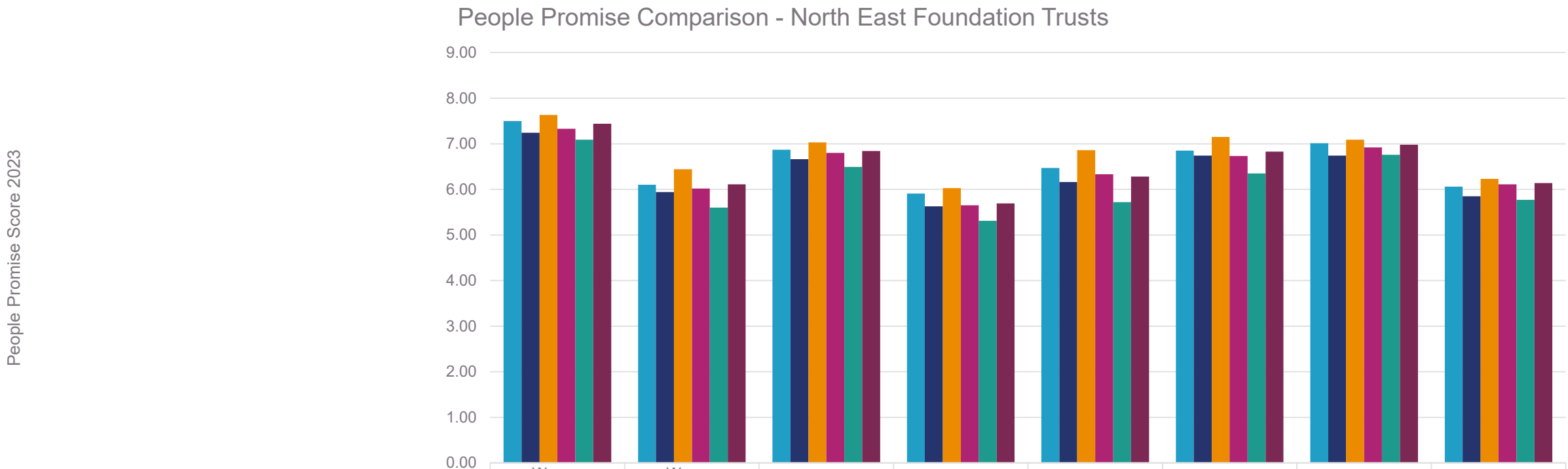
Gateshead Health NHS Foundation Trust



QEF: People Promise 3-year Trend

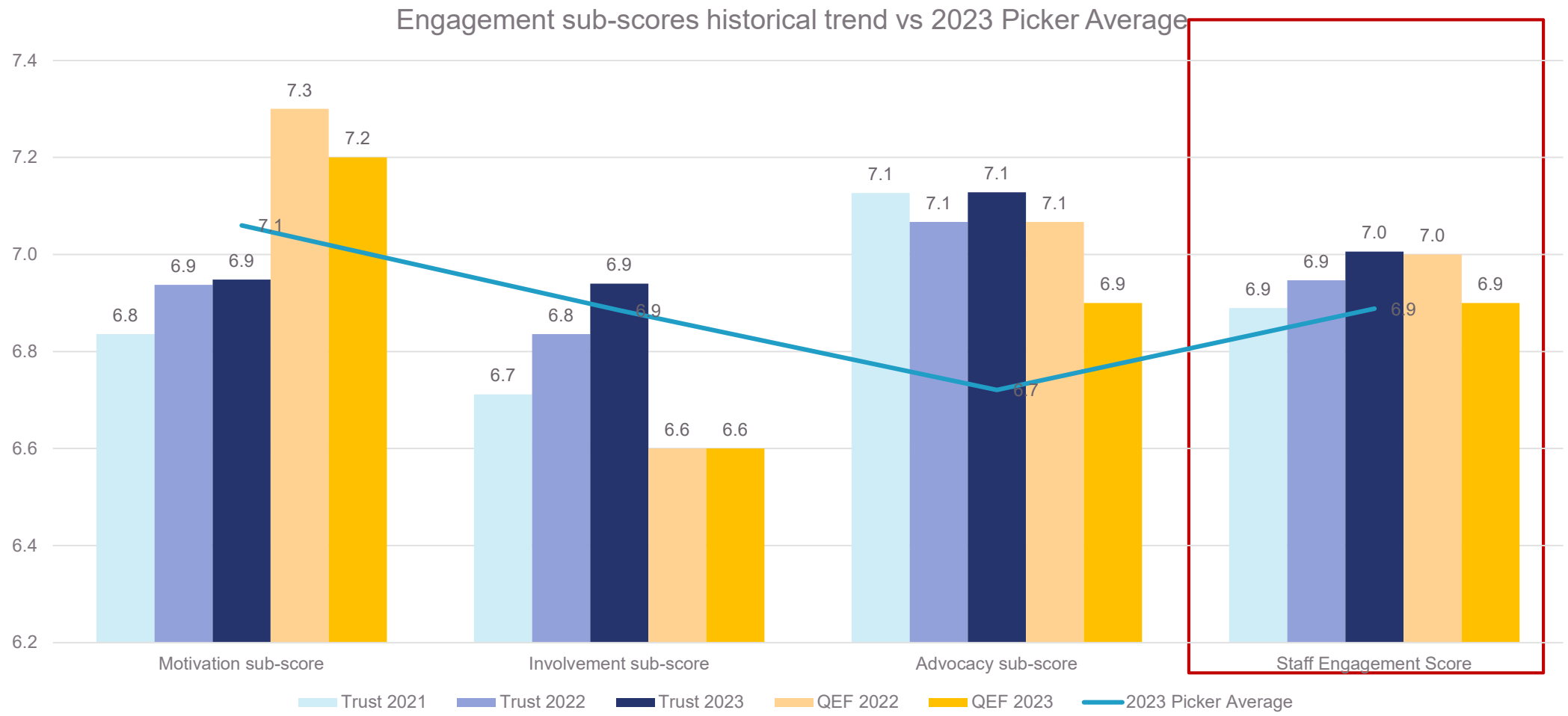


People Promise - Regional Comparator



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are always learning	We work flexibly	We are a team	Staff engagement	Morale
Gateshead Health NHS Foundation Trust	7.50	6.10	6.87	5.91	6.47	6.85	7.01	6.06
County Durham and Darlington NHS Foundation Trust	7.24	5.94	6.66	5.63	6.16	6.74	6.74	5.85
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	7.63	6.44	7.03	6.03	6.86	7.15	7.09	6.23
South Tyneside and Sunderland NHS Foundation Trust	7.33	6.02	6.80	5.65	6.33	6.73	6.92	6.11
The Newcastle upon Tyne Hospitals NHS Foundation Trust	7.09	5.60	6.49	5.31	5.72	6.35	6.76	5.77
North Tees and Hartlepool NHS Foundation Trust	7.44	6.11	6.84	5.69	6.28	6.83	6.98	6.14

Group 2021 – 2023 engagement scores vs Picker average



Staff Networks - Overall Positive Direction

D-ABILITY STAFF NETWORK

Yes (603)	No (1485)
60%	66%

GHNFT LGBT+ Network @ghntlgbt

Heterosexual / straight (1926)	Gay / lesbian, Bisexual, Other (100)	I would prefer not to say (101)
65%	61%	51%

GEM Global Ethnic Majority

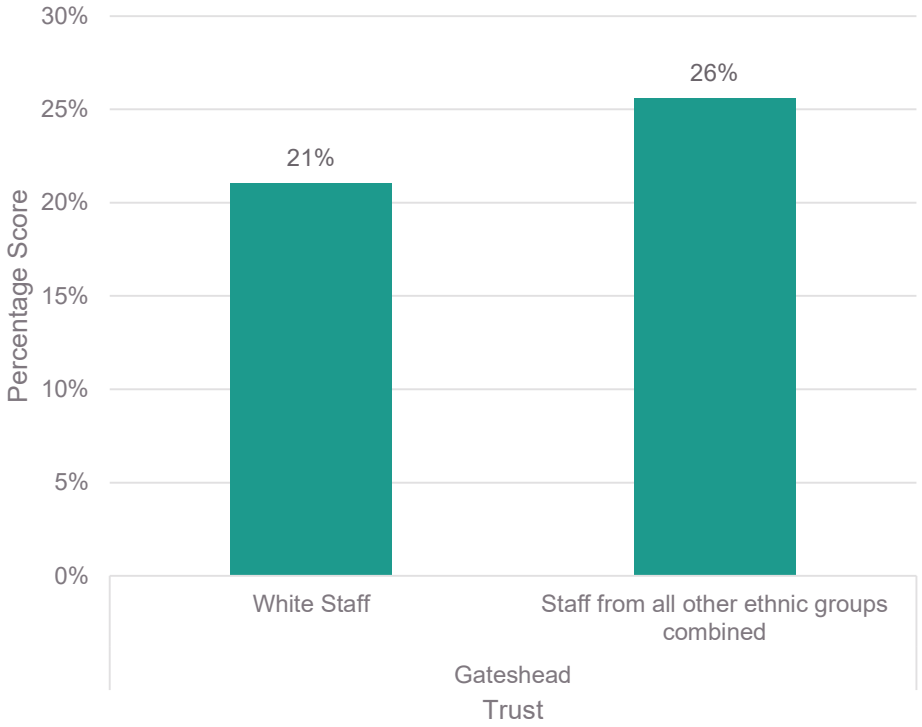
White (1961)	Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/ Caribbean/ Black British, Other ethnic group (164)
64%	66%

Female (1686)	Males (350)	Prefer not to say (70)
65%	64%	46%

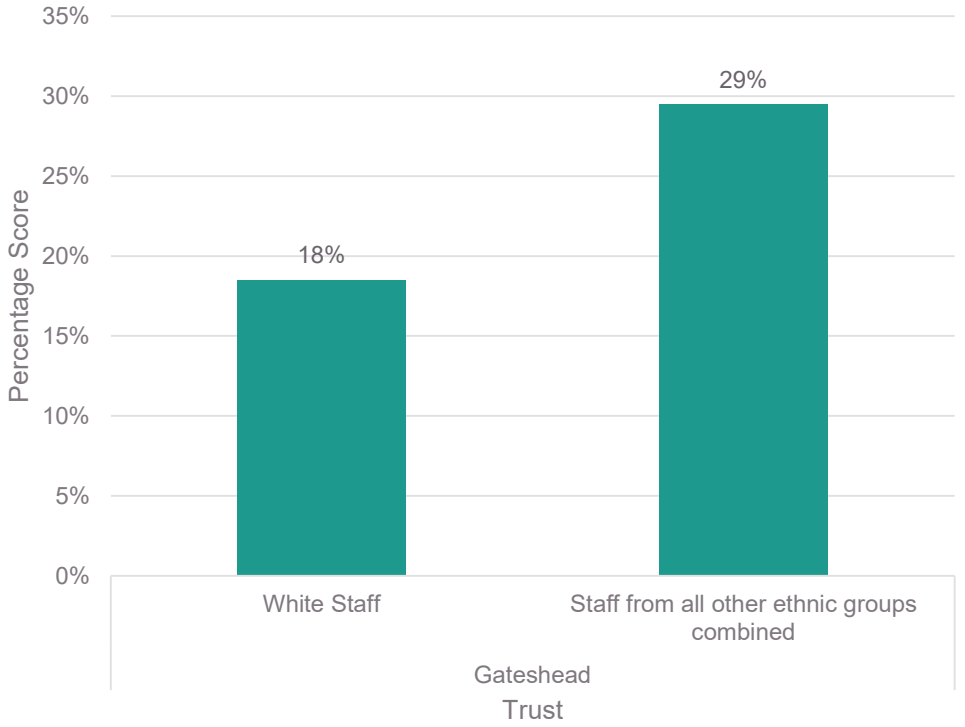
Bullying, Harassment or Abuse – WRES

Gateshead Health NHS Foundation Trust

Percentage of staff experiencing harassment, bullying or abuse **from patients, relatives or the public** in the last 12 months (2023)

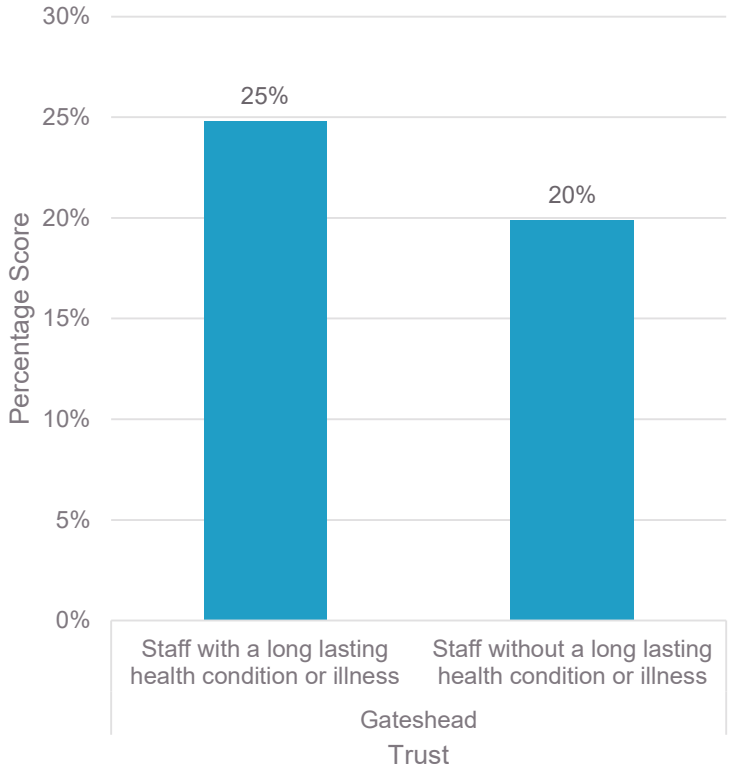


Percentage of staff experiencing harassment, bullying or abuse **from staff** in the last 12 months (2023)

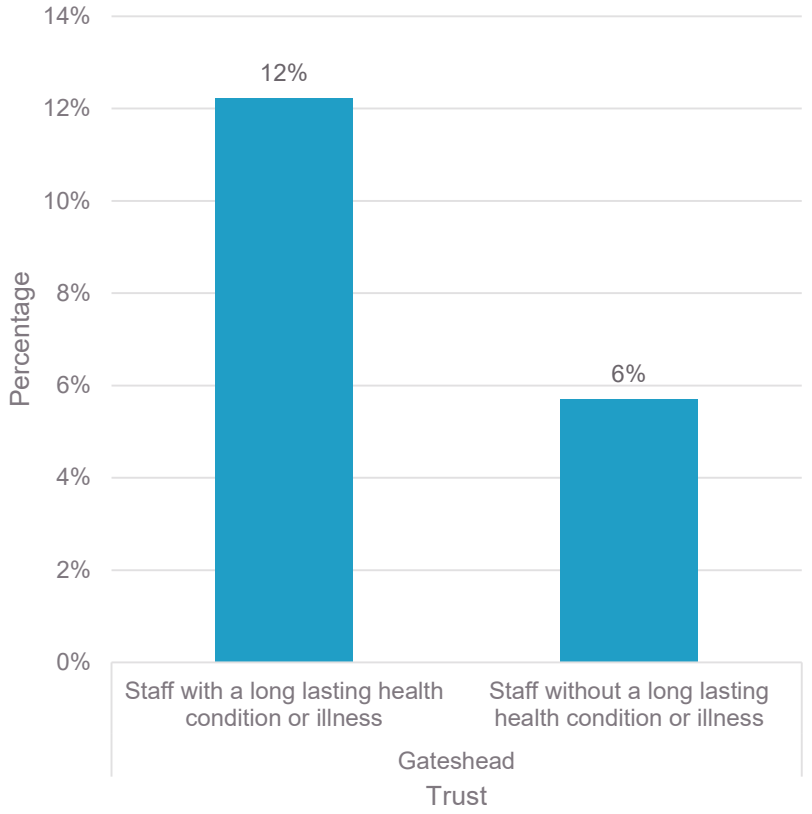


Bullying, Harassment or Abuse – WDES

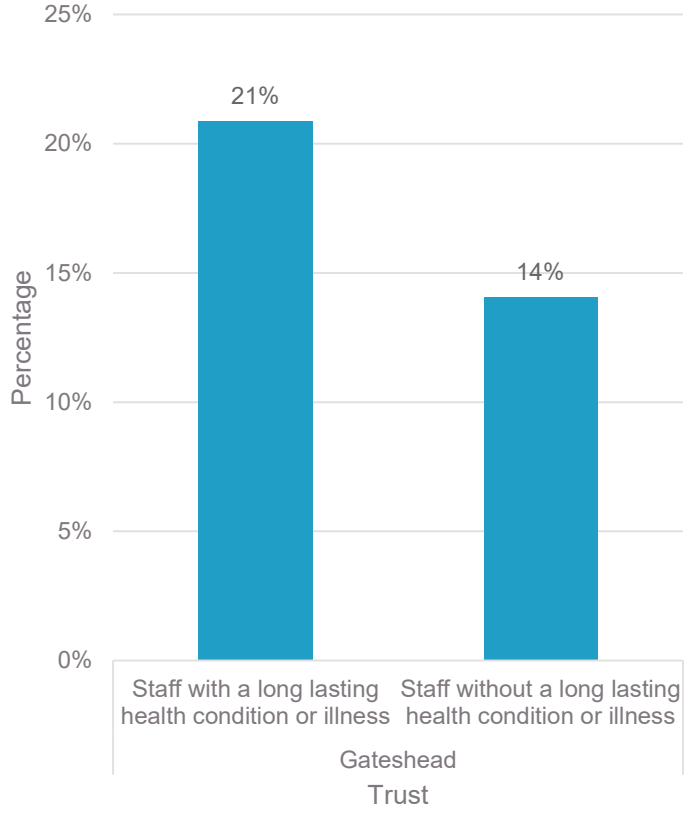
Percentage of staff experiencing harassment, bullying or abuse **from patients/service users, their relatives or the public** in the last 12 months. (q14c) 2023



Percentage of staff experiencing harassment, bullying or abuse **from managers** in the last 12 months. (q14b) 2023



Percentage of staff experiencing harassment, bullying or abuse **from other colleagues** in the last 12 months. (q14c)2023



Progress Update
Areas of focus from 2022 Survey

Gateshead Health NHS Foundation Trust

Freedom to speak up has maintained its position at 67% for the Trust and has increased 3% for QE Facilities to 64%.

Appraisal Quality 88% completion for Trust, and 81% for QEF, significantly above the Picker average. Questions regarding the quality of the appraisal have also improved.

Bullying and Harassment Continue to be above average for bullying and harassment and physical violence at work. However, last experience of physical violence reported was 2% below the Picker average and trending as one the Trust and QEF bottom questions.

Key Findings

- The Trust is in line with the leading indicator objective for **engagement** to be maintained at 7, QE Facilities closely behind at 6.9.
- The further investments in personal development are having the intended impact with people promise theme **we are always learning** increasing year on year for both the Trust and QEF.
- Being **compassionate and inclusive** remains Gateshead's strongest people promise theme.
- **We work flexibly has improved each year,** although there is further work to do in this area as there was a large variation between business units.
- **Burnout scores are improving** both for the Trust and QE Facilities, which may be the green shoots of covid recovery, supported by turnover falling 5% since summer 2022.
- **Freedom to speak up scores remain consistent with 2022** but anticipate positive movement in the 2024 survey as FTSU guardian becomes further embedded into the post.
- **Those who identify as LGBT, or prefer not to disclose their gender, and those who identified as having a disability rated less positively** than those who did not have a disability or identified as straight/heterosexual.

Next Steps: Data

- **Local Questions** – this data will be analysed and used to inform the culture programme actions.

- **Free Text comments** - themed and shared with SMT and key stakeholders.

- **WRES/WDES Data** – inform EDI Managers portfolio of work and the EDI workforce high impact actions

Next Steps: Actions - Group-wide

Gateshead Health NHS Foundation Trust

1. Use the culture programme as the vehicle to further improve scores in relation to:
   - Bullying and harassment via the zero-tolerance working group, alongside reporting incidents.
   - People promise theme we are a team through improving civility and respect and living in line with our values.

2. Continue to promote a culture of speaking up, and taking action as a result of feedback from colleagues championed by our Freedom to Speak Up Guardian

3. Continue with our commitment to the NHS Equality, Diversity and Inclusion Improvement Plan, and use this to enhance the experience of those who identify with any of our staff networks.

4. Increase dialogue between the staff networks and the executive team and board to better understand their lived experiences and challenges.

5. A continued focus on flexible working

6. Clinical Engagement on results, themes and actions

Conclusion

Gateshead Health NHS Foundation Trust

What has this years survey told us?

- Overall positive results however, acknowledge that team level results are very mixed
- Initiatives already underway will seek to improve the majority of areas where the scores have deteriorated or remained the same
- We have more to do to show the impact of completing the survey
- There are some real differences between the Trust and QEF results

What are we doing?

- Increased **EMT/Corporate** oversight and involvement this year
- Wide cascade of results
- Comms campaign to bring the results to life
- Continue the work to address areas of concern
- Local teams to discuss and work on bespoke actions for their area

Gateshead Health NHS Foundation Trust

Report Cover Sheet

Agenda Item: 19

Report Title:	**Consolidated Finance Report – Part One**			
Name of Meeting:	Finance & Performance Committee			
Date of Meeting:	26th March 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 – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Not applicable			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity, and inclusion*	The Trust had an approved 2023-24 planned deficit of **£12.588m.** However, following an additional ICB system allocation of £4.636m in February the deficit plan is revised to **£7.952m** As of February 24, the Trust has reported an actual deficit of **£7.437m** after adjustments for donated assets and gains and losses of asset disposal. This is a favourable variance of **£0.046m** from its year-to-date target for reasons detailed in the body of this report. As of February 24, the Trust is forecasting achievement of its revised planned deficit totalling **£7.952m.** The Trust has an approved 2023-2024 capital programme totalling **£29.792m**. However, following changes to schemes funded from external and charitable funds the Trust is reporting against an updated capital programme of **£26.681m.**			

	As of February 24, the Trust has reported actual capital spend totalling **£12.033m**, and a reported under-spend of **£12.639m** against the year to date plan for reasons in the body of this report. As of February, the Trust is forecasting capital spend totalling **£24.549m**.				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper.*	The recommendation to Board is to receive the report, discuss the potential implications and record partial assurance for the achievement of the 2023-2024 planned deficit as a direct consequence of the reported year to date position and financial risks. To note the summary of performance as of February 2024 (Month 11) for the Group (inclusive of Trust and QE Facilities, excluding Charitable Funds).				
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:	Achieving financial sustainability				
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)	3127 Overall risk of not meeting financial plan, with contributing risks relating to activity (3102) and efficiency (3103).				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

1. Introduction

1.1 The purpose of this report is to provide a summary of financial performance as of 29th February 2024 (month 11) for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds).

1.2 Reporting for February is against the Trusts 2023-2024 financial plan which reports an adjusted annual deficit of £7.952m inclusive of the achievement of a £15.900m cost reduction target and achievement of elective recovery funding income (ERF) totalling £2.654m.

2 Income and Expenditure

2.1 The Trust has reported a deficit of £7.483m for the period April 23 to February 24 and £7.437m after the adjustment for donated assets, gains / loss on disposal of assets.

2.2 This is a favourable variance of £0.046m against the Trusts financial plan as detailed on the Trust Statement of Comprehensive Income (SOCI) as presented in Table 1.

2.3 For the month of February 24 the Trust has reported actual income of £36.472m and total year to date income of £353.026m. This is a favourable variance of £1.356m against the Trusts financial plan. The year-to-date variance comprises of less income than planned for variable income streams included in the scope of the national elective recovery fund initiative totalling £0.630m, and the impact of unachieved CRP £0.877m, offset by national funding to cover industrial action pressures of £1.754m and more income across other income categories of £1.109m.

2.4 For the month of February 24 the Trust has reported actual operating expenditure of £32.762m and total year to date operating expenditure of £357.569m. This is an adverse variance of £6.524m against the Trusts internal financial plan. The year-to-date variance comprises of an overspend on pay budgets totalling £4.974m and non-pay budgets totalling £0.556m in addition to an underachievement of CRP totalling £0.993m across pay and non-pay budgets.

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

STATEMENT OF COMPREHENSIVE INCOME

February 23-24	NHSE APRIL - MARCH 24 FINAL PLAN					VARIANCE		
	Annual Plan	Plan In Month	Actual In Month	Plan to Date	Actual to Date	Variance (Actual - Plan)	Previous Month Variance	Movement in Month
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Operating								
Operating Income from Patient Care activities								
Income From NHS Care Contracts	(347,139)	(32,872)	(32,972)	(318,157)	(319,529)	(1,372)	(1,272)	(100)
Income From Local Authority Care Contracts	(295)	(35)	(32)	(260)	(280)	(20)	(24)	4
Private Patient Revenue	(735)	(61)	(60)	(674)	(685)	(11)	(13)	2
Injury Cost Recovery	(500)	(42)	(52)	(458)	(470)	(11)	(1)	(11)
Other non-NHS clinical revenue	(153)	(13)	(12)	(141)	(129)	12	11	1
Total Operating Income From Patient Care activities	**(348,823)**	**(33,023)**	**(33,127)**	**(319,690)**	**(321,093)**	**(1,403)**	**(1,299)**	**(104)**
Other Operating Income								
Education and Training Income	(11,881)	(1,329)	(1,337)	(10,907)	(10,896)	11	19	**(8)**
R&D Income	(1,032)	(88)	(96)	(970)	(1,064)	(94)	(87)	**(7)**
Funding outside of System Envelope	0	0	0	0	0	0	0	-
Other Income	(20,519)	(1,467)	(1,912)	(19,015)	(19,922)	(907)	(462)	**(445)**
Donations & Grants Received	(229)	(19)	0	(210)	(50)	160	141	**19**
Cost Improvement Programme - Income	(978)	(101)		(877)	0	877	776	**101**
Total Other Operating Income	**(34,639)**	**(3,004)**	**(3,345)**	**(31,980)**	**(31,932)**	**47**	**387**	**(340)**
Total Operating Income	**(383,463)**	**(36,027)**	**(36,472)**	**(351,670)**	**(353,026)**	**(1,356)**	**(912)**	**(445)**
Operating Expenses								
Employee Expenses - Substantive	253,047	21,496	20,716	228,639	223,902	(4,736)	(3,957)	**(779)**
Employee Expenses - Bank	530	46	863	489	8,179	7,690	6,873	**817**
Employee Expenses - Agency	2,234	271	324	2,013	3,942	1,929	1,876	**53**
Employee Expenses - Other	1,297	102	122	1,201	1,292	91	72	**19**
Cost Improvement Programme - Pay	2,003	(218)		2,680	0	(2,680)	(2,898)	**218**
Total Employee Expenses	**259,111**	**21,696**	**22,025**	**235,021**	**237,315**	**2,294**	**1,966**	**328**
Purchase of Healthcare - NHS bodies	8,440	737	868	7,704	7,737	33	(98)	**131**
Purchase of Healthcare - Non NHS bodies	4,153	328	448	3,823	3,678	(145)	(266)	**120**
Purchase of Social Care	0	0	0	0	0	0	0	-
NED's	187	16	15	171	155	(17)	(16)	**(1)**
Supplies & Services - Clinical	36,384	3,126	2,697	33,331	35,324	1,993	2,422	**(429)**
Supplies & Services - General	3,158	264	257	2,863	2,611	(252)	(245)	**(7)**
Drugs	23,150	1,884	1,767	21,277	20,888	(389)	(272)	**(118)**
Research & Development expenses	11	0	3	11	35	23	21	**3**
Education & Training expenses	1,950	188	240	1,729	1,894	165	113	**52**
Consultancy costs	967	37	30	760	700	(59)	(52)	**(7)**
Establishment expenses	4,271	315	360	3,957	4,195	238	192	**45**
Premises	19,635	1,669	1,895	17,955	18,098	143	(82)	**225**
Transport	1,916	156	147	1,758	1,533	(225)	(216)	**(9)**
Clinical Negligence	7,933	696	692	7,244	6,994	(250)	(246)	**(4)**
Operating Leases	107	14	6	93	(341)	(434)	(426)	**(8)**
Other Operating expenses	9,025	535	496	5,709	7,358	1,649	1,687	**(39)**
Cost Improvement Programme - Non Pay	(4,253)	(575)	0	(3,673)	0	3,673	3,098	**575**
Reserves	0	(0)	0	(0)	0	0	0	**0**
Operating Expenses included in EBITDA	**376,145**	**31,086**	**31,946**	**339,733**	**348,174**	**8,441**	**7,581**	**860**
Depreciation & Amortisation - Purchased / Constructed	6,879	571	571	6,308	6,297	(11)	(12)	**1**
Depreciation & Amortisation - Donated / Granted	242	16	18	226	231	5	3	**2**
Depreciation & Amortisation - Finance Leases	5,112	426	276	4,686	3,131	(1,555)	(1,405)	**(150)**
Impairment & Revaluation	100	8	(50)	92	(264)	(356)	(298)	**(59)**
Operating Expenses excluded from EBITDA	**12,333**	**1,021**	**815**	**11,312**	**9,394**	**(1,918)**	**(1,712)**	**(206)**
Total Operating Expenses	**388,471**	**32,107**	**32,762**	**351,045**	**357,569**	**6,524**	**5,869**	**654**
(Profit)/Loss from Operations	**5,008**	**(3,920)**	**(3,710)**	**(624)**	**4,543**	**5,167**	**4,957**	**210**
Non Operating								
Non-Operating Income								
Finance Income	(2,224)	(215)	(164)	(2,010)	(2,133)	(124)	(175)	**51**
Total Non-Operating Income	**(2,224)**	**(215)**	**(164)**	**(2,010)**	**(2,133)**	**(124)**	**(175)**	**51**
Non-Operating Expenses								
Finance Costs	483	40	55	443	677	234	219	**15**
Gains / (Losses) on Disposal of Assets	0	0	0	0	0	0	0	**0**
PDC dividend expense	3,885	324	324	3,561	3,562	1	1	**0**
Total Finance Costs (for non-financial activities)	**4,368**	**364**	**379**	**4,004**	**4,239**	**234**	**220**	**15**
Other Non-Operating Expenses								
Misc. Other Non-Operating expenses	0	0	0	0	0	0	0	
Total Non-Operating Expenses	**4,368**	**364**	**379**	**4,004**	**4,239**	**234**	**220**	**15**
(Surplus) / Deficit Before Tax	**7,152**	**(3,771)**	**(3,495)**	**1,370**	**6,648**	**5,277**	**5,002**	**275**
Corporation Tax	914	86	104	803	1,020	217	200	**17**
(Surplus) / Deficit After Tax	**8,066**	**(3,684)**	**(3,392)**	**2,174**	**7,668**	**5,495**	**5,202**	**292**
Balancing Adjustment to NHSE Plan		**301**		5,420		(5,420)	(5,119)	(301)
(Surplus) / Deficit After Tax from Continuing Operations	**8,066**	**(3,384)**	**(3,392)**	**7,593**	**7,668**	**74**	**82**	**(8)**
Remove capital donations / grants I&E impact	(114)	(10)	(18)	(110)	(231)	(121)	(113)	(8)
Adjusted Financial Performance (Surplus) / Deficit	**7,952**	**(3,394)**	**(3,410)**	**7,483**	**7,437**	**(47)**	**(30)**	**(17)**

Table 1: Trust Statement of Comprehensive Income

3 Cost Reduction Programme (CRP)

3.1 Included in the Trusts 2023-24 financial plans is an annual CRP requirement of £15.900m of which the Trust achieved £12.273m as of February 24 and £12.672m for the financial year. This equates to 79.7% of the annual target.

Business Unit	23-24 Annual Target £000	23-24 YTD Target £000	23-24 YTD Achieved £000	23-24 YTD Variance £000	23-24 Annual Achieved £000	23-24 Annual Variance £000	23-24 Annual Achieved %
Chief Executive	(0.012)	(0.011)	0.000	0.011	0.000	0.012	0.0%
Chief Operating Officer	(0.111)	(0.098)	(0.010)	0.089	(0.010)	0.102	8.6%
Clinical Support & Screening	(3.479)	(3.073)	(3.216)	(0.144)	(3.240)	0.239	93.1%
Community	(1.211)	(1.070)	(1.028)	0.042	(1.062)	0.149	87.7%
Director Of Nursing	(0.186)	(0.165)	(0.352)	(0.188)	(0.352)	(0.166)	189.2%
Estates & Facilities	(0.195)	(0.172)	0.000	0.172	0.000	0.195	0.0%
Finance & Information	(0.566)	(0.499)	(0.513)	(0.014)	(0.532)	0.034	94.0%
Medical Director	(0.025)	(0.022)	(0.055)	(0.033)	(0.055)	(0.030)	221.6%
Medicine & Elderly	(3.129)	(2.763)	0.000	2.763	0.000	3.129	0.0%
People & Organisational Development	(0.202)	(0.178)	(0.165)	0.013	(0.165)	0.038	81.4%
Surgical Services	(3.284)	(2.901)	(2.662)	0.239	(2.685)	0.599	81.7%
Corporate Cost Reduction	(3.500)	(3.191)	(4.271)	(1.080)	(4.571)	(1.071)	130.6%
Total	**(15.900)**	**(14.143)**	**(12.273)**	**1.870**	**(12.672)**	**3.228**	**79.7%**

Table 2:2023-24 Cost Reduction Performance

4 Income & Expenditure Forecast

4.1 The Trust is reporting achievement of its revised planned deficit totalling £7.952m deficit.

4.2 Scenario modelling suggests this will be achieved with a series of agreed mitigations to reduce spend, improve productivity and maximise income and non-recurrent flexibility.

5 Cash and Working Balances

5.1 Group cash as of 1st April 23 totalled £49.335m. The cash position as at the end of February totals £43.663m an increase of £12.645m, however this includes £11.026m of Public Dividend Capital (PDC) which has been drawn to finance capital expenditure in 2023/24 programme. The net adjusted cash balance therefore totals £32.637m, an increase of £1.619m from January (£31.018m). This cash balance is equivalent to an estimated 31.68 day's operating costs (30.11 days January).

5.2 The liquidity metric has improved by 0.64 days against January to -3.37 days, however this continues to be below the plan of 7.05 days for the same period. This is due to a £7.763m decrease in working capital balance against plan and an increase of £23.905m in operating costs, net of depreciation.

5.3 The balance sheet is presented in Table 4.

Statement of Position - February 2024

	2023/2024 January 2024 Group	2023/2024 February 2024 Group	Movement from Prior Month	2023/2024 February 2024 QEF	2023/2024 February 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	144,993	147,888	2,896	1,175	146,714
Right of Use Assets	8,855	8,579	(276)	0	8,579
Trade and Other Receivables, Net	1,924	1,928	4	814	1,114
Finance Lease - Intragroup				41,326	0
Trade and Other Receivables - Intragroup Loan	0	0	0		7,403
Total Non Current Assets	155,852	158,476	2,624	43,394	180,634
Current Assets					
Inventories	5,114	5,307	193	2,835	2,472
Trade and Other Receivables - NHS	4,963	8,658	3,695	347	8,311
Trade and Other Receivables - Non NHS	7,049	5,095	(1,954)	1,901	3,195
Trade and Other Receivables - Intragroup				8,528	96
Trade and Other Receivables - Other	0	0	0		0
Prepayments	5,988	4,886	(1,102)	351	4,535
Cash and Cash Equivalents	31,018	43,663	12,645	6,275	37,389
Other Financial Assets - PDC Dividend	0	0	0		0
Accrued Income	1,858	1,307	(551)	788	518
Finance Lease - Intragroup				61	0
Trade and Other Receivables - Intragroup Loan					361
Total Current Assets	55,990	68,916	12,927	21,086	56,877
Liabilities					
Current Liabilites					
Deferred Income	5,271	6,401	1,130	78	6,323
Provisions	2,183	2,191	7	314	1,877
Current Tax Payables	5,125	5,058	(66)	406	4,652
Trade and Other Payables - NHS	1,012	1,775	763	351	1,425
Trade and Other Payables -Intragroup				96	8,528
Trade and Other Payables - Other	7,744	7,313	(431)	1,508	5,805
Lease Liabilities	3,843	3,576	(267)	0	3,576
Other Financial Liabilities - Accruals	31,887	31,560	(327)	8,794	22,766
Other Financial Liabilities - Borrowings FTFF	499	499	0	0	499
Other Financial Liabilities - PDC Dividend	1,295	1,619	324	0	1,619
Other Financial Liabilities - Intragroup Borrowings	0	0		361	0
Finance Lease - Intragroup	0	0		0	61
Total Current Liabilities	58,861	59,993	1,132	11,908	57,131
NET CURRENT ASSETS (LIABILITIES)	(2,871)	8,923	11,794	9,178	(255)
Non-Current Liabilities					
Deferred Income	2,011	2,011	0	1,719	293
Provisions	2,236	2,236	0	0	2,236
Trade and Other Payables - Other	-	0	0	0	0
Lease Liabilities	5,380	5,380	0	0	5,380
Other Financial Liabilities - Accruals	0	0	0	0	0
Other Financial Liabilities - Intragroup Borrowings	0	0	0	7,403	0
Other Financial Liabilities - Borrowings FTFF	12,012	12,012	0	0	12,012
Finance Lease - Intragroup				0	41,326
Total Non-Current Liabilities	21,639	21,639	0	9,122	61,245
TOTAL ASSETS EMPLOYED	**131,343**	**145,761**	**14,418**	**43,451**	**119,134**
Tax Payers' and Others' Equity					
PDC	149,767	160,793	11,026	0	160,793
Taxpayers Equity	0	0	0	0	0
Share Capital	0	0	0	16,824	0
Retained Earnings (Accumulated Losses)	(28,318)	(24,927)	3,392	26,627	(51,553)
Other Reserves	0	0	0	0	0
Revaluation Reserve	9,795	9,795	0	0	9,795
Misc Reserve	99	99	0	0	99
TOTAL TAXPAYERS EQUITY	131,343	145,761	14,418	43,451	119,134
TOTAL ASSETS EMPLOYED	**131,343**	**145,761**	**14,418**	**43,451**	**119,134**

Table 4: Statement of Financial Position

6 Capital

6.1 The Trusts 23-24 CDEL limit had been set at £9.469m. This included an expected 5% 'bonus' to the ICS if it achieved certain financial targets. Unfortunately, these targets have not been achieved and subsequently each Trust within the ICS has seen their respective CDEL allocation reduced. The Trust's revised CDEL allocation for 2023/2024 is now £9.018m, a reduction of £0.451m. The Board approved to spend £1m above its original CDEL allocation.

6.2 The Trust is forecasting capital spend of £24.549m. The latest forecast assumes all schemes funded by PDC and charitable awards will be delivered and utilise the full funding allocation. Funding sources for CDEL is summarised in the table below.

Capital Funding	£000's	£000's
Net Depreciation*		5,989
Internal Cash		3,662
PDC Funded Schemes		
CDC	11,376	
Digital Diagnostics	760	
MRI	2,381	
Screening Equipment	145	
AI Diagnostics Imaging Technologies	106	14,768
Charity Funded Schemes		
Jubilee Gardens	70	
Patient Quiet Room	30	
ECC Staff Room	18	
Private Patients Cubicle	12	130
Total		24,549

* After Principal Loan Repayments

6.3 Capital spend to 29th February totalled £12.0335m; £12.639m less than the year-to-date plan. Expenditure in the year was in respect of the new operating model, community diagnostic centre, building maintenance, MRI, equipment replacement, Bowel Cancer Screening, H&S Investment, Energy Conservation Schemes and schemes carried forward from the 2022-2023 programme.

Kris Mackenzie, Group Director of Finance & Digital
March 2024

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 20

Report Title:	Combined Leading Indicators & Elective Recovery Report			
Name of Meeting:	Trust Board			
Date of Meeting:	27th March 2024			
Author:	Deborah Renwick			
Executive Sponsor:	Kris Mackenzie			
Report presented by:	Kris Mackenzie /Jo Halliwell			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☒
	This report presents progress, risk and assurance in relation to the Trust's Leading Indicators and Elective Recovery Programme for the reporting period of February 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*	SMT retrospectively			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal*	**Leading Indicator Summary:** **Will continually improve the quality and safety of our services for our patients:** Risks continue within Quality and Safety Domains: • The number of C.Difficile cases reported continue to be in excess of the annual stretch allowance of 23 with 34 cases reported between April and February. • Falls harm rates are for the third month above the upper control limit, with 3.96 falls per 1,000 beds days reported in February. Further deep dives are investigations are underway to understand the reasons for the increase in falls and gain assurance. • Progress against the CQC Quality Improvement plan remains stable: • Risk of plans not achieving remains stable and there are no overdue actions.			

• *Equality, diversity and inclusion*	**We will improve productivity and efficiency of our operational services**
	• There were no DTA breaches in February. The Trust's year to date total remains static at 98. Representing a huge improvement in the reduction of patients waiting for a bed, in the same period last year 1,328 patients waited longer than 12 hours for bed.
	• The Trust's supporting break through objective, and national focus area of minimising ambulance handover delays is also continues to perform well.
	  ○ 56.8% of ambulance conveyances were handed over within 15 mins.
	  ○ There were no ambulance delays over 30 mins.
	  ○ Zero 60 minute+ handovers since the 3rd January.
	• Whilst the 4-hr target is not part of the LI's or breakthrough objective metrics – the Committee should also note that performance is improving, with February's performance at 69.03% and at the time of writing this report March to date performance is at 73.1%.
	• RTT 52 week waiters continue to improve: with 86 patients waiting longer than 52 weeks. There are 75 projected year end over 52 week waiters.
	
	We will be a great organisation with a highly engaged workforce
	• Staff survey results have improved our staff engagement score to 7 against a plan of 6.9.
	• Group sickness absence rates improved in month from 6.3% to 5.6%
	• Vacancy rates improved slightly from 2.3% to 2.2%
	
	We will achieve financial sustainability:
	Risks remain within CRP and Pay and non-pay spend, Over-all plan is demonstrating a positive variance.
	• CRP below planned levels in month £894k, adverse variance YTD of £1.8m.
	• Pay spend over planned levels in month £988k, adverse variance YTD of £8.8m.
	• Non pay spend over planned levels in month by £166k, adverse variance YTD of £4.1m
	• Year to date forecast deficit against plan improved with a £46k positive variance against plan.
	
	Elective Recovery Summary:
	
	Elective and diagnostic activity continue to over-perform, whilst new outpatients and follow-up outpatients are below required levels:

	M11: Forecast outturn summary against activity plan: • New Outpatients: 97% • Follow-up Outpatients:116% • Daycase: 103% • Inpatient: 94% • Diagnostics 103% **February DM01** performance is at 92.1% **Year end DM01** performance is forecast at 91.9% • MRI capacity reduction, audiology capacity and workforce issues and echocardiology workforce issues have impacted on recovery plans. Continued delivery oversight at Access & Performance to support mitigating current capacity and workforce risks to deliver within target remains a key priority over the coming months. Despite Industrial Action significant improvements continue to be made in reducing our **RTT long waiters:** • Overall PTL size is below planned levels at 11,986 • Zero > 104 week waiters • Forecast > 52 week breaches have been reduced from 85 to 75 in month. • Risk of 3 patients at year end waiting over 65 weeks. Two patients have TCI's very close to year end, 1 patient is under pathway review, alternative treatment options are currently being discussed with the patient. The Trust was the only provider in NENC to achieve **90% of RTT patients waiting over 12 weeks validated by 31st December**. This position is being maintained into Q4 with current performance at 92%. Cancer continues to perform well across faster diagnosis, 31 day treatments and reducing our long waiters – Specific tumour groups undertake deep dives to review issues report into Access and Performance meetings where commissioned workstreams are tasked to undertake improvement work. Issues remain within our challenged shared pathways, where collaborative discussions are underway to resolve issues. Partnership working and balancing tumour specific performance within the Trust and within the Alliance remains a priority.	
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.	
	Aim 1 ☒	We will continuously improve the quality and safety of our services for our patients

Trust Strategic Aims that the report relates to:	**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:	• Improving the productivity and efficiency of our operational services • Improving the quality and safety of our services for our patients • Being a great organisation with a highly engaged workforce • Achieving financial sustainability				
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)	• Elective activity: 3102 (Positive) • Cancer: 1784 Long waiters: (Positive) • RTT 52 week waiters: 3261 (Positive) • DM01 MRI Scanner: 3277 (Same) * new risk Audiology • Waiting List/Validation/DQ: 2689 (Positive)				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

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Leading Indicators & Elective Recovery Combined Report

February 2024 data

March 2024 committees

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Gateshead Health NHS Foundation Trust

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Section 1: Leading Indicators

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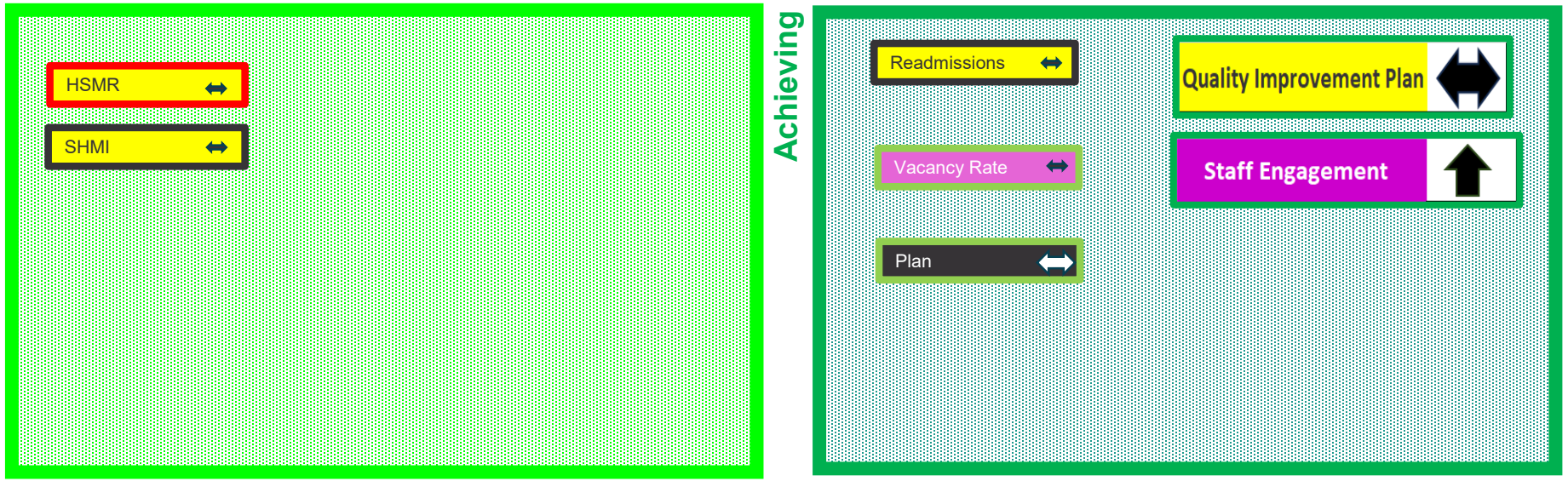
Leading Indicators Heatmap: February 2024

Gateshead Health NHS Foundation Trust



Domains linked to indicators

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

Arrows signify movement from quadrant to quadrant in month

Heatmap Key

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

Leading Indicator Summary Narrative

Gateshead Health NHS Foundation Trust

Metrics achieving: A new addition to this quadrant: Staff Engagement Score at 7.0 in the staff survey, all other metrics have maintained quadrant status.

New in Segment: Engaged workforce (Appendices pg 34)
The staff survey embargo has now been lifted, and the **staff engagement score is now at 7.0** (in line with the planned target of 6.9). The **Group vacancy rate is at 2.2%,** well below the 2023/24 threshold of 5%.

Quality & Safety (Appendices pg 30)
The Trusts **CQC quality improvement plans** remain in this quadrant with no over-due actions, 12 are on track for achievement, 11 actions were completed (an improvement from 3 last month) with a risks of non-achievement reducing from 4 to 2 actions. Plans are in place to manage the risk with SMT oversight.

Achieving financial stability: (Appendices pg 36)
M11 position against **financial plan** is demonstrating a positive variance of 16k and a positive cumulative year to date variance of £46k.

Metrics not achieving BUT improving: 3 LI metrics remain within this quadrant; all demonstrating an improved position since last month. Group Sickness Absence breakthrough objective has improved into this quadrant in February improving from 6.3% to 5.6%

Effective & Responsive – Elective Care (Appendices pg 26)
RTT 52 weeks: Position is improving steadily with a continued focus on reducing our long waiters by the end of the financial year. There were 112 over 52 week waiters at the end of February, the current year end projection of waits at year end is 75, representing a positive improvement forecast from 86 in January. Plans to mitigate against specialty level risks include: additional internal sessions, realignment of direct clinical care in the job plans, technical and clinical validation of the waiting list, and use of mutual aid, Independent Sector has not been successful due to complexity of patients waiting.

Effective & Responsive – Urgent Care (Appendices pg 23)
12 Hour trolley Waits: There were Zero in February, which means our 98 12-hr delays reported year to date remains static from the last reporting period.. The Last >12-hr delay occurred on 6th January, for context there were 1,328 > 12 hrs delays reported in the same period last year.
Ambulance hand overs continue to improve steadily with 56.8% of if conveyances handed over within 15mins. The Trust continues to perform well in minimising ambulance down time due to delayed hand overs. The Trust will share improvement experiences at the NECA UEC Improvement event in March.

Quality & Safety (Appendices pg 31)
Harm Rates from falls fell slightly to 3.96 per 1,000 bed days in February from 4.16 in January. This is the third month where the metric is above the upper control limits having typically been in expected ranges. January and February have seen a significant increase in the number of low harm falls (in comparison to no harm falls), whereas there was a small reduction in the number of overall falls reported. Initial analysis indicates that this may be attributable to the change to a new reporting system in late 2023. It is quicker and easier to report incidents on this system, and it has no default settings so this may have led to more accurate reporting of harm.

Leading Indicator Summary Narrative

Gateshead Health NHS Foundation Trust

Metrics not achieving and also deteriorating: 4 LI metrics remained in this quadrant in month (all 4 have deteriorated further from last month) Staff engagement score improved out of this quadrant into achieving and improving.

Effective & Responsive (Appendices pg 22)

- 8.81% of patients were admitted to a bed within an hour of the decision to admit, a deterioration from January's position of 10.5%. The figure has fluctuated in month across the year between 7.49% and 12.25%, all of which are well below the 60% threshold set internally. This metric and threshold is currently under review. A new patient flow meeting format has now been embedded, which includes increased actions to improve flow and monitoring of 1 hour DTA to bed. Stranded patient meetings have also been restarted to reduce length of stay.

Provision of care (Appendices pg 25)

- The Trusts overall length of stay (LOS) deteriorated very slightly in month from 4.72 to 4.77 days in February it remains above the target of 4 days set for the overall length of stay in 23/24. Work to reduce LOS across the Trust is highlighted as closely and into the system wide winter plan. Identify priorities within clinical pathways to allow timely and appropriate resource allocation (outputs from CSG). Further development of frailty at the front door to reduce admissions, embedded use of the virtual ward, criteria led discharge, red and green days, development of the discharge lounge and better use of digital enablers.

Quality & Safety (Appendices pg 29)

- With 5 new incidents in February 2024, C. Difficile rates deteriorated in month from 29 in January to 34 in February. The Trust had an annual allowance of 23 cases, this was breached in December, therefore as result January's & February's incidents have increased the gap the allowance further for this year. The year to date total of 34 cases is in line with the volume of cases reported by M11 last year. The IPC team report that Regional levels of C-diff are high, and most trusts are seeing similar trajectories. National trajectories are set using data from spring & summer – which don't take into account C.Diff seasonality with more cases occurring during the winter months. Our Local actions are set out in a 10 point focused action plan, and now include a new audit assistant appointment to support focused improvements.

Productivity & Efficiency – Finance (Appendices pg 36)

- Cost Reduction savings were -£894k below planned levels for February, resulting in a year to date adverse variance of -£1.8m. Pay and non pay spend were both higher than planned levels in month by £ 988k and £166k respectively, and continue to demonstrate adverse year to date variances of £8.8m over planned levels for pay and non-pay at £4.1m over planned levels.

Gateshead Health NHS Foundation Trust

Section 2: Elective Recovery

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Priorities: Elective Recovery & Transformation

Gateshead Health NHS Foundation Trust

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

Waiting List Management:

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

System Resources:

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

Back to Basics:

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

Productivity:

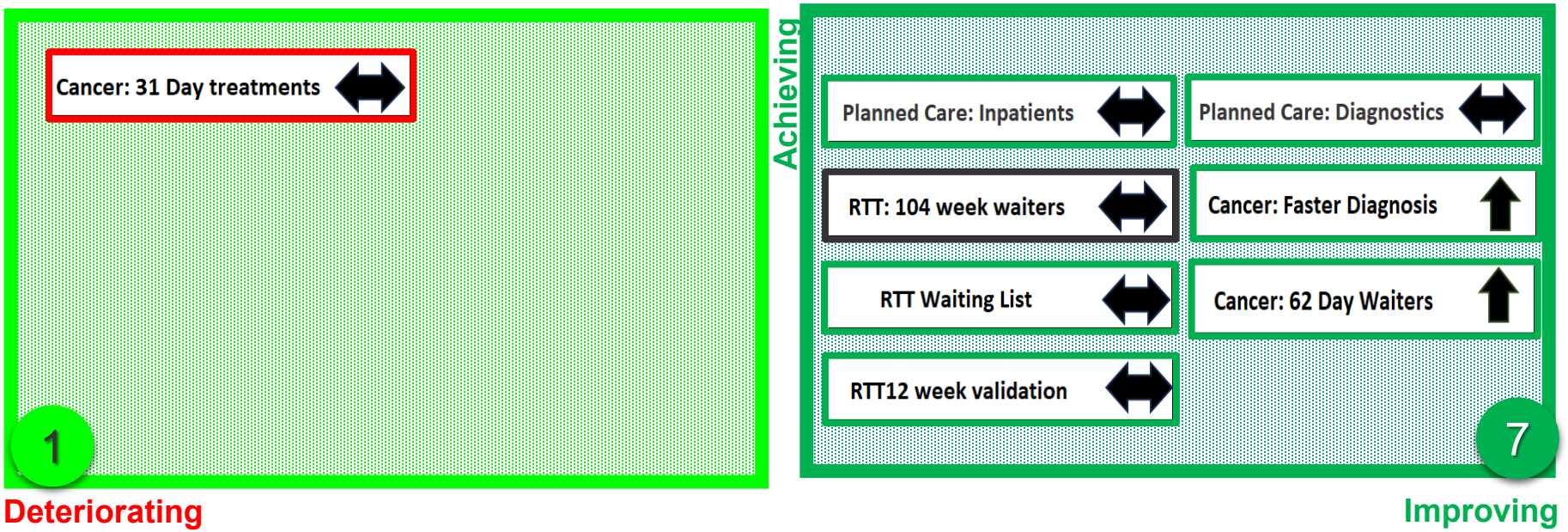
- Reducing unnecessary follow-up outpatient activity and converting activity to areas which add value to patient care
- Theatre productivity to ensure effective & efficient use of theatre resources

Transforming Clinical Pathways:

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

Elective Recovery Heatmap: February 2024

Gateshead Health NHS Foundation Trust



Arrows signify movement from quadrant to quadrant in month

Heatmap Key

Achieving plan, Trajectory, and target, although demonstrating a deteriorating position **Standards to watch and intervene**	Achieving plan and maintaining or improving performance **Standards to maintain**
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Elective Recovery Summary Narrative

Gateshead Health NHS Foundation Trust

Metrics achieving: 7 metrics in the quadrant, 5 remained from last month with 2 improved in (Faster Diagnosis and 62 day waiters) 2 deteriorated out (RTT: 1x 78 week waiter for patient choice & Cancer Performance against 62 day treatments)

Planned Care Activity

- The theatres efficiency work from the GIRFT reviews and the implementation of the Theatres Road Map has resulted in an increase in theatres activity. The total number of elective cases undertaken in theatres continues to improve with positive 103% (+818) planned forecast out-turn in Electives (day cases and inpatients combined).
- Diagnostic activity is also forecast to deliver 103% or 2,214 diagnostic tests above plan.

Waiting List Management

- Long waiting patients continue to be reviewed in the weekly Access & Performance meeting as well as validation. Additional activity, recent validation work and Access Policy application review has all contributed to the RTT PTL being at its lowest all year and is now circa July 22 levels, having reduced by around 15% (circa 2,000 patients) since the high at the start of November when validation began. The Trust continues to have no 104, and an in month 78-week waiters with zero forecast for year end. The number of 65-week waiters is slowly reducing, with three patients being closely monitored to achieve the year end forecast, plans are in place manage the risk in 52-week current PTL projections.

Cancer Standards

- Whilst there continue to be capacity and booking risks in the early parts of our pathways in some tumour specific groups, which subsequently impact on the 62-day performance metric further down the pathway. Challenges continue with multi provider pathways and reliance on other providers to deliver key pathway elements. A revision of the cancer improvement workstreams reporting into Access and Performance are underway to support focus pieces of work in on the areas of greatest risk. Actions that are being developed by services around these challenges are beginning to yield improvements. The 28-day FDS performance remains fairly stable, and achievement against the 31 day standard is strong and 14 day improvements are steadily increasing month on month. Planned levels of 62 day waiters continues to be below planned for levels.

Metrics achieving BUT deteriorating: 1 metric remined in this quadrant, and two improved.

Cancer Standards

- The 31 day treatment standard remains above 96%, performance has deteriorated from 99.1% in January to 96.2%. The Trust remains a strong performer in NENC and continues to benchmark well within these measures.

Elective Recovery Summary Narrative

Metrics not achieving BUT improving: 4 metrics are in this quadrant, 1 moved in since last month as it has improved (DM01) and one moved out: RTT performance has deteriorated

DM01 Performance – Improved from last month's validated position of 90.6% in January to 92.1% in February, which is which is 1.3% above planned recovery trajectory level for February. Challenges continue in Audiology, echocardiology and in MRI (as a result of the reduced scanner capacity due from the second scanner programme). Barium, Colonoscopy, Flexi-Sigmoidoscopy, Gastroscopy, Cystoscopy, Dexa, and Urodynamics were all above the 95% target and performed better than planned, while MRI and echocardiology were below 95% and below planned trajectories. The year end forecast has now deteriorated to 91.9% from 94.4%, largely driven by challenges in Audiology and MRI. The revised recovery plan is being actively managed and monitored at Access and Performance to mitigate and improve the risk.

Planned Care Outpatient First Appointments - Activity relating to first outpatient appointments are below planned levels, with forecast outturn projected at 95% of planned levels. Waits to first outpatient appointments being reviewed in weekly Access and Performance Clinics and we are reinstating partial booking. A Full outpatient transformation programme is being developed – priorities within the plan include: undertaking clinical triage models and reviewing prevention of referrals, utilising Advice & Guidance booking systems, whilst reviewing of Patient Initiated Follow Up (PIFU) to extend and/or evidence benefits. Current PIFU levels are below plan at 3.2%, a fall from 3.6% in December.

RTT: 52 weeks waits - Position is improving steadily with a continued focus on reducing to as low as possible the number of patients waiting over 52w by the end of the financial year. Current forecasts place circa 75 patients at risk, plans to mitigate against specialty level risks include: additional internal sessions, realignment of direct clinical care in the job plans, technical and clinical validation of the waiting list, and use of mutual aid and utilising Independent Sector options.

RTT: 65 weeks waits - Continued focus through the weekly Access and Performance meetings with pathways forecasting and early interventions to prevent extended waits. There are currently 8 patients waiting over 65 weeks, and three patients at risk of waiting longer than 65 weeks at year end. Two patient have TCIs very close to year end and one is patient is currently choosing to delay surgery until after the year end and will be treated on 4th April. This patient will be waiting over 78 week waiter.

Metrics not achieving and deteriorating: 4 metrics are in this quadrant, with three moving in since last month (RTT performance, Cancer 62 Day treatments and RTT 78 week waiter.

RTT waits within 18 weeks – 67.8% of our patients are currently waiting less than 18 weeks, this represents a slight deterioration in performance from 68.3% in January. 68% The Trust remains slightly below the latest NENC published average of 70%, but above the latest national average at 58.3%. Validation of the waiting list at 12 weeks has affected removals from both over 18 weeks and under 18 weeks which will impact on achieving this standard for a period.

Cancer 62 day treatments - Current performance data of 67.8% (un-finalised) places February's 62-day treatment metric into this quadrant. Work is on-going to improve the front end of the pathways and collaborate with partners across challenged shared pathways.

Demand & Activity

Gateshead Health NHS Foundation Trust

Demand
- 8.7% above planned levels in February
- 3.6% above plan year to date

Activity Summary – Month 11 February
- Activity is **109.5%** of planned for activity levels or **111.7%** of revised (2% adjusted) plan.
- Both figures are the third highest levels of planned for activity this year, following last month which was second.
- In February, elective inpatients, new outpatient & diagnostics again overdelivered against plan, new outpatient for the second month in a row.
- While February's variances to plan were smaller than January, this trend of higher levels of activity against plan continue to support an overall cumulative year to date improvement.

Activity Summary - Year to Date
- Positive variance of 18,352 against plan **(+5.8%)**
- Positive variance of 24,706 against revised plan **(+7.9%)**
- Driven by: Day case, diagnostics and more follow-up outpatients than planned levels
- New outpatients below planned levels, and follow-up outpatients continue to be behind on planned reduction levels.
- Elective inpatients below planned levels but have improved significantly since October, being above plan in each of those months.

Activity Risks - Revised adjustment of 2% still identifies M11 FOT positions of :
- Inpatients: -184 **(93%)**
- New OP: -1,879 **(95%)**
- FU OP: +25,194 **(114%)**
- IA: Cancelled activity is circa 0.6% of overall plan (including Feb 24 industrial action)

MRR Referrals Plan	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Trend	M1-M11
Demand Plan	4,185	4,743	4,442	3,628	3,816	4,141	4,014	3,983	4,128	4,214	4,068	4,277	3,225	4,063	3,856		43,785
Referrals Received	3,225	4,063	3,856	4,560	3,814	4,349	4,657	4,179	4,012	4,056	4,373	4,259	3,424	4,478	4,222		45,823
Variance	-960	-680	-586	932	-2	208	643	196	-116	-158	305	-18	199	415	366		1,672

Activity Summary All POD's	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Trend	M1-M11
Total Plan	25,249	28,683	26,180	29,244	29,117	30,631	27,859	31,665	28,364	29,954	30,922	28,940	25,419	27,685	27,395		317,951
Restated Plan (2% adjusted)					28,535	30,019	27,302	31,032	27,797	29,355	30,304	28,362	24,911	27,132	26,848		311,597
Actuals	27,355	30,911	28,358	31,432	28,978	30,717	32,073	30,034	31,082	29,626	32,506	32,268	26,921	32,112	29,986		336,303
Variance Plan	2,106	2,228	2,178	2,188	-139	86	4,214	-1,631	2,718	-328	1,584	3,328	1,502	4,427	2,591		18,352
Variance Restated Plan					443	698	4,771	-998	3,285	271	2,202	3,906	2,010	4,980	3,138		24,706
Industrial Action Cancellations					353	107	153	172	239	161	100	0	157	251	145		1,838

POD Variance	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Trend	M1-M11
Inpatients	-64	4	-77	-109	-56	-76	-91	-82	-29	-12	29	5	27	56	10		-219
Daycase	48	-137	-15	-15	-364	16	474	-199	231	-33	127	181	42	61	-12		524
New Outpatients	-52	-129	75	-447	-713	-326	28	-859	296	-685	-180	-98	-343	214	8		-2,658
Follow-up Outpatients	1,723	1,984	2,091	2,619	1,314	745	3,429	177	2,059	743	1,484	2,886	1,261	2,700	2,419		19,217
Diagnostics	450	507	104	140	-327	-283	375	-680	161	-349	117	346	338	559	166		423

POD Variance Adjusted Plans (-2%)	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Trend	M1-M11
Inpatients	-64	4	-77	-109	-51	-70	-85	-76	-24	-7	34	10	31	60	15		-163
Daycase	48	-137	-15	-15	-313	68	521	-144	278	18	179	231	88	115	41		1,082
New Outpatients	-52	-129	75	-447	-600	-208	145	-735	403	-567	-55	24	-241	320	116		-1,398
Follow-up Outpatients	1,723	1,984	2,091	2,619	1,584	1,035	3,674	474	2,323	1,023	1,773	3,146	1,490	2,948	2669		22,139
Diagnostics	450	507	104	140	-186	-138	515	-531	303	-207	263	484	463	699	296		1,961

Transformation

Gateshead Health NHS Foundation Trust

Transformation Metrics	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Trend	RAG
PIFU (5%)	1.9%	2.5%	3.4%	3.6%	3.1%	3.5%	3.4%	3.3%	3.1%	3.2%	3.6%	3.8%	3.6%	3.2%	2.9%		
Digital Outpatients (25%)	26.8%	25.8%	24.5%	25.6%	22.0%	23.8%	23.4%	24.6%	24.4%	22.5%	23.0%	23.3%	23.6%	22.4%	21.6%		
Advice & Guidance (A&G - 16%)	7.6%	7.3%	8.2%	9.3%	7.4%	7.6%	8.4%	8.6%	6.6%	9.8%	7.6%	7.8%	8.5%	8.2%	8.1%		
Appointment Slot Issues (ASI's) 2WW's	49.5%	12.1%	35.9%	33.4%	43.2%	27.8%	18.3%	27.8%	19.8%	22.5%	16.8%	9.5%	45.7%	7.1%	16.8%		
DNA Rates (6%)	8.9%	7.6%	7.8%	7.8%	6.9%	7.7%	7.6%	7.6%	7.2%	7.4%	8.1%	7.4%	8.5%	8.5%	7.6%		
Theatre Utilisation Funded Capacity (85%)	80.20%	84.70%	81.30%	77.90%	69.9%	78.6%	75.4%	70.9%	68.4%	81.6%	90.9%	92.4%	80.9%	86.7%	89.2%		
Theatre Utilisation of sessions ran (85%)	81.60%	81.60%	84.80%	81.10%	81.0%	83.2%	81.6%	81.9%	82.2%	82.1%	81.8%	83.1%	81.0%	80.7%	82.2%		
Daycase Rates (85%)	91.9%	91.1%	91.0%	91.8%	91.3%	91.9%	92.7%	92.0%	92.0%	90.8%	89.9%	90.4%	90.0%	91.1%	90.6%		

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

DM01 Diagnostic Performance - Actual

Gateshead Health NHS Foundation Trust

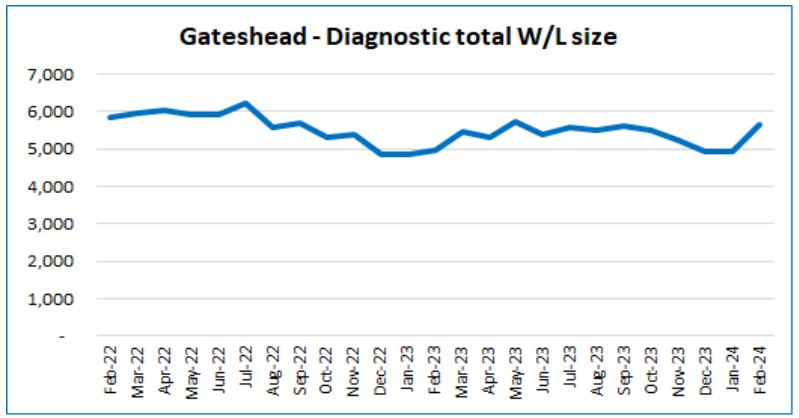
Latest validated month: Feb 92.1%

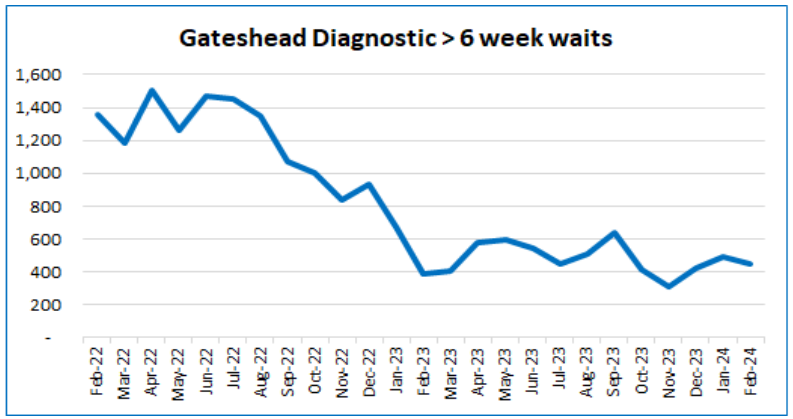
Last Month's performance: **Jan: 90.6%%**

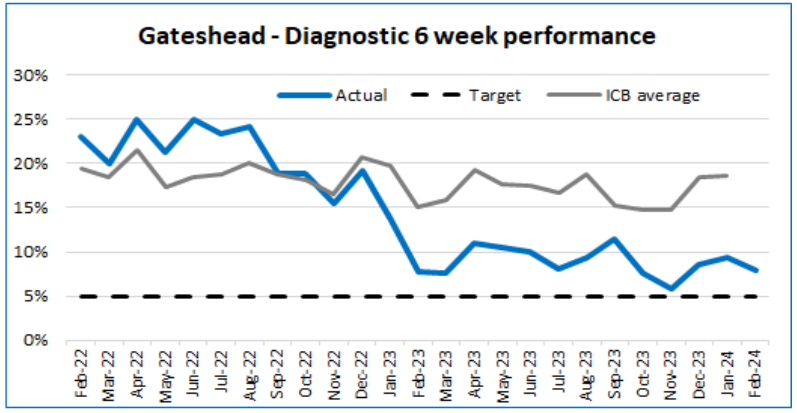
Current performance: **Feb: 92.1%**

Year end projection: **91.9%**

Monthly Diagnostic Activity | Feb-24	Activity during month			Number of Patients Waiting at Month End			Diagnostic Performance (% of patients waiting > 6wks)	Diagnostic Performance (% of patients waiting < 6wks)
GATESHEAD HEALTH NHS FOUNDATION TRUST	Waiting list	Planned	Unscheduled	< 6 week waiters	> 6 week waiters	*Total Waiting List*		
Total	**6754**	**741**	**803**	**5198**	**447**	**5645**	**7.9%**	**92.1%**
Magnetic Resonance Imaging	738	94	56	584	122	706	17.3%	82.7%
Computed Tomography	1576	250	702	508	5	513	1.0%	99.0%
Non-obstetric ultrasound	1875	167	45	1965	21	1986	1.1%	98.9%
DEXA scan	317	18	0	360	4	364	1.1%	98.9%
Cardiology - echocardiography	473	109	0	592	37	629	5.9%	94.1%
Urodynamics - pressures and flows	45	46		21	0	21	0.0%	100.0%
Audiology - Audiology Assessments	984	0	0	426	231	657	35.2%	64.8%
Barium Enema	39	1	0	15	0	15	0.0%	100.0%
Gastroscopy	272	24	0	248	8	256	3.1%	96.9%
Colonoscopy	222	32	0	253	12	265	4.5%	95.5%
Flexi sigmoidoscopy	65	0	0	82	2	84	2.4%	97.6%
Cystoscopy	148	0	0	144	5	149	3.4%	96.6%
Test Type: Endoscopy (Total)	**707**	**56**	**0**	**727**	**27**	**754**	**3.6%**	**96.4%**







DM01 Diagnostic Performance & Forecast

Gateshead Health NHS Foundation Trust

Year end: 91.9%

		ACTUALS							Forcasts as of: 20/12/2024		19/02/2024	Variances: Actual to forcast			Forcast as of 19/2/24
		Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Dec-23	Jan-24	Feb-24	Dec-23	Jan-24	Feb-24	Mar-24
Barium Enema	Waiters	106	111	97	85	59	14	15	80	70	17	-21	-56	-2	21
	>6wks	42	55	37	19	12	-	-	20	11	5	-8	-11	-5	2
	Performance	60.4%	50.5%	61.9%	77.6%	79.7%	100.0%	100.0%	75.0%	85.0%	70.6%	4.66%	15.00%	29.41%	90.5%
CT	Waiters	406	405	446	455	413	474	513	440	400	428	-27	113	85	451
	>6wks	5	6	1	3	8	11	5	4	2	3	4	3	2	3
	Performance	98.8%	98.5%	99.8%	99.4%	98.1%	97.7%	99.0%	99.0%	99.5%	99.3%	-0.92%	-0.43%	-0.32%	99.3%
MRI	Waiters	340	417	453	557	597	608	706	700	800	650	-103	-94	56	675
	>6wks	2	5	1	4	44	97	122	108	130	110	-64	-8	12	130
	Performance	99.4%	98.8%	99.8%	99.3%	92.6%	84.0%	82.7%	84.6%	83.8%	83.1%	8.06%	0.30%	-0.36%	80.7%
Non-obstetric ultrasound	Waiters	2,070	2,162	2,030	1,798	1,518	1,504	1,986	2,300	2,100	1,550	-782	-114	436	1,567
	>6wks	54	130	31	8	30	13	21	8	14	16	22	7	5	17
	Performance	97.4%	94.0%	98.5%	99.6%	98.0%	99.1%	98.9%	99.6%	99.4%	99.0%	-1.61%	-0.41%	-0.03%	98.9%
Audiology	Waiters	647	641	625	569	510	605	657	497	403	549	13	254	108	492
	>6wks	288	348	267	206	228	257	231	204	141	222	24	90	9	178
	Performance	55.5%	45.7%	57.3%	63.8%	55.3%	57.5%	64.8%	59.0%	65.0%	59.6%	-3.71%	-0.17%	5.28%	63.8%
Colonoscopy	Waiters	332	308	335	270	276	270	265	350	350	280	-74	-85	15	276
	>6wks	32	24	16	8	14	10	12	25	21	13	-11	-9	1	13
	Performance	90.4%	92.2%	95.2%	97.0%	94.9%	96.3%	95.5%	93.0%	94.0%	95.4%	1.93%	1.47%	0.11%	95.3%
Flexisigmoidoscopy	Waiters	100	97	89	86	74	69	84	90	80	75	-16	4	9	76
	>6wks	21	10	3	3	1	4	2	11	6	3	-10	-4	-1	3
	Performance	79.0%	89.7%	96.6%	96.5%	98.6%	94.2%	97.6%	88.0%	93.0%	96.0%	10.65%	4.62%	1.62%	96.1%
Gastroscopy	Waiters	231	244	254	211	233	262	256	230	220	223	3	36	33	235
	>6wks	21	13	9	12	11	5	8	16	13	11	-5	-5	-3	10
	Performance	90.9%	94.7%	96.5%	94.3%	95.3%	98.1%	96.9%	93.0%	94.0%	95.3%	2.28%	2.88%	1.58%	95.7%
Cystoscopy	Waiters	146	139	86	99	134	135	149	140	140	173	-6	9	-24	145
	>6wks	8	14	2	-	4	9	5	8	8	34	-4	-3	-29	7
	Performance	94.5%	89.9%	97.7%	100.0%	97.0%	93.3%	96.6%	94.0%	94.5%	80.3%	3.01%	-1.17%	16.30%	95.2%
Dexa	Waiters	447	466	511	486	440	360	364	440	430	361	-	66	3	372
	>6wks	5	5	20	17	9	9	4	7	2	8	2	2	-4	5
	Performance	98.9%	98.9%	96.1%	96.5%	98.0%	97.5%	98.9%	98.5%	99.5%	97.8%	-0.50%	-0.55%	1.12%	98.7%
Urodynamics	Waiters	24	25	21	12	27	31	21	30	20	27	-3	1	-6	28
	>6wks	1	2	-	-	1	-	-	2	1	1	-1	-1	-1	1
	Performance	95.8%	92.0%	100.0%	100.0%	96.3%	100.0%	100.0%	95.0%	95.0%	96.3%	1.30%	5.00%	3.70%	96.4%
Echocardiography	Waiters	643	594	559	605	632	601	629	600	600	597	32	29	32	585
	>6wks	33	28	29	28	62	47	37	30	30	29	32	7	8	29
	Performance	94.9%	95.3%	94.8%	95.4%	90.2%	92.2%	94.1%	95.0%	95.0%	95.1%	-4.81%	-0.88%	-1.02%	95.0%
Trust Totals	Waiters	5,492	5,609	5,506	5,233	4,913	4,933	5,645	5,897	5,613	4,930	-984	31	715	4,923
	>6wks	512	640	416	308	424	462	447	443	378	454	-19	69	-7	398
	Performance	90.7%	88.6%	92.4%	94.1%	91.4%	90.6%	92.1%	92.5%	93.3%	90.8%	-1.12%	-1.18%	1.30%	91.9%

In month performance improved in February to 92.1% from 90.6% in January, this was 1.30% above projected overall performance in the month.

Modalities consistently achieving 95% on DM01 in the last 3 months: CT, non-obstetric ultrasound, Gastro, Dexa and Urodynamics.

Modalities above 95% and performing better than planned in February: Barium, Colonoscopy, Flexi-Sigmoidoscopy, Gastroscopy, Cystoscopy, Dexa, Urodynamics

Modalities below 95% but performing better than planned in February: Audiology

Modalities below 95% and below planned trajectory levels in February: MRI and Echocardiography

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

The year end forecast remains at 91.9%, largely driven by challenges in Audiology and MRI. The main modality risk affecting year end performance position is Audiology. A recovery plan has been developed which includes a review of processes around triage, patient access and short notice cancellations. For MRI the building work to support a Second scanner has resulted in at loss off capacity, and challenges have emerged with cover scanner arrangements. Mitigating actions are reviewed weekly in Access & Performance to support managing risks and delays.

The current action plan forecasts remain that the two biggest challenge areas MRI and Audiology to achieve DM01 in August 2024. With the overall Trust achieving in July 2024.

Cancer Performance

Gateshead Health NHS Foundation Trust

Cancer Current Performance Positions

	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Trend
2 week Waits	83.3%	79.8%	82.3%	82.7%	75.0%	75.1%	75.7%	76.9%	78.5%	76.8%	80.6%	83.4%	83.3%	83.6%	84.4%	
28 Day Faster Diagnosis (75%)	76.0%	75.3%	77.3%	76.2%	75.2%	72.0%	78.8%	76.9%	78.1%	77.7%	81.3%	82.2%	81.7%	78.4%	83.9%	
31 Day Diagnosis to Treatment (96%)	100.0%	99.2%	99.3%	97.2%	100.0%	99.3%	100.0%	100.0%	100.0%	99.3%	100.0%	99.2%	99.0%	98.5%	96.1%	
Cancer 31 day subsequent drugs compliance	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Cancer 31 day subsequent surgery compliance	100.0%	95.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.2%	100.0%	100.0%	100.0%	100.0%	100.0%	90.9%	
62 Day Referral to Treatment (85%)	61.7%	56.5%	60.4%	66.9%	66.7%	68.6%	68.6%	69.6%	73.1%	64.4%	54.8%	57.5%	47.9%	62.7%	55.9%	
62 Day Referral to Treatment Screening	91.4%	88.5%	91.5%	93.9%	89.1%	92.7%	84.0%	78.1%	84.2%	82.4%	76.5%	82.4%	91.9%	75.0%	71.8%	
62 Day Referral to Treatment Upgraded	0.0%	0.0%	40.0%	0.0%	66.7%	50.0%	42.9%	36.4%	20.0%	77.8%	87.2%	80.9%	86.3%	87.2%	85.1%	

Cancer Performance Summary	Combined Metrics From October 2023	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Year end Risk
28 Day FDS		76.8%	78.4%	80.4%	76.1%	83.4%	
31 Day		100%	99.4%	99.4%	99.1%	96.4%	
62 Day Combined		68.6%	69.5%	65.1%	72.5%	67.8%	

Cancer Recovery &Transformation Metrics

	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Trend	Year end Risk
> 62 Day waiters - **PLAN** (2ww classic pathway)					65	61	64	69	67	70	60	55	59	62	59		
> 62 Day waiters actual - **ACTUAL** (2ww classic pathway)	58	64	62	41	64	68	52	59	43	55	58	69	39	50	41		
Variance					-1	7	-12	-10	-24	-15	-2	14	-20	-12	-18		
Backlog > 104 days (2ww classic pathway)	11	12	9	7	11	11	9	6	9	11	5	13	7	10	5		
BPTP (Revised methodology Apr-23) Now only inc. Prostate / Colorectal	11%	18%	17%	14%	6%	17%	13%	46%	17%	12%	16%	21%	17%				
CQUIN 04 Timed Diagnostic Pathways (35-55%)	37%	37%			23%			18%			27%						
Referrals with Faecal Immunochemical Test (FIT)					78.4%	86.1%	85.9%	89.5%	89.7%	93.1%	85.9%	96.3%	85.7%				

Performance Risk Summary:

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

- Last Month waits: Jan **76.1%**
- This Month waits: **Feb 83.1%**
- Year end: **>75%**

New 31 Day Treatment Standard (96%)

- Last Month's waits: Jan **99.1%**
- This Month: Feb **96.2%**
- Year end: **>96%**

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

- Last Month's waits: Jan 72.5%
- This Month: Feb **67.8%*** (indicative)
- Year end: >70%

Over 62 day waits against plan

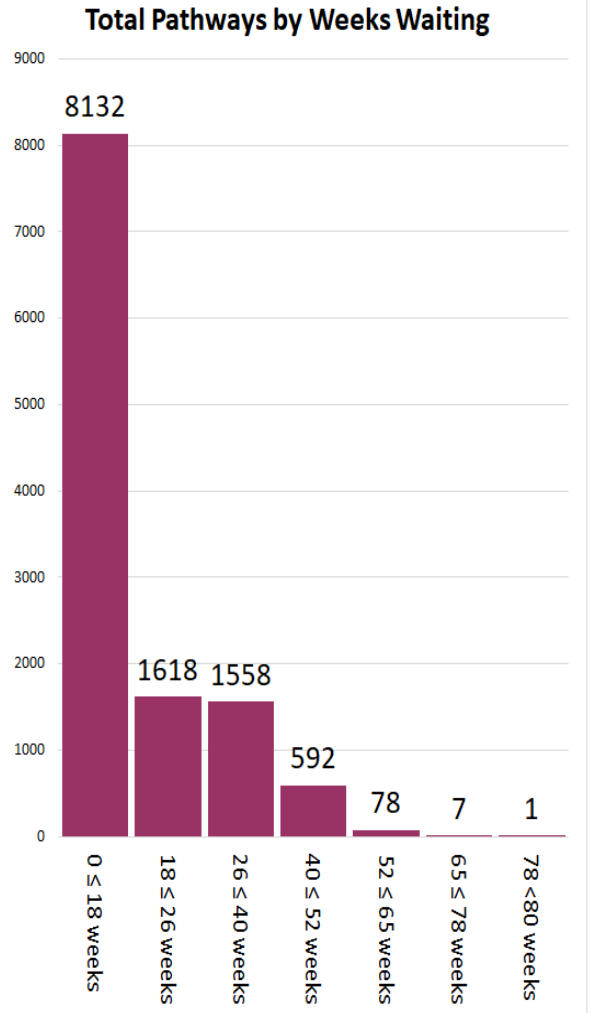
- Last Month's waits: Jan **50**
- This Month: Feb 41
- Year end: **< = 55**

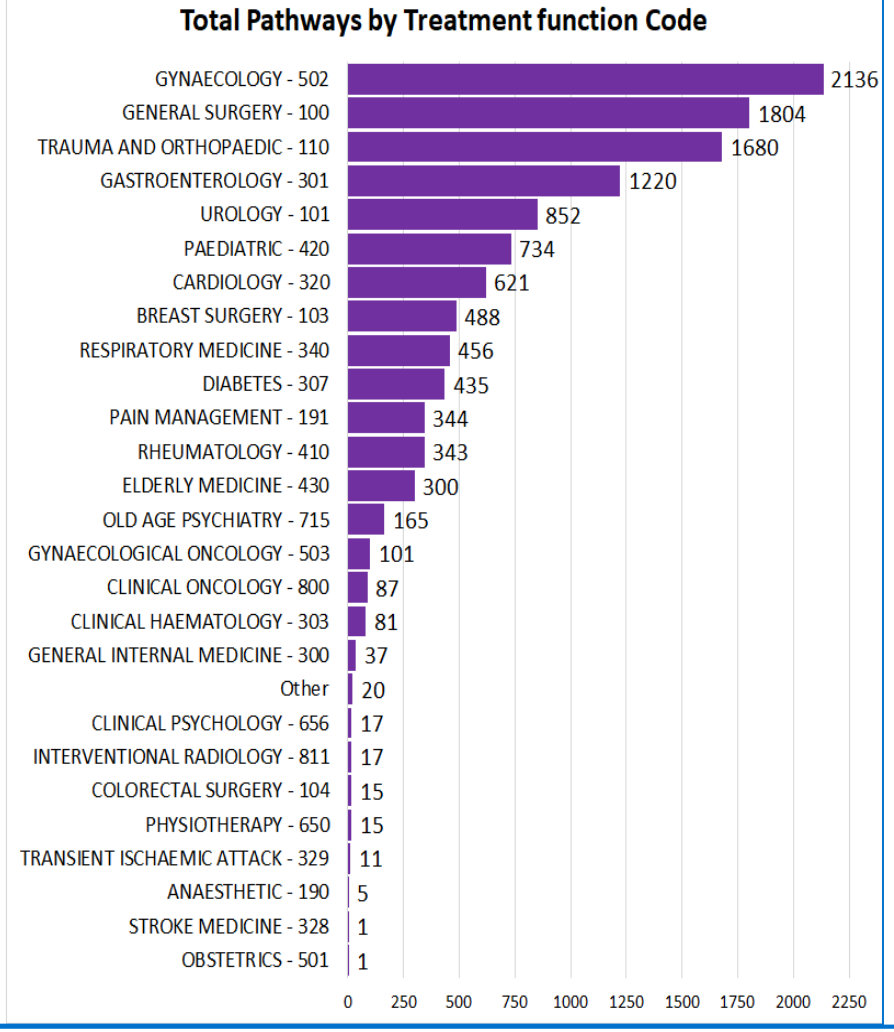
RTT Waiting List Summary

Gateshead Health NHS Foundation Trust

RTT Waiting List Breakdown current snap-shot view

(Waiting list up to and including 10th March 2024)





Waiting List Plan

Last month's waits:	Current waits:	Year end
Feb **12,083**	**11,986**	**<14,020**

Over 104 week waiters (zero)

Last month's waits:	Current waits:	Year end:
Feb **Zero**	**Zero**	**Zero**

Over 78 week waiters (zero)

Last month's waits:	Current waits:	Year end:
Feb **1**	**1**	**1**

Over 65 week waiters (zero)

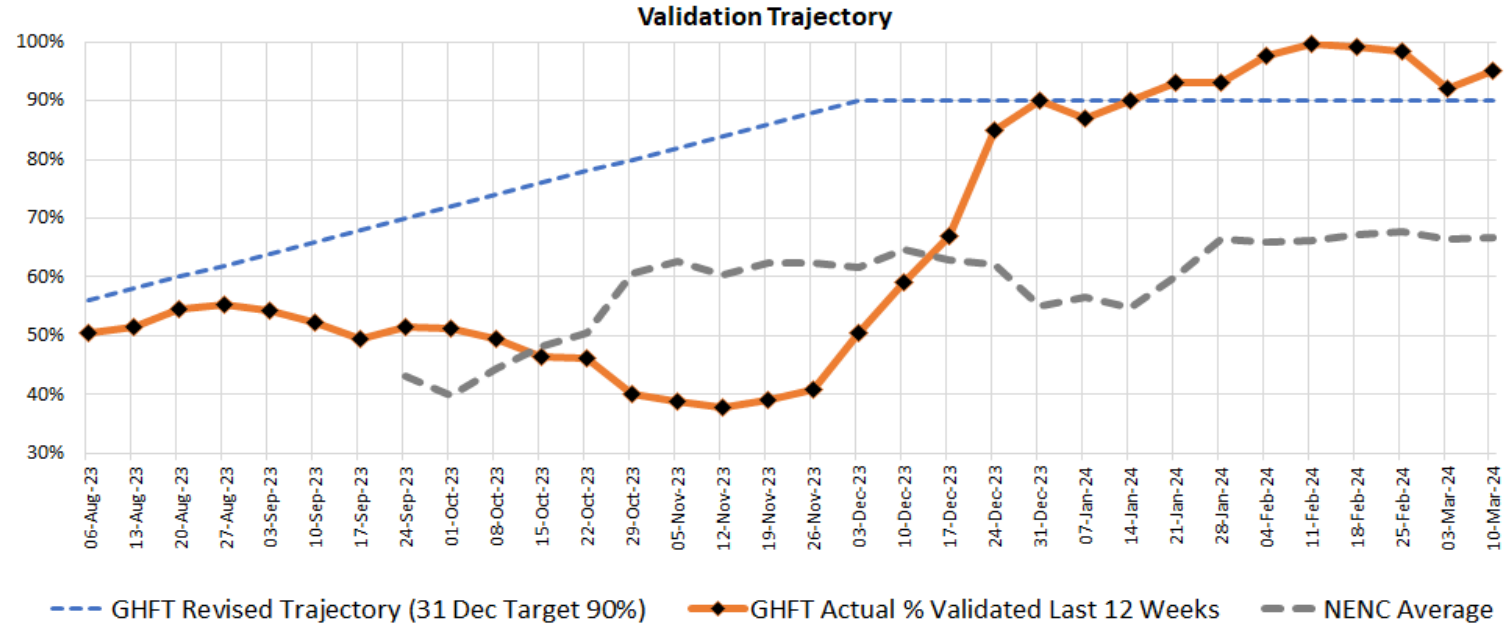
Last month's waits:	Current waits:	Year end:
Feb **10**	**8**	**1**

Over 52week waiters (minimise)

Last month's waits:	Current waits:	Year end:
Feb **112**	**86**	**Circa 75**

RTT Assurances: Validation

RTT: Validation 90% of patients waiting > 12 weeks



% Validated within previous 12 weeks	W/E 28/01/24	W/E 04/02/24	W/E 11/02/24	W/E 18/02/24	W/E 25/02/24	W/E 03/03/24	
GATESHEAD HEALTH NHS FOUNDATION TRUST	93.1%	97.7%	99.6%	99.2%	98.3%	92.0%	
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	73.4%	71.9%	70.0%	85.9%	87.3%	#N/A	
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	51.3%	52.6%	52.1%	51.7%	53.6%	56.8%	
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	86.7%	86.0%	84.3%	83.9%	80.7%	79.9%	
SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	60.8%	60.5%	54.7%	58.8%	58.9%	58.6%	
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	50.6%	50.2%	48.9%	49.0%	48.6%	43.5%	
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	60.1%	54.9%	58.2%	57.2%	57.4%	57.3%	
NORTH CUMBRIA INTEGRATED CARE NHS FOUNDATION TRUST	92.5%	92.5%	97.7%	97.7%	97.7%	95.8%	
NORTH EAST & NORTH CUMBRIA (acute Trusts)	**66.5%**	**65.9%**	**66.1%**	**67.3%**	**67.7%**	**66.5%**	

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

Validation Recovery – February 2024: Assurances

- The Trust continues to exceed the ask to have 90% of patents validated who are waiting more than 12 weeks.
- Gateshead Health continues to be only one of two Trusts in the NENC area to achieve this ask, and maintain it. North Cumbria have continued to also achieve the 90% target (see benchmarking table below).
- Our successful processes in approaching validation continues to be shared and adopted with NENC colleagues in support of system wide improvements.
- The waiting list has reduced by 14.5% or 1898 (based on the latest weekly PTL of the 10th March) since targeted validation began at the start of November. Our current PTL stands 2036 or 14.5% lower than planned for levels at the end of March.
- Sustaining our validated position remains a priority and features in 2024/25 Operational Plans.
- Waiting List managers are actively reviewing learning from validation and linking with training.
- There is a medium-term plan to review validation models going forward & options appraise the best for the Trust.

Outpatient Position – GP referrals

Gateshead Health NHS Foundation Trust

Average waiting time by specialty in weeks

Specialty	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Trend
Gynaecological Oncology			17.0	2.3	3.8		2.9		1.9		8.2		
Obstetrics	4.0	3.7	3.7	3.7	3.4	3.3	3.4	3.3	3.9	3.4	5.9	4.6	
Trauma & Orthopaedics	6.1	6.6	6.9	6.7	5.6	7.1	7.9	6.3	6.6	4.1	6.1	4.6	
Clinical Haematology	3.1	3.9	4.0	2.6	3.0	2.9	4.8	2.8	2.9	1.9	4.3	4.9	
Respiratory Medicine	10.1	8.9	9.7	13.7	13.7	14.1	15.4	17.1	16.1	11.3	10.6	6.0	
General Surgery	6.4	7.9	8.0	7.4	8.0	7.6	7.0	7.0	8.4	6.6	6.0	7.4	
Diabetic Medicine	3.9	10.1	9.9	7.1	6.6	19.6	11.4	9.4	9.0	8.4	8.7	13.0	
Geriatric Medicine	17.9	12.4	17.3	13.3	14.1	15.5	16.3	16.0	16.9	14.4	14.1	14.3	
Paediatrics	10.1	10.6	12.4	12.9	10.6	13.0	14.0	13.9	14.7	13.3	16.1	14.9	
Urology	10.0	11.5	16.1	15.5	15.4	16.4	16.0	15.4	15.1	15.6	17.7	17.6	
Cardiology	14.0	15.1	15.1	16.6	19.9	21.0	22.7	22.7	22.9	21.6	16.4	18.5	
Rheumatology	4.1	4.6	3.3	5.3	11.1	11.1	8.1	9.5	17.8	20.4	18.4	19.4	
Gastroenterology	17.1	18.2	18.7	20.1	21.3	22.2	23.1	23.3	24.6	24.9	25.4	25.1	
Gynaecology	18.0	20.1	21.1	23.1	23.2	23.6	26.7	26.8	27.9	25.9	28.1	28.0	
Pain Management	52.6	25.9	52.1	52.0	61.5	59.2	56.6	50.3	41.9	41.9	42.1	46.1	

Extremely High Priority/ Risk > 20 weeks
High Priority/Risk 12-20 weeks
Medium Priority 6-12 weeks
Within Expected <6 weeks

Pressures: February 2024

Extremely High Priority/ Risk > 20 weeks

- Pain Management 46.1 (exc.MSK)
- Gynaecology 28.0
- Gastroenterology 25.1

High Priority/Risk 12-20 weeks

- Rheumatology 19.4
- Cardiology 18.5
- Urology 17.6
- Paediatrics 14.9
- Geriatric Medicine 14.3
- Diabetic Medicine 13.0

Medium Priority 6-12 weeks

General Surgery 7.4

Within Expected <6 weeks

- Respiratory Medicine 6.0
- Clinical Haematology 4.9
- Obstetrics 4.6
- Trauma & Orthopaedics 4.6

Section 3: Leading Indicator Appendices

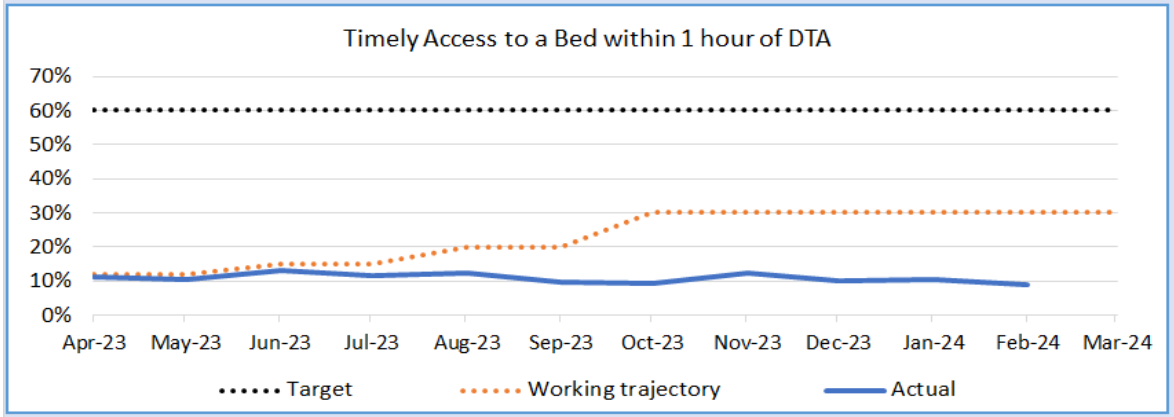
Gateshead Health NHS Foundation Trust

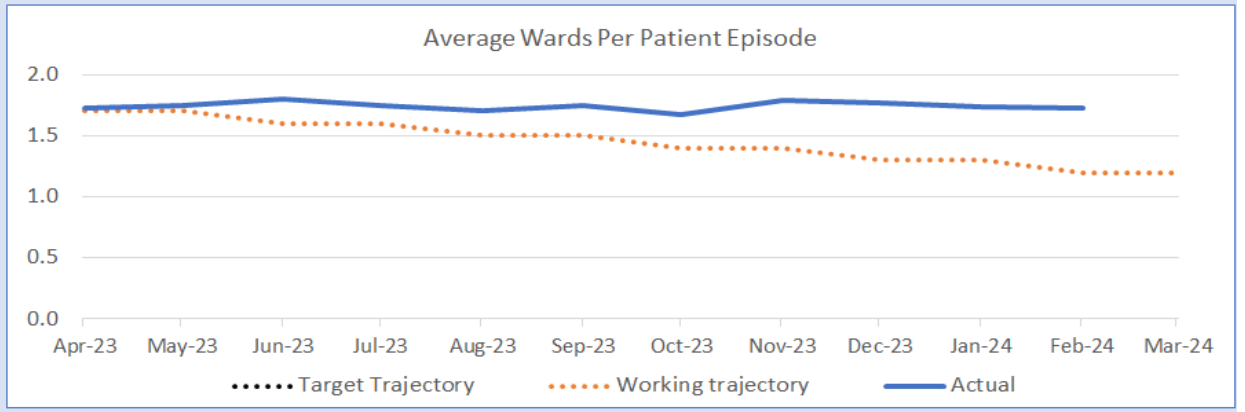
We will improve productivity and efficiency of our operational services

We will improve productivity and efficiency of our operational services

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

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





Indicator	Leading Indicator	Period	Target	Target Type	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Trend
Timely Access to a Bed within an Hour of DTA	LI	Feb-24	>60%	Loc	9.58%	11.01%	10.49%	12.92%	11.61%	12.22%	9.51%	9.11%	12.25%	10.03%	10.55%	8.81%	
Reduction in the average number of wards per patient episode	BO	Feb-24	TBA	Loc	1.81	1.73	1.75	1.80	1.75	1.76	1.75	1.67	1.79	1.77	1.74	1.73	
Patients Moving to the Right Bed	BO		TBA	Loc	(this measure is currently not available as under development)												

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

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

Causal Factors: Patients remaining in the bed base with no criteria to reside. Reducing bed availability for acute admissions. Digital solution and consistency of reporting linked to the criteria to reside information data set. Further work needed on the BO metrics.

Actions being taken: Programme to relaunched and engage the organisation in criteria to reside. Review of the BO metrics as part of the leading indicators to link to operational actions.

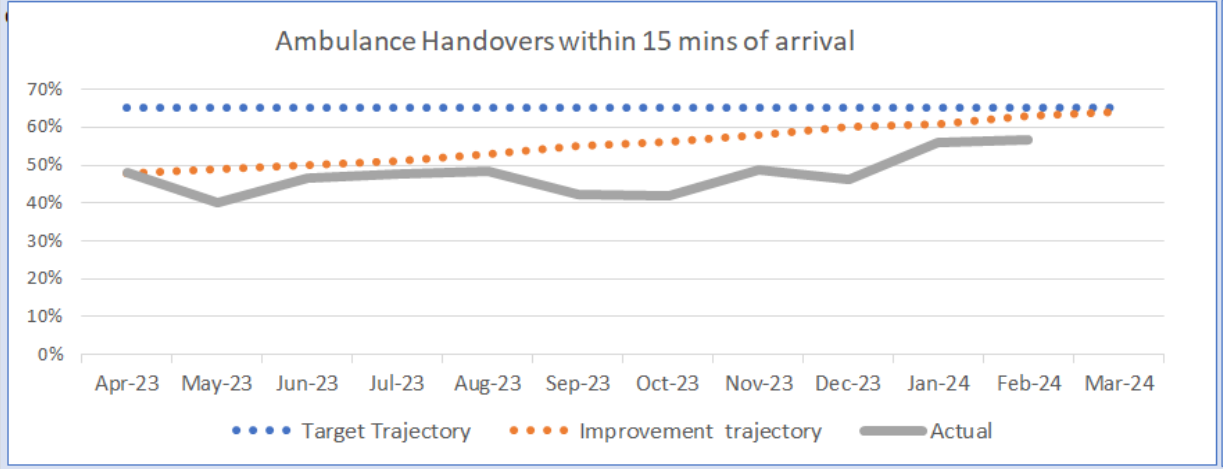
New patient flow meeting format now embedded, which includes increased actions to improve flow and monitoring of 1 hour DTA to bed, with a recent focus now to the 4 hr standard. Stranded patient meetings also restarted to reduce length of stay.

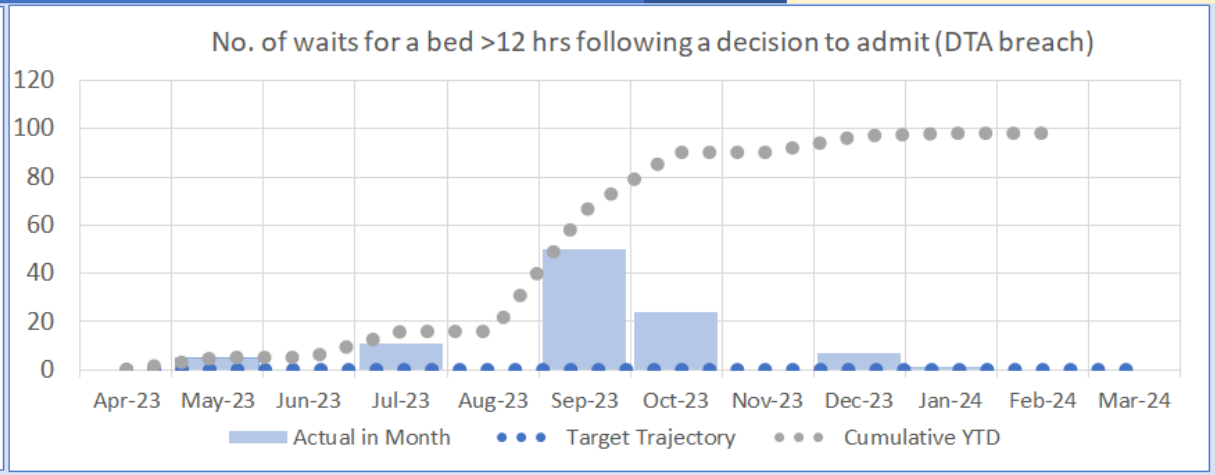
Weekend discharge service in place to increase discharges on Saturday and Sundays

Winter ward opened 05/11/23 and move away from medically optimised wards which slow flow due to multiple moves of patients.

We will improve productivity and efficiency of our operational services

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





Indicator	Leading Indicator	Period	Target	Target Type	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Trend
Ambulance Handovers within 15 mins from arrival	BO	Feb-24	65%	Nat.	48.0%	48.0%	40.3%	46.6%	47.8%	48.3%	42.4%	41.7%	48.9%	46.1%	55.9%	56.8%	
Waits for a bed >12 hrs following a decision to admit (DTA breach)	LI	Feb-24	Zero	Nat.	80	0	5	0	11	0	50	24	0	7	1	0	

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

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

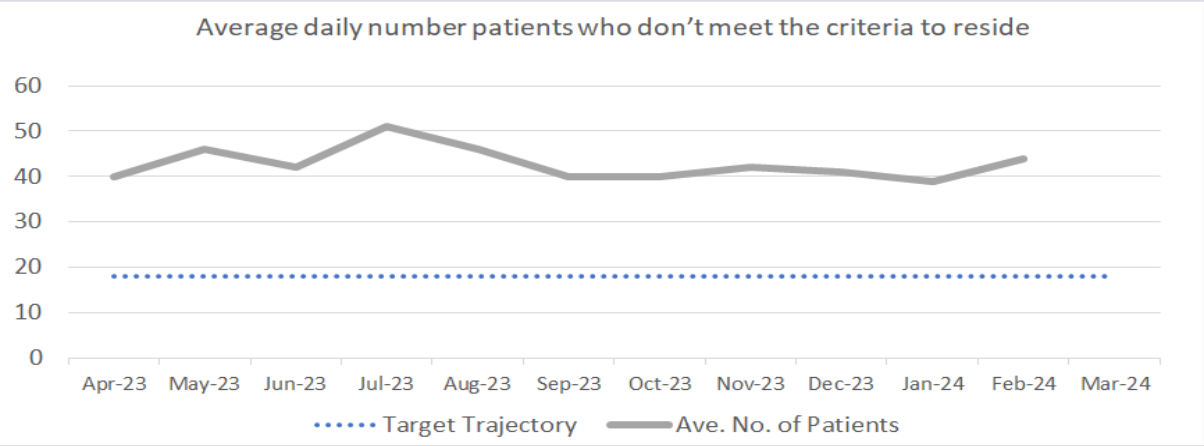
Causal Factors:
'Clustering' of ambulance arrivals making handover difficult at peak times due to environmental constraints within the department. Decision to place in patients within the Same Day Emergency Care environment – reducing SDEC capacity and increasing delays within the Emergency Department.

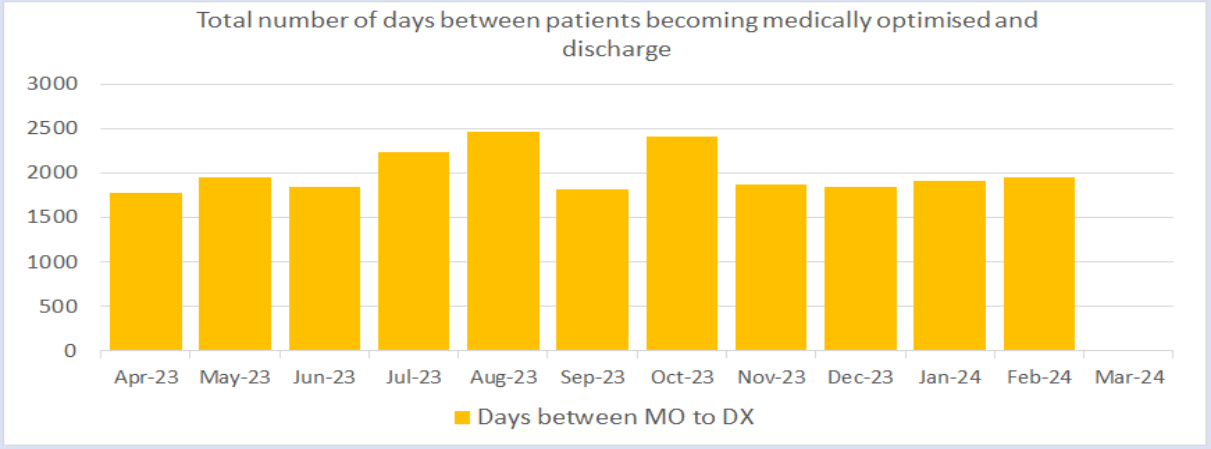
Actions being taken:
Review of the ambulance conveyances and identification of 'peak' clustering periods. Meeting with NEAS set up to review conveyance levels and timings. Internal ED action plan progressing to reduce delays. Review of the impact of SDEC being used as additional inpatient capacity. Weekly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

We will improve productivity and efficiency of our operational services

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

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





Indicator	Leading Indicator	Period	Target	Target Type	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Trend
Average daily number patients who don't meet the criteria to reside	BO	Feb-24	≤18	Loc.	43	40	46	42	51	46	40	40	42	41	39	44	
Total days between patients becoming MO and discharged	BO	Feb-24	Monitor	Loc.	2798	1783	1952	1851	2236	2467	1818	2407	1877	1851	1916	1948	

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

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

Causal Factors: Despite winter pressures the average number of patients daily who do not meet the criteria to reside has only remained static and the work on reducing time between MO and discharge continues.

The number of out of area patients awaiting discharge on pathways 1-3 remain high. There remains challenges with patients being discharged to Sunderland. There remain challenges in finding suitable placements for certain patients with challenging behaviours and additional needs.

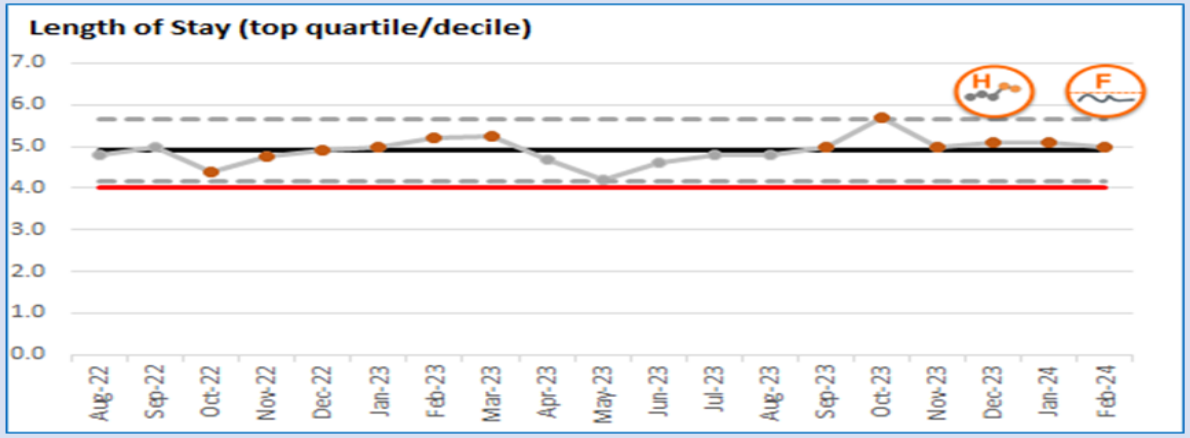
Actions being taken: Daily review of patients on list of patients who are medically optimised. Daily allocation of patients to appropriate out of hospital placements. Strategic planning with social care to identify and appropriately and commission system capacity to reduce pathway 1-3 delays.

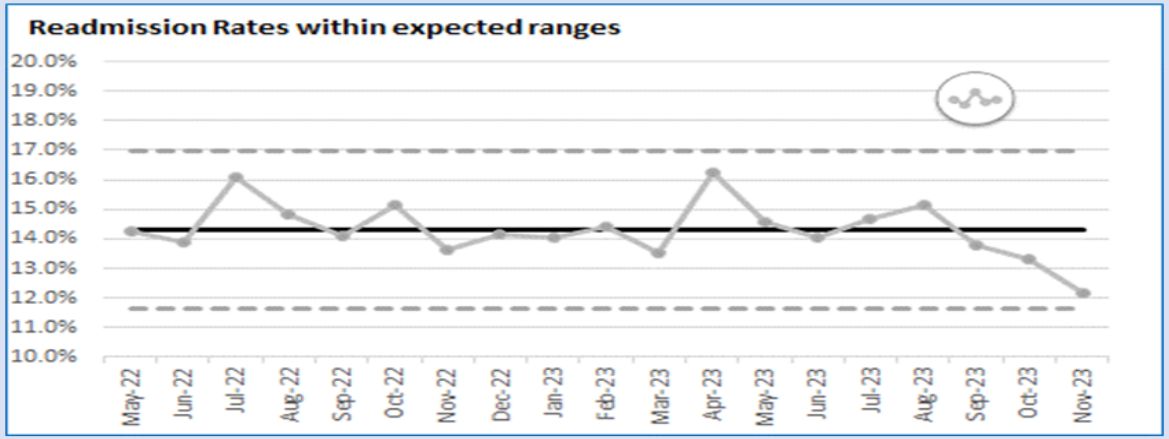
A weekly stranded patient review led by the Matrons has been introduced to further ensure that patients are not remaining in hospital unnecessarily in addition to daily ward review processes.

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

We will improve productivity and efficiency of our operational services

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





Indicator	Leading Indicator	Period	Target	Target Type	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Trend
Trust overall length of stay	LI	Feb-24	Top Quartile <4	Loc.	5.23	4.68	4.26	4.44	4.5	4.56	4.73	5.52	4.78	4.85	4.72	4.77	
Elective (exc. DC)		Feb-24	Monitor	Loc.	3.09	4.26	2.52	2.66	3.91	2.48	3.75	3.25	2.17	2.8	2.66	2.86	
Non Elective		Feb-24	Monitor	Loc.	5.45	4.72	4.43	4.6	4.55	4.66	4.83	5.79	5.1	5.08	4.96	5	
Readmission Rates	BO	Nov-23	Monitor	Loc.	13.5%	16.2%	14.6%	14.0%	14.6%	15.2%	13.8%	13.3%	12.1%				

Risks

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

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

Risk Mitigation

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

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

Causal Factors:

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

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

Actions being taken:

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

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

Gateshead Health NHS Foundation Trust

We will improve productivity and efficiency of our operational services

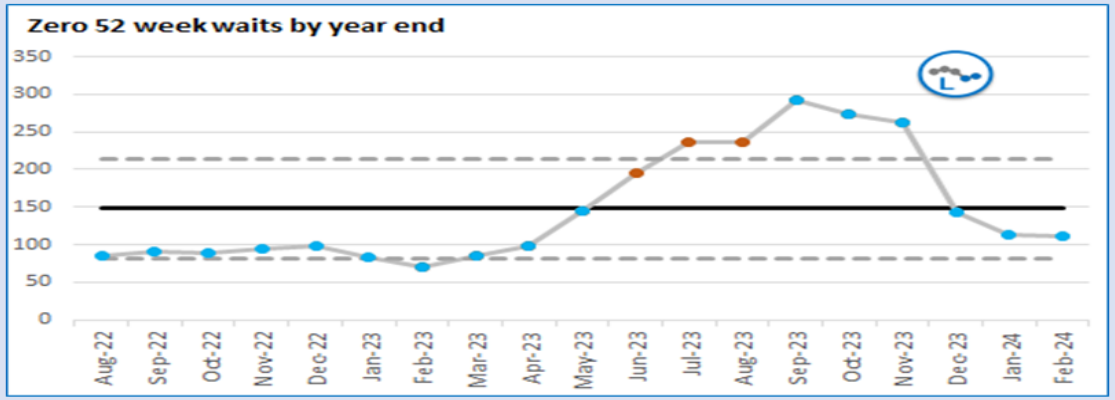
LI: Reduce to 0 the number of 52 week waiters on the RTT waiting list, by the year end

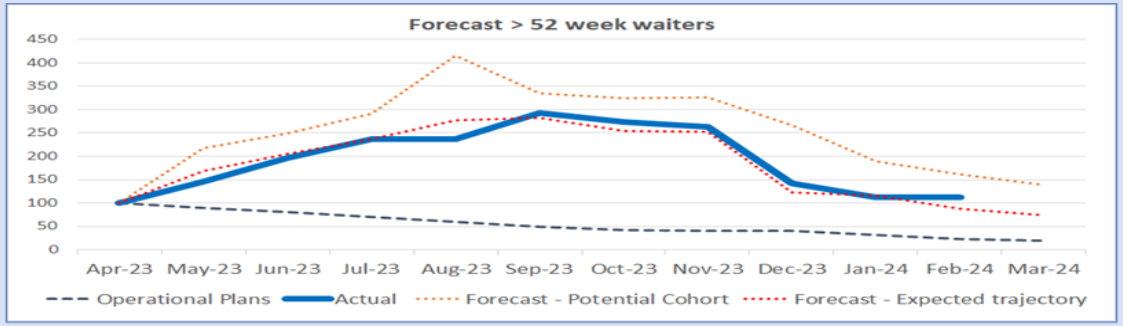
Status: LI

Director: Amy Muldoon
Ops Lead: Ross Peddie
Oversight: Elective Care Programme

	52 week waits numbers / actual and projections											
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Operational Plans	100	90	80	70	60	50	42	41	40	31	23	
Actual	100	145	196	236	237	293	274	263	143	113	112	
Forecast - Potential Cohort	100	217	249	292	415	335	324	327	266	190	161	138
Forecast - Expected trajectory	100	169	205	236	278	283	255	252	122	116	88	73
Forcasted		02-May	05-Jun	17-Jul	17-Aug	19-Sep	19-Oct	19-Nov	10-Dec	14-Jan	19-Feb	18-Mar

Speciality (Black- Actual/Grey forecast)	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Paediatrics	44	70	82	104	92	110	119	124	0	0	0
Pain	21	28	49	58	58	86	63	42	32	26	15
Trauma and Orthopeadics	10	22	25	34	45	47	43	53	59	43	46
General Surgery	14	13	21	25	26	34	36	30	34	19	15
Urology	4	9	10	10	9	6	2	5	5	11	10
Gynae	2	2	2	3	6	7	5	6	11	10	20
Gastro	3	1	6	2	0	2	6	3	0	3	4
Cardiology	2	0	1	0	1	1	0	0	2	1	2





Risks: Long waits resulting in poor patient experience & risk of complaints. Increased clinical risk & litigation. Reputational risk of not meeting Constitutional standards and Operational Plan targets.

Risk Mitigation: Weekly Access and Performance meetings with all Business Units developed to support specialty level recovery plans, specifically reviewing patients over 52w/65w. Service line recovery plans which suggest zero 52 week waits by March 24 won't be achieved are escalated to Senior Management Team for awareness and support. Continue to explore mutual aid support at a system level for specialties with long waiters. Full plans for the "65-week" cohort patients being presented at Access & Performance meeting.

Causal Factors: Industrial action leading to cancellation of elective activity and site pressures resulting in the loss of elective beds and activity. Data quality and inconsistency of practice in RTT management. Decentralized management of waiting list. Demand and capacity challenges to accommodate longest waiters in Pain, Paediatrics, T&O, Gynaecology, and General Surgery. Financial pressures to support additional capacity to recover the long waiter position.

Actions being taken: Recovery plans developed and agreed as part of weekly Access and Performance Meeting, focussing on the reduction of long waiter cohort. Revised format of weekly Access and Performance Meeting on broader performance that may impact long waiters, such as diagnostics. Weekly patient level review of long waiters as part of weekly meeting. Weekly forecasting on year end position regarding long waiters provided to senior management team. Exploring digital mutual aid and use of the independent sector. Involvement in regional mutual aid support group where challenged specialties are discussed and mutual aid explored. Business case progression for increased capacity in challenged specialities where applicable. Review of clinical pathways and transformation through the elective care programme. Exploring a review of the waiting list and existing validation processes. Focussed validation exercise taking place across the Trust.

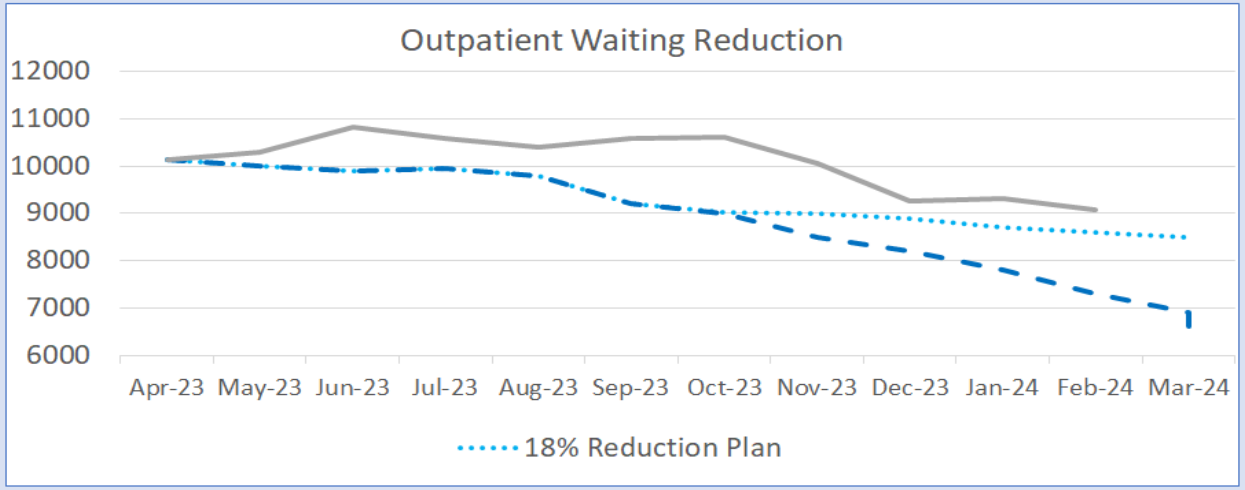
Gateshead Health NHS Foundation Trust

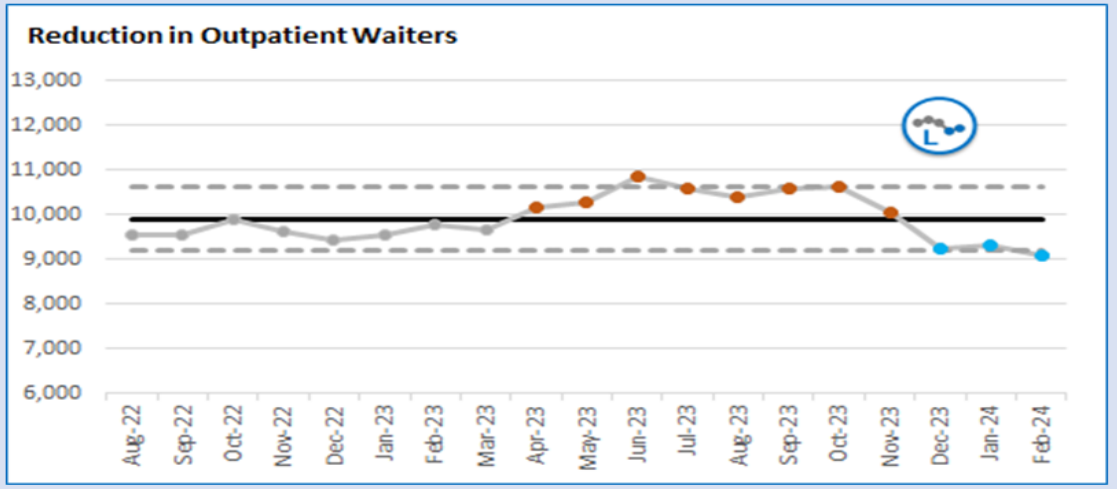
We will improve productivity and efficiency of our operational services

BO: A reduction in the RTT PTL outpatient waiting list

Status: BO

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





Indicator	Leading Indicator	Period	Target	Target Type	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Trend
No of outpatient on the RTT waiting list	BO	Feb-24	7,500	Loc.	9643	10146	10283	10835	10584	10387	10580	10601	10044	9249	9323	9070	

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

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

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

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

1st 'superclinic' for Gynae took place in March on an evening where a large number of long waiters were seen in their first appointment. Scoping additional dates for further sessions

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

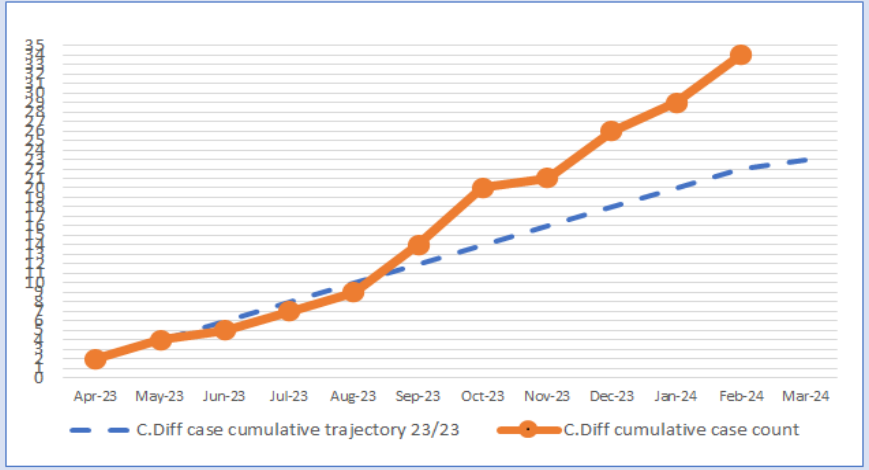
NHS
Gateshead Health
NHS Foundation Trust

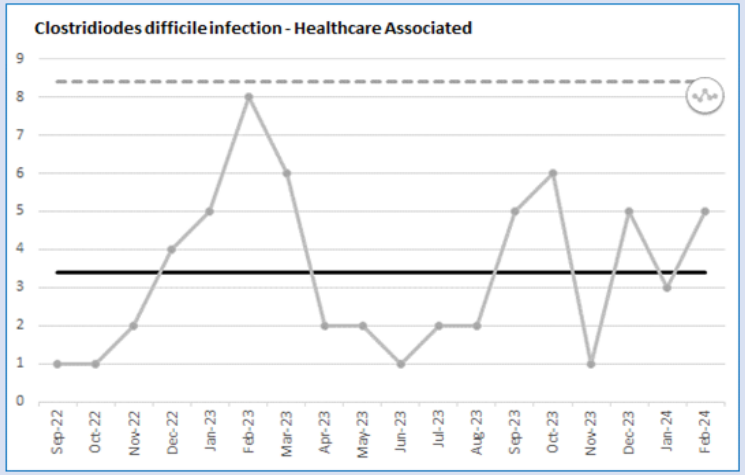
We will continually improve the quality and safety of our services for our patients

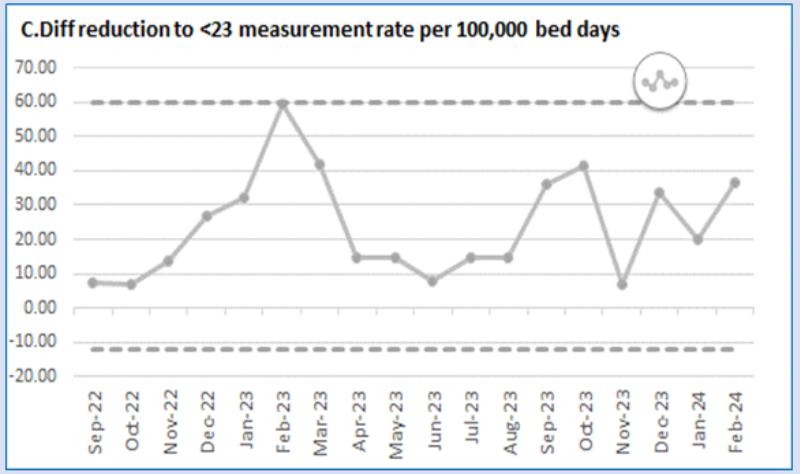
We will continually improve the quality and safety of our services for our patients

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

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







C Difficile	C.Diff Reduction target of <23 actual incidents for 2023/24											
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Healthcare Associated	2	2	1	2	2	5	6	1	5	3	5	
Total YTD (target no more than 23 in the year)	2	4	5	7	9	14	20	21	26	29	34	
Community Associated	2	0	0	0	2	2	0	0	1	2	1	

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

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

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

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

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

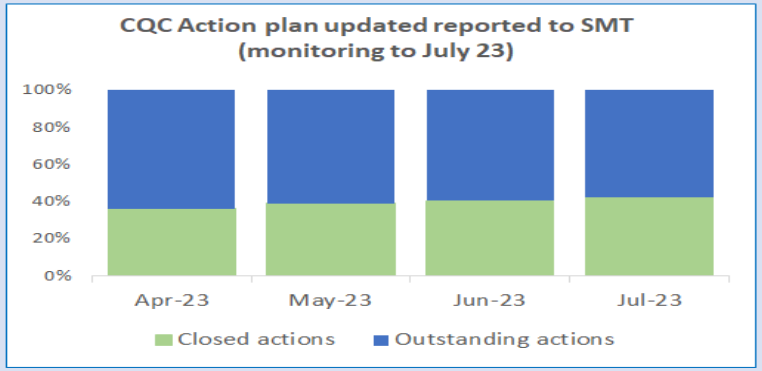
If cluster or outbreak of C-diff is identified, ribotyping of sample taken to be sent to UKHSA for identification in case of more virulent strain. Regular regional meetings to discuss action plans regarding C-diff infections is in place.

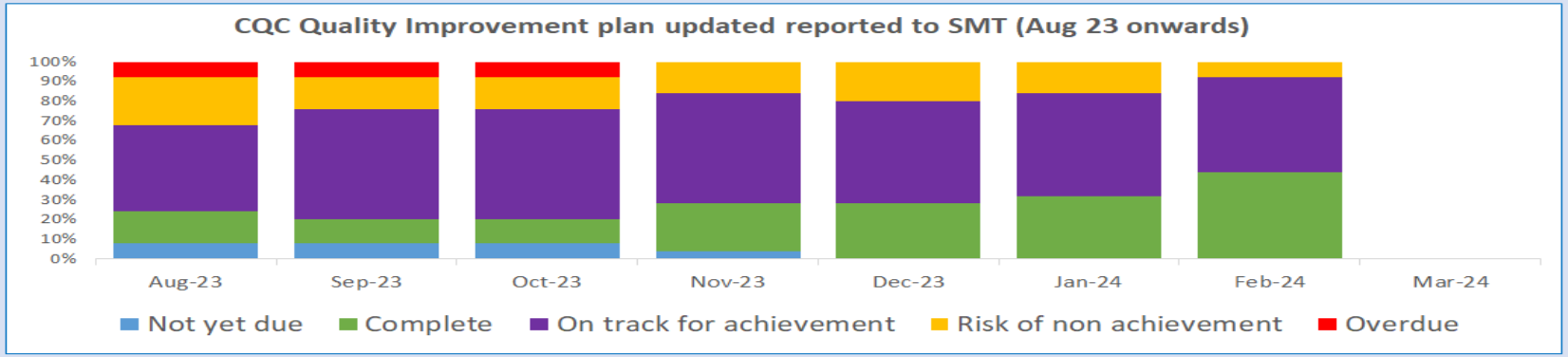
Gateshead Health NHS Foundation Trust

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

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

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





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

	Quality Improvement Plan updated reported to SMT											
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Total Actions	New monitoring from Aug 23 onwards				25	25	25	25	25	25	25	25
Overdue					2	2	2	0	0	0	0	
Risk of non achievement					6	4	4	4	5	4	2	
On track for achievement					11	14	14	14	13	13	12	
Not yet due					2	2	2	1	0	0	0	
Complete					4	3	3	6	7	8	11	

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

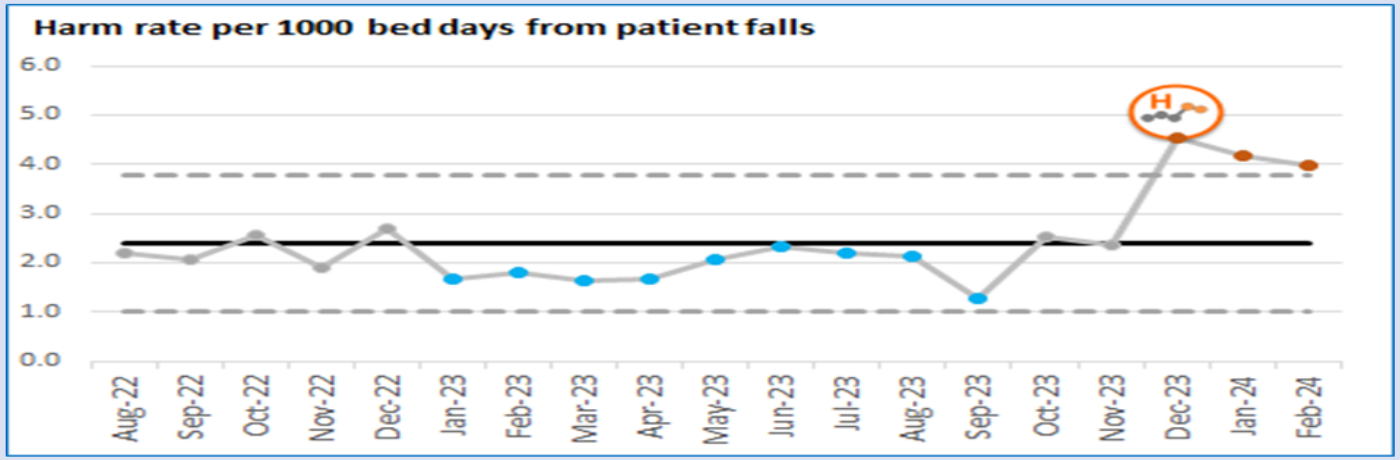
Risk Mitigation:
CQC compliance officer in post. Regular reporting to SMT. Actions clearly allocated to identified leads with clear timescales.

Causal Factors:
Changes to CQC regulations and requirements.

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

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

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



	Monthly harm from falls											
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Harm rate per 1,000 bed days from patient falls	1.67	2.13	2.31	2.21	2.13	1.27	2.54	2.37	4.55	4.16	3.96	
Improvement Trajectory	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	TBA	

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

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

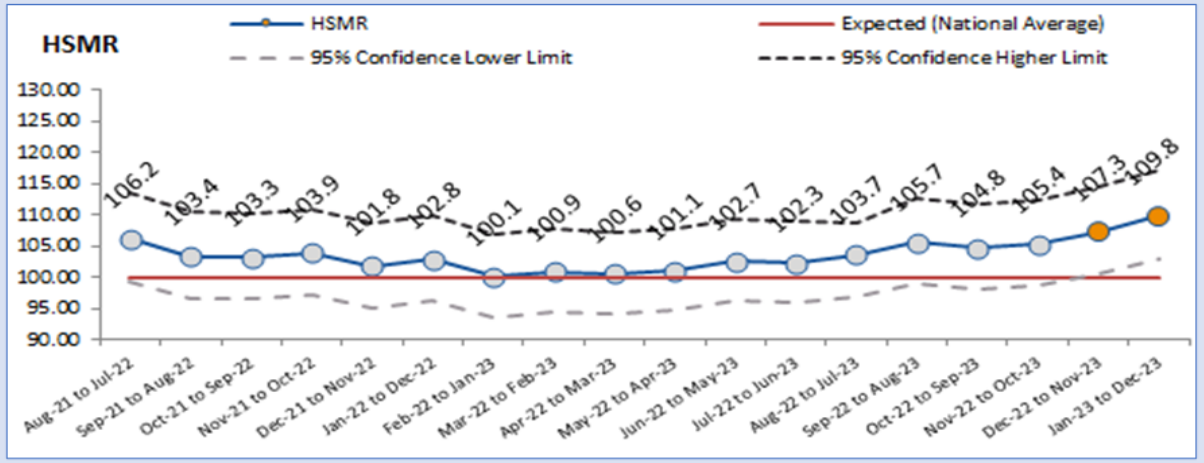
Causal Factors: No inpatient falls provision to support with training, education, and expertise.

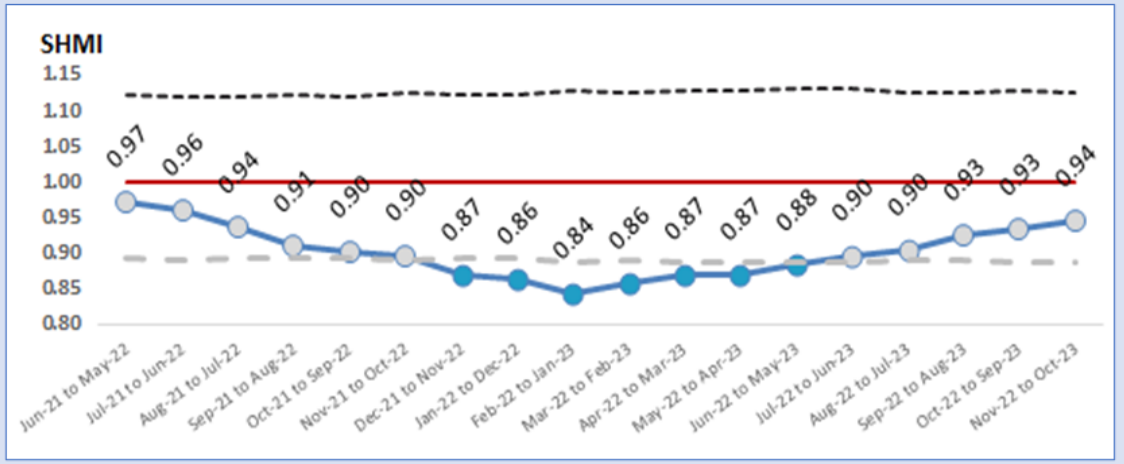
January saw a significant increase in the number of low harm falls (in comparison to no harm falls), whereas there was a small reduction in the number of overall falls reported. Initial analysis indicates that this may be attributable to the change to a new reporting system in late 2023. It is quicker and easier to report incidents on this system, and it has no default settings so this may have led to more accurate reporting of harm.

Actions being taken: Review of how we monitor falls and learn from incidents. Continuation of 'Avoiding Falls Level of Observation Assessment Tool (AFLOAT)', the aim was to reduce specific falls risk, improve patient safety and improve patient outcomes and experience. Audits of compliance will now be commenced. Further monitoring of the low harm falls will commence to further understand the data.

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

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





Indicator	Leading Indicator	Period	Target	Target Type	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Trend
Summary Hospital Mortaility Indicator (SHMI) (rolling 12 months)	BO	Oct-23	≤1	Nat.	0.87	0.87	0.88	0.9	0.9	0.93	0.93	0.93			
Hospital Standard Mortality Ratio (HSMR) (rolling 12 months)	BO	Dec-23	`	Nat.	100.6	101.1	102.7	102.3	103.7	105.7	104.8	105.4	107.3	109.8	

Risks: Both the HSMR and SHMI are quality benchmarking metrics, that monitor Trust performance in relation to mortality against statistical expectation calculated from national datasets. The HSMR is showing deaths 'Higher than Expected' with a score of 109.8 against the national average figure of 100. The SHMI remains with deaths 'Expected' with the latest figure of 0.94 however an increasing trend is observed. A likely explanation for the SHMI score is the inclusion of SDEC activity within the inpatient dataset from Sep-21. Observed deaths will remain the same, however the increased volume of activity results in higher expected deaths being calculated by the model. Once SDEC activity moves to Type 5 A&E activity (Planned early 2024-25) then the SHMI score is likely to increase at

Risk Mitigation: Cases scoring more than Hogan 1 are subject to a review at Mortality Council, a proportion of these cases are also patient safety incidents and would go through the Trusts Patient Safety Learning Panel. Since the inception of the Medical Examiner Service in September 2020, all deaths are reviewed and cases may be escalated for additional investigations i.e., Mortality Council, patient safety investigation. Mortality review data for the last 12 months demonstrates that 99.9% of deaths reviewed were 'Definitely not preventable' with 97.1% of cases reviewed identified as 'Good practice'.

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

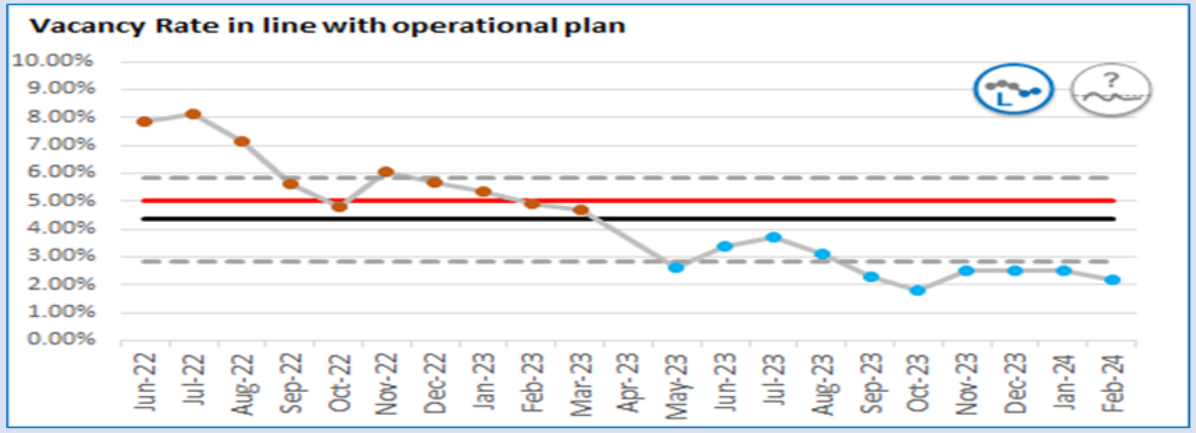
Actions being taken: The process for reviewing deaths were patients had a serious mental illness diagnosis. The process is embedded for those over 65, however the process to review under 65s relies on input from CNTW. The process has now been agreed with CNTW, they will review the backlog of cases and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

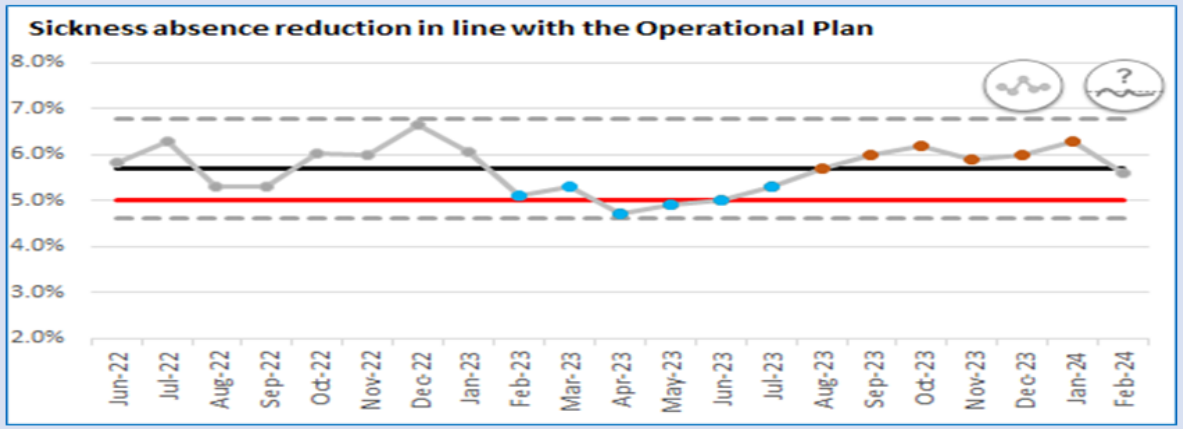
Gateshead Health NHS Foundation Trust

We will be a great organisation with a highly engaged workforce

We will be a great organisation with a highly engaged workforce

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





Indicator	Leading Indicator	Period	Target	Target Type	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Trend
Trust Staff Survey rate - Engagement score	LI	Q3	SS: 6.9	Loc.		6.77			5.92			7.00	October figure released March 24 - results from staff survey				
Group Staff Vacancy rates	BO	Feb-24	≤5%	Loc.	4.7%	Not Available	2.6%	3.4%	3.7%	3.1%	2.3%	1.8%	2.5%	2.5%	2.3%	2.2%	
Group Sickness Absence	BO	Feb-24	≤5%	Loc.	5.30%	5.0%	4.9%	5.0%	5.3%	5.7%	6.0%	6.2%	5.9%	6.0%	6.3%	5.6%	

Risks

Engagement Score: Low levels of engagement with both Annual and Pulse Survey Results, bringing validity of measure into question. Annual Engagement score has been declining since 2018 and 2022 saw this steady for the second year at 6.9.

Vacancy Rates: Vacancies add pressure to the group and our ability to provide a safe and high-quality service.

Absence rates: Absence adds pressure to the group and our ability to provide a safe and high-quality service.

Mitigation of Risk;

Engagement Score: A revised focus on increasing engagement, particularly clinical engagement, reducing vacancy and absence rates to improve staffing levels, which is cited as a key area of concern for colleagues.

Vacancy Rates: Continued monitoring of group vacancy rates at a granular level. **Absence rates:** Robust system of absence management introduced – new policy in place >12 months.

Absence Rates: management training package available. Focused work including monthly case reviews, target setting and sickness clinics.

Causal Factors:

Engagement Score: Individuals across the organisation experiencing 'survey fatigue' or feeling that their feedback is not acted upon.

Vacancy Rates: Local & national qualified staff shortages.

Absence rates: Volume of individuals triggering and continuing to trigger the absence management policy. Pockets of strong engagement, but not universal.

Actions being taken:

Engagement Score: The 2023 staff survey results have now past the embargo period and the Trust has a 7.0 engagement figure which means that the Trust is in line with the leading indicator target.

Vacancy Rates: POD strategies including focusing on retention, absence management, health & wellbeing. The Trust has been accepted onto the People Promise Exemplar programme which will commence in February 2024, and focus on improving retention.

Absence rates: Continue with monthly case management approach of all long-term absence cases. Business Units provided with monthly short term absence reports highlighting all employees who have triggered short term absence procedure. Ongoing training and development being explored internally to support managers.

NHS
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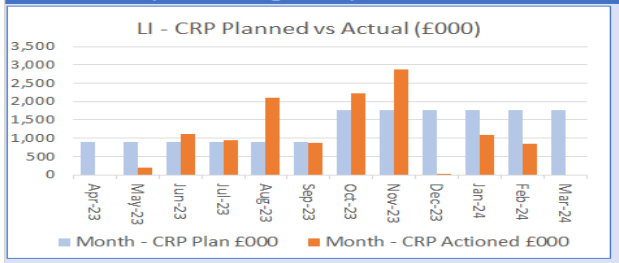
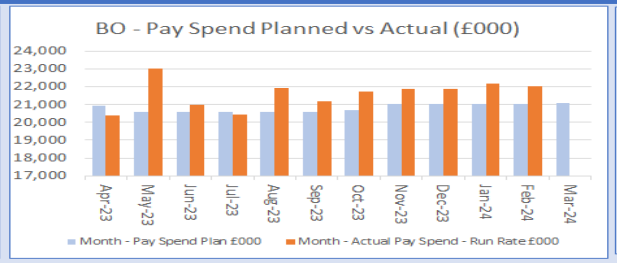
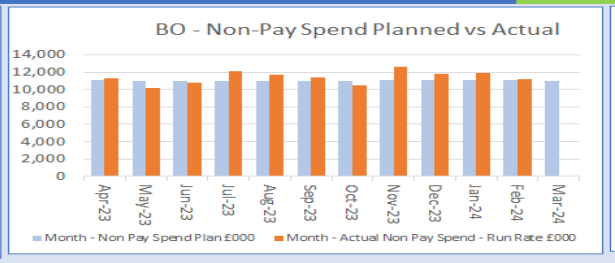
We will achieve financial sustainability

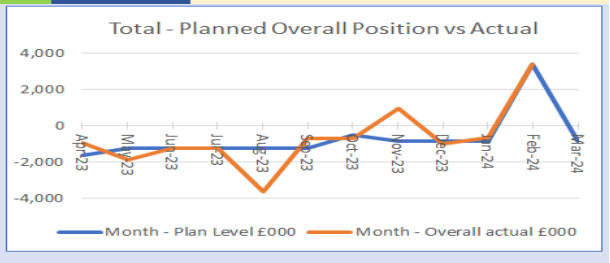
We will achieve financial sustainability

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









	Leading Indicator	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	YTD
Month - CRP Plan £000	LI	897	897	897	897	897	897	1,753	1,753	1,753	1,753	1,753		14,147
Month - CRP Actioned £000		0	191	1,116	949	2,096	861	2,231	2871	3	1095	859		12,272
Month - Variance £000		-897	-706	219	52	1,199	-36	478	1,118	-1,750	-658	-894		-1,875
YTD - CRP Plan £000		897	1,794	2,691	3,588	4,485	5,382	7,135	8,888	10,641	12,394	14,147		
YTD - CRP Actioned £000		0	191	1,307	2,256	4,352	5,213	7,444	10,315	10,318	11,413	12,272		
YTD - Variance £000		-897	-1,603	-1,384	-1,332	-133	-169	309	1,427	-323	-981	-1,875		
Month - Pay Spend Plan £000	BO	20,953	20,593	20,593	20,593	20,593	20,593	20,677	21,037	21,037	21,037	21,037		228,743
Month - Actual Pay Spend - Run Rate £000		20,379	23,002	20,994	20,451	21,913	21,154	21,724	21,896	21,896	22,189	22,025		237,622
Month - Variance £000		-574	2,409	401	-142	1,320	561	1,047	859	859	1,152	988		8,879
YTD - Pay Spend Plan £000		20,953	41,546	62,139	82,732	103,325	123,918	144,595	165,632	186,669	207,706	228,743		
YTD - Actual Pay Spend - Run Rate £000		20,379	43,381	64,375	84,826	106,739	127,893	149,617	171,513	193,409	215,598	237,622		
YTD - Variance £000		-574	1,835	2,236	2,094	3,414	3,975	5,022	5,881	6,740	7,892	8,879		
Month - Non Pay Spend Plan £000	BO	11,051	11,025	11,025	11,025	11,025	11,025	11,027	11,053	11,053	11,053	11,053		121,415
Month - Actual Non Pay Spend - Run Rate £000		11,311	10,203	10,823	12,152	11,681	11,388	10,505	12,568	11,793	11,872	11219		125,515
Month - Variance £000		260	-822	-202	1,127	656	363	-522	1,515	740	819	166		4,100
YTD - Non Pay Spend Plan £000		11,051	22,076	33,101	44,126	55,151	66,176	77,203	88,256	99,309	110,362	121,415		
YTD - Actual Non Pay Spend - Run Rate £000		11,311	21,514	32,337	44,489	56,170	67,559	78,064	90,631	102,424	114,296	125,515		
YTD - Variance £000		260	-562	-764	363	1,019	1,383	861	2,375	3,115	3,934	4,100		

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
Month - Plan Level £000	-1,628	-1,242	-1,240	-1,242	-1,242	-1,239	-472	-858	-857	-857	3,394		-7,483
Month - Overall actual £000	-954	-1866	-1211	-1216	-3625	-666	-710	978	-956	-620	3,410		-7,437
Month - Variance £000	674	-624	29	26	-2,383	573	-238	1,836	-99	237	16		46
YTD - - Plan Level £000	-1,628	-2,870	-4,110	-5,352	-6,594	-7,833	-8,305	-9,163	-10,020	-10,877	-7,483		
YTD - Overall actual £000	-954	-2,820	-4,031	-5,247	-8,872	-9,538	-10,248	-9,270	-10,226	-10,846	-7,437		
YTD - Variance £000	674	50	79	105	-2,278	-1,705	-1,943	-107	-206	31	46		

Overall position against plan

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

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

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

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

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 21

Report Title:	**Freedom to Speak up Guardian Report**			
Name of Meeting:	Trust Board			
Date of Meeting:	27th March 2024			
Author:	Tracy Healy Freedom to Speak Up Guardian (FTSUG)			
Executive Sponsor:	Amanda Venner Director of People & OD. Dr Gillian Findley, Chief Nurse, Professional Lead for Midwifery & Allied Health Professionals. Deputy CEO.			
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 Q1,2, & 3 April – December 2023			
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*	Q1 position reported to POD committee – 11th July & to Trust Board – 27th September 2023. Q2 & 3 presented to POD Committee January 2024 and QGC February 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*	**Q2 Period:** • 7 Cases were reported half of which were about Culture. • 6 cases were managed and closed in this period. **Q3 Period:** • 18 cases were reported half of which were due to Bullying and Harassment • 7 cases closed in this period. • This is a 157% Increase from Q2 to Q3. • Where concerns have been raised these are being managed in a variety of ways now with a rag rating and risk identified from a clinical perspective and those of significant high risk of patient safety being escalated immediately to Chief nurse / Deputy CEO. • Currently 8 FTSU champions in post- relaunch to be carried out in January with a wider number of champions to be recruited. • Action Plan developed from NHSE/I following the Lucy Letby case – awaiting Thirwall enquiry results for further actions.			

	• In October 2022 it was agreed all Board members would undertake the necessary three levels of FTSU training. At the time of writing 10 out of 15 Board members had completed this (66.6%). • ICB Audit for FTSU mechanisms undertaken, board report completed and presented to Board and ICB. (See Appendix 1). • FTSU Guardian Service Changes and development. *Note that all appendices are included in a supplementary information pack rather than within the main Board papers.*
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	• The Board is asked to receive this report by way of assurance on FTSU concerns and broader activity. • The Board 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 Board is asked to note the current Board member training compliance and support completion. • The Board 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.				
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 7 concerns were raised in Q1 (April 1- June 30, 2023)

1.2 7 concerns were raised in Q2 (June 30- September 30, 2023)

1.3 18 concerns were raised in Q3 (October 1- December 31, 2023). A 157% increase from Q2 -Q3. (Q4 currently has had 18 cases).

1.4 Total concerns for 2022-2023 was 34.

1.5 In October 2022 it was agreed that all Board members should complete all three levels of FTSU training. At the time of writing, 10 out of 15 Board members had completed this training (66.6%).

1.6 FTSUG position now full time since the start of Q3.

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

1.8 FTSUG supported by some of the FTSU Champions held roadshows in October for the National FTSU month this allowed launch of the new FTSUG in full time role and service changes.

1.9 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.

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

1.11 Undertaken review of service as requested by NHSE / I following Lucy Letby case (Appendix 2)

1.12 Undertaken audit as requested by ICB of current FTSU Service which was presented to Trust Board (Appendix 1)

1.13 Actioned results from audit – developed formal feedback process to allow service improvement and service / outcome satisfaction. (Appendix 1).

1.14 Review of reporting of FTSU systems undertaken and Business Case completed for decision.

1.15 Developed wider Comms plan with support of Comms Team. (Appendix 3),

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

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

1.18 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.

Note that all appendices are included in a supplementary information pack rather than within the main Board papers.

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 moving forward in 2024 will present a paper to Quality Governance Committee (QGC).

2.4 This report provides the Committee with a summary of FTSU activity from April 1-2023 – December 31- 2023 (Q1-Q3). 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.

3. Key issues / findings

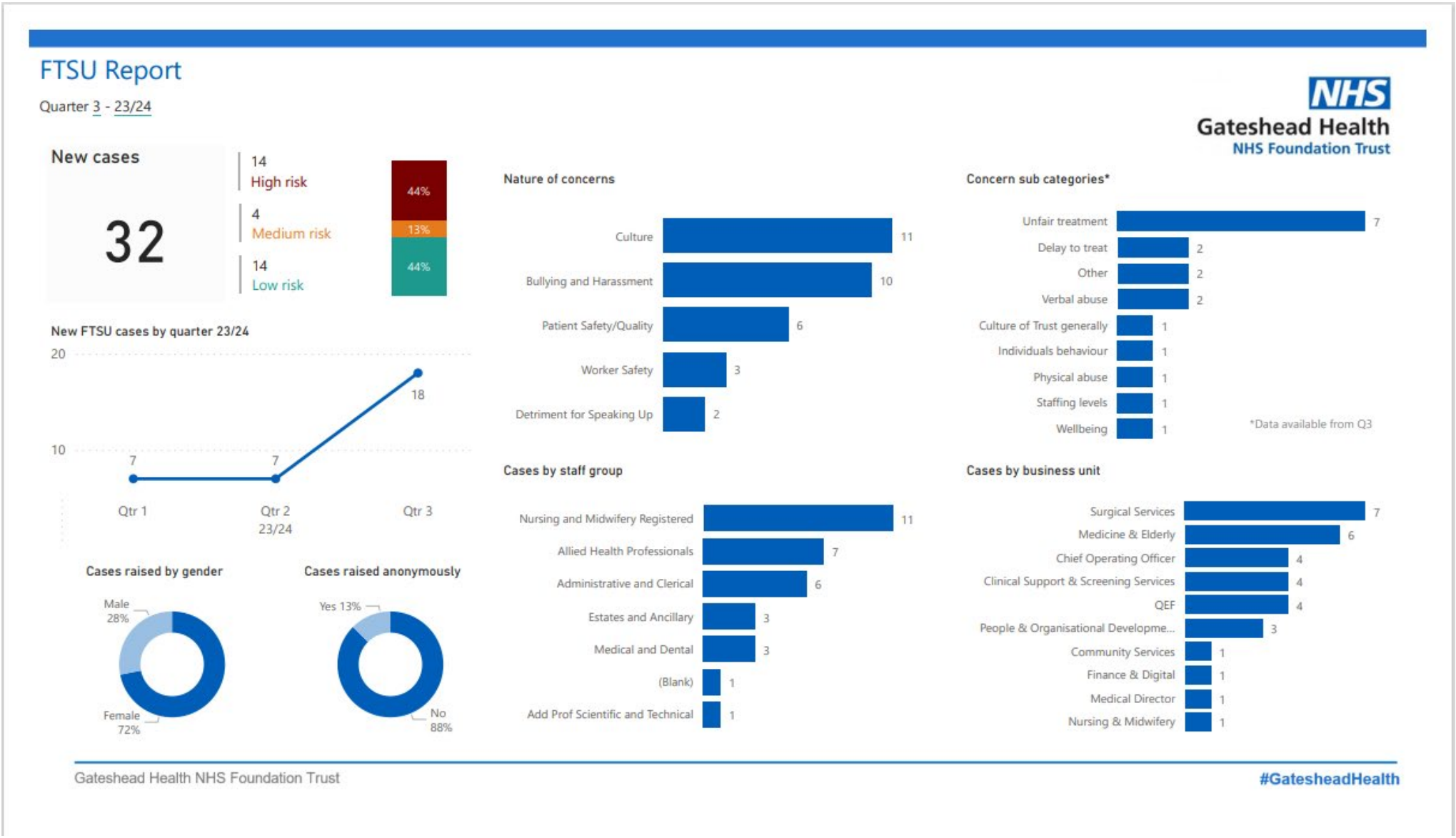
3.1 Q1-Q3 2023-24

Please see Appendix 3 for Q1 and Q2 reports. 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 shows an oversite of the FTSUG cases from Q1-Q3 with the added information fields from Q3 only (since changes in data collection has been made).

3.2 Q1 and Q2 had both 7 cases raised which within that period in Q3 we have had 18 cases raised which is an increase of 157%. This increase could be secondary to the promotion of the service and introduction of the FTSUG as well as the work which the executive team are undertaking to promote the FTSU culture. There is an expectation that case numbers will continue to rise with if staff continue to gain confidence in raising concerns and see actions / follow up from the concerns they have raised enabling a more open and transparent culture. The current data demonstrates that there is a split of 81.25% which are concerns raised about staff – culture, bullying and harassment, treatment at work etc. The other 18.75% concerns raised is directly about patient safety. 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. There is a distribution across areas of the Trust of concerns raised however moving forward the data will be broken down further to specific areas when concerns are raised to help identify hot spot areas within Business Units to support managers to be able to identify these areas and follow up with improvements.

Table 1:


FTSU Report
Quarter 3 - 23/24
NHS
Gateshead Health
NHS Foundation Trust
New cases
32
14
High risk
4
Medium risk
14
Low risk
44%
13%
44%
Nature of concerns
Culture 11
Bullying and Harassment 10
Patient Safety/Quality 6
Worker Safety 3
Detriment for Speaking Up 2
Concern sub categories*
Unfair treatment 7
Delay to treat 2
Other 2
Verbal abuse 2
Culture of Trust generally 1
Individuals behaviour 1
Physical abuse 1
Staffing levels 1
Wellbeing 1
*Data available from Q3
New FTSU cases by quarter 23/24
20
10
7
7
18
Qtr 1
Qtr 2
23/24
Qtr 3
Cases by staff group
Nursing and Midwifery Registered 11
Allied Health Professionals 7
Administrative and Clerical 6
Estates and Ancillary 3
Medical and Dental 3
(Blank) 1
Add Prof Scientific and Technical 1
Cases by business unit
Surgical Services 7
Medicine & Elderly 6
Chief Operating Officer 4
Clinical Support & Screening Services 4
QEF 4
People & Organisational Developme... 3
Community Services 1
Finance & Digital 1
Medical Director 1
Nursing & Midwifery 1
Cases raised by gender
Male 28%
Female 72%
Cases raised anonymously
Yes 13%
No 88%
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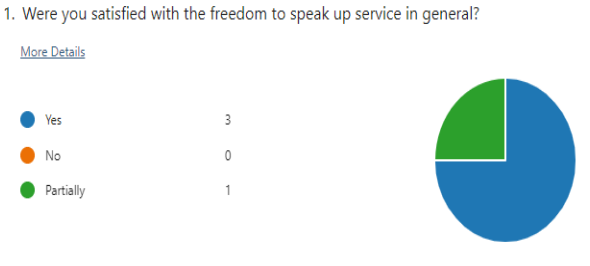
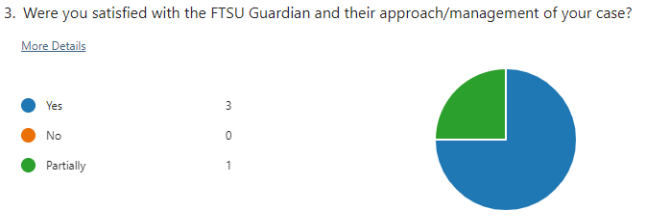
#GatesheadHealth

See below some further information from cases in Q3:

3.3 All cases have been discussed with the appropriate Senior Manager and Deputy CEO / Chief Nurse. Since writing this report there is 10 cases closed and feedback requested, 2 cases on hold due to staff circumstances, and 6 cases still open.

3.4
An Audit was requested following guidance from NHSE/I and the ICB regarding the FTSU services in Trusts, it was found a formal feedback process for the serviced was required. A report was completed regarding audit results and presented to Trust board prior to being submitted o ICB 19/12/2023. (See appendix 1). Following this process, we currently have 4 Feedback responses out of the 10 closed cases in Q3. (All 10 cases were asked to complete response).
Please see below responses:





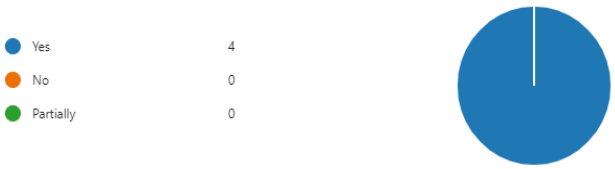
4. If partially/no, what could help to improve this?

1 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.

5. Were you happy your concern was raised correctly?

More Details



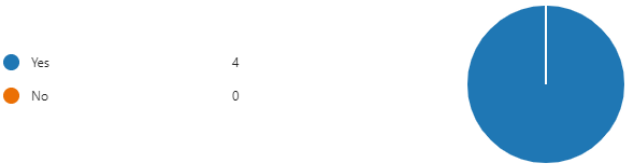
6. If partially/no, what would you suggest be done differently?

0
Responses

Latest Responses

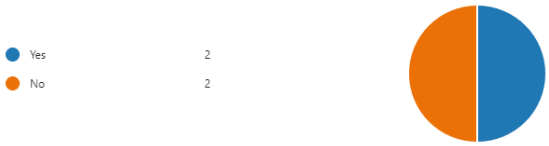
7. Did you receive updates and feedback as agreed when you met with the FTSUG?

More Details



8. Were you satisfied that the Trust followed up on your concerns and gave an appropriate response / action taken?

More Details



9. If no, what would have helped to change this?

2 Responses

ID ↑	Name	Responses
1	anonymous	I think the feedback was escalated correctly but I've not had official feedback from the trust. I was told that it was being addressed but unsure of how or what the outcomes of this were? Unsure if I needed to have the outcomes?
2	anonymous	For the executives to act openly and honestly regarding the Trusts performance

(Please note that question two answers have not been included in the report to maintain staff confidentiality).

4. Guardian Activity:

4.1 National update:
The Speaking Up data from Q2 2023/24

- 7,173 speak up cases were raised with guardians in Q2 2023/24; an 8% increase in the number of cases reported compared to the previous quarter (6,673 cases) and a 16% increase compared to the same quarter last year.
- Just under two-fifths of cases (36%) included an element of inappropriate behaviours and attitudes (other than bullying and harassment) and almost one third of cases (32%) included an element of worker safety or wellbeing.

- Almost one-fifth of cases (20%) included an element of patient safety, an increase from 17% in the previous quarter.
- 19% of cases included an element of bullying and harassment, a decrease from 21% in the previous quarter.
- 1 in every 25 cases (4%) reported to Guardians are from workers indicating that they have suffered detriment after speaking up.
- Full Annual report available on the NGO website for 2022/23.

4.2 During Q2 the previous FTSUG had 7 cases which have all now been closed. In Q3 the new FTSUG has had 130 meetings / contacts 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.

4.3 The FTSUG has developed training packages / materials for education and training at different levels. Delivering this training to numerous management teams.

4.4 FTSUG has joined the Culture Board and is actively working with all the different workstreams, including zero tolerance, show racism the red card development of bystander training.

4.5 Q2 activity has been submitted to the NGO database by the previous FTSUG and new FTSUG had worked collaboratively with data analyst to review and change the comprehensive log of activity to ensure moving forward we have more robust processes for monitoring of data to identify themes, trends and hotspots. (Table 1). This will continue to be developed if we gain a FTSU system which will allow different managers / leaders to input any concerns they have had raised and managed at a local level to demonstrate areas of proactive management.

4.6 New FTSUG has attended all staff forums and started working with international recruitment onboarding program to promote the role and importance of staff having a voice this has been positive as a link for the forums but also had staff raise concerns following some of these sessions.

4.7 FTSUG has started to engage with other key stakeholders across the Trust to build support network for staff raising concerns to ensure a wraparound support network, including Occupational Health, POD wellbeing services and PNA teams.

4.8 FTSUG has continued to be actively involved in staff induction, medical staff induction and now junior staff forums, as well as “managing well” programme which has been adapted to current requirements.
FTSUG is also working collaboratively with POD team to also be involved in the “leading well” programme in future cohorts.

4.9 FTSUG has attended the monthly Northeast and Cumbria Regional Meetings in this reporting period and will continue to attend the new sector Northeast, Cumbria, and Humberside meetings. FTSUG has been asked to be vice chair for regional meeting moving forward (awaiting induction).

4.10 A mapping process has taken place for FTSU data looking at how many different places and people concerns are currently raised to. Also, how this data is

then captured and where it is or is then not reported. This mapping will be used to inform part of the business case for an electronic centralised FTSU system.

4.11 Further development of intranet site for FTSU will be undertaken as a resource for staff and managers to access.

4.12 Development of Microsoft teams site for education and training for FTSU champions as well as an discussion forum for the Guardian and Champions.

4.13 Further Comms work to be undertaken as per plan in Appendix 3.

4.14 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.

4.15 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.

5. Recommendations:

5.1 Previous FTSU reports have been submitted to Board and committee as assurance on FTSU however due to change in FTSUG and developments which are underway but still ongoing for the FTSU service the Board and committee are asked to receive this report as partial assurance of FTSU service and broader activity.

5.2 The committee is asked to note that some concerns (10 out of 18) have been raised in this reporting period have been raised, investigated, and closed and take assurance the cases which are still open are being actively managed or monitored.

5.3 The committee are asked to note current Board member training compliance and support completion.

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 support the procurement of a FTSU system which is fit for purpose and will allow much wider capture of data and support staff to raise concerns and build confidence in the service.

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 FTSUG has taken feedback from the People OD committee, /QGC and any feedback from Trust Board regarding the report for future presentation and we have already started to collect more specific data fields to allow future reports to give the Board assurance we have a clear understanding of key themes, trends, and hotspots.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 22i

Report Title:	**Maternity Integrated Oversight Report – February 2024**			
Name of Meeting:	Part 1 Board of Directors			
Date of Meeting:	27th March 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 January 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*	This paper has been considered by the departmental Safecare, SafeCare, Risk and Patient Safety Council			
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 February 2024, we had 141 births, 0 serious incidents (SI's), 0 HSIB cases and 0 perinatal losses. • Exceptions reported – positive outlier for SATOD (smoking at time of delivery) and Induction of Labour rates **Mortality and morbidity rates:** • 0 perinatal loss during February 2024 • 0 HSIB cases • 0 Serious Incidents **MBRRACE 2022 perinatal mortality report** • Stabilised & adjusted perinatal mortality rate remains similar to our lower than similar sized units **Q3 ATAIN report:** • 25 term admissions to SCBU – reviewed & appropriate admissions • 46 babies avoided SCBU with transitional care			

	Members of the Safecare/Risk and Safety Council are asked to review the detail provided within this report for assurance.				
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:					
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)					
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 February 2024

Maternity IOR contents

- Maternity Dashboard 2023/24:
  - February 2024 data

- Exception reports:
  - Emerging risk 3355
  - MBBRACE perinatal mortality report 2022

- Items for information:
  - Perinatal Quality Surveillance minimum dataset
  - Incidents
    - No SIs reported in February 2024
    - No HSIB cases reported in February 2024
  - Perinatal Mortality and Morbidity
    - 0 perinatal losses in February 2024
  - Q3 complaints summary
  - Q3 Transitional care/ATAIN report

Maternity Oversight Report SPC Tool

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Births	Feb 24	141	-			153	114	193
Spontaneous vaginal deliveries	Feb 24	66	-			78	57	98
Assited births	Feb 24	75	-			76	48	103
Induction of Labour	Feb 24	53.00	-			65	44	87
Maternity Readmissions	Feb 24	3	-			3	-3	8
Neonatal Readmissions	Feb 24	6	-			5	-2	12
Smoking at time of booking	Feb 24	9.52%	15.00%			10.30%	4.21%	16.39%
Smoking at time of delivery	Feb 24	8.15%	6.00%			9.21%	2.34%	16.07%
In area CO at booking	Feb 24	92.06%	90.00%			85.56%	74.82%	96.30%
In area CO at 36 weeks	Feb 24	89.47%	80.00%			81.96%	72.66%	91.27%
Admitted directly to NNU (SCBU) (>37 weeks)	Feb 24	4	4			5	-2	13
Percentage Admitted directly to NNU (SCBU) (>37 weeks)	Feb 24	3.10%	6.00%			3.65%	-0.95%	8.25%
Preterm birth rate <=36+6 weeks at birth	Feb 24	8.51%	6.00%			5.98%	1.71%	10.25%
Continuity of Carer: Percentage placed on pathway (29 w	Feb 24	13.29%	-			18.05%	9.82%	26.28%
Continuity of Carer: Percentage from BAME backgrounds	Feb 24	39.13%	-			29.71%	1.21%	58.20%
Spontaneous Vaginal Births (%)	Feb 24	46.81%	-			50.95%	37.41%	64.50%
Induction Rate	Feb 24	38.41%	-			43.24%	30.80%	55.68%
Instrumental Delivery Rate	Feb 24	15.94%	-			12.14%	3.58%	20.71%
Elective C Section Rate	Feb 24	20.57%	-			18.62%	9.35%	27.90%
Emergency C Section Rate	Feb 24	17.02%	-			18.14%	7.24%	29.05%
C Section Rate	Feb 24	37.59%	-			36.77%	22.48%	51.06%
3rd or 4th degree tear (Total) Precentage	Feb 24	1.45%	5.00%			1.45%	-1.81%	4.71%
Massive PPH >=1.5L (All births)	Feb 24	9	2			9	1	16
Breastfeeding: Percentage of Initiated Breasfeeding	Feb 24	73.19%	66.20%			70.56%	54.07%	87.05%
Breastfeeding: Breasfeeding at Discharge (Transfer to Co	Feb 24	50.35%	56.20%			51.86%	38.99%	64.74%

Safe

Responsive

Maternity

Gateshead Health NHS Foundation Trust

Maternity Dashboard 2023/24

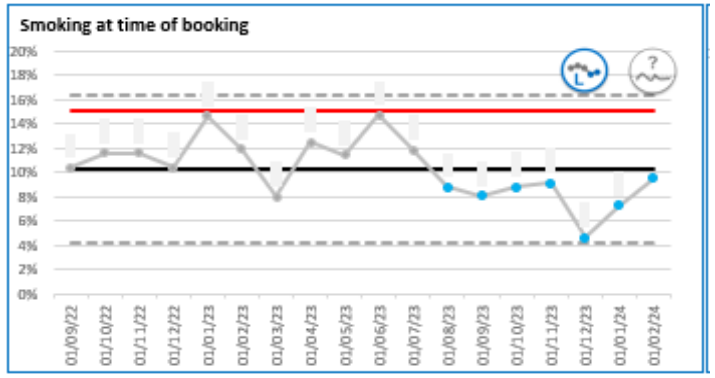
Maternity Dashboard 2023/24

Maternity

Gateshead Health NHS Foundation Trust

Safe

Responsive



- **Background**
  - Element 1 of Saving Babies Lives Care Bundle – reducing smoking in pregnancy
- **Assessment**
  - Positive SPC outlier due to decreasing smoking rates
  - Continued low rate of SATOD
  - CO target at booking of 90% & 36 weeks of 80% reached for MIS compliance
- **Actions**
  - Further audits underway to improve CO monitoring at every contact for smokers – newly implemented in August 2023 – baseline 25% compliance
  - Ongoing business case for continued funding of tobacco service – at risk for future compliance with maternity safety requirements if service no longer in place
- **Recommendations**
  - Continue to monitor all smoking in pregnancy metrics associated with MIS & SBLCB

Maternity Dashboard 2023/24

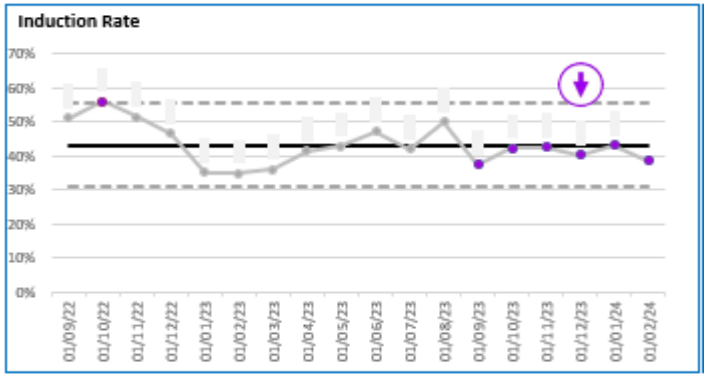
Maternity

NHS

Gateshead Health
NHS Foundation Trust

Safe

Responsive



- **Background**
  - Induction of labour flagged as positive outlier
  - There is no “target” for IOL but useful indicator for workforce planning if flagged as high
- **Assessment**
  - Low flag of no significance
- **Actions**
  - Continue to monitor & review any sustained high rates
- **Recommendations**
  - No further action required

Emerging risk 3355

Maternity

NHS Gateshead Health NHS Foundation Trust

Safe

Responsive

- **Background**
  - The ventilation system in the delivery rooms on labour ward does not provide enough air changes to remove Entonox from the atmosphere and staff are therefore exposed to higher than acceptable levels when caring for a woman using Entonox for long periods of time.
  - Previously on risk register as Trust-wide risk but following exposure testing – maternity is the only area identified as posing higher exposure risk for staff
- **Assessment**
  - Risk to staff has been highlighted in national media reports and litigation cases, as well as via RCM
  - Exposure testing performed for labour ward staff in Summer 2023
  - Staff on labour ward are potentially being exposed to higher than acceptable levels if caring for women using Entonox for long periods of time
  - Exposure levels for community staff attending homebirths have not been measured
- **Actions**
  - Added to Maternity risk register
  - Work underway to establish if portable units are a reasonable solution for Labour Ward and community staff
  - Ensure staff are using all current available mitigations – windows open if appropriate, correct positioning in room, adequate breaks, room ventilation in use
- **Recommendations**
  - Potential requirement to identify funding to address the risk to be noted

MBRRACE 2022 report

Maternity

NHS
Gateshead Health
NHS Foundation Trust

Gateshead Health NHS Foundation Trust

MBRRACE-UK perinatal mortality report: 2022 births

This report concerns stillbirths and neonatal deaths among the 1,733 babies born within your Trust in 2022. It includes details of the stillbirths and neonatal deaths for births that occurred in your Trust in 2022, as well as background information on all births.

- Birth numbers are obtained from routine data sources and may not match locally recorded numbers.
- Births before 24 completed weeks gestational age and all terminations of pregnancy are EXCLUDED.
- Neonatal deaths are reported by place of birth, irrespective of where the death occurred, as denominator data on the place of care is not available for all births

Key messages

All deaths

1. Your stabilised & adjusted stillbirth rate is **3.23 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.
2. Your stabilised & adjusted neonatal mortality rate is **0.94 per 1,000 live births**. This is lower than the average for similar Trusts & Health Boards.
3. Your stabilised & adjusted extended perinatal mortality rate is **4.18 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.

Excluding deaths due to congenital anomalies

1. Your stabilised & adjusted stillbirth rate excluding deaths due to congenital anomalies is **3.14 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.
2. Your stabilised & adjusted neonatal mortality rate excluding deaths due to congenital anomalies is **0.68 per 1,000 live births**. This is lower than the average for similar Trusts & Health Boards.
3. Your stabilised & adjusted extended perinatal mortality rate excluding deaths due to congenital anomalies is **3.81 per 1,000 total births**. This is around the average for similar Trusts & Health Boards.

Full details of your perinatal mortality rates can be found on page 2.

Recommended actions

The stabilised & adjusted mortality rates for your Trust were similar to, or lower than, those seen across similar Trusts and Health Boards. However, if the aspiration of your Trust is to seek rates comparable with the best performing countries, for example those in Scandinavia, ensure that a review using the Perinatal Mortality Review Tool (PMRT) has been carried out for all the deaths in this report to assess care, identify and implement service improvements to prevent future similar deaths.

Perinatal mortality (all deaths)

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	6	3.46	3.23	(2.43 to 3.91)	Up to 5% higher or up to 5% lower
Neonatal	0	0.00	0.94	(0.39 to 1.87)	More than 5% and up to 15% lower
Extended perinatal	6	3.46	4.18	(3.21 to 5.44)	Up to 5% higher or up to 5% lower

Perinatal mortality (excluding deaths due to congenital anomalies)

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	6	3.46	3.14	(2.46 to 3.60)	Up to 5% higher or up to 5% lower
Neonatal	0	0.00	0.68	(0.23 to 1.35)	More than 5% and up to 15% lower
Extended perinatal	6	3.46	3.81	(3.09 to 4.65)	Up to 5% higher or up to 5% lower

Comparisons with similar Trusts and Health Boards

Your estimated stabilised & adjusted mortality rate for each type of death has been compared with the average mortality rate for Trusts and Health Boards in the same comparator group and is shown below as a coloured circle:

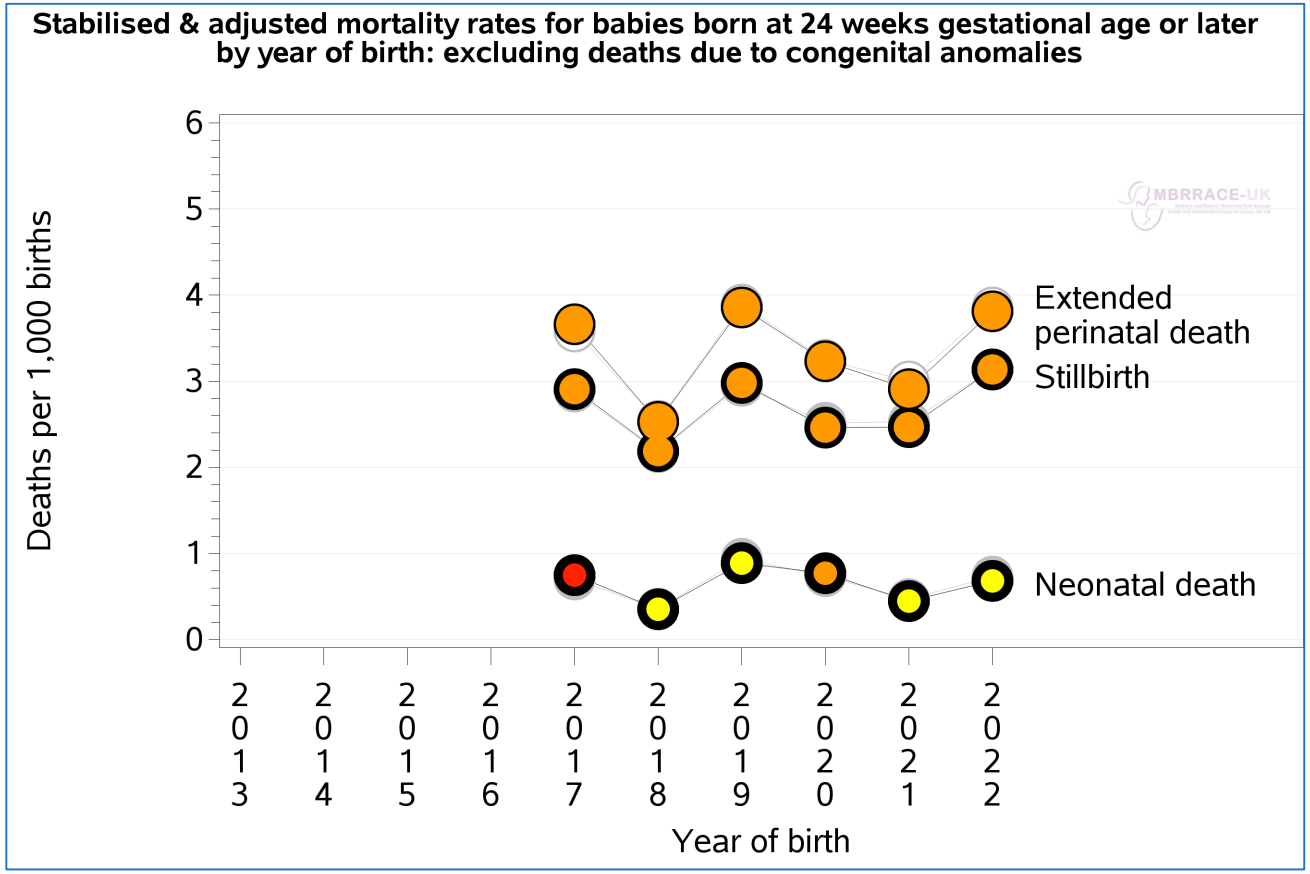
- more than 15% lower than the average for the group
- more than 5% and up to 15% lower than the average for the group
- up to 5% higher or up to 5% lower than the average for the group
- more than 5% higher than the average for the group

Trusts and Health Boards whose mortality rates are marked ● or ● should carry out an initial investigation of their data quality and possible contributing local factors that might explain the high rate. Irrespective of where they fall in the spectrum of national performance all Trusts and Health Boards should use the national PMRT to review all their stillbirths and neonatal deaths.

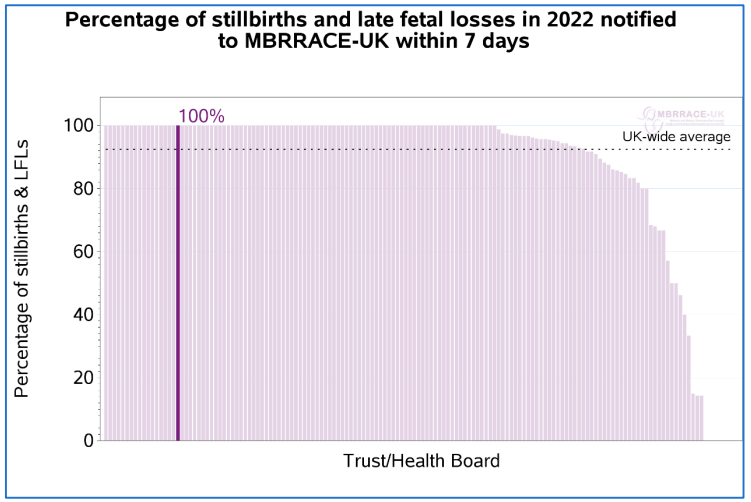
MBRRACE 2022 report

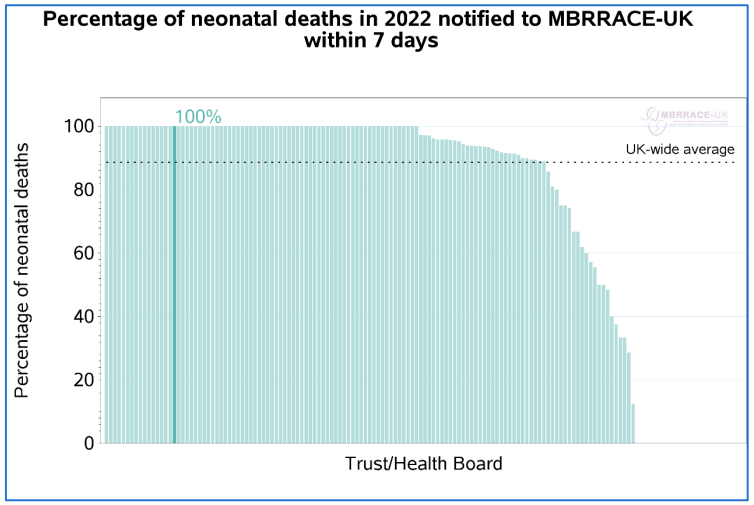
Maternity

Gateshead Health NHS Foundation Trust



- **Background**
  - 2022 stabilised & adjusted mortality rates (excluding congenital abnormalities) are similar to or lower than similar sized Trusts
- **Assessment**
  - Mortality data is checked for accuracy prior to publication of the annual MBRRACE-UK reports
  - 100% of eligible deaths were reported to MBBRACE within 7 days
  - All eligible deaths undergo PMRT review & learning is reported quarterly to Mortality & Morbidity steering group & a summary in Maternity IOR
  - 100% of families were offered a post-mortem, compared with 98% UK-wide
  - 66.7% of stillbirths were graded with an unknown cause of death, compared to 33.9% UK-wide
- **Actions**
  - Further investigation for data quality or contributing factors is recommended for Trusts with higher than average morbidity rates
  - Review of cases to understand of cause of death
- **Recommendations**
  - Explore cause of death categorisation – medical examiner support?





Maternity

NHS Gateshead Health NHS Foundation Trust

Cause of death

The tables below describe the cause of death reported to MBRRACE-UK for stillbirths which occurred in your Trust and for neonatal deaths of babies who were born in your Trust. They are listed by the primary categories of the 'Cause Of Death & Associated Conditions' (CODAC) system of death classification.

Congenital anomaly is reported as the cause of death for all deaths where a congenital anomaly is coded as either the primary cause of death or an associated condition.

In order to ensure accurate, consistent reporting using the CODAC system of death classification, Trust and Health Board Perinatal Review groups should focus on the quality of cause of death coding.

			Infection		Neonatal		Intrapartum		Congenital anomaly		Fetal	
Stillbirths	Your Trust	% (N)	0.0%	(0)	0.0%	(0)	0.0%	(0)	0.0%	(0)	0.0%	(0)
	UK-wide	%	3.2%		1.4%		1.3%		8.3%		3.8%	
Neonatal Deaths	Your Trust	% (N)										
	UK-wide	%	6.6%		42.8%		1.8%		33.7%		3.9%	

			Cord		Placental		Maternal		Unknown		Missing	
Stillbirths	Your Trust	% (N)	0.0%	(0)	16.7%	(1)	16.7%	(1)	66.7%	(4)	0.0%	(0)
	UK-wide	%	5.3%		36.3%		3.2%		33.9%		3.4%	
Neonatal Deaths	Your Trust	% (N)										
	UK-wide	%	0.3%		3.0%		0.3%		5.8%		1.9%	

Well Led

Safe

Maternity

Gateshead Health NHS Foundation Trust

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

2. Saving Babies Lives v3 compliance Q3 2022/23 71% compliance	**Maternity Incentive Scheme Q3 2023/24 Updated January 2024**	
Element 1:	Safety Action 1 (PMRT):	Safety Action 6 (SBL Care Bundle):
Element 2:	Safety Action 2 (MSDS):	Safety Action 7 (MVP):
Element 3:	Safety Action 3 (ATAIN):	Safety Action 8 (Core Competency Framework):
Element 4:	Safety Action 4 (Clinical Workforce Planning):	Safety Action 9 (Trust Board Oversight):
Element 5:	Safety Action 5 (Midwifery Workforce):	Safety Action 10 (HSIB & ENS):
Element 6:		

North East and North Cumbria
Local Maternity and Neonatal System

Complaints: Q3 23/24 current position

Maternity

NHS
Gateshead Health
NHS Foundation Trust

Final primary subject	Final sub-subject	Lessons learnt	Actions taken
Communication	None	Ensure appropriate pathways following bereavement	Feedback meeting held with family Messages shared with staff
Communication	Clear post-birth neonatal plans & risk assessment taking into account all antenatal findings	Clear communication with parents & other care providers	Feedback meeting held with family Patient story shared at Safecare & wider Trust
Staff attitude	Communication	Information provision around risks in a timely/sensitive manner	Feedback to staff involved
Communication	None	Sensitive documentation for patients choosing individualised care planning	Agreed wording for supporting informed choices conversations
Staff attitude/communication	None	Effective listening to women re own experience of pain	Apology & individual reflection

2023/24		April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Number of perinatal losses		0	1	2	0	0	0	0	1	1	1	0	
Number of HSIB cases		0	0	0	0	0	0	0	0	0	0	0	
Number of incidents logged as moderate harm or above		0	1	3	1	2	1	0	0	0			
Minimum obstetric safe staffing on labour ward		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Minimum midwifery safe staffing including labour ward (average fill rates)	Day shift	135.30%	161%	156.10%	155.20%	Staffing establishment alignments under review with nursing workforce lead			113.6%	103.2%	121.9%		
	Night shift	107.90%	108.10%	104.10%	101.70%				102.2%	106.8%	106.5%		
	CHP PD*	21.6	20.6	21.2	20.6				19.5	16.6	18.6		
Service user feedback	FFT “Overall how was your experience of our service” – total score for *very good* and *good* responses	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
	Complaints	0	0	1	0	1	3	2	0	0	2	3	
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust		0	0	0	0	0	0	0	0	0	0	0	
Coroner Reg 28 made directly to Trust		0	0	0	0	0	0	0	0	0	0	0	

ATAIN- Avoiding term admissions to SCBU

Q3 2023/24 Total births	Births >37 weeks	Total term admissions	Reasons for admission
485	325	25 (5.2%)	Respiratory symptoms (84% of admissions) Possible sepsis
		Total transitional care	**Reasons for admission**
		46 (9.5%)	Low birth weight, infection/prevention, preterm

In Q3 46 babies avoided SCBU admission through TC

25 Term infants admitted to SCBU

Item No	Link to ATAIN admission criteria	Learning	Action
1	Discrepancies between dashboard & neonatal Badger data		Ongoing work with data team to scrutinise, correct & understand data
2	84% babies admitted with respiratory symptoms	Cord blood gases not always taken when indicated (CTG concerns/admissions from theatre)	Safety messages reminder
3		Delay in paediatric reviews	Case presentations to perinatal meeting
4		68% babies admitted with respiratory symptoms born by caesarean section	Audit focussing on SCBU admissions for babies born by LSCS – to include parental counselling re risks od SCBU admission, antenatal steroids
	Gradually evolving hypoxia	Delayed recognition of rise on CTG baseline	CTG identified for use in monthly MDT CTG teaching/discussion sessions
5	Prevention of deterioration	Excellent recognition, escalation & documentation of unwell baby when attended PAU with mother	Case presentation to perinatal meeting
6	Improvement in optimisation	Delayed cord clamping – 92% First feed within 1 hour – 32%	Continue focus on early feeding – MSWs to labour ward for golden hour support
7	Documentation	Inconsistencies with resuscitation, admission, paediatric review documentation, gaps in daily reviews & SBAR handovers	Identify neonatal digital lead (current lead leaving), implement documentation audits

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 22ii

Report Title:	**Bi-annual midwifery staffing report – Q2 and Q3 2023/24**			
Name of Meeting:	SafeCare, Risk and Patient Safety Council			
Date of Meeting:	26th March 2024			
Author:	Karen Parker Head of Midwifery Claire Cameron Matron			
Executive Sponsor:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals			
Report presented by:	Karen Parker, Head of Midwifery			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☒
	This report is presented to inform Safecare council that the required staffing review has been completed within maternity and the results are now being aligned with the funded establishments,			
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*	No other meetings			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	Midwifery staffing is required to be reported on a 6-monthly basis including some specified red flags events. Significant work has taken place to understand and align midwifery budgeted establishments and current workforce. Birthrate+ workforce assessment is currently in progress – report anticipated by end of March 2024.			
Recommended actions for this meeting:	Members of the Safecare/Risk and Safety Council are asked to review the detail provided within this report for			

<table>
<tr><td>Outline what the meeting is expected to do with this paper</td><td colspan="5">information. A further detailed midwifery staffing report will follow with recommendations from Birthrate+ workforce assessment.</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">SA1.1: Continue to improve our maternity services in line with the wider learning from the Ockenden review

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="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">2928 – midwifery theatre scrub staffing

3158 - safe obstetric theatre staffing (HCAs)

3252 – neonatal nursing/ANNP safe staffing</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>

Bi-annual midwifery staffing report – Q2 and Q3 2023/24

1. Executive Summary

1.1.
The purpose of this report is to provide the Board with an overview of midwifery staffing and give assurance that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels

1.2.
The report covers the period of Q2 and Q3 of 2023/24.

1.3.
This report will in part fulfil the aims of the Maternity Incentive Scheme (Year 5) and the Three Year Delivery Plan for Maternity and Neonatal Services (2023).

1.4.
This is also aligned to the Trust objectives for growing and developing our workforce and the “staff experience” Quality Account objectives for 2023/24.

1.5.
The service is currently undergoing a Birthrate+ midwifery workforce assessment – a further staffing paper will be presented following receipt of this assessment (anticipated by end of March 2024).

1.6.
Significant work has been undertaken by the service supported by finance to understand current funded establishment. There appears to be a significant overspend and therefore any further VCF approvals, including cover of maternity leaves has been suspended pending Birthrate+ outcome

1.7.
The service is seeing a growth in birthing numbers and a separate report will follow detailing increases in births seen over the latter part of 2023/into 2024, impact on safe staffing levels, antenatal clinic waits and including service user voice to understand why birthing people are choosing Gateshead.

2. Introduction

2.1.
Safety Action 5 of the Maternity Incentive Scheme requires that:

a	A systematic, evidence-based process to calculate Midwifery staffing establishment is completed (BirthRate+)
b	Trust Board to evidence Midwifery staffing budget reflects establishment as calculated above
c	The Midwifery Coordinator in charge of Labour Ward must have supernumerary status

d	All women in active labour receive one-to-one Midwifery care
e	A Midwifery staffing oversight report that covers staffing/safety issues is shared with the Trust Board every 6 months

2.2
Our last Birthrate+ assessment (completed in 2021) recommended the following staffing establishments:

2021 Birth Rate BR Recommended wte	**91.72wte**
Specialist roles	**9.52wte**
Total wte	**101.24wte**

2.3
The Birthrate+ recommended total clinical establishment does not include the following roles:

- Head of Midwifery, Matrons/managers with additional hours for team leaders to participate in strategic planning and wider Trust business
- Additional time for Specialist Midwives to undertake audits, training of staff, etc.
- Practice Development/Informatics
- Supervision – PMA role
- Clinical Governance

2.4
The department is currently undergoing a repeat Birthrate+ assessment (report anticipated March 2024)

3. Key issues / findings

3.1.
Current position WTE (End of Q3/December 2023)*

Registered Midwives Maternity location	Actual in post	Establishment	Variance	2021 BR+ recommended	Variance
Maternity Inpatient RM total	**63.33**	**70.09**	**-6.76**	**91.72**	**+3.29**
Community RM total	**31.68**	**23.65**	**+8.03**		
RM total	**95.01**	**93.74**	**+1.27**		
Specialist midwives	**10.89**	**3.28**	**+7.61**	**9.52**	**+1.37**
Overall RM total	**105.9**	**97.02**	**-8.88**	**101.24 (-4.22)**	**+4.66**

3.2.
*Departmental vacancies and funding audit - staffing establishments and funding streams have undergone significant review since the previous staffing report with midwifery staff aligned to acute and community teams. Current midwifery workforce in post ensures that we are compliant with the safe staffing levels recommended by the 2011 Birthrate+ assessment.

3.3.
Maternity theatre scrubbing – a business case was approved in 2022 for training of theatre assistant practitioners to eventually remove midwives from theatre scrub role. This is subject to further discussions to ensure appropriate qualified staff accountability. Obstetric theatre work requires a separate theatre team to fulfil scrub, anaesthetic and HCA roles – this is not currently funded.

3.4.
Infant feeding midwife – the infant feeding role (band 7, 0.8WTE) was funded as a temporary secondment by the LMNS to support accreditation of Stage 2 UNICEF Baby Friendly status. This was achieved by the service in October 2023. The service now has until December 2024 to achieve Stage 3 compliance. There is a need to identify funding for an infant feeding coordinator to ensure UNICEF accreditation within the timeframe and for compliance with the three-year maternity and neonatal national delivery plan.

3.5.
Minimum midwifery safe staffing

Minimum midwifery safe staffing including labour ward (average fill rates)		**Nov 2023**	**Dec 2023**	**Jan 2024**
	Day shift	**113.6%**	**103.2%**	**121.9%**
	Night shift	102.2%	106.8%	106.5%
	CHPPD*	19.5	16.6	18.6

4. Position/progress since last staffing report:

4.1
UNICEF stage 2 accreditation – using temporary infant feeding role, stage 3 accreditation to be completed by December 2024.
4.2
Maternity service activity – the service is undertaking a six-monthly review of activity in response to significant increases in births towards the latter part of 2023 and into 2024. Anecdotally, this appears to be aligned to challenges experienced by neighbouring maternity services, including closures of birthing unit, withdrawal of homebirth provision and negative CQC inspections. Analysis of data from births, prospective bookings, transfers of care during pregnancy and service user voice is being collated.

Births	2021/22	2022/23	2023/24*(to end February 2024)
QE	1851	1724	1701
Home	21	14	13

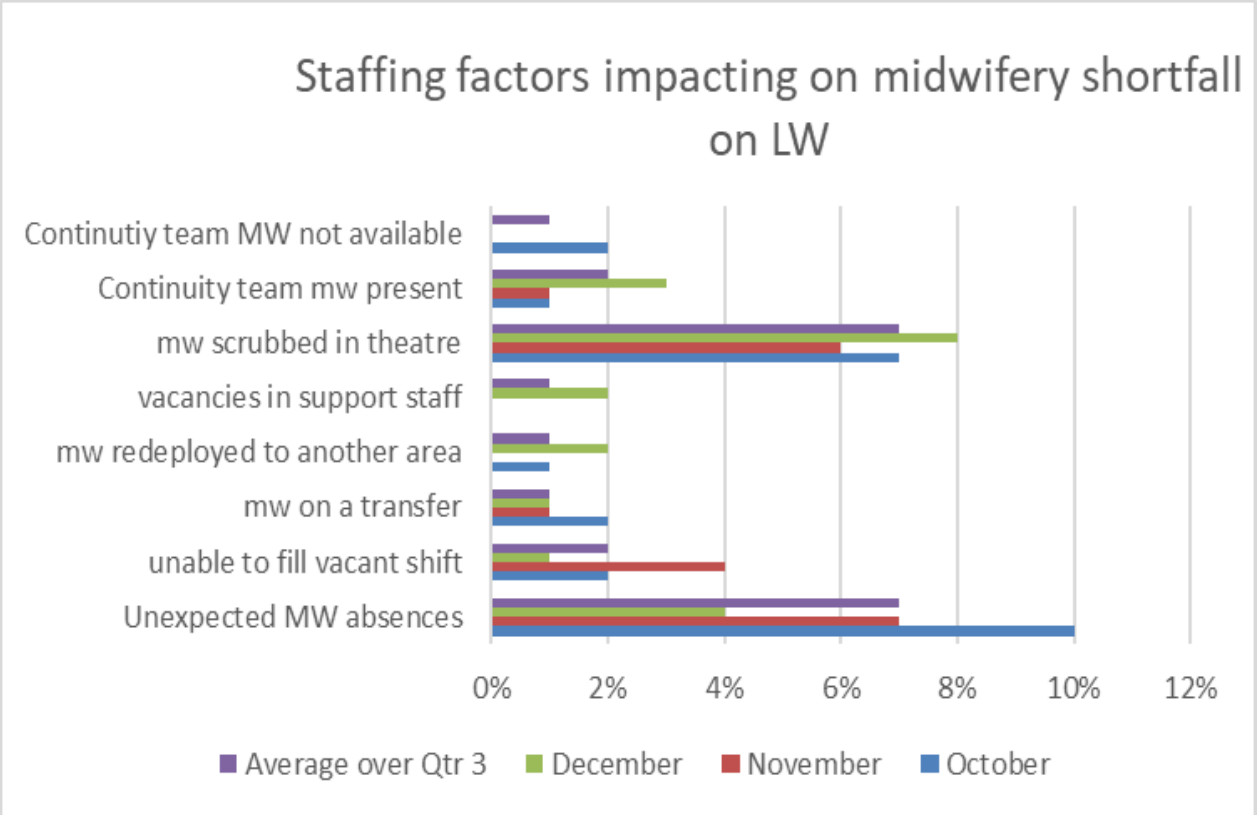
4.3

Midwifery staffing acuity:

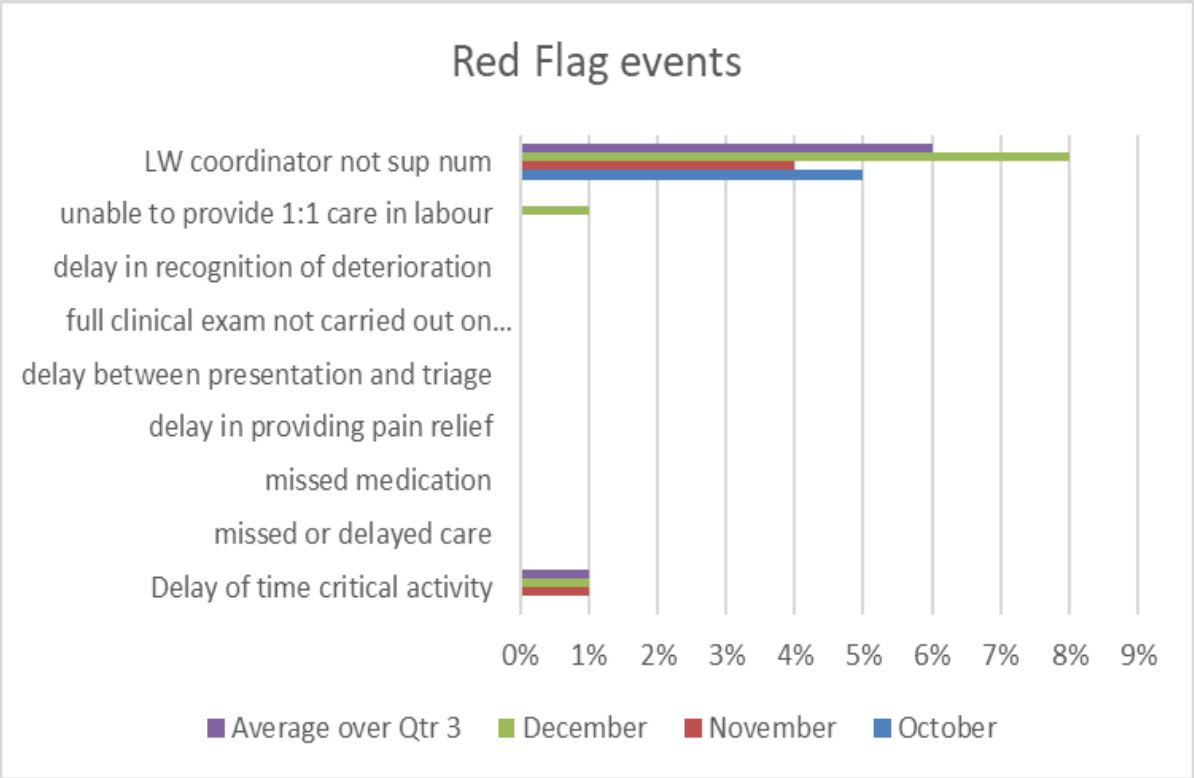
- The acuity tool is populated by the Labour Ward Coordinator. The aim is to capture workload on labour ward, including the level of care required for each patient based on how complex their care is (acuity) and match this against the midwifery staffing on the labour ward every 4 hours. The data is inputted into the tool which then calculates this workload and produces a flag based on the staffing levels, this follows a RAG rating system.

2023/24	Q4 2022/23	Q1	Q2	Q3
Staffing meets acuity	87%	86%	90%	82%
Short by up to 1 midwife	10%	7%	8%	12%
More than 1 midwife short	3%	7%	2%	6%

- The main staffing factors impacting on midwifery shortfalls were midwives scrubbed in theatre and unexpected absences



4.4
Red flag events – the main red flag event during Q3 was the supernumerary status of the labour ward coordinator which averaged at 6% non-compliance over the quarter. In 100% of the occasions when this occurred, the escalation plan was appropriately followed, the coordinator was never caring for a woman in labour and supernumerary status was achieved again within no longer than a few hours.



4.5
Managerial actions in response to red flag events and midwifery staffing acuity included redeployment to high acuity areas, utilisation of non-clinical and specialist staff, delays to elective work

4.6
Delays to IOL has decreased significantly from the same period last year, demonstrating the success of reconfiguration of the IOL pathway

4.7
Redeployment of staff to the antenatal/postnatal ward is becoming more frequent, suggesting that previous cultural barriers are shifting and areas are less likely to be working in silos. The twice-daily safety huddles remain a valuable time to ensure and predict safe staffing in all areas.

4.8
The on-call midwife was used 4 times during the quarter, totalling 1% of nightshifts. Whilst still infrequent, this totalled 24.75 hours of on-call support which is a significant increase on the previous two quarters.

4.9
During this period, there were a number of occasions when the regional (NENC) mutual aid and surge processes were activated due to pressures across the system. The QE were able to provide support on a number of occasions to other organisations.

5. Solutions / recommendations

5.1.
This report should be taken as the bi-annual midwifery staffing update. It is caveated with the ongoing work to align funding streams (both non-recurrent and additions to baseline establishments) with actual staffing posts.

5.2
A further staffing report will be prepared with the recommendations of the 2024 Birthrate+ midwifery workforce assessment

5.3
This report relates to midwifery staffing only. The acuity and numbers of birthing people receiving care from Gateshead Health is increasing with associated challenges for staffing groups across the multidisciplinary teams.

Gateshead Health NHS Foundation Trust

Report Cover Sheet **Agenda Item: 23i**

Report Title:	**Nursing Staffing Exception Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27th March 2024			
Author:	Andrew Rayner, Deputy Chief Nurse Laura Edgar, Head of Nursing Workforce			
Executive Sponsor:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Andrew Rayner, Deputy Chief Nurse			
Purpose of Report	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	This report is to provide assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis to provide adequate staffing levels.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by:				
Key issues:	This report provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls within the month of February 2024. February demonstrated areas with staffing challenges relating to sickness absence and some vacancies. During February 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 the			

<table>
<tr><td></td><td colspan="5">number of staffing incident reports raised through the incident reporting system.</td></tr>
<tr><td>Recommended actions for this meeting:</td><td colspan="5">The Board of Directors is asked to:
receive the report for assurance
note the work being undertaken to address the shortfalls in staffing</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☐</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5"></td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☐</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">There were three staffing incidences raised via InPhase during the month of February, of which there were no/low physical 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
February 2024

1. Introduction

This report details the staffing exceptions for Gateshead Health NHS Foundation Trust during the month of February 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 February 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 February 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 (%)**
90.9%	**109.1%**	**105.0%**	**112.4%**

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

Exceptions:

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

Safer Nursing Care Tool (SNCT) data collection is 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. Planned introduction of the new data collection

will commence April and September with the purpose of realigning to the bi-annual data collections once embedded.

Contextual information and actions taken

Ward 11 Winter escalation have demonstrated a reduced registered nurse fill rate for February. Ward 11 matron has reassured that there were redeployments made from other areas to support the shortfalls on ward 11, however all may not have been captured on the rostering system to reflect this. There were three red flags raised by the ward area all related to enhanced care requirements.

Cragside and Sunniside have demonstrated higher levels of healthcare support workers due to increased patient acuity and 1-1 observational care.

There were higher fill rates demonstrated in ward 8 to support the additional care of 12 telemetry monitors for patients within other ward areas of the Trust.

The exceptions to report for February are as below:

February 2024	
Registered Nurse Days	**%**
Ward 11 Winter	63.1%
Registered Nurse Nights	**%**
N/a	
Healthcare Support Worker Days	**%**
N/a	
Healthcare Support Worker Nights	**%**
N/a	

In February, 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 February, 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 February, the Trust total CHPPD was 8.3. This compares well when benchmarked with other peer-reviewed hospitals.

4. Monitoring Nurse Staffing via Incident Reporting system

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

A report of staffing concern related incidents is generated monthly and discussed at the Nursing Professional Forum. There were three staffing incidents raised via the incident reporting system. From these incidences, none relate to areas with reduced staffing fill rates in February.

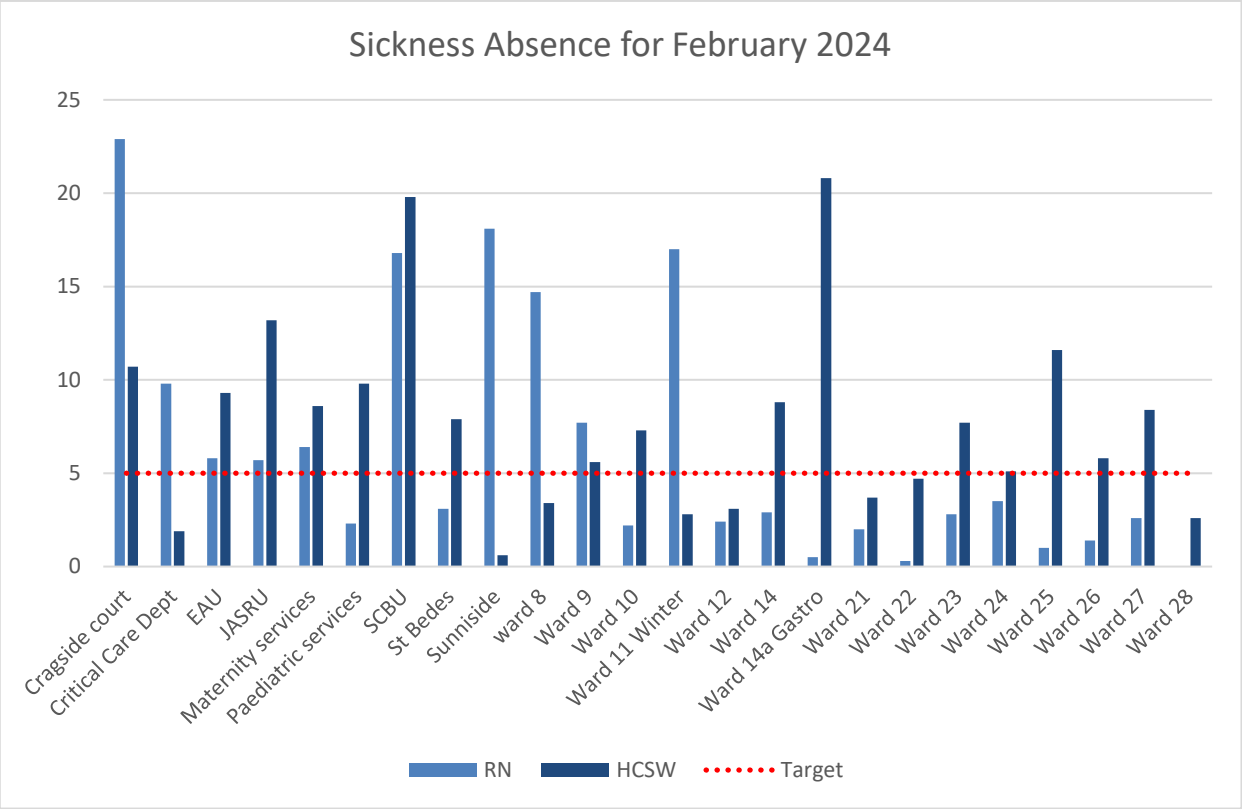
5. Nursing Red Flags

The National Institute for Health and Care Excellence (NICE) guideline for Safe Staffing for nursing in adult inpatient wards in acute hospitals (2014) recommend the use of nursing Red Flag reporting. A Nursing red flag can be raised directly as a result of rostering practice/shortfall in staffing or by the nurse in charge if they identify a shortfall in staffing requirements resulting in basic patient care not able to be delivered. Throughout the month of February there were 17 nursing red flags reported. This is compared to 19 red flags reported in January. Of those 17 Red flags raised, three of those were raised on ward 11 winter escalation where planned staffing levels fell below 75% during February.

Date	Shift type	Ward	Flag Type	Narrative
10/02/2024 20:10	Day	Ward 11 Winter Escalation	Temporary Staffing	X 3 patients needing 1-1 x2 females cohorted in a bay and X1 male in cubicle who is flu positive, off legs, confused and attempting to get out of bed. Only 2 RN and 2 HCA on night shift, escalated to senior nurse.
12/02/2024 08:12	Day	Ward 11 Winter Escalation	Missed 'intentional rounding'	2 areas enhanced care
21/02/2024 23:59	Night	Ward 11 Winter Escalation	Missed 'intentional rounding'	X4 patients needing 1-1 cohorted in female bay- high falls risk and attempting to get out of bed. X1 lady in cubicle needing 1-1 enhanced care due to high falls risk, confusion and I/P falls also attempting to wander. Escalated. short staffing.

6. Attendance of Nursing workforce

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



7. Governance

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

8. Conclusion

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

9. 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 February 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	78.1%	106.4%	92.8%	171.8%	256	6.5	9.6	16.1
Critical Care Dept	77.0%	125.0%	92.4%	89.8%	224	31.2	6.7	37.9
Emergency Care Centre - EAU	84.6%	111.0%	84.5%	122.6%	1249	6.6	4.4	11.0
JASRU	85.8%	78.2%	97.4%	142.3%	548	3.5	4.5	7.9
Maternity Unit	112.1%	120.1%	102.5%	97.9%	629	13.7	4.7	18.4
Paediatrics	123.0%	80.7%	111.6%		44	55.6	11.1	66.7
Special Care Baby Unit	80.7%	80.2%	109.8%	79.8%	117	13.9	4.2	18.0
St. Bedes	87.0%	102.0%	101.4%	100.5%	266	5.4	4.5	9.9
Sunniside Unit	76.3%	125.7%	95.4%	102.6%	198	7.0	6.2	13.3
Ward 08	98.5%	115.0%	139.6%	106.4%	599	3.9	3.4	7.3
Ward 09	89.8%	131.5%	108.8%	105.7%	717	2.8	3.1	5.9
Ward 10	80.8%	120.7%	102.4%	117.6%	654	2.8	3.3	6.1
Ward 11 Winter Escalation	63.1%	81.1%	112.4%	114.4%	701	2.7	3.0	5.7

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Ward 12	80.1%	99.6%	107.7%	110.7%	731	2.6	2.9	5.5
Ward 14 Medicine	88.8%	120.6%	123.2%	104.8%	720	2.9	3.1	6.0
Ward 14a Gastro	90.8%	102.8%	102.4%	105.7%	664	3.0	3.2	6.2
Ward 21 T&O	87.4%	128.4%	145.5%	141.4%	721	3.2	4.2	7.4
Ward 22	100.5%	105.3%	114.6%	98.4%	861	2.8	3.3	6.1
Ward 23	96.9%	121.9%	102.2%	96.9%	684	2.8	3.8	6.6
Ward 24	102.5%	99.3%	103.7%	98.5%	881	2.7	3.1	5.8
Ward 25	108.9%	81.4%	149.1%	118.2%	894	3.1	2.7	5.8
Ward 26	80.1%	123.8%	149.3%	132.1%	745	3.1	3.9	7.1
Ward 27	91.0%	118.0%	151.7%	108.8%	784	3.3	3.4	6.7
Ward 28	78.9%	111.1%	101.6%	78.2%	182	7.5	6.6	14.1
QUEEN ELIZABETH HOSPITAL - RR7EN	**90.9%**	**109.1%**	**105.0%**	**112.4%**	**14069**	4.6	3.7	8.3

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 24

Report Title:	**Board of Directors Cycle of Business 2024/25 (Part 1)**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 March 2024			
Author:	Jennifer Boyle, Company Secretary			
Sponsor:	Alison Marshall, Chair of the Board of Directors			
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 present the cycle of business for 2024/25 for approval.			
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*	• A cycle of business has been prepared for the Board of Directors for the forthcoming financial year. • This aligns with internal and external reporting requirements.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board of Directors requested to review and approve the cycle of business for the forthcoming financial year.			
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:	All – this links to good governance and controls which supports the achievement of the strategic objectives and the underpinning assurance processes.	

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** ☒

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

	Lead	Type of item	Public/Private	01/06/2024 (late May Board)	June 24 (year end only)	Jul-24	Sep-24	Nov-24	Jan-25	Mar-26
Standing Items			Part 1 & Part 2							
Apologies	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√	√	√
Declaration of interests	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√	√	√
Minutes	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Action log	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Matters arising	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Chair's Report	Chair	Standing Item	Part 1	√		√	√	√	√	√
Chief Executive's Update Report	Chief Executive	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Cycle of Business	Company Secretary	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Patient & Staff Story	Company Secretary	Standing Item	Part 1	√		√	√	√	√	√
Questions from Governors	Chair	Standing Item	Part 1	√		√	√	√	√	√
Items for Decision			Part 1 & Part 2							
Annual Declarations of Interest	Company Secretary	Item for Decision	Part 1							√
Approval of new Strategic Objectives	Director of Strategy and Planning	Item for Decision	Part 1							√
Board Assurance Framework - approval of opening position	Company Secretary	Item for Decision	Part 1	√						
Board Assurance Framework - approval of closing position	Company Secretary	Item for Decision	Part 1							√
Standing Financial Instructions, Delegation of Powers, Constitution and Standing Orders - annual review	Company Secretary / Group Director of Finance	Item for Decision	Part 1							√
Calendar of Board Meetings	Company Secretary	Item for Decision	Part 1					√		
Winter Plan	Chief Operating Officer	Item for Decision	Part 1				√			
Board Committee Annual Reviews of Effectiveness and Terms of Reference Update	Company Secretary	Item for Decision	Part 1							√
CQC Statement of Purpose and Registration	Chief Nurse	Item for Decision	Part 1							√
Items for Assurance			Part 1 & Part 2							
Board Committee Assurance Reports	Committee Chairs	Item for Assurance	Part 1	√		√	√	√	√	√
Trust Strategic Objectives - updates	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	√		√	√	√	√	√
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				√			√
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							