NHS
Gateshead Health
NHS Foundation Trust

Board of Directors (Part 1 – Public)

A meeting of the Board of Directors (Part 1 – Public) will be held at 09:30am on 26th March 2025, in Room 3, Education Centre, Queen Elizabeth Hospital / via Microsoft Teams

AGENDA

No	Start time	Item	Purpose	Lead	Paper / Verbal
1.	09:30	Welcome	Information	Chair	Verbal
2.	09:33	Declarations of interest	Information	Chair	Verbal
3.	09:34	Apologies for absence	Information	Chair	Verbal
4.	09:35	Minutes of the last meeting held on 29 January 2025	Decision	Chair	Paper
5.	09:37	Action log and matters arising	Assurance / decision	Chair	Paper
6.	09:40	Top 4 Organisational Risks	Information	Chair	Paper
7.	09:45	Patient and Staff Story – Northern Centre for Breast Research	Assurance	Project Team	Presentation
ITEMS FOR DECISION					
8.	10.00	Annual Declarations of Interest	Decision	Company Secretary	Paper
9.	10:05	Quality Governance Committee Terms of Reference	Decision	Company Secretary	Paper
10.	10:10	CQC Statement of Purpose and Registration	Decision	Chief Nurse	Paper
ITEMS FOR ASSURANCE					
11.	10:15	Chair's Report	Assurance	Chair	Paper
12.	10:20	Chief Executive's Report	Assurance	Chief Executive	Paper
13.	10:30	Great North Healthcare Alliance Progress Report	Assurance	Director of Strategy and Partnerships	Paper
14.	10:40	Governance Reports:			
		i) Organisational Risk Register	Assurance	Chief Nurse	Paper
15.	10:45	Assurance from Board Committees:			
		i) Finance and Performance Committee – February 2025 and March 2025	Assurance	Chair of the Committee	Paper
		ii) Quality Governance Committee – February 2025	Assurance	Chair of the Committee	Paper
		iii) People and Organisational Development Committee – March 2025	Assurance	Chair of the Committee	Paper
		iv) Digital Committee – February 2025	Assurance	Chair of the Committee	Paper
		v) Group Audit Committee – March 2025	Assurance	Chair of the Committee	Paper
		vi) Group Remuneration Committee – January 2025	Assurance	Chair of the Committee	Paper
16.	11:05	Annual Staff Survey Results	Assurance	Group Director of People and	Paper

No	Start time	Item	Purpose	Lead	Paper / Verbal
				Organisational Development	
17.	11:15	Freedom to Speak Up Guardian Report	Assurance	Freedom to Speak Up Guardian	Paper
18.	11:25	Board Walkabout Feedback	Assurance	Chief Nurse	Paper
19.	11:35	Finance Report	Assurance	Group Director of Finance	Paper
20.	11:45	Strategic Objectives and Constitutional Standards Report	Assurance	Group Director of Finance	Paper
21.	11:55	Learning from Deaths Quarterly Report	Assurance	Medical Director	Paper
22.	12:05	Maternity Integrated Oversight Report	Assurance	Head of Midwifery	Paper
23.	12:15	Nurse Staff Exception Report	Assurance	Chief Nurse	Paper
ITEMS FOR INFORMATION / MEETING GOVERNANCE					
24.	12:20	Cycle of Business 2025/26	Information	Company Secretary	Paper
25.	12:25	Questions from Governors in Attendance	Discussion	Chair	Verbal
26.	12:35	Any Other Business	Discussion	Chair	Verbal
27.	12:40	Date and Time of Next Meeting – 9:30am on Wednesday 21 May 2025	Information	Chair	Verbal
Exclusion of the Press and Public To resolve to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed					

NHS
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Board of Directors (Part 1 – Public)

Minutes of a meeting of the Board of Directors (Part 1) held at 9.30am on Wednesday 29th January 2025 in Room 3, Education Centre, Queen Elizabeth Hospital and via MS Teams.

Name	Position
Members present	
Mrs Alison Marshall	Chair
Mr Adam Crampsie	Non-Executive Director
Mrs Trudie Davies	Group Chief Executive
Mr Gavin Evans	Managing Director for QE Facilities
Mrs Jane Fay	Acting Group Director of Finance
Dr Gill Findley	Deputy Chief Executive / Chief Nurse
Mr Neil Halford	Medical Director of Strategic Relations
Mrs Joanne Halliwell	Group Chief Operating Officer
Mr Martin Hedley	Non-Executive Director / Senior Independent Director
Dr Carmen Howey	Group Medical Director
Mr Andrew Moffat	Non-Executive Director
Mrs Hilary Parker	Non-Executive Director
Mrs Maggie Pavlou	Deputy Chair / Non-Executive Director
Mr Mike Robson	Non-Executive Director
Mrs Amanda Venner	Group Director of People & Organisational Development
Attendees present	
Mrs Jennifer Boyle	Company Secretary
Ms Diane Waites	Corporate Services Assistant
Patient representative	Agenda Item 25/01/06
Governors and Observers	
Ms Helen Adams	Staff Governor
Mr Steve Connolly	Lead Governor
Mrs Carol Hindhaugh	Public Governor – Central Gateshead
Mr Mark Learmouth	Public Governor – Central Gateshead
Dr Andy Lowes	Staff Governor
Mr Gordon Main	Public Governor – Western Gateshead
Mrs Amy Muldoon	Director of Operations for Surgery
Apologies	
Mrs Kris Mackenzie	Group Director of Finance and Digital

Agenda Item No		Action Owner
25/01/01	**Chair's Business:** The meeting being quorate, Mrs A Marshall, Chair, declared the meeting open at 9.30 am and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. She welcomed those present including the Trust Governors and observers. Mrs Marshall highlighted that there were a number of items on the agenda for this meeting and asked presenters to take reports as read.	

Agenda Item No		Action Owner
25/11/02	**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.	
25/01/03	**Apologies for Absence:** There were apologies received from Mrs K Mackenzie.	
25/01/04	**Minutes of the Previous Meeting:** The minutes of the meeting of the Board of Directors held on Wednesday 27th November 2024 were approved as a correct record.	
25/01/05	**Matters Arising from the Minutes:** The Board reviewed the action tracker as below: • Action 24/11/11 relating to circulating the submitted response to the Change NHS consultation. This has been added to the Board document library for information therefore the action was agreed for closure. • Action 24/11/16 relating to the recommended changes to the reporting process of the Learning from Deaths report. This has been agreed and added to the cycle of business therefore action was agreed for closure. • Action 24/11/17 relating to providing further information in relation to maternity bookings and review of quality impact assessment within the Maternity Integrated Oversight Report. It was reported that capacity and performance are being monitored via the Finance and Performance Committee and the impact on safety will be considered further in the February EQIA panel therefore it was agreed that this action will be remain open until this has taken place. 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. Mrs J Boyle, Company Secretary, highlighted that Action 24/09/08 relating to updating the Standing Orders and Scheme of Delegation to reflect changes to Terms of Reference was closed at the last meeting as they were scheduled to be presented at this meeting however these will now be presented at the March meeting.	

Agenda Item No		Action Owner
25/01/06	**Patient Experience of Women's Health:** The Board welcomed a patient representative who shared their experience following some concerns raised relating to their patient journey and subsequent complaints process. This has resulted in some learning and actions being taken which the patient was very grateful for and felt that they had been listened to. The Board felt that this was very helpful to hear, and further conversations will take place via the Executive Management Team and Gateshead Health Leadership Group around the approach to complaints.	TD
25/01/07	**Board Committee Terms of Reference:** Mrs J Boyle, Company Secretary, presented the Group Remuneration Committee terms of reference and the Gateshead Health Leadership Group terms of reference for ratification. She highlighted that both of the terms of reference have been approved via the respective groups and reminded the Board around previous discussions of Board Committee terms of reference in relation to the inclusion of a new clause regarding committee quoracy which will enable Committees to reserve the right to pragmatically invite other Non-Executive Directors to attend for a single meeting in order to achieve quoracy if the lack of quoracy is short term / short notice. After consideration, it was: **RESOLVED:** to ratify the Group Remuneration Committee terms of reference, the Gateshead Health Leadership Group terms of reference and the inclusion of the new standard wording regarding quoracy within the terms of reference of the: • Quality Governance Committee; • Finance and Performance Committee; • People and OD Committee; and • Digital Committee	
25/01/08	**Chair's Report:** Mrs A Marshall, Chair, gave an update to the Board on some current issues, events and engagement work taking place across the organisation. Mrs Marshall drew attention to the Star of the Month nominations for November and December 2024 and congratulated Abby Corkindale who was the winner for October 2024 which recognised her achievements in	

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	leading the setting up of the booking team and system for the Community Diagnostic Centre. Following discussion, it was: **RESOLVED:** to receive the report for assurance.	
25/01/09	**Chief Executive's Report:** Mrs T Davies, Chief Executive, gave an update to the Board on current issues which have aligned to the Trust's Strategic Aims. Mrs Davies highlighted that the report provides some good examples of high quality care and the progress from teams within the organisation. She drew attention to Strategic Aim 3: w*e will enhance our productivity and efficiency to make the best use of resources* – which highlights the challenging circumstances over December and January with extremely high demand and patients waiting for a longer period of time. Colleagues demonstrated effective team work during this challenging time. In relation to Strategic Aim 5: *we will develop and expand our services within and beyond Gateshead* – Mrs Davies highlighted that the Great North Healthcare Alliance (GNHA) partners have continued to meet and the proposal to move towards a shared Chair across Gateshead, Newcastle and Northumbria has been agreed. The process has been shared with the Trust's Council of Governors at its extraordinary meeting yesterday (28th January 2025) and the timetable and terms of reference for the Joint Nominations Committee were approved and will also be presented at similar meetings for Newcastle and Northumbria. This will be led by Mr Martin Hedley as Senior Independent Director and the first meeting of the Joint Nominations Committee will be arranged in the next few weeks. **Update on the physician and anaesthesia associates letter:** Mrs A Venner, Group Director of People and Organisational Development, provided an update following the letter received from NHS England in December 2024 to announce an independent review of physician associates (PAs) and anaesthesia associates (AAs) ahead of the GMC regulation of the roles from 12 December 2024. She confirmed that the Trust does not employ PAs or AAs and would not look to employ any until the review is published when this will be considered as part of the organisation's wider Medical Workforce Strategy. After further discussion, it was: **RESOLVED:** to receive the report for assurance.	

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25/01/10	**Organisational Structure – Clinical Leadership:** Dr C Howey, Group Medical Director, presented the report which provides the Board with assurance and information regarding Clinical Leadership investment in the organisation to ensure that our clinical leaders have the skills, time, capacity, supporting structures and expertise to deliver in a Clinically Led, Management Supported organisation. Dr Howey highlighted that the review has taken place with the support of the Clinical Strategy Group and Gateshead Health Leadership Group and the report demonstrates the outcome of this process with proposals around the new governance arrangements to take this forward. She drew attention to the planned investment across the Divisions and Associate Medical Director roles and highlighted that interviews for roles are in the process of being held. Following a query from Mr A Crampsie, Non-Executive Director, in relation to ongoing assurances around benefits realisation, Dr Howey explained that it is intended that a report will be presented to the Gateshead Health Leadership Group in April 2026 outlining how the investment has delivered the intended benefits over the first year of implementation with a further comprehensive review for April 2030 to ensure that the model remains appropriate for the organisation. Following consideration, it was: **RESOLVED:** to receive the report for assurance.	
25/01/11	**Governance Reports:** **Board Assurance Framework:** Mrs J Boyle, Company Secretary, presented the current Board Assurance Framework (BAF) position which shows the latest updates agreed at each committee meeting. She highlighted that a new summary of progress is appended to the report to provide the Board with a more detailed overview of Committee decisions regarding the consideration of current risk scores. Two target scores have now been achieved for maternity and business growth and reductions in summary risk scores are also noted in relation to quality improvement and growing and developing our people. Some current scores have remained static all year, although it was noted that there have been actions taken to improve the control and assurance environments and Mrs Boyle explained that the BAF will continue past the year end until the new strategic objectives are agreed therefore a closure report is not expected in March 2025.	

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	Mrs Marshall highlighted that the strategic objective relating to the Great North Healthcare Alliance is monitored directly at Board therefore, it is for the Board to consider whether the current risk score can be reduced based on the progress made to-date in managing the risk. Discussion took place around whether a collective Board review should take place of those target scores that are not being progressed however it was felt that this was the responsibility of each Board Committee to ensure actions were being taken. Mrs T Davies, Group Chief Executive, felt that it would be beneficial to link this with the strategy development work and review of the new strategic objectives being led by Mr N Halford, Medical Director of Strategic Relations and Ms N Bruce, Director of Strategy and Partnerships. After consideration, it was: **RESOLVED:** to receive the report for assurance. **Organisational Risk Register (ORR):** Dr G Findley, Deputy Chief Executive and Chief Nurse, presented the updated ORR to the Board which shows the risk profile of the Trust, including a full register, and provides details of reviewed compliance and risk movements. This report covers the period 19th November 2024 to 19th January 2025. She reported that there are 19 risks on the ORR which includes one new risk relating to the winter plan and one risk score which has been increased relating to the increase in incivility and disrespectful behaviours being reported. There have also been 3 risk scores reduced, no risks have been removed and no risks have been closed. The report also highlights that there are 10 risks on the ORR with no movement in the past 6 months (July 2024 - January 2025) and are being reviewed by the Executive Risk Management Group. Following a query from Mr A Moffat, Non-Executive Director, in relation to the reduction in the risk around compliance with information Asset Registers and Data Flows, Dr Findley explained that this was due to a management plan being put in place to ensure the continuation of compliance with close monitoring being undertaken and as such the Trust is now 95% compliant. The Board noted that the top 3 organisational risks relate to finance, winter planning and the risk of an increase in incivility and disrespectful behaviour being reported which could have a negative impact on staff and require additional time and capacity to appropriately address the concerns. This could result in further health and well-being concerns and staff absence After consideration, it was:	

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	RESOLVED: to receive the report for assurance.	
25/01/12	**Assurance from Board Committees:** The Board reviewed the Committee escalation and assurance reports which provide improved processes to identify areas of concern and ongoing monitoring of assurances. **Finance and Performance Committee:** Mr M Robson, Committee Chair, provided a brief verbal overview to accompany the narrative reports following the December 2024 meeting and drew attention to the most recent meeting which took place on 28th January 2025. Mr Robson highlighted that there were four issues identified as requiring alert to the Board, the first of which relates to the continuing pressures within the emergency department and the second being the cap on the elective recovery fund by activity at month 9 which could impact on delivery plans for the last quarter of the financial year. The third alert related to the annual planning guidance which had not yet been received however intelligence work is being undertaken around potential financial pressures including system support and the achievement of the cost reduction programme. The fourth alert related to the capital plan - gaps have been identified within the scheme of delegation in relation to the approval of capital business cases which needs addressing however this will be discussed in more detail in Part 2 in relation to the approval of the Trust's capital plan. There are some areas subject to ongoing monitoring which includes: • The achievement of the planned deficit is expected due to system support however consideration should be taken around the reliance of non-recurrent funding streams which may not be available next year. • The Committee received a paper on the delivery process for the cost reduction programme and areas to focus on. Further work is to be undertaken around difficult decisions which may be required. • An update on the Community Diagnostic Centre was received which drew attention to a potential funding gap leading into the next financial year however discussions are ongoing to resolve this. The Committee received positive assurance in relation to the following areas: • The management of possible non-recurrent funds and further detail was requested in relation to cash flow which highlights the current challenges around the planning process.	

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	• The Committee received a waiting list initiative cost benefit analysis report for trauma and orthopaedics which demonstrated that the methodology could be used in other areas to support cost reduction plans. **Quality Governance Committee:** Mr A Crampsie, Committee Chair, provided a brief verbal overview to accompany the narrative report following the January meeting. He reported that there was one issue identified as requiring escalation to the Board for further action which relates to insufficient funding for Children in Care which is required to address capacity issues due to a significant increase within Gateshead. It was noted that this has been escalated to the Integrated Care Board however the business case has not been approved. Dr G Findley, Chief Nurse and Deputy Chief Executive, highlighted that discussions are taking place with the local authority around joint working, and this is being prioritised to ensure the needs of the service are being met. There are some areas subject to ongoing monitoring which includes: • The Committee continues to monitor the measure put in place around maternity capacity and it was noted that the number of births during 2024 was 2004 and may have implications for the service if that number were to be sustained. The Committee received positive assurance around on the progress of the action plan for Paediatric Hearing Services and the successful relocation of services to Blaydon. Further discussion took place around the challenges due to current financial pressures and Mrs T Davies, Group Chief Executive, highlighted that the national planning guidance was expected to be received tomorrow which will require each organisation to review services prior to wider discussions with the Integrated Care Board and provider collaborative group where risk-based decisions may be required. Mrs J Halliwell, Group Chief Operating Officer, will be working on the Trust's operational plan which will presented to the Board to review and agree recommendations. **People and Organisational Development Committee:** Mrs M Pavlou, Committee Chair, provided a brief verbal overview to accompany the narrative report following the January 2025 meeting. She reported that there were one issue requiring escalation to the Board relating to sickness absence. It was acknowledged that a lot of work is being undertaken however the Committee felt that the impact of this is not being seen in sickness absence rates with rates worsening. Mrs A Venner, Group Director of People and Organisational Development, highlighted that options were also being reviewed across the region and a dedicated focus was being addressed via the Executive Management Team. It was noted that this was an organisational wide responsibility.	

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	There are some areas subject to ongoing monitoring which includes: • Access to counselling via Occupational Health due to demand issues and Dr C Howey, Group Medical Director, highlighted that the service model is being reviewed to ensure the service meets the needs of staff. • The Committee noted that there has been a significant increase in resident doctors' exception reporting, and this is being reviewed. Following a query from Mr M Robson, Non-Executive Director, Dr Howey explained that this relates to junior doctors working over scheduled hours. Further discussion took place around the challenges in relation to sickness absence management and Mrs Davies explained that discussions were taking place with all Chief Executives and HR Directors around initiatives to reduce rates across the Provider Collaborative by 1% which could equate to a potential cost saving of £1m however it is also important to ensure that the organisation remains a compassionate employer and ensure that staff have a good experience at work. Following a query around a potential review of NHS terms and conditions, it was noted that this is not currently being considered by NHS England. **Digital Committee:** Mr A Moffat, Digital Committee Chair, provided a brief verbal overview to accompany the narrative report following the December 2024 meeting. He reported that there were one issue requiring escalation to the Board relating to the Cyber Assessment Framework. An update will be provided to the Committee at its next meeting in February 2025 and a subsequent report will be presented to the Board in March 2025. There are some areas subject to ongoing monitoring which includes: • Subject Access Requests (SARs) and Freedom of Information (FOIs) requests – the Committee noted that the Trust is still not compliant with statutory requirements and wished to remind the Board of potential risks/consequences. Mrs J Halliwell, Group Chief Operating Officer, felt that it was important to align potential digital services redesign to the strategy development work being undertaken however Mr N Halford, Medical Director of Strategic Relations, explained that further discussions are required around digital projects however a corporate approach will be demonstrated. **Audit Committee** Mr A Moffat, Audit Committee Chair, provided a brief verbal overview to accompany the narrative report following the December 2024 meeting.	Cycle of business

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	He reported that there were one issue requiring escalation to the Board relating to the QE Facilities audited accounts. It was noted that an extraordinary committee meeting was required to approve the accounts as the external audit report had not been available. Mr Moffat explained that this was a recurring issue and felt that sufficient resources should be allocated to mitigate against this. Mr G Evans, Managing Director for QE Facilities, highlighted that this had been escalated to Forvis Mazars and they have been assured that additional resource will be allocated this year however this will be monitored. Mrs Marshall thanked the Committee Chairs for their reports. After consideration, it was: **RESOLVED**: to receive the reports for assurance	
25/01/13	**Board Walkabout Feedback:** Dr G Findley, Chief Nurse and Deputy Chief Executive, provided the Board with an overview of observations and reflections from Board walkabouts, supporting triangulation with other sources of information and assurance. The report covers two visits (Procedure Investigation Unit and Maternity), both of which were concluded as being positive and the welcoming and engaging approach of colleagues was also noted. One theme which has been consistent with previous walkabouts, relates to the consideration of closer working and integration where separate teams are in place across linked areas and Mrs J Halliwell, Chief Operating Officer, highlighted that some scoping work is being completed however this also links to the reflection work being completed around the viability and benefits realisation of the operating model. Following a query from Mrs Marshall in relation to timescales, Mrs Halliwell explained that this will be confirmed following the agreement of whether subject matter experts are required. Dr C Howey, Group Medical Director, felt that wide stakeholder engagement was required to ensure that voices are heard and experiences shared to take actions forward. Dr G Morrow, Non-Executive Director, felt that it was also important to consider patient experience in particular communication and information flows and Mrs Halliwell confirmed that a collective approach will be undertaken. Discussion took place around the balance of visits to enable a visible Board presence but also experience the day to day running of departments and opportunities to engage with staff and patients. It was felt that this may be different for Non-Executive Directors as they are not regularly onsite however it was suggested that it may be beneficial to consider some specific areas. Mrs T Davies, Group Chief Executive,	

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	agreed to develop some options and this will be brought back to the Board for discussion. After consideration, it was **RESOLVED**: to receive the report for assurance	TD
25/01/14	**Finance Report:** Mrs J Fay, Acting Group Director of Finance, provided the Board with a summary of financial performance for April to December 2024 (Month 9) for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds). Mrs Fay highlighted some of the key points and reported that the Trust is planning to achieve a revised planned deficit of £7.333m following the allocation of some non-recurrent deficit support to the Integrated Care Board to deliver breakeven across the system. For December 2024, the Trust has reported an actual deficit of £6.536m which is ahead of plan. Capital spend has been less than planned however plans are in place for this to be achieved. Cash balances are healthy which is informed by the delivery of the forecast deficit and capital programme. Following a query from Mr A Crampsie, Non-Executive Director, in relation to assurance around the cost reduction plans, Mrs Fay highlighted that this required further collective Board discussion, and this will take place later in the meeting. After consideration, it was: **RESOLVED:** to receive the Month 9 financial position and note partial assurance for the achievement of the forecast 2024/25 planned deficit as a direct consequence of the reported year to date position and financial risks.	
25/01/15	**Strategic Objectives and Constitutional Standards Report:** Mrs J Halliwell, Group Chief Operating Officer, presented the progress, risks and assurance in relation to the Trust's Strategic Objectives for Month 9 2024/25. Mrs Halliwell highlighted that detailed discussions took place at the Finance and Performance Committee with a focus on the deterioration in urgent and emergency care performance across all dimensions which is reflective of current system pressures however is being picked up as part of the regional groups and winter debrief sessions. Following consideration, it was:	

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	RESOLVED: to receive the report for assurance and note the key areas of improvement and challenge.	
25/01/16	**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 2024 including the NHS England core standards self-assessment final submission. Mrs Halliwell explained that there were no significant changes to the care standards assurance process nationally however there were changes to the local submission and check and challenge process. Following this robust process, the self-assessment of the EPRR core standards resulted in a compliance rating of substantial compliance for 2024 compared to a partial assurance in 2023. The Board acknowledged this achievement and thanked the team for their efforts and hard work. After further discussion, it was: **RESOLVED:** to receive the report for assurance.	
25/01/17	**Maternity Integrated Oversight Report:** Dr G Findley, Chief Nurse and Deputy Chief Executive, presented a summary of the maternity indicators for the Trust for December 2024. She drew attention to the key performance indicators within the Maternity Dashboard and highlighted that the department is fully compliant for the maternity incentive scheme reporting and an update on the Avoidable Term Admission in the Neonatal Unit (ATAIN) Quality Improvement Project for fetal well-being was provided which demonstrates a sustained low flag for admissions and an improvement in “fresh eyes” audit compliance. Following discussion, it was: **RESOLVED:** to receive the report for assurance.	
25/01/18	**Maternity Incentive Scheme (MIS) Compliance Report:** Dr G Findley, Chief Nurse and Deputy Chief Executive, presented a summary of the MIS compliance for the Trust for December 2024.	

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	Dr Findley highlighted that the maternity service is reporting 96% compliance therefore full compliance with the ten safety actions have been achieved. The report has been reviewed and approved by the Quality Governance Committee therefore full compliance will be declared to NHS Resolution for sign off by 3rd March 2025. It was noted that any monies recovered by achieving full compliance must be ringfenced for use in the maternity service and this has been agreed by the Board in accordance with CNST and Ockenden requirements. Following consideration, it was: **RESOLVED:** to receive the report for assurance and recommend the submission of the Board declaration to NHS Resolution.	
25/01/19	**Nurse Staffing Exception Report:** Dr G Findley, Chief Nurse and Deputy Chief Executive, presented the report for December 2024 which provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls. Dr Findley highlighted that December has demonstrated some areas with staffing challenges relating to sickness absence and enhanced care requirements as well as periods of increased patient activity with surge pressures resulting in the need to open escalation areas. Work is being undertaken to create monthly dashboard metrics which will be monitored via the People and Organisational Development Committee. Following discussion, it was: **RESOLVED:** to receive the report for information and assurance.	
25/01/20	**Bi-annual Inpatient Safer Nursing Care Staffing Report:** Dr G Findley, Chief Nurse and Deputy Chief Executive, presented the report which provides the Board with assurance that the nursing workforce within the Trust is safe, competent, and compliant with National Institute for Clinical Excellence (NICE), National Quality Board (NQB) and NHS England's Safer Staffing guidelines and standards at a time when nationally nursing is facing the greatest recruitment and retention challenges. Dr Findley reported that the newest version of the tool has been used for this report however highlighted that the recommended headroom	

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	calculation for this version is 22% compared to 21% which the Trust has used in the past. Dr Findley explained that discussions need to take place to confirm whether this is accepted as a standard across the region and some benchmarking work is therefore taking place. Mrs A Venner, Group Director of People and Organisational Development highlighted that a safer staffing review is taking place via the regional Chief People Officer Group therefore will feed into the regional work. It is therefore recommended that there are no changes to staffing at this time however the tool will be re-run this month (January 2025) to ensure consistent application of the new tool before further recommendations are made. Dr G Morrow, Non-Executive Director, queried whether there had been any work to review whether any complaints have been received as a result of staffing levels and Dr Findley explained that the report looks at any incidents and ward by ward comparator metrics are monitored. After consideration, it was: **RESOLVED:** to receive the report for information and assurance.	
25/01/21	**Cycle of Business 2024/25:** Mrs J Boyle presented the cycle of business for 2024/25 which outlines forthcoming items for consideration by the Board. This provides advanced notice and greater visibility in relation to forward planning. After consideration, it was: **RESOLVED:** to review the cycle of business for the remaining of the financial year 2024/25.	
25/01/22	**Questions from Governors in Attendance:** Mr G Main raised a query in relation to the flu vaccination rates and felt that further work should be undertaken to ensure staff who work within vulnerable areas receive it. Mrs A Venner, Group Director of People and Organisational Development, explained that discussions around uptake levels have taken place at the People and Organisational Development Committee and campaigns have been replicated across the region which includes walking the wards and drop-in clinics and plans are in place around increased “myth-busting” communications following a reduction in uptake post Covid. Mr A Moffat, Non-Executive Director, felt that it would be useful to compare results to anyone who is eligible to receive the flu vaccination within the Gateshead population and Mrs T Davies, Group Chief Executive, explained that the data should be available from Public Health	

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	and an outline position could be provided via the People and Organisational Development Committee.	POD committee
25/01/23	**Any Other Business:** There was no other business discussed.	
25/01/24	**Date and Time of Next Meeting:** The next meeting of the Board of Directors will be held at 9.30am on Wednesday 26th March 2025.	
Exclusion of the Press and Public: Resolved to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed.		

PUBLIC BOARD ACTION TRACKER

Gateshead Health NHS Foundation Trust

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

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
24/11/17	27/11/2024	Maternity IOR	To provide further information in relation to maternity bookings and review of quality impact assessment	29/01/2025	JH/NH	Capacity and performance are being monitored via the Finance and Performance Committee and impact on safety will be considered further in February EQIA panel. It was agreed that this action will remain open until this has taken place.	
25/01/06	29/01/2025	Patient Story	To discuss the approach to complaints via the Executive Management Team and Gateshead Health Leadership Group	26/03/2025	TD	March 25 – discussed as part of the new complaints policy at Gateshead Health Leadership Group. Confirmed that all complaints now receive a telephone call contact from the team. **Action recommended for closure.**	
25/01/13	29/01/2025	Board Walkabout Feedback	To develop some options around balance of visits and bring back to Board for discussion	26/03/2025	TD	March 25 – time is protected in the diaries as part of the refresh and commitment to Board walkabouts. This is documented in the Board Walkabout paper on the agenda. **Action recommended for closure**	

Closed Actions from last meeting

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
24/09/08	24/09/2024	Terms of Reference	To ensure that the Standing Orders and Scheme of Delegation are updated to reflect changes to Terms of Reference	29/01/2025	JB	Nov 24 – to be scheduled for January's Board meeting. Added to cycle of business therefore action agreed for closure Jan 25 – it was noted that the updated Standing Orders and Scheme of Delegation will be deferred until March meeting. **Feb 25 – recommendation to reopen the action until updates are made**	
24/09/09	24/09/2024	National Pay Award	To review and update the wording in the SFIs and Scheme of Delegation relating to Board approval of national pay awards.	27/11/2024	Kmac	Nov 24 - links to action 24/09/08 therefore action agreed for closure as above Jan 25 – as above **Feb 25 – recommendation to reopen the action until updates are made**	
24/11/11	27/11/2024	Chief Executive's Report	To circulate the response submitted in relation to the Change NHS consultation	29/01/2025	TD	Jan 25 – added to Board document library for information. Action agreed for closure.	
24/11/16	27/11/2024	Learning from Deaths report	To discuss the recommended changes to the reporting process and agree what the Board should receive to add to the cycle of business	29/01/2025	GF/JB	Jan 25 – agreed reporting months of March, June, September and November. Added to cycle of business. Action agreed for closure.	

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Top 4 Organisational Risks – March 2025

The top 4 organisational risks as agreed by the Executive Risk Management Group on 3 March 2025 are as follows:

Top 3 Organisational Risks:

Risk Id	Division	Description	Initial Risk Grade	Grade	Target Grade
2969	Medical Services	Risk of patient harm due to length of stay in ED resulting in potential regulatory action and poor patient experience.	20	20	8
4417	People & OD	There is a risk that promoting an environment that encourages speaking out and creating a psychologically safe culture has led to increased reports of poor behaviour. This could have a negative impact on staff and require additional time and capacity to appropriately address the concerns. This could result in further health and well being concerns and staff absence.	15	15	6
4694	Finance	Risk that the Trust will not achieve a break-even revenue plan for 2025-26 and a deterioration from the 2024-25 planned deficit, resulting in a deterioration to Trusts NHS Oversight Framework rating.	25	20	10
4705	Digital	Risk of considerable clinical and operational impact to patient care due to instability of PACS environment. This is resulting in delayed diagnosis and treatment plans across services, as well as delayed discharges, resulting in significant disruption to patient pathways throughout the organisation.	25	20	4

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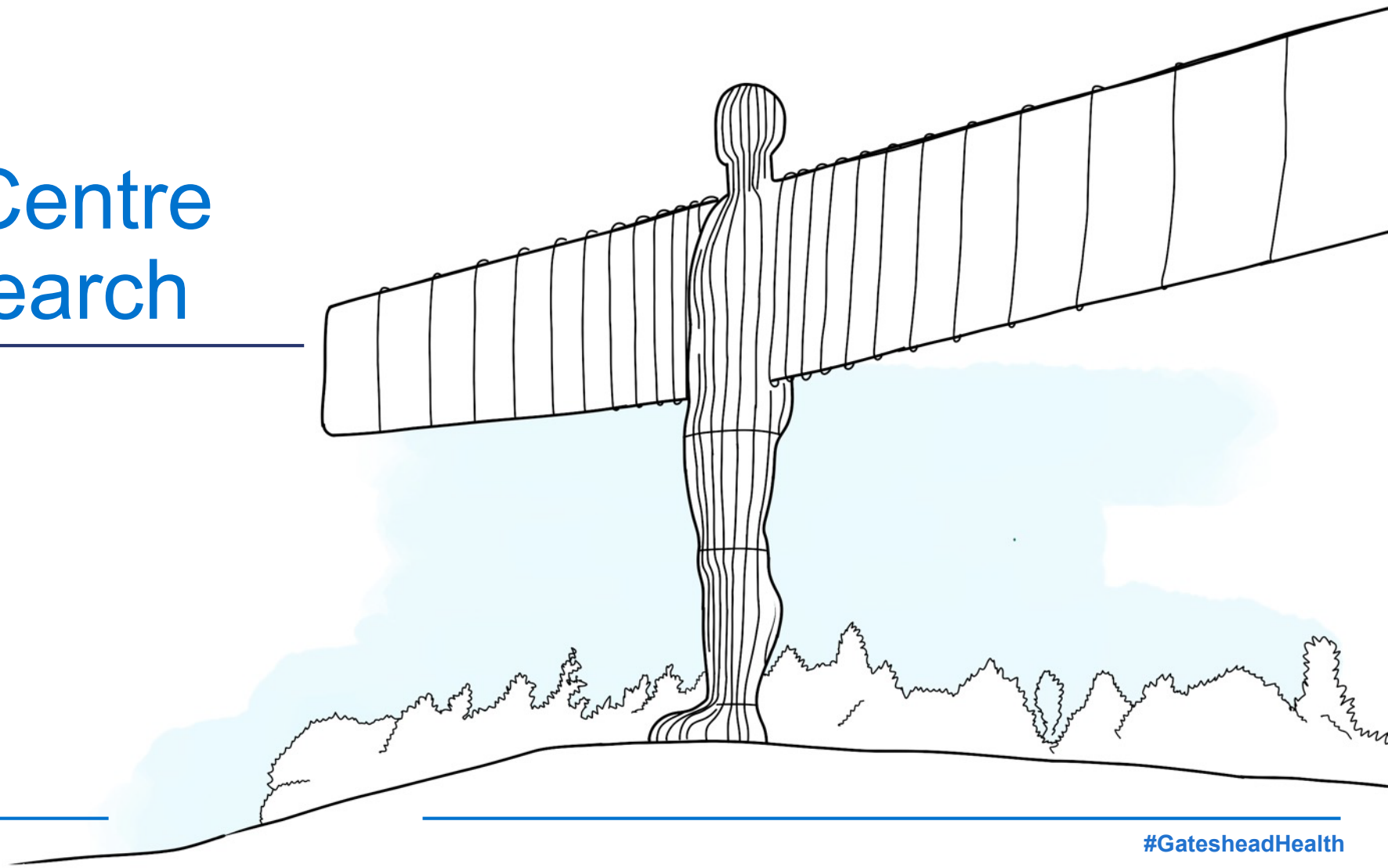
The Northern Centre for Breast Research

Dr Simon Lowes

26th March 2025



Why is research important in the NHS?

Research-active Trusts lead to improved quality of patient care

Engagement in interventional research is associated with higher CQC ratings

Patients report greater satisfaction with their care in research-active Trusts

Research is part of the NHS constitution

Research in the Breast Unit

We currently participate in a wide variety of research

- Clinical
- Laboratory-based

Many staff members play significant lead roles in a variety of regional and national organisations, including contributing to national guidelines and national research studies

This is under-recognised by patients and staff

We are also well below our potential capability

By formally bringing this work together we can:

- Ensure it is appropriately recognised
- Increase and strengthen our involvement in research in a way that benefits:

  the Trust

  the patients it serves

  the wider community – regionally, nationally, and beyond

Current Research Studies within the Breast Unit

NHS Gateshead Health NHS Foundation Trust

Active Clinical Research Studies

SMALL

ATNEC BREAST CANCER STUDY

SWEET

Mammo-50

PICASSO

optima personalised treatment of breast cancer

Teesside University

Upcoming Clinical Research Studies

CeSar Optimising Imaging for Breast Cancer Treatment

The TADPOLE Study

MAMMA VAD

Other Active Research Studies

Newcastle University

WCDS WOMEN'S CANCER DETECTION SOCIETY GATESHEAD

NATIONAL BREAST IMAGING ACADEMY

Vice Chair of the Trust R&D Council

Honorary Clinical Senior Lecturer at Newcastle University

Northern School of Radiology Research Lead

Lead organiser, Northern Radiology Annual Scientific Meeting

NIHR RDN Specialty Group Lead for Imaging, NENC
Chair of the NIHR Imaging Group's Workforce Working Group

RCR Academic Committee Member

Faculty Radiologist for the NICE Breast Cancer Committee

Executive Committee Officer and Treasurer, British Society of Breast Radiology

Radiology Lead for the iBRA-NET Localisation Group

Joint Radiology Lead for the National Breast Imaging Academy's (NBIA) e-learning programme

Editorial Board Member *Clinical Radiology* (Elsevier)

Committee Member, Women's Cancer Detection Society (WCDS)

www.rcr.ac.uk

Clinical Radiology
The Royal College of Radiologists

Guidance on screening and symptomatic breast imaging
Fourth edition

Clinical Radiology 74 (2019) 676–681

Contents lists available at ScienceDirect

Clinical Radiology

journal homepage: www.clinicalradiologyonline.net

Evidence for avoiding the biopsy of typical fibroadenomas in women aged 25–29 years

K. Taylor [a,*], S. Lowes [b], E. Stanley [c], P. Hamilton [b], A. Redman [b], A. Leaver [b], C. Smith [c], R. Lakshman [a], H. Vandersluis [a], M.G. Wallis [a]

[a] Department of Radiology, Cambridge Breast Unit, Cambridge University Hospitals NHS Foundation Trust, Cambridge Biomedical Campus, Hills Road, Cambridge CB2 0QQ, UK
[b] Breast Screening and Assessment Unit, Queen Elizabeth Hospital, Gateshead NE9 6SX, UK
[c] Mater Misericordiae University Hospital, Eccles St, Inns Quay, Dublin D07 R2WY, Ireland

rad review of women's health

Wire-free localisation techniques for impalpable breast lesions

RAD Magazine, 50, 584, 11-12

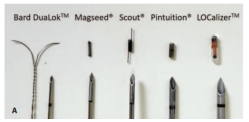
Dr Simon Lowes
Consultant breast radiologist
Gateshead Health NHS Foundation Trust
simon.lowes@nhs.net

The mainstay of treatment for most breast cancers is breast conserving surgery. Impalpable breast lesions usually require image-guided localisation in advance of surgery, which facilitates the surgeon in identifying the target intra-operatively, allowing the area of disease to be excised with clear margins, while also ensuring that excess normal tissue is not removed.

In this regard, breast imaging teams have significant responsibility in ensuring that localisations are done accurately and in a way that is as helpful to the surgeon as possible. There are a variety of different types of breast lesions that require localising, including invasive tumours, lesions of uncertain malignant potential (B3), and areas of malignant calcification, as well as lymph nodes in the axilla.

For decades, the standard localisation technique has been guidewires, which are inserted on the morning of surgery using either ultrasound or stereotactic guidance (**figure 1**). Guidewires work well in that they are cheap, readily available and relatively easy to insert. On the downside, they need to be inserted on the morning of surgery, which can operation, plus the patient is left with a guidewire protruding from their skin, which can become dislodged if snagged.

In recent years, a number of wire-free implantable localisation devices have been developed, helping to mitigate some of the drawbacks associated with guidewires. There are currently five main devices in use in the UK, all of which have their own advantages and disadvantages over guidewires and relative to one other. These are radioactive iodine seeds, paramagnetic seeds (Magseed, Endomag, Cambridge), radiofrequency identification (RFID) tags (LOCalizer, Hologic, Marlborough, Massachusetts), radar reflector (Scout, Merit Medical, Aliso Viejo, California), and magnetic seeds (Pintuition, Sirius Medical, Eindhoven, the Netherlands) (**figure 2**). All five are similar in principle in that they are small, cylinder-like devices pre-loaded into an introducer needle, allowing deployment under image-guidance into the target lesion. The key advantage that all five devices offer over guidewires is that they can be inserted



Clinical Radiology 77 (2022) 749–758

Contents lists available at ScienceDirect

Clinical Radiology

journal homepage: www.clinicalradiologyonline.net

A national survey investigating the impact of the COVID-19 pandemic on core and higher breast radiology training in the UK

S. Carpenter [a], Y. Graham [b], T. Kulkarni [c], I. Lyburn [d,e,f], S. Vinnicombe [d], S. Sharma [g], N. Sharma [b], S. Lowes [a,i,*]

NICE National Institute for Health and Care Excellence

iRefer Making the best use of clinical radiology

Clinical Radiology 75 (2020) 942–949

Contents lists available at ScienceDirect

Clinical Radiology

journal homepage: www.clinicalradiologyonline.net

Use of Hologic LOCalizer radiofrequency identification (RFID) tags to localise impalpable breast lesions and axillary nodes: experience of the first 150 cases in a UK breast unit

S. Lowes [a,b,*], A. Bell [c], R. Milligan [c], S. Amonkar [c], A. Leaver [a]

[a] Breast Screening and Assessment Unit, Queen Elizabeth Hospital, Gateshead, NE9 6SX, UK
[b] Translational and Clinical Research Institute, Newcastle University, NE2 4HH, UK
[c] Department of Surgery, Queen Elizabeth Hospital, Gateshead, NE9 6SX, UK

Clinical Radiology 79 (2024) e1288–e1295

Contents lists available at ScienceDirect

Clinical Radiology

journal homepage: www.clinicalradiologyonline.net

Results of shared learning of a new radiofrequency identification localization device—a UK iBRA-NET breast cancer localisation study

Jenna L. Morgan [a,b], James Harvey [c,d], Simon Lowes [e,f], Robert Milligan [e], Suzanne Krizak [c], Yazan Masannat [g,h], Amtul Carmichael [i], Suzanne Elgammal [j], Mina Youssef [k], Gloria Petralia [l], Rajiv V. Dave [c,d,*] on behalf of the iBRA-NET Localisation Study Group

Clinical Radiology 72 (2017) 991.e1–991.e13

Contents lists available at ScienceDirect

Clinical Radiology

journal homepage: www.clinicalradiologyonline.net

A national survey exploring UK trainees' perceptions, core training experience, and decisions to pursue advanced training in breast radiology

S. Lowes [a,*], M. Bydder [b], R. Sinnatamby [c]

[a] Department of Radiology, Queen Elizabeth Hospital, Gateshead, UK
[b] Department of Radiology, Nightingale Centre & Genesis Prevention Centre, University Hospital of South Manchester, Manchester, UK
[c] Department of Radiology, Cambridge Breast Unit, Cambridge University Hospitals, Cambridge, UK

NICE National Institute for Health and Care Excellence

NICE advice

Contrast-enhanced spectral mammography for breast cancer

Medtech innovation briefing
Published: 30 August 2022
www.nice.org.uk/guidance/mib304

Clinical Radiology 78 (2023) e668–e675

Contents lists available at ScienceDirect

Clinical Radiology

journal homepage: www.clinicalradiologyonline.net

Pre-operative localisation of axillary lymph nodes using radiofrequency identification (RFID) tags: a feasibility assessment in 75 cases

S. Lowes [a,b,*], S. El Tahir [a], S. Koo [a], S. Amonkar [c], A. Leaver [a], R. Milligan [c]

[a] Breast Screening and Assessment Unit, Queen Elizabeth Hospital, Gateshead, NE9 6SX, UK
[b] Translational and Clinical Research Institute, Newcastle University, NE2 4HH, UK
[c] Department of Surgery, Queen Elizabeth Hospital, Gateshead, NE9 6SX, UK

Cancer and Metastasis Reviews
https://doi.org/10.1007/s10555-020-09879-6

NON-THEMATIC REVIEW

Solute transporters and malignancy: establishing the role of uptake transporters in breast cancer and breast cancer metastasis

Rachel Sutherland [1,2] · Annette Meeson [1] · Simon Lowes [2,3]

European Journal of Surgical Oncology 45 (2019) 519–527

Contents lists available at ScienceDirect

European Journal of Surgical Oncology

journal homepage: www.ejso.com

High risk (B3) breast lesions: What is the incidence of malignancy for individual lesion subtypes? A systematic review and meta-analysis

Nerys Dawn Forester [a,*], Simon Lowes [b], Elizabeth Mitchell [c], Maureen Twiddy [c]

[a] Breast Screening and Assessment Unit, Royal Victoria Infirmary, Queen Victoria Road, Newcastle, NE1 4LP, UK
[b] Breast Screening and Assessment Unit, Queen Elizabeth Hospital, Gateshead, NE9 6SX, UK
[c] Hull York Medical School, Institute of Clinical and Applied Health Research, The Allam Medical Building, University of Hull, Hull, HU6 7RX, UK

Journal of Plastic, Reconstructive & Aesthetic Surgery (2018) 71, 1521–1531

ELSEVIER

BAPRAS British Association of Plastic Reconstructive and Aesthetic Surgeons

JPRAS An International Journal of Surgical Reconstruction www.JPRASurg.com

Review

Breast imaging for aesthetic surgery: British Society of Breast Radiology (BSBR), Association of Breast Surgery Great Britain & Ireland (ABS), British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS)

Simon Lowes [a,*], Fiona MacNeill [b], Lee Martin [c,1], Joe M. O'Donoghue [d,2], Mandana O. Pennick [e], Alan Redman [a], Robin Wilson [f,3]

BJS, 2024, znae007
https://doi.org/10.1093/bjs/znae007
Collaborative Research Proceedings

OXFORD Collaborative Research

Wire- and radiofrequency identification tag-guided localization of impalpable breast lesions: iBRA-NET localization study

James Harvey [1,2], Jenna Morgan [3,4], Simon Lowes [5,6], Robert Milligan [5], Emma Barrett [7], Amtul Carmichael [8], Suzanne Elgammal [9], Tahir Masudi [10], Chris Holcombe [11], Yazan Masannat [12], Shelley Potter [13,14], Rajiv V. Dave [1,2,*] and the iBRA-Net Localization Study Collaborative

[1] The Nightingale Breast Cancer Centre, Wythenshawe Hospital, Manchester University NHS Foundation Trust, Manchester, UK
[2] Division of Cancer Sciences, Faculty of Biology, Medicine and Health, University of Manchester, Manchester, UK
[3] Department of Oncology and Metabolism, University of Sheffield Medical School, Sheffield, UK
[4] Jasmine Centre, Doncaster and Bassetlaw Teaching Hospitals NHS Trust, Doncaster, UK
[5] Breast Unit, Gateshead Health NHS Foundation Trust, Gateshead, UK
[6] Translational and Clinical Research Institute, Newcastle University, Newcastle upon Tyne, UK
[7] Department of Medical Statistics, Wythenshawe Hospital, Manchester University NHS Foundation Trust, Manchester, UK
[8] University Hospital of Derby and Burton NHS Foundation Trust, Queens Hospital, Burton upon Trent, UK
[9] Breast Unit, University Hospital Crosshouse, NHS Ayrshire and Arran, Crosshouse, Kilmarnock, UK
[10] Breast Unit, Rotherham NHS Foundation Trust, Rotherham, UK
[11] Breast Unit, Royal Liverpool University Hospital, Liverpool, UK
[12] Breast Unit, Aberdeen Royal Infirmary, Aberdeen, UK
[13] National Institute for Health Research Bristol Biomedical Research Centre, University Hospitals Bristol and Weston NHS Foundation Trust, Bristol, UK
[14] Bristol Breast Care Centre, North Bristol NHS Trust, Bristol, UK

*Correspondence to: Rajiv V. Dave, The Nightingale Breast Cancer Centre, Wythenshawe Hospital, Manchester University NHS Foundation Trust, Southmoor Road, Manchester, M23 9LT, UK (e-mail: localisationstudy@gmail.com)

Members of the iBRA-NET Localization Study Collaborative are co-authors of this study and are listed under the heading Collaborators.

Clinical Radiology 76 (2021) 239–240

Contents lists available at ScienceDirect

Clinical Radiology

journal homepage: www.clinicalradiologyonline.net

Editorial

Virtual special issue on breast MRI

S. Lowes [a,b,*]
[a] Breast Screening and Assessment Unit, Queen Elizabeth Hospital, Gateshead, NE9 6SX, UK
[b] Translational and Clinical Research Institute, Newcastle University, NE2 4HH, UK
E-mail address: simon.lowes@nhs.net

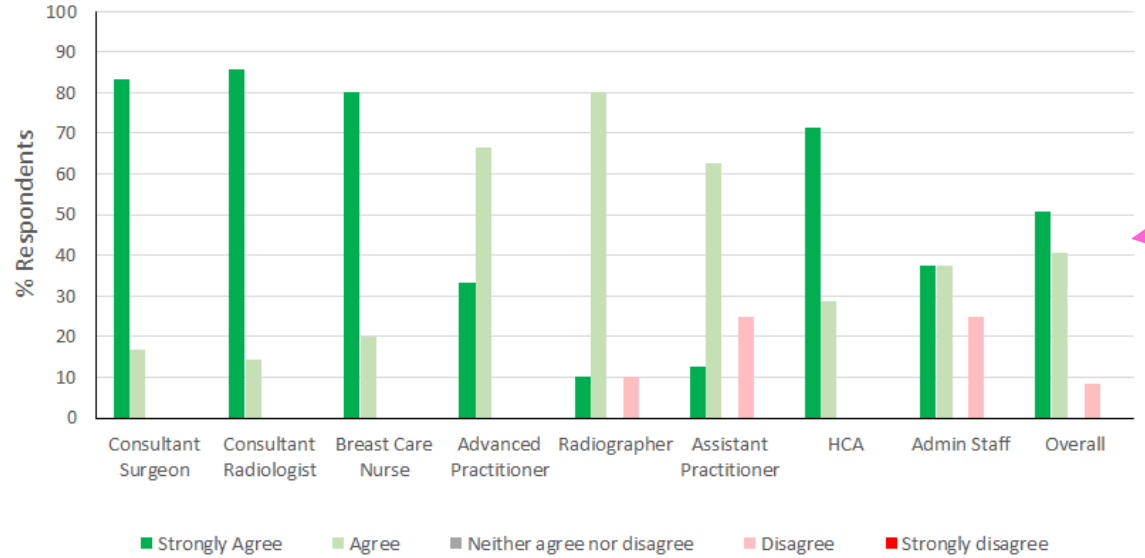
BREAST

Diagnostic and interventional imaging techniques in breast cancer

Simon Lowes
Alice Leaver
Alan Redman

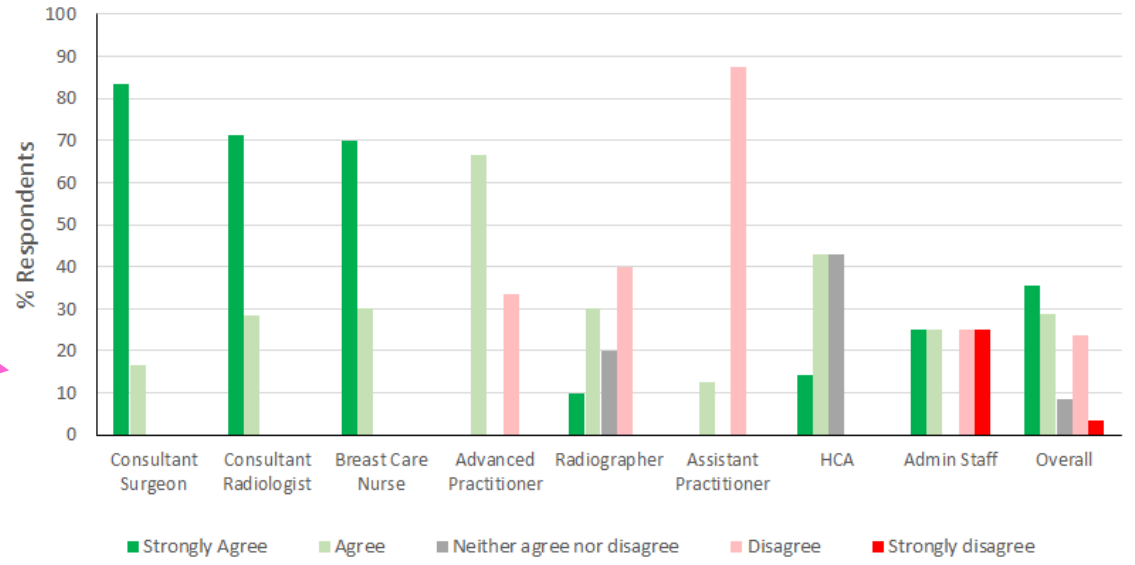
any significant abnormality will be biopsied under image guidance to allow tissue diagnosis. Patients may then have staging using cross-sectional imaging modalities, and MRI can be used to monitor response to neoadjuvant chemotherapy or to aid surgical planning. Prior to surgical excision of breast cancers, radiologists may be required to localize the lesion using ultrasound or stereotactic (mammographic) guidance to assist the surgeon in accurate tumour removal with satisfactory margins. Imaging is also key in follow-up assessment and detecting recurrence.

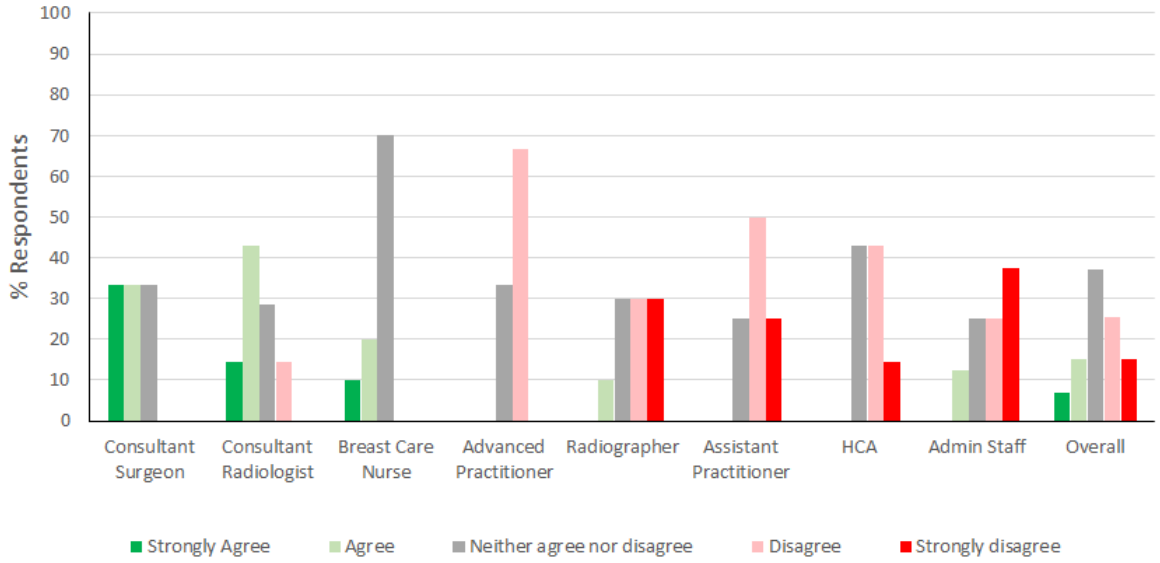
These established diagnostic and interventional imaging techniques continue to evolve, and there is a constant drive to develop new approaches to help achieve the best possible outcomes for the patient. Some of the more promising new developments are discussed below.



"I am aware that this breast unit is actively involved in research studies"

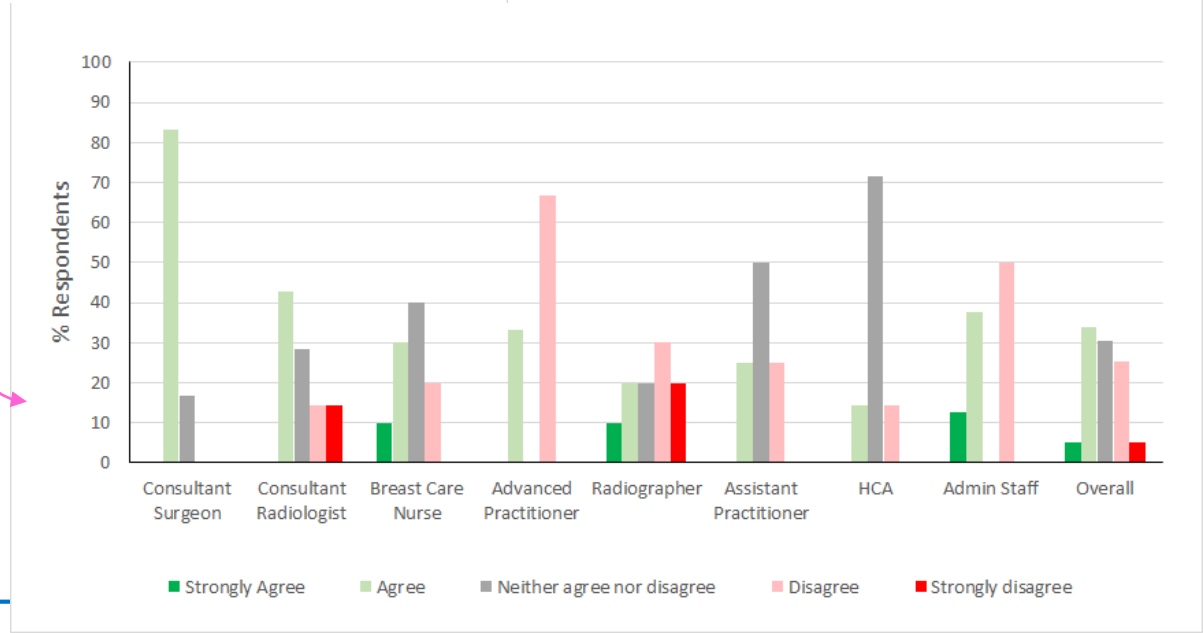
"If asked, I could name or describe at least one research study that this unit is currently involved in"

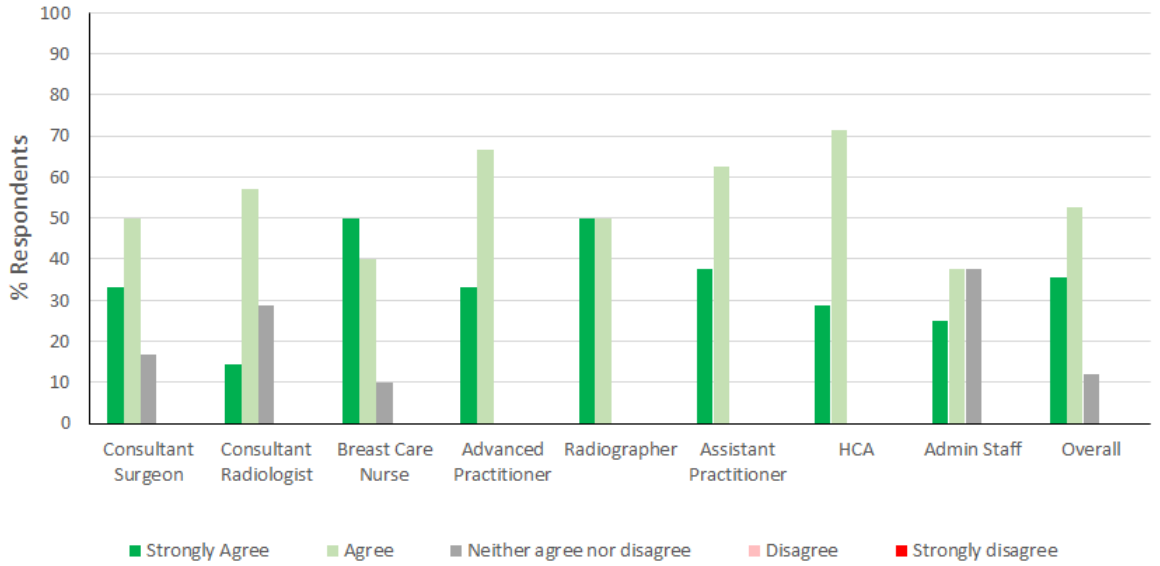




"I feel I am actively involved with research within the unit"

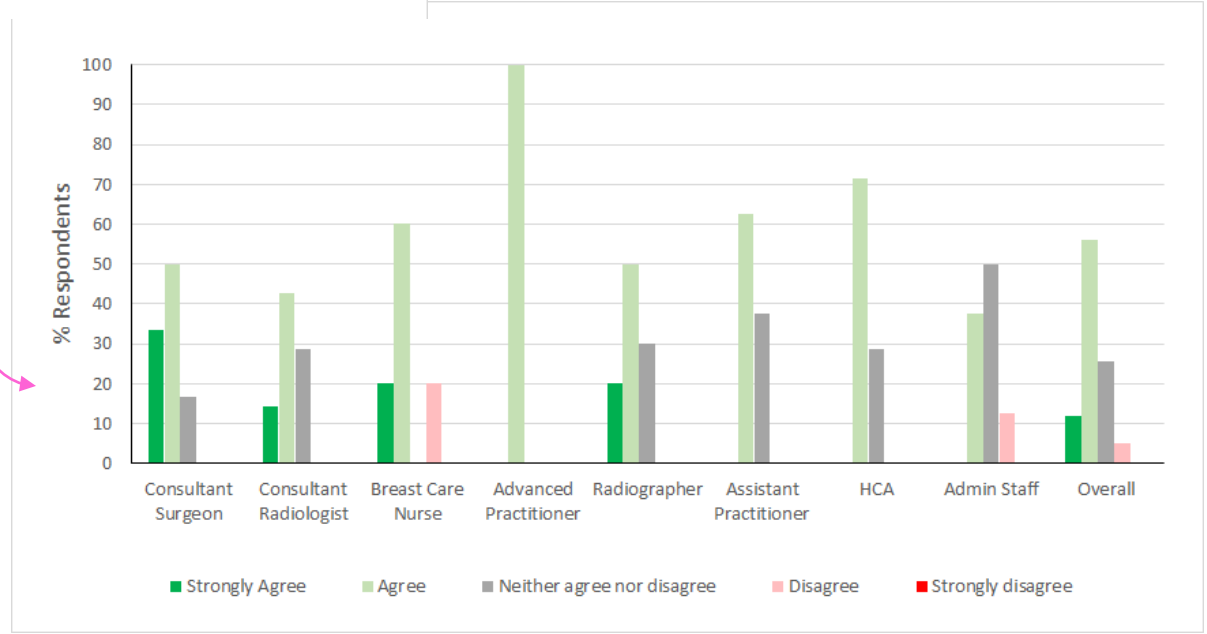
"I am happy with my current level of involvement with research in the department"

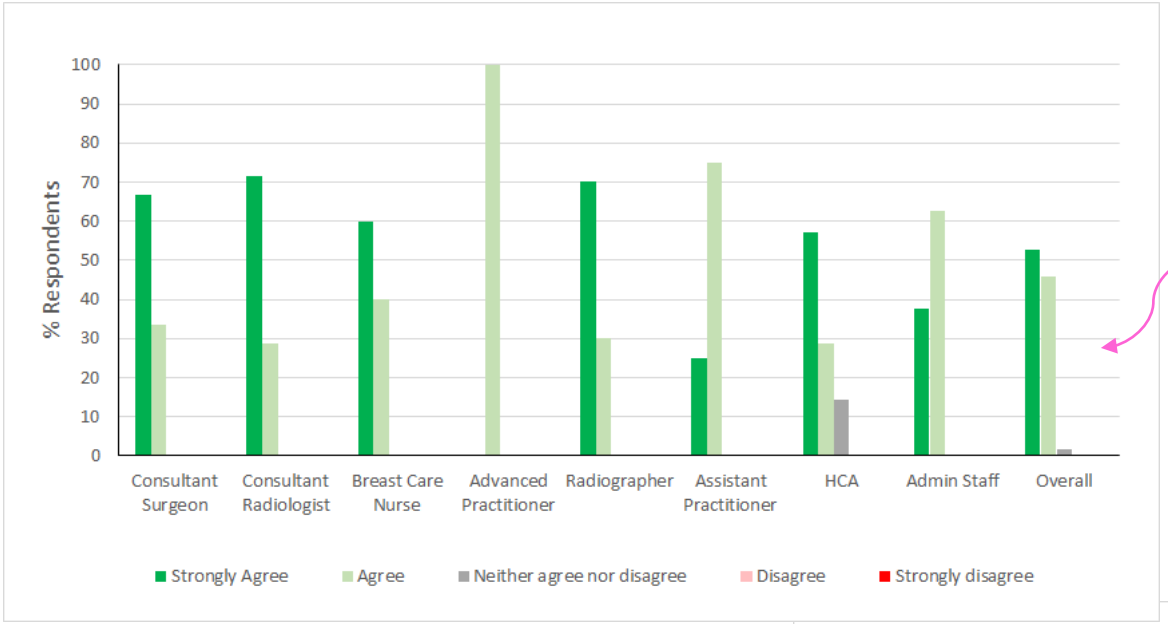




"I would like to be made more aware of the research activity within the unit"

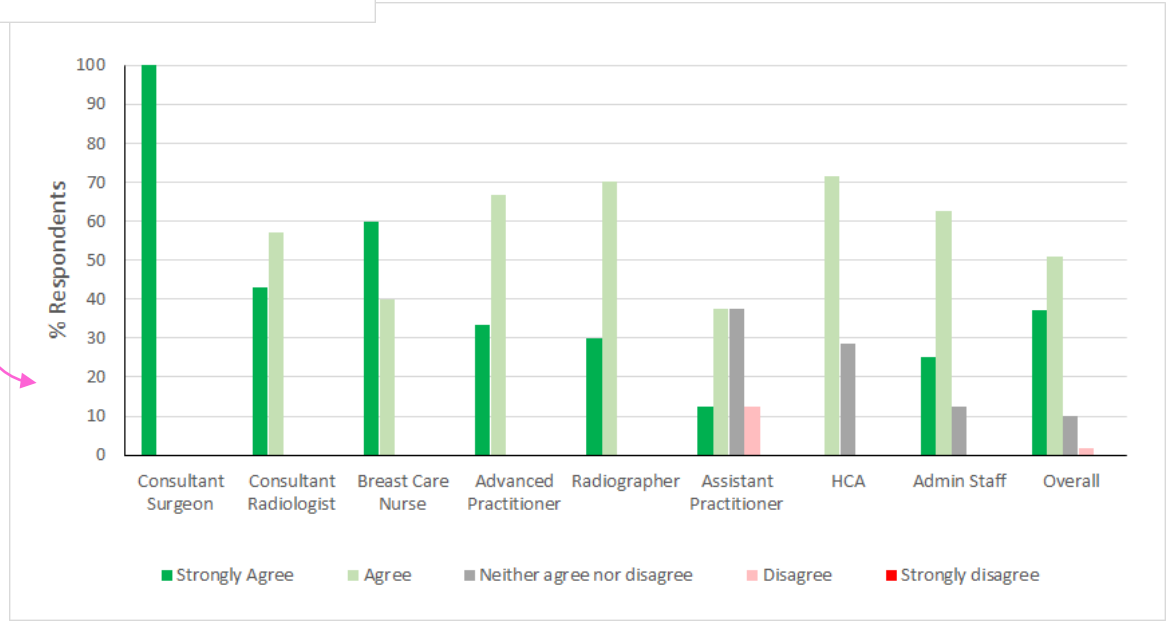
"Given the opportunity I would like to become involved with research within the unit"

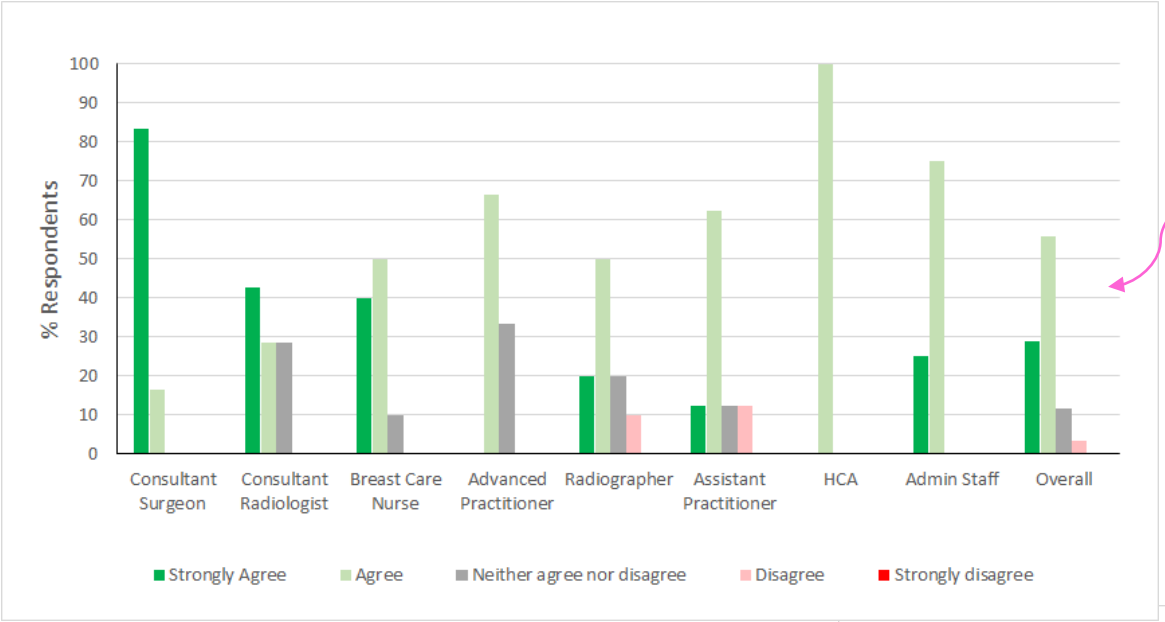




"Overall I feel that participating in research is important for improving patient care"

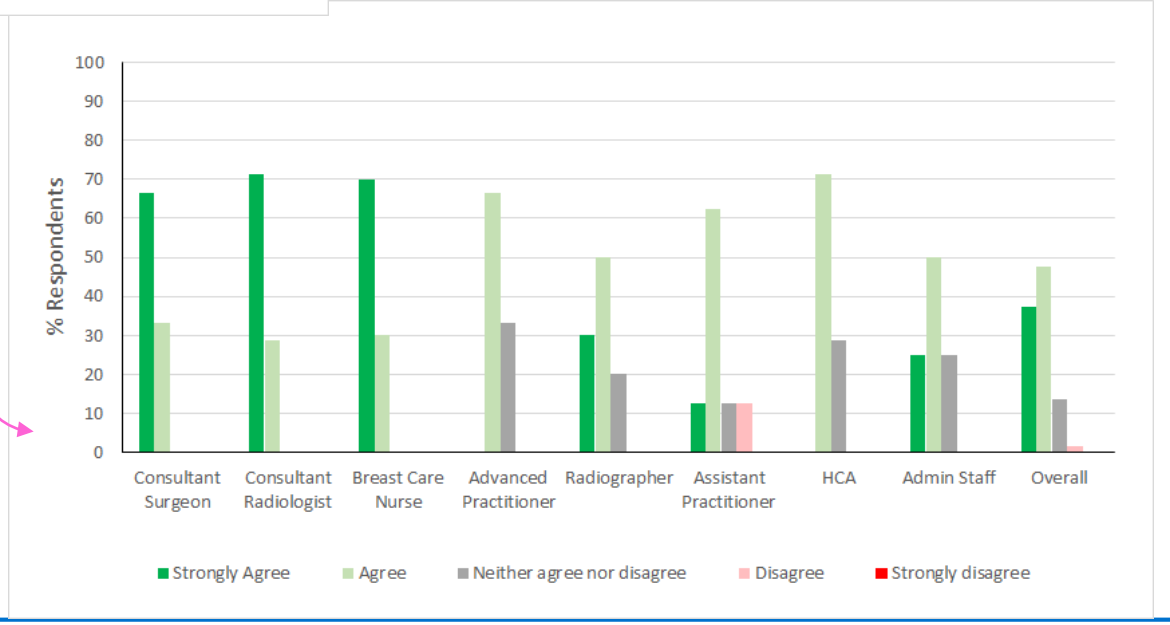
"Specifically I feel that research-active departments can provide better care for patients"

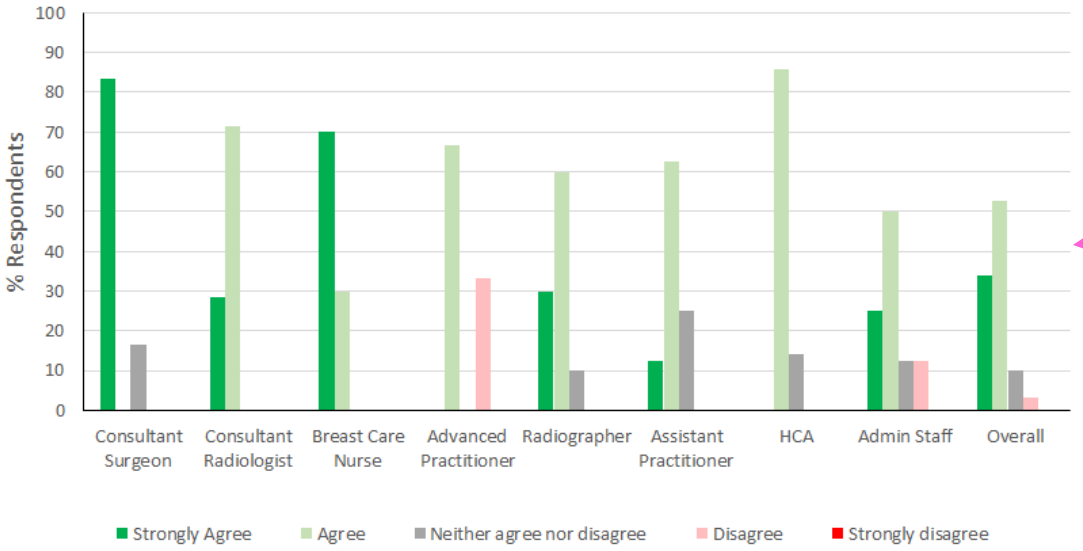




"I feel that patients are more likely to have confidence in a department that is actively involved in clinical research"

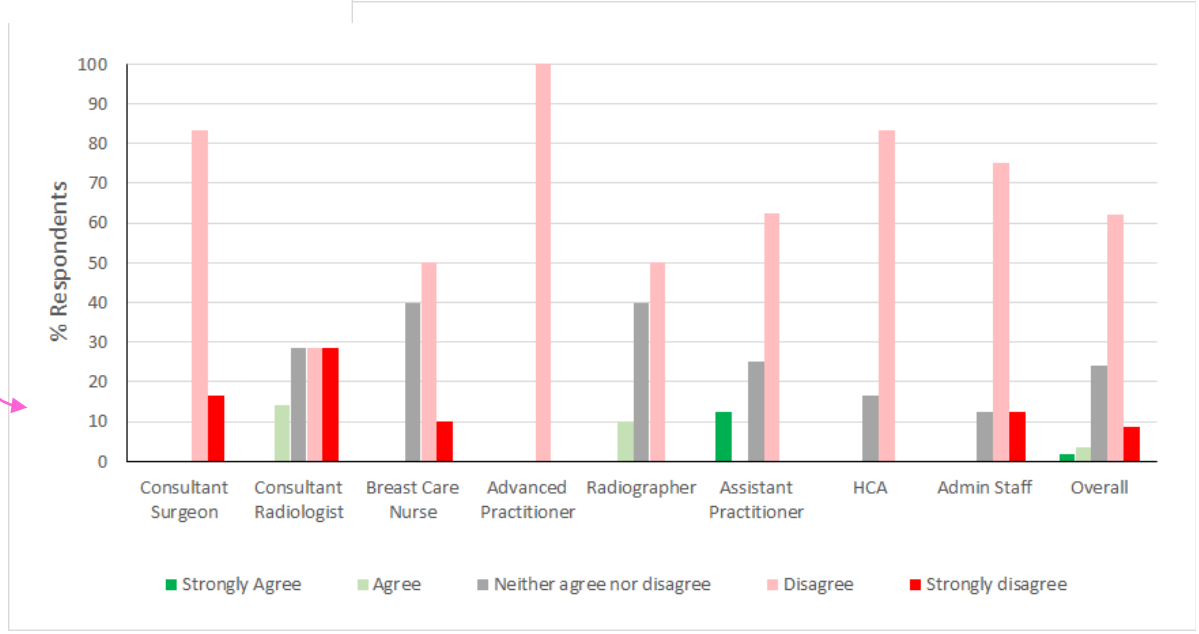
"I feel that research-active departments overall have a better reputation than departments that do not participate in research"





"Overall I would feel better about the department I worked in if I knew it was contributing to its field at a national or international level, such as contributing to national guidance or national/international research"

"As things stand at the moment I think the unit should concentrate less on its research and more on patient care"



Survey findings

- Overall staff in all groups recognise the importance of participating in research for the benefit of patient care
- Most respondents agree that patients will have more confidence in a unit that is research-active
- Most staff felt that research active departments have a better reputation
- Staff would feel better about the department they worked in if they knew it was contributing to research and national guidance
- Not all staffing groups are aware of the type and extent of research that is done within the breast unit
- The responses suggest there is appetite across all staff groups to have greater awareness of, and involvement in, the research that is being conducted in the unit.


NORTHERN CENTRE for
BREAST
RESEARCH

Purpose

Our aim is to establish a Research Centre affiliated with the clinical Breast Unit and the Trust's R&D Department that allows all breast-related research to be brought together irrespective of discipline/specialty

Our Mission Statement

"To engage in multidisciplinary, high quality breast care research to make a positive difference to patient care."

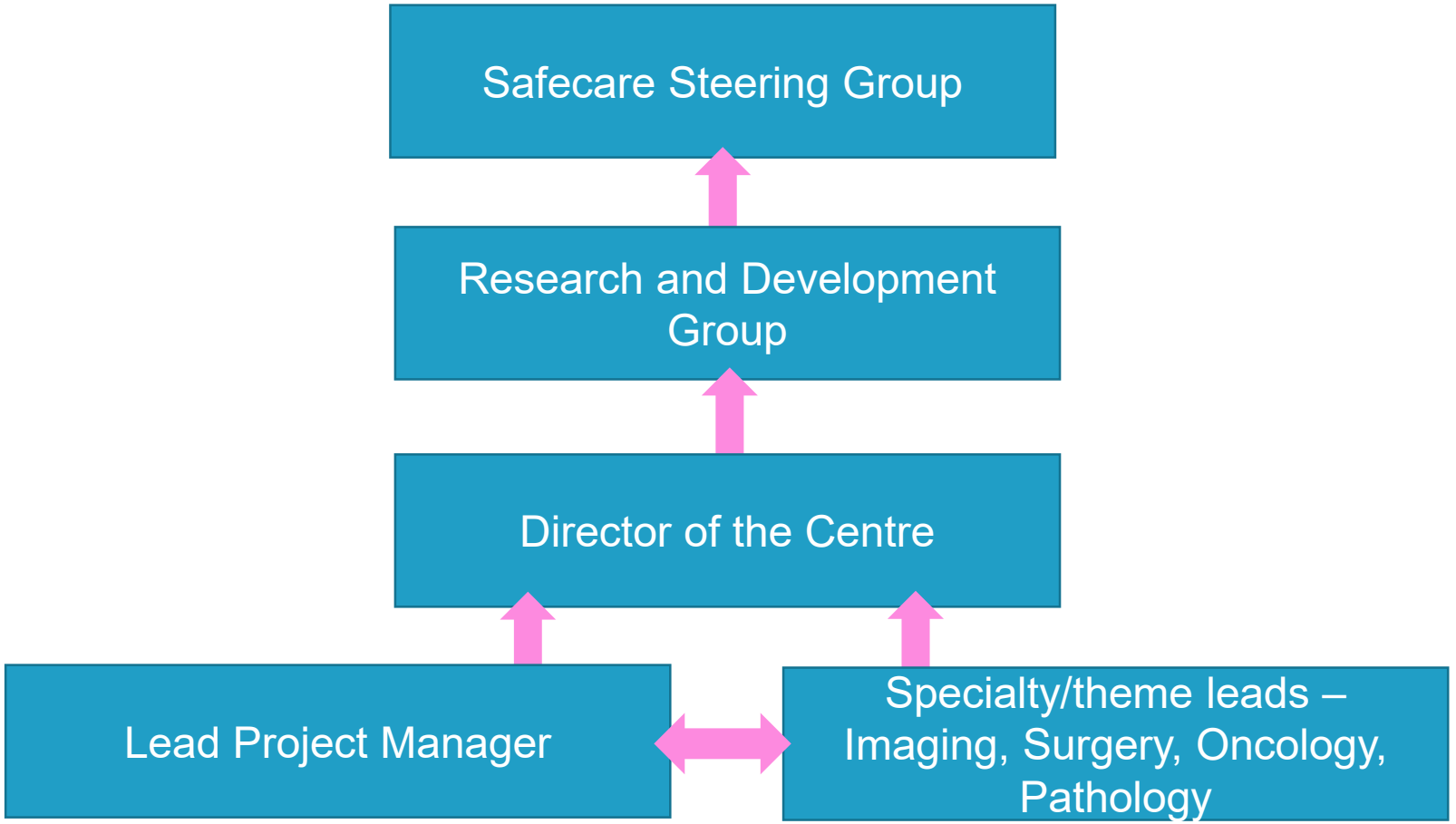
Simon Lowes
Rob Milligan
Lucy
Blackwell

Gateshead Health
NHS Foundation Trust

What will the Research Centre look like?

- It will be run within the existing space of the breast unit
- The term ‘Centre’ makes reference to the bringing together of staff participating in breast research to form a cohesive unit
- Administrative and financial structure
- It will benefit from appropriate branding to give it internal and external identity
- The concept is to use existing resources wherever possible to establish a foundation on which to build for the future


NORTHERN CENTRE for
BREAST
RESEARCH
NHS
Gateshead Health
NHS Foundation Trust


Safecare Steering Group
Research and Development Group
Director of the Centre
Lead Project Manager
Specialty/theme leads – Imaging, Surgery, Oncology, Pathology

Aims and benefits

Gateshead Health NHS Foundation Trust

Patient benefits

Improve patient experience

Improve quality of care

Increase confidence in our breast services

Increase treatment options for patients

Staff benefits

Increase confidence in their workplace

Improve staff morale

Provide an environment to support more staff in becoming research-active

Benefits to the Trust

Raise profile

Boost reputation

Benefits to the Breast Unit

Foster a culture of learning and evidence-based practice

Increase patient recruitment to clinical studies

Wider benefits

Help train researchers of the future

Increase research delivery

Increase collaboration with partner organisations such as NIHR/RDN, universities, industry

Increase our own de novo research

Next steps

- Branding
- Signage
- Launch aimed for 21st May 2025 to coincide with the week of International Clinical Trials Day

Gateshead Health
NHS Foundation Trust

Thank you

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 8

Report Title:	**Annual Declarations of Interest for the Board of Directors**			
Name of Meeting:	Board of Directors			
Date of Meeting:	26 March 2025			
Author:	Jennifer Boyle, Company Secretary			
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:** ☐
	To approve the latest Board of Directors' Register of Interests, ensuring it is publicly accessible through the Board papers.			
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*	Interests have been declared in accordance with local and national policy and in accordance with the Trust's governance documents. Unless stated on the register declarations have been made by Board Members during March 2025 and therefore represent the latest record of interests declared.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is requested to formally approve the annual register of interests for the Board of Directors.			

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:	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.	

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** ☒

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	01/01/2023	present	
			Non-Executive Director - XR Therapeutics	01/03/2024	present	
			Trustee - Terrence Higgins Trust	01/05/2022	present	
Trudie	Davies	Chief Executive	Chair of Regional and North East and North Cumbria Workforce Board	2024	present	
			Member of North East and North Cumbria Provider Collaborative	2023	present	
Gavin	Evans	QEF Managing Director	None			
Jane	Fay	Acting Group Director of Finance	Married to Chief Finance Officer, North East and North Cumbria ICB	01/01/2025	present	Appointed as Acting Group Director of Finance in January 2025
Gill	Findley	Chief Nurse/Deputy Chief Executive	None			
Neil	Halford	Medical Director for Strategic Relationships	None			
Joanne	Halliwell	Group Chief Operating Officer	None			
Martin	Hedley	Non-Executive Director and Senior Independent Director	Chair & Non-Executive Director - RSCH Pharmacy Limited	01/04/2020	present	Chair of an NHS subsidiary
			Governor, Vice Chair - Gateshead College	01/04/2020	present	
			Managing Director - Vision Achievement Limited	01/02/2014	present	
Carmen	Howey	Medical Director	None	01/07/2024	present	Commenced in post at the Trust in July 2024
Kris	Mackenzie	Group Director of Finance	None			*Note declaration is from March 2024*
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		present	
			Spouse - Chair of Believe Housing Ltd	2024	present	
			Spouse - Chair of Trustees for Newcastle United Foundation		present	
			Spouse - Ambassador of North Northumberland Hospice Care	2015	present	
			Spouse - Chair of Regional Development Committee, Prince's Trust		present	
			Spouse – Vice Chair of Northumberland Church of England Academy Trust		present	
Andrew	Moffat	Non-Executive Director	Non-Executive Director of Advanced Northumberland	24/04/2023	present	
Gerry	Morrow	Non-Executive Director	Medical Director and Editor - Agilio Software Ltd	02/20212	present	Commenced in post at the Trust 1 December 2024
Hilary	Parker	Non-Executive Director	Trustee - Newcastle University Development Trust	2012	present	Charitable Trust
			Non-Executive Director of QE Facilities Ltd (wholly owned subsidiary of GHNHSFT)	01/10/2023	present	
Mike	Robson	Non-Executive Director	Chair of Newcastle Hospitals Pharma Services Ltd	01/12/2024	present	
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	
			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: 9

Report Title:	**Quality Governance Committee – Terms of Reference**			
Name of Meeting:	Board of Directors			
Date of Meeting:	26 March 2025			
Author:	Jennifer Boyle, Company Secretary			
Executive Sponsor:	Gill Findley, Chief Nurse			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To ratify the revised terms of reference for the Quality Governance Committee			
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*	Quality Governance Committee – 28 February 2025			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	This is an interim update to the terms of reference for Quality Governance Committee to align with the changes made to the governance structure. The terms of reference now reflect more streamlined reporting from the Tier 2 SafeCare Steering Group to the Committee. This is an interim update and it is expected that further changes may be required as the new structure continues to embed. The revised terms of reference align to the new cycle of business for 25/26. The Quality Governance Committee reviewed a copy of the terms of reference with tracked changes to enable full visibility of the adjustments made and were satisfied with the changes. The Committee approved the changes and recommend the terms of reference to the Board for ratification.			

Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	On the recommendation of the Quality Governance Committee the Board of Directors is requested to review and ratify the revised terms of reference.	
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:	• Evidence full compliance with the Maternity Incentive Scheme (MIS) and the Ockenden actions • Full delivery of the actions within the Quality Improvement Plan leading to improved outcomes and patient experience with particular focus on improvements relating to mental health, learning disabilities and cancer. • Work at place with public health, place partners and other providers to ensure that reductions in health inequalities are evidenced with a focus on women's health • Work collaboratively as part of the Gateshead system to improve health and care outcomes to the Gateshead population	

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** ☒		

Tier 1 Board Committee

Terms of Reference

Gateshead Health NHS Foundation Trust

Quality Governance Committee

Constitution and Purpose – The Quality Governance Committee is a formal Tier 1 committee of the Board with delegated responsibility to monitor, review and make recommendations to the Trust Board with regard to all aspects of quality of clinical care; quality and clinical governance systems; clinical risk issues, research & development; and regulatory standards of quality and safety.

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

Date Adopted / Reviewed	February 2025
Review Frequency	Annually
Review and approval	Quality Governance Committee – February 2025
Adoption and ratification	Trust Board – March 2025 (TBC)

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

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

Committee duties and responsibilities	
Strategy, planning and risk	To **seek assurance over the delivery of the strategic objectives** mapped to the Committee for monitoring at the commencement of

	the financial year. This will be conducted via review of the Leading Indicators / Integrated Oversight Report. To approve and seek assurance over the **delivery of national and local-level strategies** relating to the remit of the Committee. To seek assurance over actions taken to address **strategic emerging quality-related developments / issues** through the routine overview reports provided by the Chief Nurse, Medical Director and ICB. To **review the sections of the Board Assurance Framework (BAF)** mapped to the Committee for oversight and assurance, triangulating the control and assurance assertions on the BAF with the assurances and risks identified during each meeting. To **review the quality / medical–related risks on the Organisational Risk Register**, seeking assurance over the effective management of these risks towards the achievement of their target scores. The Committee will triangulate the risk registers against the assurances and risks emerging from the meeting for completeness. To seek assurance over compliance with the **Emergency Preparedness, Resilience and Response (EPRR) standards** to order to ensure that potential risks to patient safety are effectively mitigated.
Safety	The **Leading Indicators Report** will be used to provide an overview of aspects of safety performance (in accordance with the metrics defined in NHS England and Improvement's Single Oversight Report) and enable spotlight reporting on areas of greatest risk. This report includes maternity and neonatal quality and safety indicators and is also reviewed by the Board (resulting in monthly review of maternity metrics). Seek assurance that the Trust has **effective systems for safety**, with particular focus on quality, patient safety, staff safety and wider health & safety requirements. This should also include routine assurance regarding compliance with **safe staffing levels** and well as the outcome from the **Safer Nursing Care Tool** reporting. Seek assurance over the **robustness of procedures to ensure that adverse incidents and events are detected, openly investigated, with lessons learned being promptly applied** and appropriately disseminated in the best interests of patients, of staff and of the Trust. To seek assurance that the Trust embeds **learning from deaths** and had a robust process in place which complies with mandatory requirements. The Committee will receive assurance reports relating

	to learning from deaths (including the annual report), mortality data and reports from the Medical Examiner. To seek assurance that the Trust appropriately **responds to requests and requirements from coroners and other regulatory bodies** in respect of patient safety. To seek assurance over **health and safety** compliance through quarterly updates and the health and safety annual report. Through the reporting from **SafeCare Steering Group** the Committee will seek to gain assurance that: • the Trust has in place such systems of work and controls that **ensure medicines are effectively managed** and complaint with legislative requirements. • the Trust has in place such systems of work and controls that **ensure medical devices are effectively managed** and complaint with legislative requirements. • the Trust has in place systems of work and controls that ensure **infection prevention and control** is effectively managed and compliant with legislative requirements. To gain assurance that **safeguarding** is compliant with national and local requirements such that patients are safe in the Trust's care. On behalf of the Board the Committee will seek assurance on **maternity services** bi-monthly through the maternity oversight report. To seek assurance that quality and safety concerns raised via **Freedom to Speak Up** are appropriately addressed and lessons learned.
Patient experience	The **Leading Indicators Report** will be used to provide an overview of aspects of patient experience metrics (in accordance with the metrics defined in NHS England and Improvement's Single Oversight Report) and enable spotlight reporting on areas of greatest risk. Seek assurance that the Trust has **effective systems for delivering a high quality experience** for all its patients and users, with particular focus on **involvement and engagement** for the purposes of learning and making improvement. To provide assurance to Trust Board that there are robust systems for **learning lessons from complaints**, and action is being taken to minimise the risk of occurrence of adverse events. This should

	include the **sharing of aspects of good practice identified through compliments** and patient feedback. To seek assurance that the Trust is **delivering high quality care for patients with learning disabilities** in accordance with nationally and locally prescribed standards via the reporting from SafeCare Steering Group. The Committee will seek assurance over embedding of good practice or improvement actions resulting from **patient surveys**. To seek assurance that work is being undertaken to address **health inequalities** and improve patient outcomes and experience in this regard.
Clinical effectiveness, leadership and training	The **Leading Indicators Report** will be used to provide an overview of aspects of clinical effectiveness and outcomes (in accordance with the metrics defined in NHS England's Single Oversight Report) and enable spotlight reporting on areas of greatest risk. Seek assurance that the Trust has **effective systems for monitoring clinical outcomes and clinical effectiveness,** with particular focus on ensuring patients receive the best possible outcomes of care across the full range of Trust activities. To seek assurance over the **effective engagement of clinical leads** in the development and delivery of quality improvement initiatives. To seek assurance that clinical audit processes support effective clinical practice via the assurance and escalations from SafeCare Steering Group.
Regulatory and governance	To monitor, scrutinise and provide assurance to the Trust Board on the Trust's **compliance with core regulatory standards**, including the Care Quality Commission's Fundamental Standards, quality-related elements of NHS England metrics and NICE guidance. This will be conducted via assurances and escalations from the SafeCare Steering Group. On behalf of the Board, take a lead role in **seeking assurance that the Trust's annual Quality Account is compliant with regulatory requirements**, reflective of the main achievements and challenges during the year and has been appropriately consulted upon. The Committee will receive six-monthly updates on progress against the Quality Account priorities.

	To triangulate through assurance the **robustness of quality-assurance processes relating to all research undertaken** in the name of the Trust and / or by its staff, in terms of compliance with standards and ethics, and clinical and patient safety improvement processes. To receive for information and assurance **Internal Audit reports** pertaining to the remit of the Committee. To receive for information and assurance any **reports from external reviews** pertaining to the remit of the Committee, for example Regulation 28 reports. To review any material **emerging regulatory guidance / requirements** in relation to quality and clinical matters on behalf of the Board.

Reporting and monitoring	
Sub-groups	The following sub-groups report into the Committee via Gateshead Health Leadership Group: • SafeCare Steering Group (with additional reports from divisional SafeCare meetings on a rotational basis). The minutes and summary of assurances and escalations documents are received by the Committee as part of the flow of assurance through the Trust's governance structure. The Committee will receive detailed assurance reports from the Mental Health Act Legislation Committee.
Board reporting	An assurance report from the Committee will be presented by the Chair to the next meeting of the Board of Directors.
Monitoring	Compliance with the terms of reference will be reviewed via an annual self-assessment. This will inform any proposed revisions to the terms of reference and the cycle of business. The outcome of the effectiveness and terms of reference review is presented to the Board of Directors following consideration by the Committee.

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 10

Report Title:	**Updated CQC Statement of Purpose**			
Name of Meeting:	Board of Directors			
Date of Meeting:	Wednesday 26 March 2025			
Author:	Mrs Lindsay Grieves, CQC Compliance Manager			
Executive Sponsor:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals			
Report presented by:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	The Statement of Purpose is a CQC registration requirement document that must be regularly reviewed and updated to reflect any changes in the organisation and the description and location of services.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Gateshead Health Leadership Group on 6th February 2025.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	The 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 has 2 large satellite site, Bensham Hospital and the Community Diagnostic Centre (CDC). It also has an additional 92 satellite sites as detailed within part 3, where Regulated activities may be delivered at or			

	from. This includes AAA Screening provided within 11 HM Prisons. All updates have been highlighted for ease, these include the addition of 2 Community hubs where Maternity Community Midwives consult with patients and the inclusion of Jo Halliwell as a Registered Manager for Surgical procedures and Diagnostic and screening procedures. Updates to the Statement of Purpose identified have been submitted to the CQC.				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	To receive this document 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 strategic 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 – new risks, or those already recognised on our risk management system with risk reference number):	3111 – Regulatory requirements in relation to CQC registration				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Part 1

The provider's name, legal status, address and other contact details

Including address for service of notices and other documents

Statement of purpose, Part 1

Health and Social Care Act 2008, Regulation 12, schedule 3

The provider's business contact details, including address for service of notices and other documents, in accordance with Sections 93 and 94 of the Health and Social Care Act 2008

1. Provider's name and legal status							
Full name[1]	Gateshead Health NHS Foundation Trust						
CQC provider ID	RR7						
Legal status[1]	Individual	☐	Partnership	☐	Organisation	☒	

2. Provider's address, including for service of notices and other documents	
Business address[2]	Gateshead Health NHS Foundation Trust Queen Elizabeth Hospital Sheriff Hill
Town/city	Gateshead
County	Tyne and Wear
Post code	NE9 6SX
Business telephone	0191 482 0000
Electronic mail (email)[3]	trudie.davies4@nhs.net

By submitting this statement of purpose you are confirming your willingness for CQC to use the **email address** supplied at Section 2 above for service of documents and for sending all other correspondence to you. Email ensures fast and efficient delivery of important information. If you do not want to receive documents by email please check or tick the box below. We will not share this email address with anyone else.

I/we do **NOT** wish to receive notices and other documents from CQC by email	☐

[1] Where the provider is a partnership please fill in the partnership's name at 'Full name' in Section 1 above. Where the partnership does not have a name, please fill in the names of all the partners at Section 3 below

[2] Where you do not agree to service of notices and other documents by email they will be sent by post to the business address shown in Section 2. This includes draft and final inspection reports. This postal business address will be included on the CQC website.

[3] Where you agree to service of notices and other documents by email your copies will be sent to the email address shown in Section 2. This includes draft and final inspection reports.

Please note: CQC can deem notices sent to the email or postal address for service you supply in your statement of purpose as having been served as described in Sections 93 and 94 of the Health and Social Care Act 2008. The address supplied must therefore be accurate, up to date, and able to ensure prompt delivery of these important documents.

3. The full names of all the partners in a partnership	
Names:	

Part 2

Aims and objectives

Aims and objectives

What are your aims and objectives in providing the regulated activities and locations shown in part 3 of this statement of purpose

Introduction

Established in 2005, we were one of the first Foundation Trusts in the country and since then have consistently delivered the highest levels of care for our patients. We now offer 478 hospital beds across the Gateshead region and employ approximately 5,100 people and have a revenue turnover of around £363m.

We provide a range of acute and community services across our key sites (Queen Elizabeth Hospital, Bensham Hospital and Blaydon Primary Care Centre) as well as a number of minor sites in Gateshead. In addition to providing a range of District General Hospital services, the Trust is also an Integrated Community Provider, which includes offering care in the homes of our patients.

The Trust received an overall rating of 'Good' following the last full site inspection in 2019, with 'Outstanding' for the Caring domain. In February 2023, CQC inspected Maternity Service at Queen Elizabeth hospital as part of their national maternity inspection programme and we received an overall rating of 'Good', with 'Good' from both the Well Led and Safe Domains.

Partnership working

The Trust is an active partner in the "Gateshead Cares" system board. We are committed to the Alliance Agreement which underpins collaborative system wide-working and accountability in Gateshead.

The Trust has worked in partnership with Newcastle Hospitals NHS Foundation Trust to develop a bespoke Community Diagnostic Centre located within the Metrocentre shopping centre this will provide for the population of the North East a host of screening services including MRI and CT scans as well as a many others.

Specialist services

Alongside a full range of local hospital services, we also provide specialist services, including:

- Breast screening service for Gateshead, South Tyneside, Sunderland and parts of Durham. The Trust offers high standards of treatment – from screening and diagnosis to treatment.
- Specialist gynaecological cancer treatments provided by the Trust have developed a positive reputation both nationally and internationally. Services are now provided beyond the Gateshead region to the Scottish borders, through to Cumbria and Whitby.
- The North East Bowel Cancer Screening Hub for the National Bowel Cancer and AAA Screening Programme, provides services for a population of around seven million people.
- Leading care in our state-of-the-art facilities including our Emergency Care Centre, Pathology Centre of Excellence and the North East Surgery Centre.
- Maternity services are rated as Good by the Care Quality Commission (CQC) and are among the best in the country.
- Robotic surgery capacity is available which allows for robotic keyhole surgery to be offered to patients.
- The Gateshead Fertility Centre is one of the top ten IVF clinics in the country, successfully having created hundreds of new families in the North East over the last decade.

Vision and Values

We undertook a significant amount of engagement with colleagues, governors and stakeholders to develop our new vision, values and strategy which launched in early 2022/23.

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

The Trust's vision was developed through engagement with our people to identify what matters to us as an organisation - now and in the future**. #GatesheadHealth, proud to deliver outstanding and compassionate care to our patients and communities**.

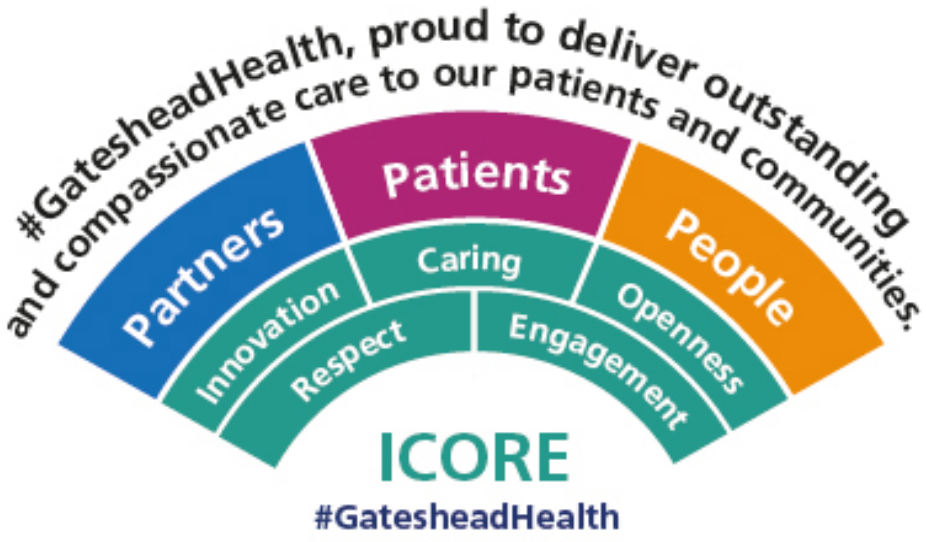
Through engagement with our people and partners, we have recognised how important it is that we use the title 'Gateshead Health' to be inclusive to all of the people who work for and represent the Trust.

- We believe in the patient being at the heart of everything we do
- We also want to work well with our partners to give you the best experience possible
- We want to be the best employer, creating the right conditions for our staff to excel
- We want to spend our money wisely, that means being held accountable to you by a board of non-executive directors and governors
- Living our values every day

Our values are the golden thread that runs through everything we do. Following a Trust-wide consultation with our people, they remain unchanged as the feedback was that our values continue to resonate and remain important.

Our values (demonstrate what we believe in and how we will behave)

The Trust values have been grouped together to form the acronym ICORE - Innovation, Care, Openness, Respect and Engagement. Our Trust values are the 'golden thread' which runs through everything we do; it is the core of who we are.



The aims and goals of Gateshead Health NHS Foundation Trust

Our aims:

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

Our goals: what success looks like by March 2025 and how we will measure this:

- **Patients - Compassionate care is at the very heart of everything we do at Gateshead Health**

The patient communities we serve at Gateshead Health are very important to us. Everyone who works at the Trust is committed to providing the highest standards of safe care to our patients at the right time and in the right place.

Our focus areas:
1. Caring for all our patient communities
2. Providing safe, high-quality care
3. Offering increasingly integrated care
4. Making every contact compassionate and caring

How will we measure our success:

- Friends and Family Test results
- An increase in compliments and reduction in common themes and trends within complaints
- Feedback via Governor engagement
- National Patient survey results
- National Audit results
- Delivering our Quality priorities
- Positive patient feedback
- Meeting our performance standards
- Improvements in statistical measures of health and care outcomes
- Delivery of safety priorities and improvement of maternity metrics in the Integrated Oversight Report
- An ‘Outstanding’ CQC rating for caring.

- **People - The people at Gateshead Health are our greatest asset**

Our people are key to achieving our aim of being a great organisation with a highly engaged workforce. In every conversation held while developing this strategy, the value and importance of our people has shone through.

Our focus areas:
1. Caring for the health and wellbeing of our people
2. Being a great place to work

3. Ensuring a diverse, inclusive and engaged culture

How will we measure our success?

- Reduction in sickness absence
- Improvements in the WRES/WDES for delivering improved staff experience
- A reduction in vacancy rates and staff turnover
- Improved responses to staff survey
- Annual staff survey overall staff engagement score within the top 20% of our benchmark group
- Increase in annual staff survey % of staff experiencing opportunities for career and skills development.

- **Partners - We respect and work closely with our partners to deliver outstanding care**

We have always recognised the value of working closely with others that share our values and commitment to patient care. Meaningful partnerships provide opportunities to address recruitment and retention challenges, generate economies of scale, and improve patient pathways.

Our focus areas:
1. Being a force for good
2. Acting as a key partner
3. Working with our education partners

How will we measure our success?

- Regularly seek and act on feedback from partners to become a truly collaborative organisation
- Increased footprint for service delivery
- Achieving our sustainability targets
- Positive feedback from members of the community
- Delivery of agreed health inequalities action plan
- Delivery of Gateshead Cares priorities and action plans
- Working with our key partners to deliver care closer to home to deliver a decrease in discharge times

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.~~

Cragside ward is an inpatient dementia assessment and treatment unit. The ward has 16 single, ensuite bedrooms and aims to provide a comprehensive and holistic assessment of the older person's physical, psychological, behavioural, social and spiritual needs through validated assessment tools and multidisciplinary working.

Sunniside Unit is a 10 bedded Older Persons Mental Health Unit serving the population of Gateshead for people with a diagnosis of a functional mental health condition and are experiencing crisis requiring admission to hospital.

There are also separate buildings for:

- Children's Services Out-Patient Department
- Women's Health: an outpatient clinic for Obstetrics and Gynaecology

- St. Bede's Unit: an inpatient specialist palliative care ward for end of life care

All buildings are designed to be used as hospital buildings. All have wheelchair and vehicle access and other provisions and adaptations as necessary for disabled access.

Bensham Hospital is two miles away from the Queen Elizabeth Hospital in Gateshead and is classed as a large satellite site. A range of services are provided including the Gateshead Memory Hub which provides care and support for people aged 65 years and over who have been given a diagnosis of a Dementia as well as a Younger Person's Mental Health Clinic. Working in partnership with NEAS, our Rapid Response Service offer timely support to patients at home who have experienced a recent fall. A combined team of an Occupational Therapist (OT) and a Paramedic complete medical and functional assessments in the patient's own home referring on to other services and agencies as appropriate, aiming to keep the patient safe at home. Staff may arrange for further medical review, or rehabilitation assistive equipment in a bid to minimise the risk of further falls and support people to live as independently as possible. The Adult Speech and Language Therapy (SLT) Service clinic assesses and manages people with swallowing, communication, voice and fluency difficulties caused by a range of different conditions. Our Registered Audiologists provide high quality Audiology clinics and care from this site. The Podiatry service provides clinics facilitated by Podiatrists and Advanced Podiatry Assistants, who provide screening, treatment and education to patients, empowering them to self-care, and preventing future foot pathology. A Biomechanics Service provides gait analysis and the provision of insoles, pressure-relieving devices, and dynamic devices to realign the foot and improve gait and associated foot problems. There are no overnight beds Bensham Hospital.

The Community Diagnostic Centre is a modern purpose-built healthcare facility located within the Metrocentre shopping centre and is designed to be accessible for people with disabilities. This is approx. 6.5 miles from the Queen Elizabeth hospital and is classed as large satellite site. The CDC provides the following screening and diagnostic services to the population of the North East; MRI, CT, Ultrasound, Echocardiograph, ECG including holter monitoring, Respiratory assessments, Sleep investigations, Phlebotomy and Ambulatory BP monitoring. The CDC have no overnight beds at this location. The building contains patient waiting areas, consultation rooms, toilets and reception areas.

The Queen Elizabeth Hospital and associated satellite sites are staffed by qualified doctors, nurses, allied health professionals and support staff. Supervised students and trainees in these fields are also present. All staff are appropriately qualified for their role in accordance with regulations.

The Queen Elizabeth Hospital also has a further 92 satellite sites as detailed below where Regulated activities may be delivered at or from. The management of these sites/services takes place from the Queen Elizabeth Hospital and as such, the Trust considers these satellite sites as exempt under CQC Locations Rule 9 from been classed as individual locations:

Satellite site name	Satellite site address	Services provided

Accrington PALS Primary Health Care Centre	1 Paradise Street, Accrington, BB5 2EJ	• AAA Screening
Acklam Medical Centre	Trimdon Avenue, Middlesbrough, Cleveland, TS5 8SB	• AAA Screening
Alnwick Bondgate Practice	Infirmary Drive, Alnwick, Northumberland, NE66 2NL	• AAA Screening
Barbara Castle Way Primary Health Centre	Blackburn, BB2 1AX	• AAA Screening
Berwick Infirmary	Infirmary Square, Berwick upon Tweed, Northumberland, TD15 1LT	• AAA Screening
Bewick Centre	Bewick Rd, Bensham, Gateshead, NE8 1UA	• Community Midwives Clinical Room
Birtley Medical Group	Durham Road, Birtley, Tyne and Wear, DH3 2QT	• Anticoagulation/Warfarin Clinics
Birtley SureStart Children's Centre	15 Kinross Close , Birtley, Tyne and Wear, DH3 2HG	• Community Midwives Clinical Room
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: Chief Operating Officer		
Diagnostic and screening procedures	☒	
Registered Manager(s) for this regulated activity: Chief Operating Officer		
Management of supply of blood and blood derived products etc	☐	
Registered Manager(s) for this regulated activity:		
Transport services, triage and medical advice provided remotely	☐	
Registered Manager(s) for this regulated activity:		
Maternity and midwifery services	☒	
Registered Manager(s) for this regulated activity: Chief Nurse		
Termination of pregnancies	☒	
Registered Manager(s) for this regulated activity: Medical Director		
Services in slimming clinics	☐	
Registered Manager(s) for this regulated activity:		
Nursing care	☐	
Registered Manager(s) for this regulated activity:		
Family planning service	☒	
Registered Manager(s) for this regulated activity: Medical Director		

Fill in a separate part 3 for each location

The information below is for location no.:	2		of a total of:	5	locations

Name of location	Blaydon Primary Care Centre
Address	Blaydon Primary Care Centre Shibdon Road Blaydon on Tyne
Postcode	NE21 5NW
Telephone	0191 2834500
Email	trudie.davies4@nhs.net

Description of the location

(The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc)

Blaydon Primary Care Centre is a modern purpose built health care building used by the Trust and Local Authority. The building has a room designed and constructed for Audiometrics including child hearing screening, an X-ray facility and a diagnostics suite for breast screening as well as AAA Screening. It has a number of consultation and treatment rooms and a minor surgery room for day case minor procedures.

The Podiatry service provides clinics facilitated by Podiatrists and Advanced Podiatry Assistants, who provide screening, treatment and education to patients, empowering them to self-care, and preventing future foot pathology. A Biomechanics Service provides gait analysis and the provision of insoles, pressure-relieving devices, and dynamic devices to realign the foot and improve gait and associated foot problems. The service also undertakes specialist services including Diabetes Outpatient Clinics, where the key function is rapid assessment and treatment for patients experiencing diabetic foot ulceration, with the aim of healing ulceration as quickly as possible and promoting better awareness of the risk factors and improving the prevention of further foot complications. Nail surgery is also facilitated which involves the full/partial removal of toenails for patients with recurrent toenail problems. This is carried out under local anaesthetic as well as Electrosurgery, which involves the removal of long-standing lesions such as plantar corns, and verrucae that have not responded to conventional treatment. These procedures are exempt from classification as the Regulated activity “Surgical Procedures” under Schedule 2, Paragraph 4 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, however this site has been registered for “Surgical Procedures” due to the minor surgery room for day case minor procedures.

Other clinics are provided including Anticoagulation/Warfarin clinics; a Complex Wound Clinic which provides assessment and ongoing management for patients with complex wounds and a Bladder and Bowel Clinic, which provides services for both adults and children. The Speech and Language Therapy (SLT) Service assesses and manages people with swallowing, communication, voice and fluency difficulties caused by a range of different conditions. A Walk in Centre service is also provided at this location.

There are no overnight beds at this location. The building contains patient waiting areas,

toilets, reception area and office space for the Macmillan team, West Locality team and Inner West Locality team. All staff are appropriately qualified for their role in accordance with regulations.	
No of approved places / overnight beds (not NHS)	N/A

CQC service user bands

The people that will use this location ('The whole population' means everyone).

Adults aged 18-65	☐	Adults aged 65+			☐	
Mental health	☐	Sensory impairment			☐	
Physical disability	☐	People detained under the Mental Health Act			☐	
Dementia	☐	People who misuse drugs or alcohol			☐	
People with an eating disorder	☐	Learning difficulties or autistic disorder			☐	
Children aged 0 – 3 years	☐	Children aged 4-12	☐	Children aged 13-18	☐	
The whole population	☒	Other (please specify below)			☐	

The CQC service type(s) provided at this location	
Acute services (ACS)	☒
Prison healthcare services (PHS)	☐
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☐
Hospice services (HPS)	☐
Rehabilitation services (RHS)	☐
Long-term conditions services (LTC)	☐
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐
Hyperbaric chamber (HBC)	☐
Community healthcare service (CHC)	☒
Community-based services for people with mental health needs (MHC)	☐
Community-based services for people with a learning disability (LDC)	☐
Community-based services for people who misuse substances (SMC)	☐
Urgent care services (UCS)	☒
Doctors consultation service (DCS)	☒
Doctors treatment service (DTS)	☐
Mobile doctor service (MBS)	☐
Dental service (DEN)	☐
Diagnostic and or screening service (DSS)	☒
Care home service without nursing (CHS)	☐
Care home service with nursing (CHN)	☐
Specialist college service (SPC)	☐
Domiciliary care service (DCC)	☐
Supported living service (SLS)	☐
Shared Lives (SHL)	☐
Extra Care housing services (EXC)	☐
Ambulance service (AMB)	☐
Remote clinical advice service (RCA)	☐
Blood and Transplant service (BTS)	☐

Regulated activity(ies) carried on at this location		
Personal care	☐	
Registered Manager(s) for this regulated activity:		
Accommodation for persons who require nursing or personal care	☐	
Registered Manager(s) for this regulated activity:		
Accommodation for persons who require treatment for substance abuse	☐	
Registered Manager(s) for this regulated activity:		
Accommodation and nursing or personal care in the further education sector	☐	
Registered Manager(s) for this regulated activity:		
Treatment of disease, disorder or injury	☒	
Registered Manager(s) for this regulated activity: Medical Director		
Assessment or medical treatment for persons detained under the Mental Health Act	☐	
Registered Manager(s) for this regulated activity:		
Surgical procedures	☒	
Registered Manager(s) for this regulated activity: Chief Operating Officer		
Diagnostic and screening procedures	☒	
Registered Manager(s) for this regulated activity: Chief Operating Officer		
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: Chief Operating Officer		
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: Chief Operating Officer		
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: Chief Operating Officer		
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:		

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:	3	Managers working for the provider shown in part 1

1. Manager's full name	Dr Carmen Howey

2. Manager's contact details	
Business address	Medical Director Trust Headquarters Queen Elizabeth Hospital
Town/city	Gateshead
County	Tyne and Wear
Post code	NE9 6SX
Business telephone	0191 482 0000
Manager's email address[1]	
Carmen.howey@nhs.net	

[1] Where the manager has agreed to service of notices and other documents by email they will be sent to this email address. This includes draft and final inspection reports on all locations where they manage regulated activities.

Where the manager does not agree to service of notices and other documents by email they will be sent by post to the provider postal business address shown in Part 1 of the statement of purpose. This includes draft and final inspection reports on all locations.

Please note: CQC can deem notices sent to manager(s) at the relevant email or postal address for service in this statement of purpose as having been served, as described in Sections 93 and 94 of the Health and Social Care Act 2008. The address supplied must therefore be accurate, up to date, and able to ensure prompt delivery of these important documents to registered managers.

3. Locations managed by the registered manager at 1 above (Please see part 3 of this statement of purpose for full details of the location(s))	
Name(s) of location(s) (list)	Percentage of time spent at this location

4. Regulated activity(ies) managed by this manager		
Personal care	☐	
Accommodation for persons who require nursing or personal care	☐	
Accommodation for persons who require treatment for substance abuse	☐	
Accommodation and nursing or personal care in the further education sector	☐	
Treatment of disease, disorder or injury	☒	
Assessment or medical treatment for persons detained under the Mental Health Act	☐	
Surgical procedures	☐	
Diagnostic and screening procedures	☐	
Management of supply of blood and blood derived products etc	☒	
Transport services, triage and medical advice provided remotely	☐	
Maternity and midwifery services	☐	
Termination of pregnancies	☒	
Services in slimming clinics	☐	
Nursing care	☐	
Family planning service	☒	

5. Locations, regulated activities and job shares

Where this manager does not manage all of the regulated activities ticked / checked at 4 above at all of the locations listed at 3 above, please describe which regulated activities they manage at which locations below.

Please also describe below any job share arrangements that include or affect this manager.

The Regulated Activities highlighted within Section Four are managed by Executive Directors of the Trust from their base at Trust Headquarters of the Queen Elizabeth Hospital, Gateshead.

The information below is for manager number:	2	of a total of:	3	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.

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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:	3	of a total of:	3	Managers working for the provider shown in part 1

1. Manager's full name	Mrs Joanne Halliwell

2. Manager's contact details	
Business address	Chief Operating Officer 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]	
Joanne.halliwell4@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
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Chair's Report

Alison Marshall, Chair of the Board of Directors

26 March 2025

Board updates and engagement

Gateshead Health NHS Foundation Trust

Board of Directors

- Joined a number of our Non-Executive Directors at the North East and North Cumbria Systemwide Non-Executive Directors engagement session in Newcastle on 24 February. The engagement session included an outline of the role of the Integrated Care Board (ICB) as well as a focus on the NHS 10 year plan 3 shifts – moving care from hospitals to communities; making better use of technology; and focussing on prevention.
- Andrew Moffat, Non-Executive Director Chair of the Group Audit Committee and Digital Committee, has announced his intention to leave the Board on 30 June 2025. We are working with Governors to commence Non-Executive Director recruitment for 2 positions (as Mike Robson reaches the end of his term on the same date).

Engagement

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

- Attendance at NHS England North East and Yorkshire regional workshop on the NHS operating model
- Attendance at the CEO roadshows
- Attendance at Integrated Care Partnership Chairs' meeting – attended by NHS chairs, local authority leaders and the voluntary sector
- Chaired Great North Healthcare Alliance Committees in Common and Joint Committee meetings
- Attended NHS 10 Year Workshop event in Sunderland
- Meeting with the Leader and Chief Executive of Gateshead Council
- Met with the Chair of South Tyneside and Sunderland NHS FT
- Chaired Consultant interviews panels
- Attended ICB Chair and FT Chairs forum
- Attended the Clinical Strategy Group away day
- Attended national NHS Chair and CEO meeting in London on 13 March
- Visited the Community Diagnostic Centre at the Metro Centre with Sir Paul Ennals, Interim Shared Chair for Newcastle and Northumbria FTs, our Chief Operating Officer, Director of Operations for Clinical Support and Screening division and representatives from Newcastle's radiology team

Governor and Member Updates

- We held a **Council of Governors** meeting on 19 February where a number of key decisions were made and assurances received, including:
  - Formally approving the process for the appointment of the Lead and Deputy Lead Governors;
  - Formally ratifying key aspects relating to the Shared Chair recruitment, including the job description, remuneration and appointment of the recruitment advisors;
  - Presentations from the Non-Executive Director chairs of the Digital and Charitable Funds Committees;
  - Receiving the outcomes of the annual Council of Governors' effectiveness survey – the Membership Governance and Development Committee will be undertaking a deeper dive into the results and identifying any resulting actions;
  - Receiving an update on the annual planning process and the development of the 5 year strategy. This includes a focus on financial sustainability, the challenges that we face in relation to this and the difficult decisions which will need to be considered as a result; and
  - Receiving an informative presentation on the targeted lung health checks and the impact of the checks on population health.
- We have been seeking nominations to fill the three vacant seats in the newly merged Central and Eastern Gateshead constituency. Four nominations have been received and therefore a **contested election** will be held with voting commencing on Friday 28 March and closing at 5pm on Thursday 24 April. Good luck to the four candidates!
- The election company has performed a **data cleanse** for Central and Eastern constituency to ensure that our database is accurate and up-to-date. This has resulted in a significant reduction in our constituency members by 78% from 8,585 members to 1,842 members. Whilst this is a large reduction in members we now have an up-to-date membership database for the constituency and we can be assured that it accurately reflects those who wish to be current members. Other public constituencies will be cleansed during the next round of elections.
- Our **Joint Nomination Committee (JNC)** members have been working with counterparts at Newcastle and Northumbria Foundation Trusts to develop and commence the process for the recruitment of the Shared Chair across all three Trusts. As outlined in the CEO's report the recruitment process is now underway with applications closing on 7th April.
- A quarterly **Governor workshop** was held in March 2025. This provided Governors with opportunities to share views on three important areas – the annual plan for 2025/26, the 5 year strategy and the quality priorities for 2025/26.

Star of the Month Nominations

January

- Emily Bowmaker
- Michelle Thomas
- Jemma Crawford

February

- Hannah Brown
- Lisa Breheny
- Will Warrington
- Leah Prudham

You're a Star Winner

Michelle Thomas

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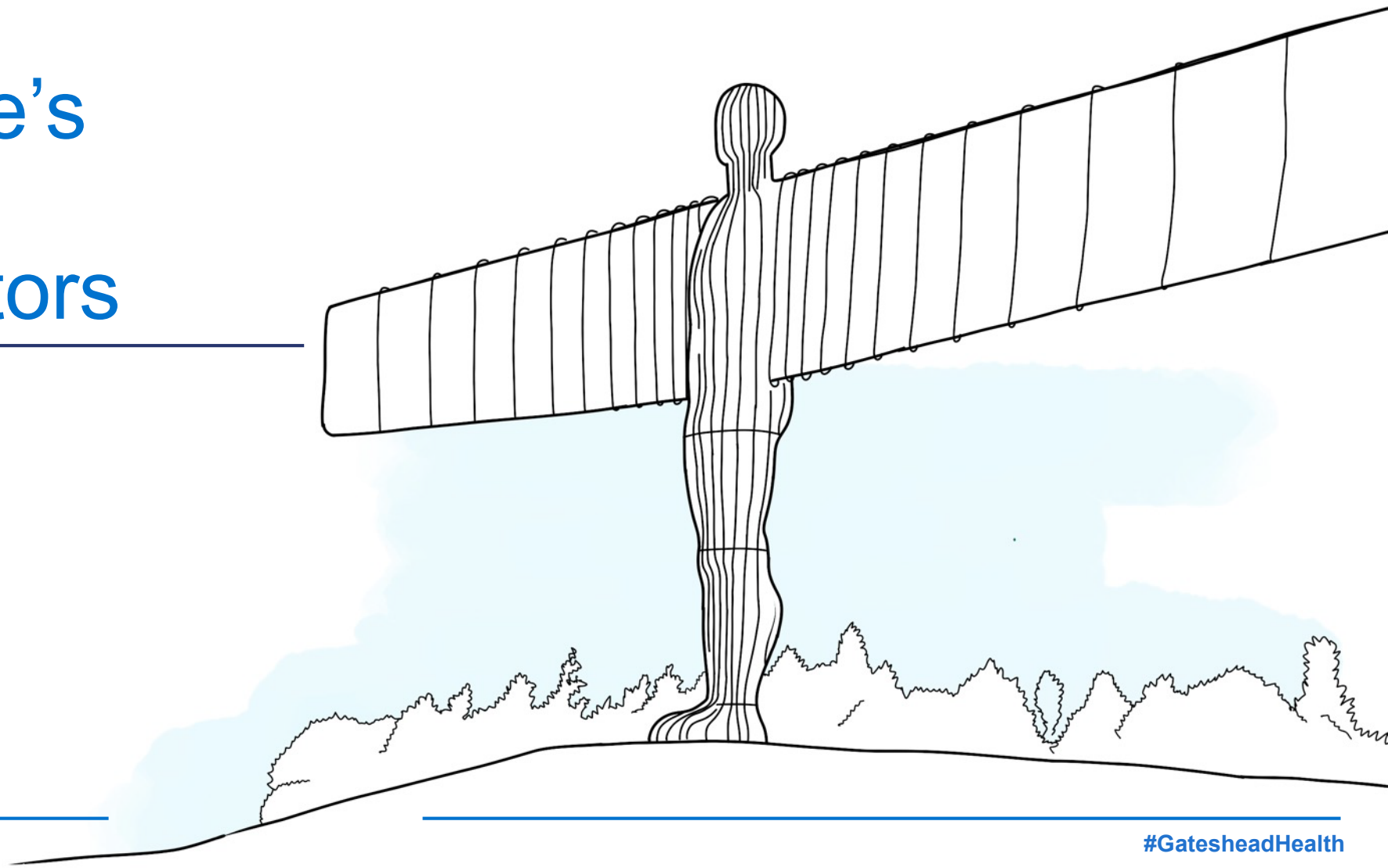
Chief Executive's Update to the Board of Directors

Trudie Davies, Chief Executive

26 March 2025



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

- We are undertaking a **review of our model of care** with the aim of reducing long waits for our patients and improving patient flow through the hospital. We recognise that we need to work differently across the whole organisation to prevent our patients being cared for over long periods in our emergency department and ensure patients reach speciality teams quickly to receive their expert care. Joanne Halliwell and Mark Dale are leading this important piece of work which will involve significant collaboration with our clinical and non-clinical teams.
- Dr Ruth Da Silva, Occupational Therapist, and the team in the Jubilee Acute Stroke Rehabilitation Unit (JASRU) have been taking part in a study in partnership with Durham and Oxford Universities. The study uses a **new screening tool to assess visual perception** following a stroke (the Oxford Visual Perception Screening Tool). The tool takes just under 15 minutes to administer and screens patients for 15 different potential issues providing a much quicker assessment process for patients and staff.
- We are increasing our **focus on falls**, as our falls rate has increased. Work is planned to reinvigorate the falls group and workstream and work with wards with increased falls rates to provide additional training.
- Our **new pharmacy robot** has been installed in the Pharmacy department. The department has used robotic systems for over 20 years but the new robot revolutionises medicine dispensing, supporting faster, safer and more efficient dispensing processes. It enables pharmacy and clinical colleagues to dedicate more time to patient-facing activities.
- We hosted our first **Harvey's Lab Tour** – this is a unique programme run by the Institute of Biomedical Science (IBMS). The programme helps young patients feel less anxious about medical tests by showing them exactly what happens to their samples after they visit the hospital. By opening up the world of medical science to young people, Harvey's Lab Tours is helping to inspire the next generation of scientists while making hospitals a little less scary for children who need medical tests.
- We have been ranked as the **43rd in Newsweek's ranking of the World's Best Hospitals 2025**. The ranking is based on an extensive evaluation process including an online survey of medical experts, patient experience data and quality metrics. This reflects a 7 place improvement from 2024 and recognises our continued commitment to providing high-quality healthcare.
- A **paediatric network visit** took place in early March. The formal report is awaited but positive feedback was received at the end of the visit.

NHS Gateshead Health NHS Foundation Trust

Engagement, involvement and visits:

- CEO Roadshows
- Team Brief
- Meetings with the Emergency Department, Pharmacy, lead therapists, apprentices
- Clinical Strategy Group

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

- The **2025/26 planning round** has been particularly challenging. We recognise the challenge associated with maintaining the size of our workforce given the significant financial pressures across the whole NHS. We maintain our ambition to have a highly engaged workforce and deliver high quality care to our patients despite these challenges.
- Following announcements earlier this month regarding the **level of change and challenge facing the NHS**, including NHS England and Integrated Care Boards, we have been engaging with our colleagues to provide support and share as much information as we have available to us. We recognise that this an unsettling time for people and that uncertainty and change brings anxiety. Workforce and corporate services in particular are areas that all NHS organisations are being asked to look at given the scale of the financial challenges ahead. We know this will be a particularly unsettling time for corporate colleagues and held a dedicated question and answer session to enable colleagues to ask questions of the Executive team and share thoughts on what support and communications would be helpful. This was attended by over 180 colleagues. The detail behind the national asks is not yet clear, but we are committed to continuing to share information transparently and promptly when received.
- We hosted our **annual Apprenticeship Awards** as part of National Apprenticeship Week 2025. The awards celebrate the success of our apprentices, allow us to express our gratitude to all training providers and highlight the crucial role apprenticeships play in career and workforce development. Congratulations to all our nominees and winners! We highly value our apprenticeship scheme and are continuing to evaluate whether we can retain our clinical nurse apprenticeship function.
- We are delighted to announce that we have made a number of **consultant appointments** over the last month, including a cardiologist and two radiologists.
- All substantive Healthcare Assistants who have transitioned from **Band 2 to Band 3** roles as part of the Agenda for Change process will have received their uplift payments by the end of March.
- As part of our cultural work we have developed a **route map** to support colleagues to understand the different routes they can take to raise concerns, depending upon the nature of the concerns. A copy of the route map is included in the Freedom to Speak Up Guardian's report.
- We have been **engaging with our clinical leaders** as part of the development of the model of care outlined on the previous slide and to support the left shift to community in line with the three shifts identified as part of the NHS 10 year plan process. This has included meeting with our Lead Occupational Therapist, Claire McAuley, and Lead Physiotherapist, Sarah Hackett, to seek their thoughts and input. From 1 April our community allied health professions will integrate into the Clinical Support and Screening division – this provides an excellent opportunity to join up service delivery.

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

- We experience an **unexpected loss of our PACS system** earlier in the month. Despite the hard work of a number of teams it took some time to be able to restore the system and bring this back into full use. This impacted on a number of services and we are working on a longer term solution to minimise the risks of the problem reoccurring. Assurance can be provided that business continuity plans were followed and there were no incidences of patient harm identified during the downtime. Sincere thanks to all colleagues who worked hard to resolve the issues and maintain services during this time. We continue to work to understand the cause of the failure and have recognised PACS instability as one of our top organisational risks this month.
- Work has continued to develop the **annual plan** for the Trust. This has been developed through engagement with clinical colleagues, divisions, corporate teams, Alliance partners, the Board of Directors and Council of Governors. As previously reported 2025/26 is expected to be challenging, particularly financially, and the process has therefore included consideration of difficult decisions which may be required to deliver the plan.
- We have been reviewing **productivity metrics** through national benchmarking to identify where our greatest opportunities exist in relation to delivering efficient and responsive services for our people and patients. Our productivity and quality metrics improved during 2023/24 and into 2024/25 which provides a good indicator for the future. We are engaging with our clinical colleagues at Clinical Strategy Group to review the benchmarking and shape future plans.
- We have continued to experience **norovirus outbreaks** since the previous update in January. This has impacted on our clinical areas and resulted in some ward closures to contain the outbreaks.

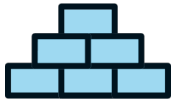
Strategic Aim 4: We will be an effective partner and be ambitious in our commitment to improving health outcomes

- We celebrated **International Women's Day** with our Women's Network and Women in Medicine Network. As part of the celebrations we participated in a celebratory event at Newcastle Civic Centre. This provided an opportunity for us to showcase how we are supporting women's health in Gateshead and beyond as part of our centre of excellence for women's health ambition. At the event Carmen Howey, Group Medical Director, and Nithya Ratnavelu, Associate Medical Director for Cancer, were recognised as inspiring women.
- We have received some excellent feedback from one of our resident doctors, receiving an appreciation for our inpatient respiratory consultants on wards 9 and 10 who have supported their training, learning and development during their time on the ward. The resident doctor noted they '*have never worked in a more inclusive and supportive team*'.
- As part of the Great North Healthcare Alliance a hosted 'Big Research and Innovation Conversation' took place to showcase the great work across the organisations. Alison Harvey, Simon Lowes and Lucy Blackwell represented the Trust and will be joining the working group to help guide the Alliance workstream. As part of the event Simon Lowes, Consultant Breast Radiologist, showcased our work around breast research and our plans for the Northern Centre for Breast Research.

Engagement, involvement and visits:

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

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



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- We look forward to welcoming David Elliot as the **new shared Chief Digital Officer** for the Great North Healthcare Alliance Trusts on the east coast. This will provide an excellent opportunity to share good practice, develop a core standard across the Trusts and support each other to deliver efficient and effective digital offerings.
- The process for the **Shared Chair appointment** is underway with the application process now underway. The process is due to conclude by the end of May 2025.
- Engagement work has continued in relation to the **development of the 5 year strategy**. This has included engagement sessions with the Board, Governors, Clinical Strategy Group and online and in-person engagement opportunities for all staff.
- In relation to the **Community Diagnostic Centre** at the Metro Centre there is an exciting opportunity to expand services as part of phase 2 of this project. We are currently working up an outline proposal for this. This supports our strategic intent of being a diagnostic centre of excellence.

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Report Cover Sheet Agenda Item: 13

Report Title:	**Great North Healthcare Alliance Progress Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	26 March 2025			
Author:	Alliance Formation Team			
Executive Sponsor:	Trudie Davies, Chief Executive Alison Marshall, Chair			
Report presented by:	Nicola Bruce, Director of Strategy and Partnerships / Alliance Formation Team member for Gateshead Health			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	To provide an update on the progress made in respect of the Great North Healthcare Alliance			
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*	Alliance Steering Group Committee in Common – 6 March 2025			

Key issues:
Briefly outline what the top 3-5 key points are from the paper in bullet point format
 	
Consider key implications e.g.
• *Finance*
• *Patient outcomes / experience*
• *Quality and safety*
• *People and organisational development*
• *Governance and legal*
• *Equality, diversity and inclusion*
	• This paper provides an update on the work undertaken and ongoing to form and develop the Great North Healthcare Alliance, which brings together:
	  ○ Gateshead Health NHS Foundation Trust;
	  ○ North Cumbria Integrated Care NHS Foundation Trust;
	  ○ Northumbria Healthcare NHS Foundation Trust; and
	  ○ The Newcastle upon Tyne Hospitals NHS Foundation Trust.
	• There are clear opportunities and benefits for patients from closer working, whilst recognising there are also benefits that come from each individual Trust's identities and integrity as separate organisations. Specific deliverables from the Alliance work plan have begun to demonstrate these benefits, and the improved experiences and outcomes for patients.
	• We have established the Alliance with a Collaboration Agreement signed by each of the four organisations. This agreement underpins meetings of Trust Board			

<table>
<tr><td></td><td colspan="6">Committees in Common to steer and govern the Alliance work plan, as well as a Joint Committee between three of the trusts to focus work in certain areas, and bilateral discussions between trusts.</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 Trust Board is asked to note the progress made.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="5">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust strategic objectives that the report relates to:</td><td colspan="6">Full delivery of the actions within the Quality Improvement Plan leading to improved outcomes and patient experience with particular focus on improvements relating to mental health, learning disabilities and cancer.
Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.
Growing and developing our people in order to improve patient outcomes, reduce reliance on temporary staff and deliver the 24-25 workforce plan.
Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025.
Evidence of reduction in cost base and an increase in patient care related income by the end of March 2025 leading to a balanced financial plan for 2025-26.
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’.
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, Women’s health and commercial opportunities.</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>
</table>

Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	• 4694 Risk that the Trust will not achieve a break-even revenue plan for 2025-26 and a deterioration from the 2024-25 planned deficit, resulting in a deterioration to Trusts NHS Oversight Framework rating. (20) • 4713 The 2025-26 financial plan requires the delivery of £33m cost reduction programme on a recurring basis. If this is not achieved the Trust will not achieve its 25-26 financial plan and fail to reduce its underlying deficit. (16) • 4705 Risk of considerable clinical and operational impact to patient care due to instability of PACS environment. This is resulting in delayed diagnosis and treatment plans across services, as well as delayed discharges, resulting in significant disruption to patient pathways throughout the organisation. (20) • 2341 There is a risk to ongoing business continuity of service provision due to the ageing of the Trust estate (16)		
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

Great North Healthcare Alliance – update

Overview and vision:

1. The Newcastle upon Tyne NHS FT, Gateshead NHS FT, Northumbria Healthcare NHS FT and North Cumbria Integrated Care NHS FT have been working together as the Great North Healthcare Alliance since January 2024.

2. An overview of the Alliance and our guiding objectives are as follows:

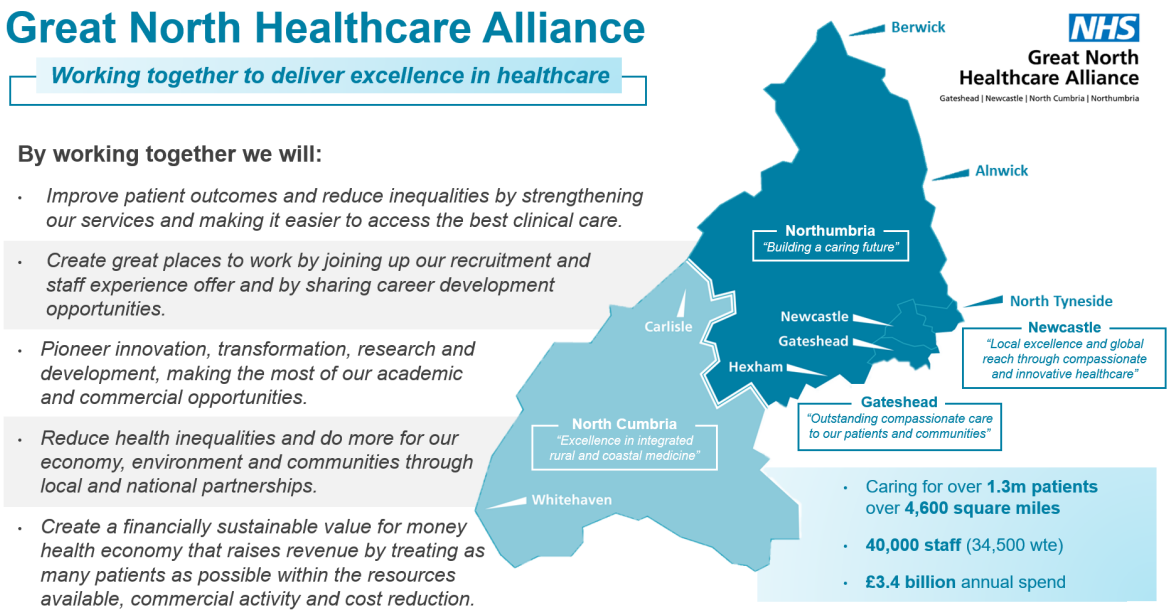

Figure 1 – Alliance overview

3. The Alliance is intended in large part to change ways of working across the four trusts, supplementing existing practice and working more closely in partnership with neighbouring organisations to drive better decision making for the benefit of patients, staff and external partners.

4. Our Alliance vision is therefore based on *how* we should work – both individually and together – and *what* we will aim to achieve. This vision has been developed and approved by each of the Alliance Trust Boards and there has been positive engagement and feedback on it from partners including the Integrated Care Board, local authorities, and NHS and University partners.

5. How we will work – our foundations:

Our purpose is to deliver high quality, safe and reliable care to our population, with fairer outcomes for all and equal access regardless of geography.	**Our patients are at the centre of our decision making but our staff are key to success.**
Our Alliance is based upon creating energy, engagement and innovation within our workforce, to enable them to deliver what we aspire to.	**We believe that working together at scale across our different leadership domains will breed cultural and clinical change.**

6. How we will work – our principles:

Acting together	• **Patients see us as 'one NHS'**, so we must work and design our services to meet this. • We will speak with **one voice to influence collectively** and ensure our communities get the investment and support we deserve • We will keep focused on the fact that we are **first and foremost healthcare delivery organisations** ➢ we exist to serve patients with rapid access to care, positive experiences, the best possible outcomes, and preventing illness in the first place • **Excellence** – our ambition is to achieve the highest possible standards in healthcare, national and global leaders, supported by technology, commercial, innovation, education, research and development.

Subsidiarity	• We understand the value in care being delivered locally – we will take every opportunity to **provide the widest range of services in local settings**, whilst recognising that services need the appropriate infrastructure to be safe. • The **identities** of and sense of belonging in our individual organisations must be retained and built on – no Trust wants to lose what is special about them, and what is good for one Trust is good for all. • We will **leverage the best of each organisation for the benefit of all**, building on the distinct strengths of each organisation. • We will **trust, empower and give permission to all leaders** to work across the Alliance to co-design services, feeling both accountable for and supported to deliver, under pinned by our ICB-wide leadership compact.
Effective planning	• Our Alliance activities will be made **where opportunities to do so arise, and to an agreed plan**. We will plan and deliver jointly where possible and desirable, and work with commissioners jointly. • We want to **grow the support and opportunities our teams have**, and our work plan will have this at its heart. • We want to **put as much money as possible into frontline care treating and preventing** illness, which is why our planning will seek to maximise value for the Alliance £ ensuring affordability, productivity, minimal waste and duplication, and maximising external investment. • Our collective planning and decision making will be supported by **strong governance processes** that are shared where desirable and possible.

Accountability and engagement	• In delivering our work plan and ways of working we want to **maintain and increase our lines of local accountability**, to our staff, communities and our local partners. • We will retain **accountability within our individual places** and the visibility of local leaders in local places. Alongside this, we want to improve the accountability that local places have over issues that are greater, multi-place scale. • Our principles of partnership working and behaviours will be led by our ICB-wide **leadership compact.** • We want **genuine and honest engagement** with partners both within our organisations and externally. • Local partners will **have a say in the decisions** that affect them, and we will continue to develop our Alliance work plan and vision with their input.

7. What we aim to deliver in the next five years:

Clinical pathways	• CQC 'good' or above rating in each organisation, exceeding the constitutional standards, simplified patient flow using all available resources, and a reputation for being best in the country once again • Improved and sustainable footing for fragile and vulnerable services, starting with urology, oral and maxillofacial surgery, urgent and emergency care, cancer, and women's services. • Brought together clinical teams from across the Trusts to jointly review each clinical specialty and to prioritise a programme of clinical pathway redesigns to improve services for patients. This will be informed by rich access, experience and outcomes insights and data, demographic pressures that we know are coming, and the views of patients, staff and partners • Improved local access to all constituent parts of specialised service pathways and clinical research – from tertiary settings, to acute and community, so that more patients can benefit. • Boosted and prioritised primary and community care, we will work closely with primary care networks, and provide a strong, dedicated strategic leadership with supporting corporate infrastructure to deliver integration with community and secondary care • Made a positive step change in tackling health inequalities - including in reducing poverty by helping local people not at work

	due to sickness to get healthcare support to get back to work as fast as possible. • Ensure individuals are treated in the right place at the right time by working with social care partners in local government and private providers to maximise our delivery of social care integration and respond to national policy.
People and processes	• Remove the barriers and annoyances for our people that stop them from making full use of their professional skills, creating new opportunities, delegating power and responsibility so they work to their potential level. • Opportunities for joined up recruitment, brand and workforce development programmes that supports local people into stretching careers, with succession and that recognises specific fragile staffing areas. • Community promise that supports local growth - including promotion of health careers, social value, and a healthy green environment. • Single point of contact for local and regional partners to raise and discuss issues and opportunities – including the Integrated Care Board, Local Government, Universities and Primary Care Networks. • Innovation, research and development that helps design and deliver improvements to patients and local services, reaches its commercial potential, is led by our centres of excellence, and is internationally recognised. • NHS England Oversight Framework segment 2 or better positions for each organisation, with financial sustainability across the Alliance. • Explore joined up corporate services to support value for money and reduce outliers – for instance, coordinated procurement • Commercial strategy delivery that takes rapid decisions, moves first, and is based on our combined assets. • Single, unified governance structure for decision-making across the Alliance, supported by a collaboration model that is in itself, innovative.
Physical assets	• Coordinated estates strategies and decisions with 'big build' developments in each Alliance trust that is supported by external investment • Because 20% of our patients already flow between our hospitals, deliver: ➢ digital interoperability across the Alliance trusts,

	➢ seamless service pathways, whilst not risking system resilience, ➢ a clear & accessible interface for patients that supports patient choice. • Prioritise money for patient care by ensuring organisations maximise the benefits from subsidiaries.

8. Taking together the foundations and principles for *how* we will work, and the ambitions of *what* we will do provides a clear framework for delivering the objectives set out in figure 1 and the benefits that comes from these.

Progress to date:

9. Since the previous update to Trust Boards held in public, we have had a number of notable successes that demonstrate progress against the objectives and vision outlined above. A few highlights include:

   i. **Community Diagnostic Centre (CDC)** – the Metro Centre CDC opened in October 2024, and has already enabled over 16,000 people, mostly from Newcastle and Gateshead, to have a diagnostic test more quickly and/or more closer to home. Another CDC will be opened in Workington, North Cumbria in the coming months.

   ii. **Cardiology** – positive engagement between clinical teams has supported a 30% reduction in the waiting time for patients with Acute Coronary Syndromes (ACS) to be transferred between the Royal Victoria Infirmary, and Queen Elizabeth Hospital and Northumbria Specialist Emergency Care Hospital for revascularisation. This has also reduced occupied hospital bed days for patients.

   iii. **Audiology** – improvements in the service provided by Newcastle Hospitals means many more patients are now having their hearing assessments done within the 6 week national waiting time standard. This is creating resource to improve local provision across Northumberland and North Tyneside, with further improvements expected in the coming months.

   iv. **Paediatrics** – this joint workstream has built positive relationships between the four Trust teams, leading to increased hospital capacity being opened compared to the past ten years and better sharing of best practice. Issues that affect patient services are being tackled together.

   v. **Urology** – honest and positive discussions between the trusts has agreed joint solutions to issues in these patient services. Although performance is still not where any trust would want it to be, positive progress has been seen for instance the elimination of >52 week waits for Gateshead. We expect substantive improvements to be increasingly demonstrated over the coming year.

vi. **Interstitial Lung Disease (ILD)** – changing pathways for patients with ILD to transfer to more local provision for them in Northumbria. Part of these changes include Northumbria clinicians being able to prescribe key drugs for patients in a more timely manner than previously. Around 120 patients are being offered the opportunity to transfer their care.

vii. **Hepato-pancreato-biliary (HPB)** – Northumbria taking on appropriate patients to share capacity more evenly, and Northumbria surgeons looking to use the Freeman Hospital Day Treatment Centre to increase capacity.

viii. **Community outpatients** – supporting local services provided by Newcastle to move to a local, newly refurbished site alongside Northumbria services – providing services from neighbouring organisations in a 'one NHS' site.

ix. **Digital** – Agreeing a longer-term plan to deliver an interoperable set of digital services to enable information and data to exchange across the Alliance to effectively support patients and frontline services. We have appointed a lead Chief Information Officer to coordinate this work across Newcastle, Gateshead and Northumbria, working closely with North Cumbria. This work, which will increase in pace, has led to some early quick wins from projects including shared WiFi, use of cloud services, and joint procurement opportunities for certain core services.

x. **Research and Innovation** – hosting an Alliance-wide session to agree priority areas for our combined research and innovation experience, expertise and assets to work together for the benefit of the Alliance.

xi. **Estates planning** – a shared business case looking at long-term estates opportunities across the four trusts has been developed, for discussion on possible investment sources to deliver this.

xii. **Financial planning** – open engagement between Finance Directors to support short and medium-term financial planning in particular, in order to plan a path for the Alliance trusts to return to a balanced financial position, and for this to be sustainable.

Governance arrangements:

10. Relationships across the four organisations have developed at pace to support joint working on Alliance priorities. The Alliance Steering Group of the Chairs and CEOs from the four organisations meets monthly as Committees in Common. Since our previous update to Public Boards, these arrangements have been strengthened through a Joint Committee and three sets of bilateral arrangements.

    i. Joint Committee: a tighter form of governance, with delegations from Trust Boards, has been established between Newcastle Hospitals, Northumbria Healthcare and Gateshead Health as members, and with North Cumbria colleagues attending. The Joint Committee has a specific focus initially on certain financial planning for 2025/26, digital interoperability, and research and innovation.

ii. Bilateral arrangements: in order to progress work bilaterally between organisations, more formal arrangements have been put in place between Newcastle Hospitals and North Cumbria. Sub-Committees in Common will drive progress on ensuring high quality tertiary service provision across North Cumbria alongside other clinical and corporate workstreams. Other bilateral arrangements have also been established between other organisations, for instance Newcastle and Northumbria who meet regularly to work through shared clinical service issues and improve service delivery for patients. A similar Newcastle and Gateshead bilateral group is about to be set up.

Developing and delivering the work plan in collaboration:

11. We have sought to develop the work plan – be it clinical services, corporate approaches and Alliance governance – in collaboration with Trust Boards and Governing Bodies across the trusts, as well as external partners where appropriate.

12. The members of the four Trust Boards have met together twice for half day workshops looking at progress made and future opportunities – positive feedback overall was received for both events. A joint event for Governors from the organisations is being held in April to supplement the invaluable input that they have made through the respective Councils of Governor meetings.

13. In addition, we have ensured that the Integrated Care Board (ICB) for the North East and North Cumbria has been involved in informing the vision, work plan and governance arrangements for the Alliance. Most recently, a supportive session was held in December 2024 with the ICB Chair and Chief Executive – at this session the ICB provided an update on some stakeholder engagement work on the Alliance vision and work plan that they had supported with external partners. This included important and helpful feedback from local universities, primary care groups, and local authorities. This has informed the work plan workstreams and deliverables and is something that we will build on in the next 12 months.

14. In accordance with the principles for Alliance working set out earlier in this paper, the governance arrangements are intended to be as *de minimus* as possible and support collaborative working relationships across all levels of the Alliance partners, be it executives, non-executives, Governors, clinical leads, operational leads, and frontline staff. Equally, they have been established and agreed by Trust Boards in such a way to not change the independence of Trust Boards and Governing Bodies, or the delegations, powers and authorities that Chief Executive Officers already have.

Summary assessment:

15. Looking back over the first year of the Alliance, progress has been good. Enthusiasm for working together across organisations has been evident, a number of tangible benefits have already been delivered, and there is momentum in support of greater collaboration. Trust and relationships between the organisations have never been in such a positive position. Although there has been variation in progress between workstreams, we have learnt lessons from these instances to ensure that we are

delivering benefits from Alliance working. Leadership and communication have been critical parts of our work at different levels throughout our organisations. We have also recognised that there is a strong need to measure and celebrate progress, and that project governance and management works best for the Alliance where it is kept as light touch as possible.

Recommendation

16. The Trust Board is asked to:

    i. Note the progress made.

Great North Healthcare Alliance Formation Team
Martin Wilson, Newcastle; Nicola Bruce, Gateshead;
Stephen Park, North Cumbria; and Andrew Edmunds, Northumbria

11 March 2025

Gateshead Health
NHS Foundation Trust

Agenda Item: 14i

Report Title:	**Organisational Risk Register (ORR)**			
Name of Meeting:	Board of Directors			
Date of Meeting:	26th March 2025			
Author:	Marie Malone, Corporate and Clinical Risk Lead.			
Executive Sponsor:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals/Deputy CEO			
Report presented by:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals/Deputy CEO			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	To ensure the Board and Committees are clearly sighted on those risks that have an organisational -wide impact, the organisational risk register is compiled by the Executive Risk Management Group (ERMG) of those risks that impact on the delivery of strategic aims and objectives. This includes risks included within the Board Assurance Framework (BAF) as well as risks identified by the Group for inclusion as having an organisational impact and impact on delivery of strategic aims and objectives. The supporting report shows the risk profile of the ORR, includes a full register, and provides details of review compliance, and risk movements.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	The attached report is received into the Gateshead Health Leadership Group (GHLG) Meeting, the Executive Risk Management Group meeting every month, as well as relevant committees.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience*	Risks on the ORR were comprehensively discussed at previous ERMG meetings in February and March 2025. The following updates and movements agreed:			

<table>
<tr><td>

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

</td><td colspan="5">-In the period of 19th January- 19th March 2025, there were 5 risks added, 1 escalation, 2 reductions, 4 closures.

Trends of risk movement in 6-month period is detailed within the paper.
Summary of Movements over 12-month period is shown within the attached report.
Compliance with reviews is static in period and sits at 89% for risks and 100% for associated actions.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The Board are asked to:

• Review the risks and actions on the report and discuss and seek further information relating to risks as appropriate.
• Note movements over 6-month period.
• Take assurance that risks are reviewed in line with risk management arrangements.
• Be sighted on the top 4 risks for the organisation.</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 look to utilise our skills and expertise beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">Each risk is linked to a corporate objective, see report.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Safe
☒</td><td>Effective
☒</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and InPhase reference)</td><td colspan="5">Included in report</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

Organisational Risk Register

1. Executive Summary

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

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

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

The supporting report shows the risk profile of the ORR, includes a full register, and provides details of review compliance, and risk movements, including movement over the previous 6 months.

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

Organisational Risk Register

2. Movements in period

Following ERMG meetings in February and March 2025, 5 risks has been added to the ORR.

There has been 1 escalation, 2 reductions, and 4 closures 2 risks removed from the ORR.

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

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

- **2969 (Medicine)** Risk of patient harm due to length of stay in ED resulting in potential regulatory action and poor patient experience.
    - Escalated from 16 to 20
    - National outlier with no improvement in performance realised over previous 12 months.
    - Risk statement reworded to reflect current challenges and focus on quality element of the risk.
    - Gaps remain around effective model of care delivery.

3 financial risks have been raised regarding the considerable challenges forecast for the forthcoming year 2025/2026, and these replace the financial risks for 2024/25.

- **4694 (Finance)** Risk that the Trust will not achieve a break-even revenue plan for 2025-26 and a deterioration from the 2024-25 planned deficit, resulting in a deterioration to Trusts NHS Oversight Framework rating. (20)

    - Replaces Finance risk for 2024/25
    - Horizon scanning has forecasted significant likelihood of non-achievement of the Organisations financial plan in the new financial year
    - Top Organisational risk.

- **4713 (Finance)** The 2025-26 financial plan requires the delivery of £33m cost reduction programme on a recurring basis. If this is not achieved the Trust will not achieve its 25-26 financial plan and fail to reduce its underlying deficit. (16)

    - Replaces previous CRP Financial risk for 204/25
    - Dedicated Strategic Lead and Programme Management Office to support the delivery of an on-going cost reduction work programme underpinned by a new cost reduction framework and governance.

- **4714 (Finance)** The Trusts 25-26 financial plan includes an income target which is earned from the delivery of activity. If planned activity is not achieved there is a risk the Trust may not achieve planned income targets and overall delivery of it's 25-26 financial plan. (12)
    - Weekly activity & performance clinics to monitor activity performance and develop plans for recovery
    - Monthly financial review of actual performance against planned income targets.

1 risk added pertaining to the recent significant clinical impact of PACS (Picture Archiving and Communication System) downtime.

- **4705 (Digital)** Risk of considerable clinical and operational impact to patient care due to instability of PACS environment. This is resulting in delayed diagnosis and treatment plans across services, as well as delayed discharges, resulting in significant disruption to patient pathways throughout the organisation. (20)

    - Formal incident response framework in place
    - BCPs enacted and EPRR oversight
    - Additional vitrea licences obtained to improve availability of images while under BCP
    - Top Organisational risk, significant high scoring clinical risk

Risks reduced:

2 risks have reduced in period:

- **4554 (Digital)** risk that the trust is not sufficiently protected against the current and evolving cyber threats. Vulnerabilities in protection increase the risk of significant service disruption due to unavailability of business-critical systems. (10)
    - Positive progress of the IRM programme.
    - Cyber exposure scoring deemed as one of top performing Trusts in the country.
    - Reduced from 15 to 10 [reduced likelihood to unlikely]

- **3132 (QEF)** Risk of harm to staff (psychological and physical) due to exposure to violence and aggression from patients and visitors who exhibit challenging behaviours. This could result in injury, increased absence from work, staff morale and confidence and potentially effect recruitment and retention.
    - Analysis of incidents has demonstrated lower levels of harm experienced
    - Establishment of violence and aggression group has supported further mitigation
    - Risk reduced from 15 to 12

Risks removed from the ORR

5 risks in total have been removed, 3 of which have been closed.

2 risks have reduced in score and removed from the ORR:

- **4635 (COO)** The winter plan is built on a set of underpinning forecasts and principles. There is a risk that the actual position varies from these to such an extent that is results in an inability for the plan to be delivered in whole or in part. (12)
    - Reduced to 12
    - Decrease in Flu and upper respiratory incidents
    - Extension of ARI Hub until end of March 2025

- **4577 (Finance)** Risk that the trust does not achieve its 2024/25 planned deficit totalling £7M and does not deliver its CRP, resulting in significant impact on financial sustainability.
    - Reduced from 20 to 10
    - deficit will have been achieved in part by year end, however, new risk 4694 for 2025/26 supersedes this risk.

Risks closed:

4 Risks have been closed

- **4559 (MD Office)** There is a risk that appropriate support is not available to our medical staff to enable good rota management and strategic medical workforce modelling. This could result in errors and non-compliance with contractual obligations as well as a lack of engagement and morale. There is a secondary financial risk that this contributes to significant overspend on our medical workforce. (16).
    - Reduced from 16 to 8 (achievement of target score) (reduced likelihood to 2 [unlikely])
    - Staffing gaps have been filled to provide additional support
    - Team fully trained on rota development/management with QA undertaken
    - Financial element of the risk remains, this has resulted in the addition of a new risk at high level.

3 financial risks below have been superseded by new risks (as above) assessed against the financial challenges forecast for 2025/26.

- **2424 (Finance)** Risk that Efficiency requirements are not achieved on a recurrent basis.
- **2425 (Finance)** Activity is not delivered in line with planned trajectories, resulting in the Trust having reduced access to elective recovery funding.
- **4577 (finance)** Risk that the trust does not achieve its 2024/25 planned deficit totalling £7M and does not deliver its CRP, resulting in significant impact on financial sustainability.

3. Movements over 6-month period 1st October- 1st March 2025

We have seen active mitigation undertaken over the 6-month period, resulting in a reduction of 4 ORR risks as demonstrated in the below table.

Risk ID	Risk Stage	Open	Risk Title	Owner	Business Unit	Service	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
4576	Current Risk		Non compliance with SARs response turnaround time could result in ICO imposed penalties.	Gill Findley	Digital	Digital Transformation and Assurance	15	15	12	12	12	12
3132	Current Risk		Exposure to incidents of violence and aggression	Kate Clark	QE Facilities	Facilities	15	15	15	15	12	12
4554	Current Risk		Cyber Threats and Vulnerabilities	Gill Findley	Digital	IT	15	15	15	10	10	10
4405	Current Risk		Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure.	Dianne Ridsdale	Digital	Digital Transformation and Assurance	16	16	8	8	8	8

We have seen two risks escalated in 6-month period:

Risk ID	Risk Stage	Open	Risk Title	Owner	Business Unit	Service	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
2969	Current Risk		Risk of patient harm due to length of stay in ED	Alex Diggles	Medical Services	Med 1	16	16	16	16	20	20
4417	Current Risk		Increase in incivility and disrespectful behaviours being reported	Amanda Venner	People & OD	Workforce Development	12	15	15	15	15	15

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

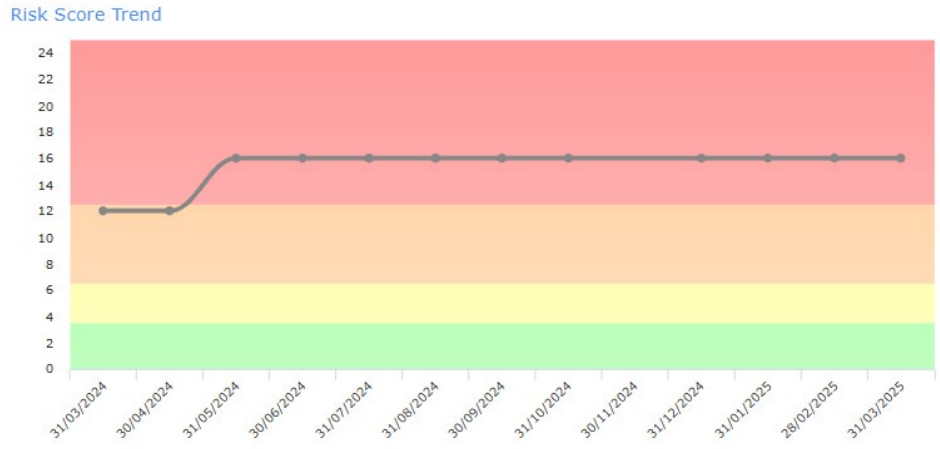
There are 9 risks on the ORR with no movement in the past 6 months (October 2024-March 2025)

Risk ID	Risk Stage	Risk Title	Owner	Business Unit	Service	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
2341	Current Risk	There is a risk to ongoing business continuity of service provision due to ageing trust estate	Anthony Pratt	QE Facilities	Estates	16	16	16	16	16	16
4402	Current Risk	Inability to support legislation and best practice associated with records management	Catherine Bright	Digital	Health Records	16	16	16	16	16	16
3107	Current Risk	Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings	Kate Hewitson	Surgical Services	Obstetrics	15	15	15	15	15	15
4591	Current Risk	Risk of significant service disruption due to GP collective actions including reduction in shared care service provision	Neil Halford	Chief Executive Office	Chief Executive Office	15	15	15	15	15	15
4525	Current Risk	Risk of Lack of a strategic workforce planning	Natasha Botto	People & OD	Human Resources	12	12	12	12	12	12
4541	Current Risk	Risk of governance failure as we transition to new governance arrangements	Gill Findley	Nursing, Midwifery & Quality	Corporate Nursing	12	12	12	12	12	12
4574	Current Risk	A risk of being unable to relocate in the event of an evacuation due to capability and capacity issues within the estate that may potentially result in patient safety issues	David Patterson	Chief Operating Officer	EPRR	12	12	12	12	12	12
4575	Current Risk	Non compliance with FoI response turnaround time could result in ICO imposed penalties.	Gill Findley	Digital	Digital Transformation and Assurance	12	12	12	12	12	12
2438	Current Risk	Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures.	Gill Findley	Nursing, Midwifery & Quality	Quality Governance	8	8	8	8	8	8

Further detailed trends as follows:

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

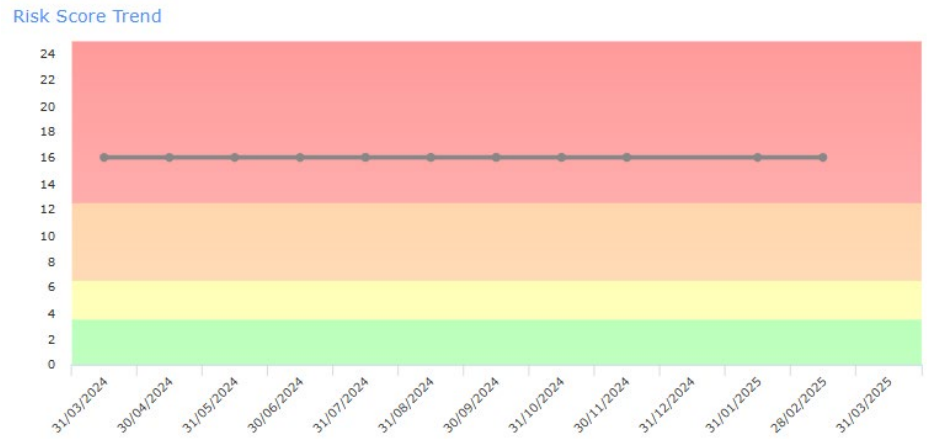
Added February 2023 at score of 12. Increased to 16 in April 2024, with no further movement to date.



- **Risk 4402 Digital**- The current mixed economy of health records - paper held offsite, active paper records managed on site, digital copies within the electronic document management system, live records within clinical system - may impact the trusts ability to comply with records management best practice and legislative requirements (such as retention/destruction periods for records). This could lead to regulatory and reputational harm. (16)

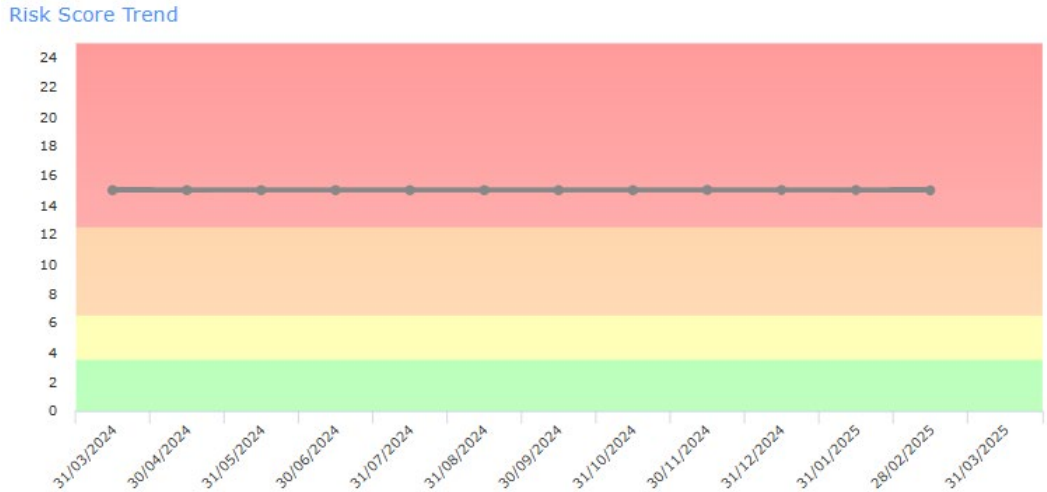
Added November 2023 at score 16. No change since its addition.

Note: Wording of risk has been updated in February 2025 to highlight the ongoing challenges around the use of multiple systems of data throughout the organisation.



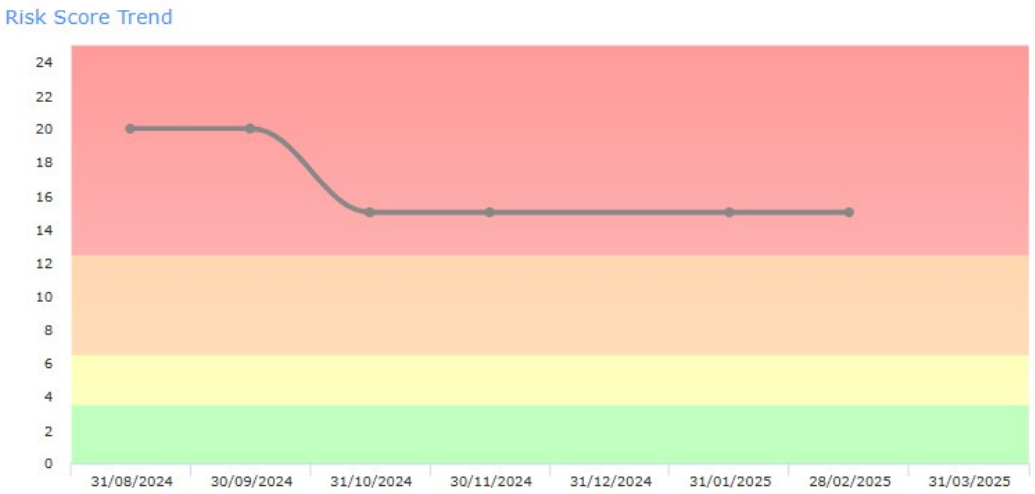
- **Risk 3107 Surgery**- Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings (15)

Added November 2022 at 15. No change since its addition.



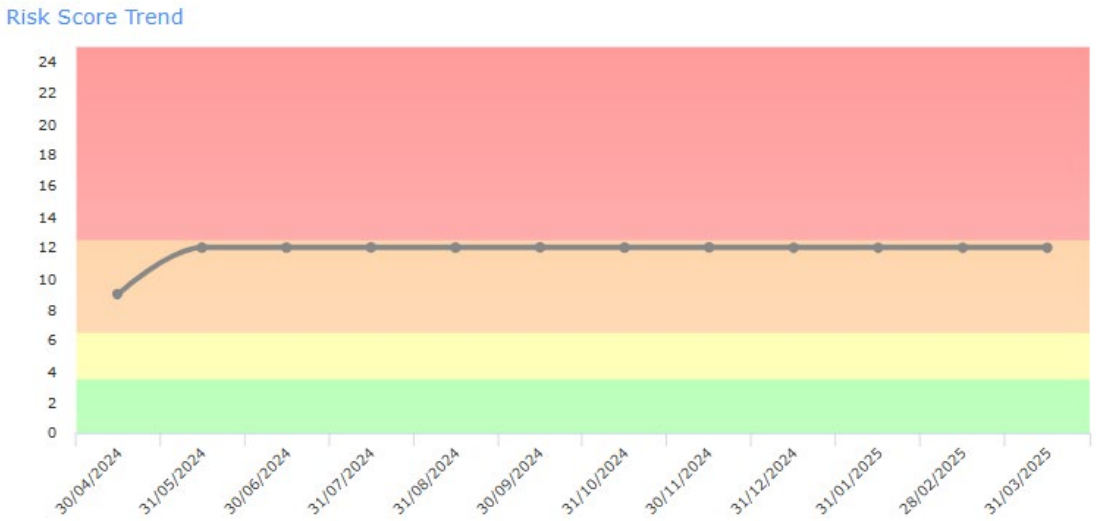
- **Risk 4591 (CEO)** Risk of significant service disruption due to GP collective action including reduction in shared care service provision (15)

Added in August 2024. Reduced from 20 to 15 in October 2024. No change since October 2024.



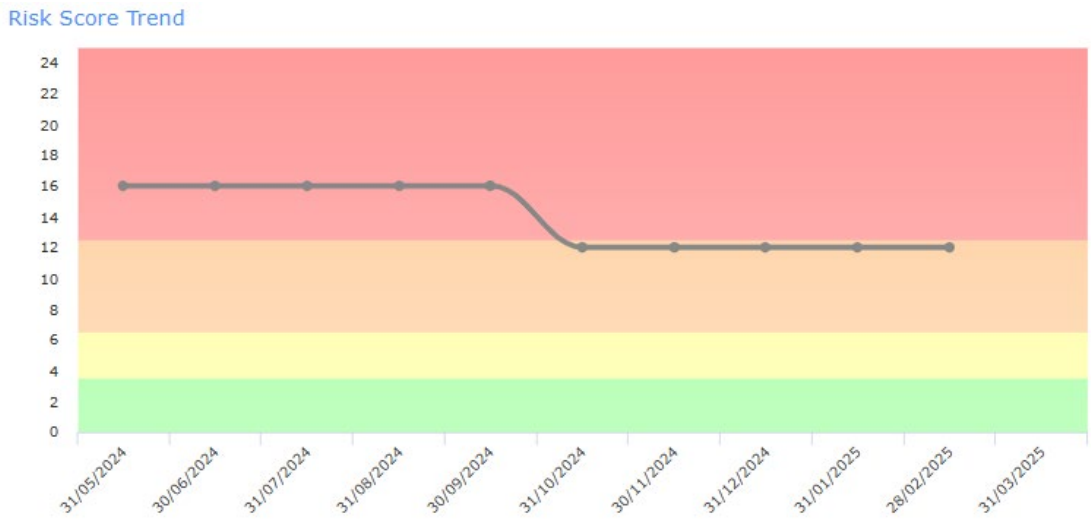
- **Risk 4525 (POD)** Risk of Lack of a strategic workforce planning (12)

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



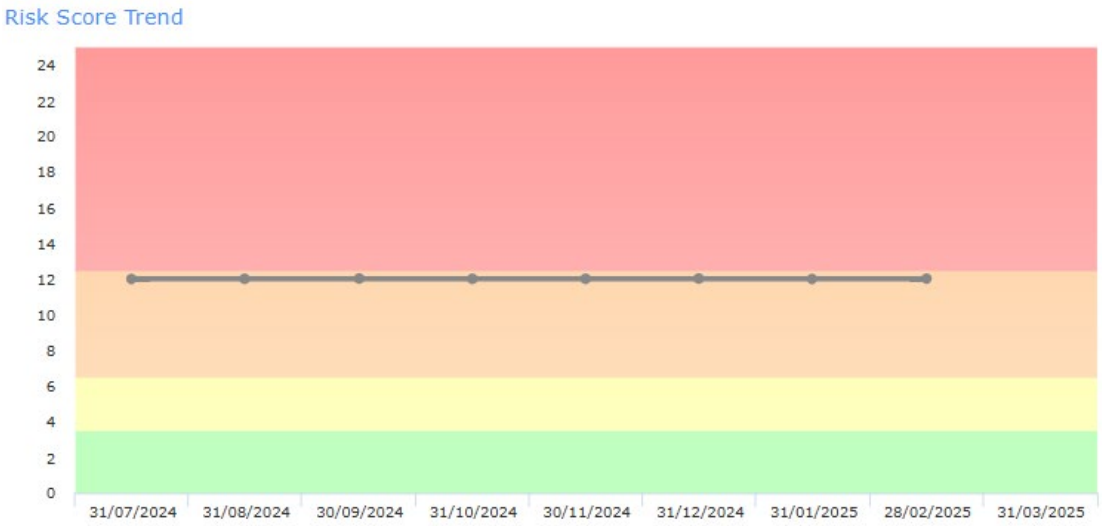
- **Risk 4541(NMQ)** Risk of governance failure as we transition to new governance arrangements (12)

Added in May 2024. Reduced from 16 to 12 in October 2024. No change since October 2024.



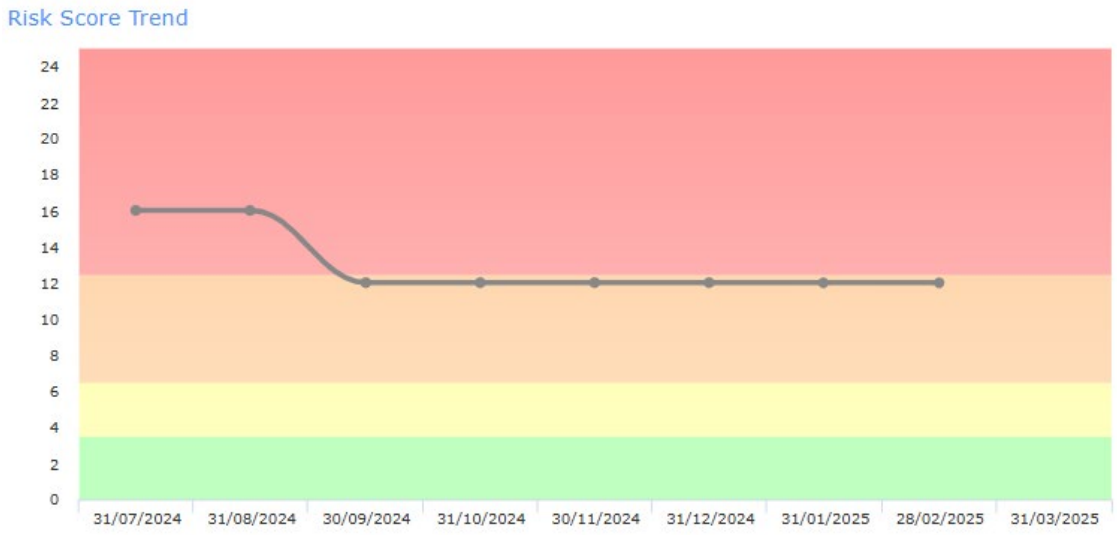
- **4574 COO** A risk of being unable to relocate in the event of an evacuation due to capability and capacity issues within the estate that may potentially result in patient safety issues (12)

Added July 2024 score of 12. No change since its addition.



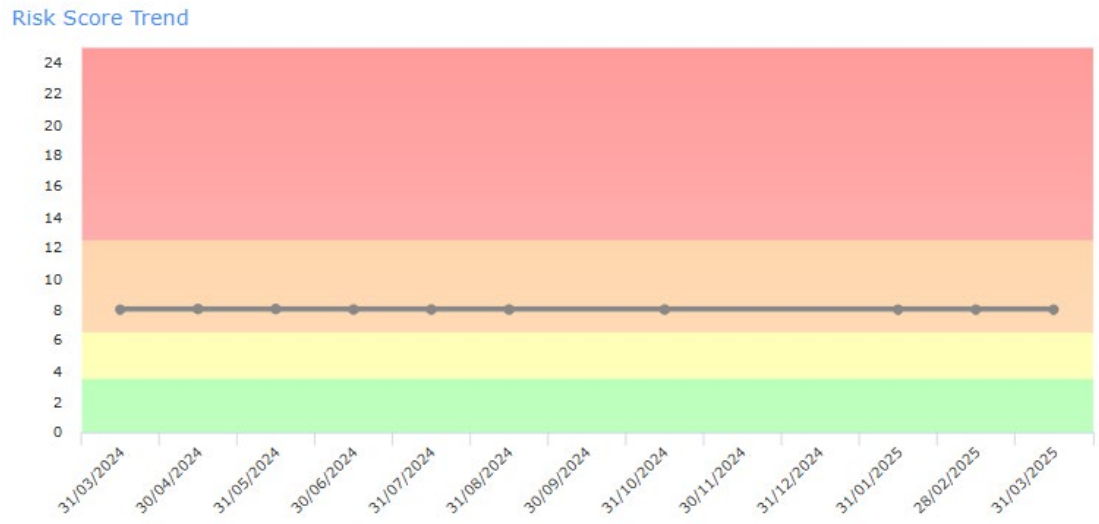
- **Risk 4575 Digital-** Non-compliance with Freedom of Information response turnaround time could result in ICO imposed penalties. (12)

Added in July 2024. Reduced from 16 to 12 in September 2024. No movement since September 2024.



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

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



4. **Top Organisational Risks:**

The following 4 risks were agreed at March's meeting:

1- **Finance**- non achievement of a 2025-26 break-even revenue plan and likely deterioration from 2024-25 planned deficit of £12m
2- **Medicine**- Risk of patient harm due to length of stay in ED
3- **POD-** Increase in incivility and disrespectful behaviours being reported.
4- **Digital-** Instability of PACS environment

- **4694 (Finance)**. Risk that the Trust will not achieve a break-even revenue plan for 2025-26 and a deterioration from the 2024-25 planned deficit, resulting in a deterioration to Trusts NHS Oversight Framework rating. (20)

- **2969 (Medicine)** Risk of patient harm due to length of stay in ED resulting in potential regulatory action and poor patient experience**.** (20)

- **4417 (POD)** Risk that promoting an environment that encourages speaking out and creating a psychologically safe culture has led to increased reports of poor behaviour. This could have a negative impact on staff and require additional time and capacity to appropriately address the concerns. This could result in further health and well-being concerns and staff absence. (15)

- **4705 (Digital)** Risk of considerable clinical and operational impact to patient care due to instability of PACS environment. This is resulting in delayed diagnosis and treatment plans across services, as well as delayed discharges, resulting in significant disruption to patient pathways throughout the organisation. (20)

5. **Current compliance with Risk reviews:**

Risk review compliance is currently at 89%. Action review compliance is 100%.

This is in comparison to previous reporting period. (95% and 81% respectively)

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

6. **Recommendations**

The Board of Directors are asked to:

- Review the risks and actions and discuss and seek further information relating to risks as appropriate.
- Note risk movements over the last 6 months.
- Have full sight of the agreed top 4 Organisational risks.
- Take assurance over the development and review of the Organisational Risk Register as per risk governance framework.

Organisational Risk Report- Board of Directors. March 2025.

Total Risks (Current/Managed)
19

People 4

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

Quality 5

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Safety	Digital	4705	Risk of considerable clinical and operational impact to patient care due to instability of PACS environment.	20
Safety	Digital	4554	Cyber Threats and Vulnerabilities	10
Safety	Surgical Services	3107	Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings	15
Safety	Nursing, Midwifery & Quality	2438	Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures.	8
Effectiveness	Chief Executive Office	4591	Risk of significant service disruption due to GP collective actions including reduction in shared care service provision	15

Finance 4

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Finance	Finance	4694	Non achievement of a 2025-26 break-even revenue plan and likely deterioration from 2024-25 planned deficit of £12m	20
Finance	Finance	4713	The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis	16
Finance	Finance	4714	2025-26 planned activity is not achieved resulting in the Trust not achieving planned income targets	12
Business Continuity	QE Facilities	2341	There is a risk to ongoing business continuity of service provision due to ageing trust estate	16

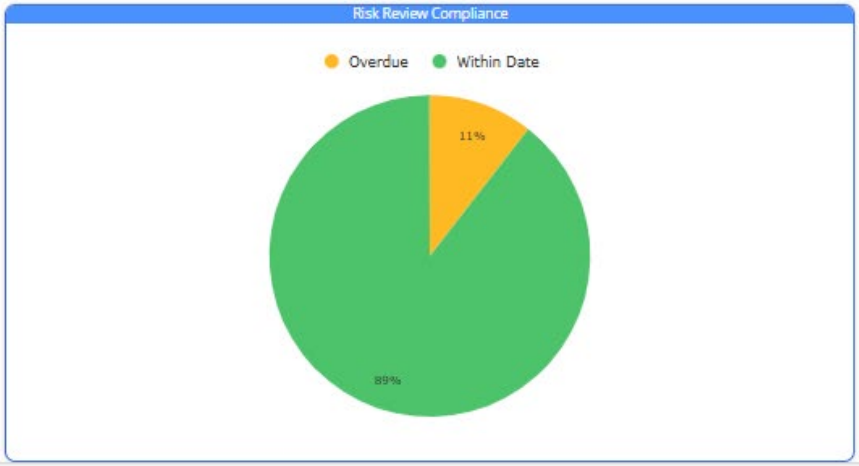
Regulation 6

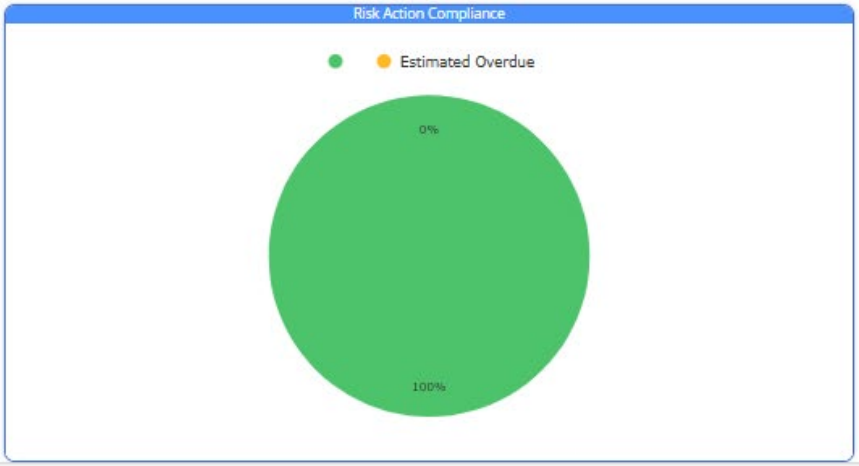
Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Compliance	Medical Services	2969	Risk of patient harm due to length of stay in ED	20
Compliance	Digital	4402	Inability to support legislation and best practice associated with records management	16
Compliance	Digital	4575	Non compliance with FoI response turnaround time could result in ICO imposed penalties.	12
Compliance	Digital	4576	Non compliance with SARs response turnaround time could result in ICO imposed penalties.	12
Compliance	Digital	4405	Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure.	8
Compliance	Nursing, Midwifery & Quality	4541	Risk of governance failure as we transition to new governance arrangements	12

Changes to Current Score over 12 Months

Risk ID	Risk Stage	Open	Risk Title	Owner	Business Unit	Service	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025
4705	Current Risk		Risk of considerable clinical and operational impact to patient care due to instability of PACS environment.	Gill Findley	Digital	Systems												20
2969	Current Risk		Risk of patient harm due to length of stay in ED	Alex Diggles	Medical Services	Med 1	16	16	16	16	16	16	16	16	16	16	20	20
4694	Current Risk		Non achievement of a 2025-26 break-even revenue plan and likely deterioration from 2024-25 planned deficit of £12m	Jane Fay	Finance	Finance											20	20
2341	Current Risk		There is a risk to ongoing business continuity of service provision due to ageing trust estate	Anthony Pratt	QE Facilities	Estates	12	16	16	16	16	16	16	16	16	16	16	16
4402	Current Risk		Inability to support legislation and best practice associated with records management	Catherine Bright	Digital	Health Records	16	16	16	16	16	16	16	16	16	16	16	16
4713	Current Risk		The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis	Jane Fay	Finance	Finance												16
3107	Current Risk		Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings	Kate Hewitson	Surgical Services	Obstetrics	15	15	15	15	15	15	15	15	15	15	15	15
4591	Current Risk		Risk of significant service disruption due to GP collective actions including reduction in shared care service provision	Neil Halford	Chief Executive Office	Chief Executive Office					20	20	15	15	15	15	15	15
4417	Current Risk		Increase in incivility and disrespectful behaviours being reported	Amanda Venner	People & OD	Workforce Development	12	12	12	12	12	12	12	15	15	15	15	15
4576	Current Risk		Non compliance with SARs response turnaround time could result in ICO imposed penalties.	Gill Findley	Digital	Digital Transformation and Assurance				15	15	15	15	15	12	12	12	12
4575	Current Risk		Non compliance with FoI response turnaround time could result in ICO imposed penalties.	Gill Findley	Digital	Digital Transformation and Assurance				16	16	12	12	12	12	12	12	12
4541	Current Risk		Risk of governance failure as we transition to new governance arrangements	Gill Findley	Nursing, Midwifery & Quality	Corporate Nursing		16	16	16	16	16	12	12	12	12	12	12
4525	Current Risk		Risk of Lack of a strategic workforce planning	Natasha Botto	People & OD	Human Resources	9	12	12	12	12	12	12	12	12	12	12	12
3132	Current Risk		Exposure to incidents of violence and aggression	Kate Clark	QE Facilities	Facilities	15	15	15	15	15	15	15	15	15	15	12	12
4574	Current Risk		A risk of being unable to relocate in the event of an evacuation due to capability and capacity issues within the estate that may potentially result in patient safety issues	David Patterson	Chief Operating Officer	EPRR				12	12	12	12	12	12	12	12	12
4714	Current Risk		2025-26 planned activity is not achieved resulting in the Trust not achieving planned income targets	Jane Fay	Finance	Finance												12
4554	Current Risk		Cyber Threats and Vulnerabilities	Gill Findley	Digital	IT			15	15	15	15	15	15	15	10	10	10
4405	Current Risk		Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure.	Dianne Ridsdale	Digital	Digital Transformation and Assurance	16	16	16	16	16	16	16	16	8	8	8	8
2438	Current Risk		Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures.	Gill Findley	Nursing, Midwifery & Quality	Quality Governance	8	8	8	8	8	8	8	8	8	8	8	8

Risk review and action review compliance. March 2025





4 Top Organisational Risks.

Risk Id	Division	Description	Initial Risk Grade	Grade	Target Grade
2969	Medical Services	Risk of patient harm due to length of stay in ED resulting in potential regulatory action and poor patient experience.	20	20	8
4417	People & OD	There is a risk that promoting an environment that encourages speaking out and creating a psychologically safe culture has led to increased reports of poor behaviour. This could have a negative impact on staff and require additional time and capacity to appropriately address the concerns. This could result in further health and well being concerns and staff absence.	15	15	6
4694	Finance	Risk that the Trust will not achieve a break-even revenue plan for 2025-26 and a deterioration from the 2024-25 planned deficit, resulting in a deterioration to Trusts NHS Oversight Framework rating.	25	20	10
4705	Digital	Risk of considerable clinical and operational impact to patient care due to instability of PACS environment. This is resulting in delayed diagnosis and treatment plans across services, as well as delayed discharges, resulting in significant disruption to patient pathways throughout the Organisation.	25	20	4

Gateshead Health
NHS Foundation Trust

Committee Escalation and Assurance Report

Name of Board Committee	Finance and Performance Committee
Date of Board Committee:	25 February 2025
Chair of Board Committee:	Mr M Robson

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

The Committee identified the following Alert items:

- CDC financial gap and risk sharing agreement with Newcastle Hospitals to be progressed.
- 2025-26 forecast plan with 8% CRP attached.
- Capital Programme 2025-26 unlikely to be fully funded.
- QEF – forecast to break-even but mitigations are needed.
- Cash position – increased focus on cash position.
- Medical staffing and deployment – to understand the implications.

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

The Committee identified the following items:

- BAF financial risk – to consider increasing level of risk to 25.
- Minimum wage top ups – flagged via the FPPAG assurance report.
- Revised planned deficit is £2.19m driven by non-recurrent elements and including £4.9m additional deficit support funding. On track to achieve.
- OOG meetings to be split with meetings held fortnightly - one meeting to focus on performance, particularly areas that are not seeing an improvement such as sickness absence.

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

The Committee received the following assurances:

- 2025-26 financial plan FLASH returns submitted.
- Positive management of temporary staffing costs.
- Financial support from Northumbria – governance in place.
- Alignment of CRP and risk between providers is taking place.

• Alliance update – progress with joint chair and update on research and innovation provided.
Risks (any new risks / proposed changes to risk scores)
• There were two new risks suggested: - Cash flows - CDC Financial framework
Cross-referrals to other Committees (by significant exception only)
• There were no cross referrals.

NHS
Gateshead Health
NHS Foundation Trust

Committee Escalation and Assurance Report

Name of Board Committee	Quality Governance Committee
Date of Board Committee:	28 February 2025
Chair of Board Committee:	Mr A Crampsie

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

- PACs ongoing incident.

- A number of meetings and audits had been stepped down due to operational pressures (falls, Health and Safety, walkabout, Mortality Council) and this is a concern for executive oversight and assurance.

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

The Committee identified the following advisory issues:

- Children in Care – there has been no approval for additional funding from the ICB but local mitigations have been put in place with the local authority.
- Mortality Council – this hasn't been running but there is a plan in place for moving forward.
- Bereavement Service - risk identified by the Medical Examiner due to some tasks usually delivered by the Bereavement Team being carried out by staff from the Medical Examiners Office and this is a breach of NHS England guidance – the risk is recognised as low and the service is being reviewed by the Medical Director.
- Falls – the Falls Working Group is working up options to address falls but there is still more work to do as there is insufficient buy-in across the whole organisation.
- ICB to join walkabouts with NEDs.
- Martha's Rule – a progress report to come back to the Committee in 6 months time.

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

Positive assurances were agreed in relation to:

- Two Associate Medical Directors (AMD) have been appointed - the AMD for Patient Safety to be invited to the Quality Governance Committee.
- Maternity Incentive Scheme – has been through CEO approval.
- Ambulance handovers and 12 hour waits in department have improved.

• Enhanced patient safety report was well received. • EPRR Core Standards – compliance rating of substantial compliance received. • EQIA – in place but needs some additional work. • Volunteers are being effectively used. • Driving improvements through patient safety lens.
Risks (any new risks / proposed changes to risk scores)
• There were no changes to risks.
Cross-referrals to Executive Directors
• There were no cross referrals.

Gateshead Health
NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	People and OD Committee
Date of Committee / Group:	Tuesday 11 March 2025
Chair of Committee / Group:	Mrs Maggie Pavlou

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

- **Sickness Absence –** Continued concern about sickness absence rates, particularly in connection with CRP. There was a specific focus on sickness due to anxiety/stress/depression and a view that the Committee was not assured of the plan to address this. This also links in to the free text comments from the staff survey which suggest a disconnect in relation to the support given for mental health issues.

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

The Committee identified the following advisory issues:

- **Gender Pay Gap** – the current approach to separate reporting of the Gender Pay Gap information by the Trust and QEF has implications for the reported gender pay gap figures. It was agreed that an overarching report would be drafted to explain the Group position and provide an overall Group figure for the year. To look to provide a Group report in future.
- **Employee relations** – there has been a significant uptick of ER cases and this is still rising. This was considered to be a positive reflection that the 'speaking up' agenda is working and reflects the findings of the staff survey, but there are concerns around timescales and the capacity to manage cases.
- **Nursing Apprenticeships** – Committee advised of decision to pause the three apprenticeship programmes for the 2025-26 financial year – to alert to Board that difficult decisions are being made.
- **EDI** – Accepted the update, but advised to ensure CRP processes do not have a disproportionate impact in relation to EDI.
- **Job Planning Compliance** – Remains below expected levels of compliance, rated as '0' level of attainment in the e-job planning for clinical workforce levels of attainment standards, the lowest attainment level due to not having e-job planning in place.
- **Nursing role profile changes** – Verbal update given with detailed update to come to next committee re timescales and progress

- **People Plan** – To be sighted on the discrepancy between the need for in-year cost reductions and the 10 year people plan.
- **Audit actions** – There is one overdue action from the QEF Staff Contracts Audit which has been outstanding since December. This audit action is being addressed and was delayed due to IT system issues, this issue is now rectified and expected to be completed by the end of March 2025.

Assure
(key assurances received and any highlights of note)

Positive assurances were agreed in relation to:

- **BAF (Strategic Aim 5) – Provider Collaborative (workforce) –** agreed that the risk rating be reduced to 6 (target risk) given the successful role of Gateshead in influencing the directions of travel, including the role of the CEO as chair of the regional workforce group.
- **Gender Pay Gap** – recognising the work of the Trust and QEF in taking forward work to address the gender pay gap and the quality of this year's report.
- **Employee relations** – assurance in relation to increased reporting of issues.
- **Workforce Planning** – assurances received over processes in place.
- **ADQM** – assurance over submission.
- **Internal Audit** – reasonable assurance rating for two recent internal audits – Absence Management and Senior Medical Job Planning.
- **Maintaining High Professional Standards (MHPS)** – assurance provided on the process and the position re trained case managers and case investigators.

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

- As above, agreed that the risk rating for BAF Strategic Aim 5 – Provider Collaborative was reduced from 9 to 6 which is the target score.

Cross-referrals to Committees or Executive Directors

There were no cross-referrals.

Gateshead Health
NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	Digital Committee
Date of Committee / Group:	5 February 2025
Chair of Committee / Group:	Mr A Moffat

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

- AI Report – The committee requested a further report on AI and how work on AI is being properly aligned.

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

- Multi Factor Authentication – it was reported that the introduction of MFS was causing some operational concerns and that a plan is in place to address these issues.
- Careflow escalation process.
- EPR – currently on track to deliver the Outline Business Case to timescales.
- CRP – the CRP for 2025-26 for Digital will be challenging.
- DSPT 2024-25 - actions are ongoing
- Co-pilot – the pilot relating to free licenses for the co-pilot system needs further discussion.
- Freedom of Information (FOIs) – there are plans to address outstanding issues in meeting timelines
- Subject Access Requests (SARs) – whilst response rates continue to fail to meet mandated timescales, improvement in response rates was noted.
- PACs Debrief/KPIs – further consideration is needed on how end user feedback is incorporated into KPIs to allow greater understanding of how systems are working.

Assure
(key assurances received and any highlights of note)

The Committee received assurance in relation to:

- PACs debrief – the action log will be monitored via the Gateshead Leadership Group.
- DDAT Steering Group is up and running
- DSPT – actions submitted as compliant for 2023-24
- Governance structures were discussed

• Internal Audit actions have been delivered. • KPIs – substantial assurance is now being provided through reported KPIs.
Risks (any new risks / proposed changes to risk scores)
There were no changes to risks.
Cross-referrals to Tier 1 Board Committees (by exception)
• None

Gateshead Health
NHS Foundation Trust

Committee Escalation and Assurance Report

Name of Board Committee	Group Audit Committee
Date of Board Committee:	4 March 2025
Chair of Board Committee:	Mr A Moffat

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

There were no alert items identified.

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)

- Freedom to Speak Up (FTSU) – the report provided assurance over compliance with the policy and the progress made over the last year was acknowledged. The Committee requested further assurance over the timely closure of FTSU concerns and the resilience of the service given that there is one FTSU Guardian (although the progress made in establishing a network of FTSU champions was noted).
- The Committee was advised of the implications of International Financial Reporting Standard 16 (IFRS16), namely that new leases now impact upon the group's Capital Departmental Expenditure Limit (CDEL).
- An update was provided in relation to the response to the external audit recommendation regarding employment contracts. Assurance was provided that a new process was now in place to strengthen the control environment, although it was reported that some historic gaps in documentation remained and that Management had resolved to accept the associated risk. The Committee sought further assessment and quantification of this risk.
- The Committee received the Internal Audit update report and approved five changes to the Internal Audit plan for 2024/25 at the request of Management. An update was provided on the progress against the plan, including the likely impact of the audit conclusions on the Head of Internal Audit opinion.
- The Committee approved the Internal Audit Plan in respect of those audits planned for Quarter 1 and Quarter 2 2025/26. Following feedback from the Executive Directors the plan for the remainder of the year will be further revised and presented to the next Audit Committee meeting for formal approval.
- The Committee received an assurance report on the clinical audit process. Assurance was provided that the national clinical audits have been completed in accordance with the plan and that the governance processes for clinical audit delivery and associated learnings continue to develop. The Committee requested that the Medical Director attends a future meeting to provide additional insight into clinical audit processes.
- The Committee discussed how it could be assured that Standing Financial Instructions (SFIs) are being complied with. It was agreed that work would be undertaken to determine

whether it would be feasible to include an assurance guide / map in the next iteration of the SFIs.
Assure ***(key assurances received and any highlights of note for the Board)***
• Executive Risk Management Group – the Committee felt assured that progress had been made in relation to strengthening the risk management control environment, as evidenced through the outputs from ERMG. • The Committee was assured that a timeline and plan is in place to enable the Trust's accounts and annual report to be signed off in accordance with the national timescales. • The Committee was assured that a plan is in place with the external auditors to commence the QE Facilities' audit earlier in the year.
Risks (any new risks / proposed changes to risk scores)
There were no changes to risks.
Cross-referrals to Tier 1 Board Committees
There were no cross referrals.

NHS
Gateshead Health
NHS Foundation Trust

Committee Escalation and Assurance Report

Name of Board Committee	Group Remuneration Committee
Date of Board Committee:	29 January 2025
Chair of Board Committee:	Martin Hedley, Senior Independent Director

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

- There were no matters of concern to alert to the Board.

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

- There were no advisory matters to share with the Board.

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

- The Committee approved the proposed temporary acting arrangement for the Group Director of Finance post, appointing Jane Fay, Deputy Director of Finance to the position of Acting Group Director of Finance.
- The Committee approved an update to the Group Remuneration policy to reflect the application of NHS England's 2024/25 very senior manager remuneration recommendations, as considered by the Committee in October 2024.

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

- No new risks had been identified during the meeting.

Cross-referrals

- None

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 16

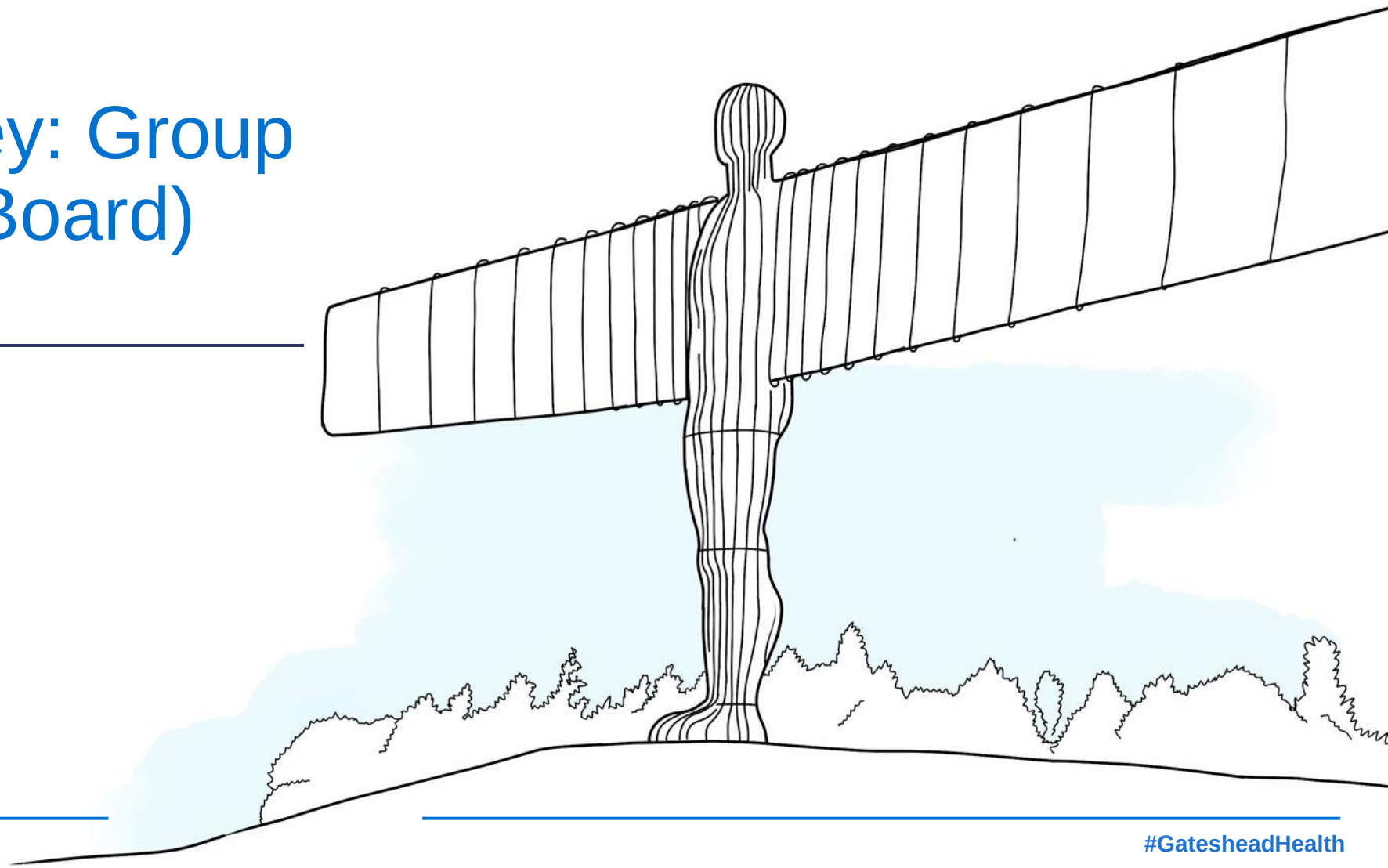
Report Title:	**2024 Annual Staff Survey Results incl. National Quarterly People Pulse Update**			
Name of Meeting:	Trust Board Part 1			
Date of Meeting:	26th March 2025			
Author:	Sam Corcoran, OD Practitioner			
Executive Sponsor:	Amanda Venner, Group Executive Director of People and OD			
Report presented by:	Amanda Venner, Group Executive Director of People and OD			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
Proposed level of assurance – <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*	People and OD Steering Group People and OD Committee			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	**High Level Overview of 2024 Staff Survey Results**: • **Highest ever completion rate for National Staff Survey & National Quarterly Pulse Survey** – could indicate higher level of staff willingness to provide honest feedback • **Need for action on incivility and engagement/wellbeing** – A renewed focus is required on tackling workplace incivility, promoting inclusivity, and ensuring engagement is a priority where staff wellbeing support is visible, accessible, and effective. • **Continue to promote National Staff Survey and National Quarterly Pulse Survey** – to continue to encourage employee participation in both surveys.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	This paper is shared with People & OD Committee for information of the 2024 annual staff survey results and an update on Wave 52 National Quarterly Pulse Survey (NQPS) survey results.			
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** ☒	

2024 Staff Survey: Group Results (Public Board)

Amanda Venner

26th March 2025



Group Staff Survey Actions following last year's survey

Gateshead Health NHS Foundation Trust

It's not ok campaign strengthened our approach to address poor behaviours to eliminate issues such as racism, harassment and discrimination

Increased clinical input in decision making across the Trust.

Culture programme revised with key workstreams focused on enhancing the culture at Gateshead

More opportunities for colleagues to meet with the executive team in informal ways

Show racism the red card training and development of 'comfortable to challenge' support

Sexual safety charter and policy launched (along with Bullying & Harassment and Violence & Aggression policies)

Revision of estates and capital plan to prioritise key clinical areas – with detailed clinical engagement at CSG.

Enhancing the Freedom to Speak Up service to encourage a culture where everyone feels safe to speak up.

Introduction to 2023 Staff Survey

Gateshead Health NHS Foundation Trust

The 2024 survey approach remains consistent with the surveys from 2021, with the realignment to the NHS People Promise, allowing for a year-on-year comparison.

A total of 119 questions were asked in the 2024 survey, of these, 113 can be compared to 2023 and 101 can be positively scored. The results include every question where the group received at least 10 responses (the minimum required).

We remain one of the higher scoring Trusts for those using Picker and in a number of areas we score higher than peers

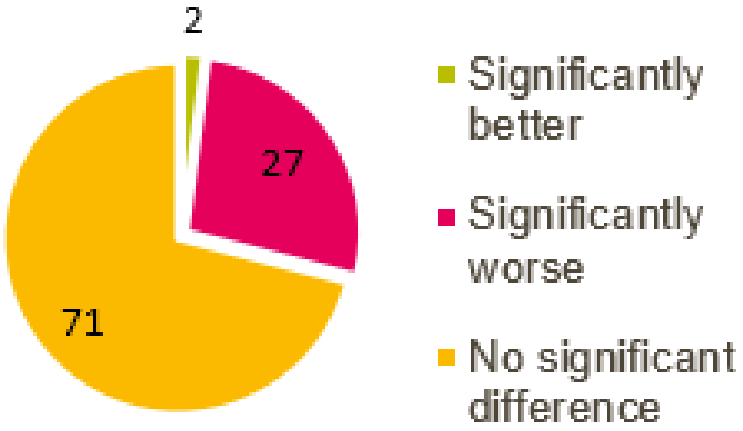
53% Group Completion Rate

53% Trust
54% QE Facilities
19% Bank

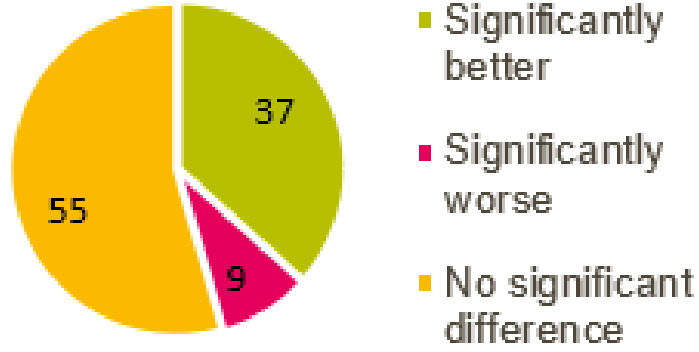
Group: Executive Summary

Gateshead Health NHS Foundation Trust

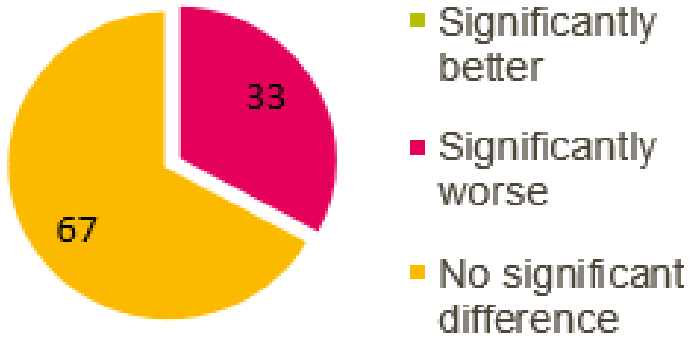
Comparison to 2023



Trust Comparison with Picker average



QE Facilities Comparison to 2023



QE Facilities Comparison with average

Executive summary 2024 - Trust

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	71%	61%
q15. Organisation acts fairly: career progression	64%	57%
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	71%	64%
q31b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	81%	74%
q4c. Satisfied with level of pay	38%	32%

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q13d. Last experience of physical violence reported	64%	71%
q2a. Often/always look forward to going to work	49%	54%
q8c. Colleagues are polite and treat each other with respect	67%	70%
q8d. Colleagues show appreciation to one another	63%	66%
q4b. Satisfied with extent organisation values my work	40%	43%

Most improved scores	Org 2024	Org 2023
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	71%	63%
q22. I can eat nutritious and affordable food at work	56%	53%
q14d. Last experience of harassment/bullying/abuse reported	50%	47%
q4c. Satisfied with level of pay	38%	35%
q12g. Never/rarely lack energy for family and friends	37%	36%

Most declined scores	Org 2024	Org 2023
q11a. Organisation takes positive action on health and well-being	56%	62%
q13d. Last experience of physical violence reported	64%	69%
q3e. Involved in deciding changes that affect work	50%	55%
q8d. Colleagues show appreciation to one another	63%	67%
q8c. Colleagues are polite and treat each other with respect	67%	71%

Tables are based on absolute % differences, not statistical significance

Executive summary 2024 - QEF

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	81%	53%
q23b. Appraisal helped me improve how I do my job	29%	23%
q11c. In last 12 months, have not felt unwell due to work related stress	71%	65%
q3g. Able to meet conflicting demands on my time at work	57%	51%
q26b. I am unlikely to look for a job at a new organisation in the next 12 months	57%	53%

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q9d. Immediate manager takes a positive interest in my health & well-being	60%	75%
q9h. Immediate manager cares about my concerns	59%	74%
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	61%	77%
q9a. Immediate manager encourages me at work	60%	75%
q9c. Immediate manager asks for my opinion before making decisions that affect my work	47%	62%

Most improved scores	Org 2024	Org 2023
q14d. Last experience of harassment/bullying/abuse reported	55%	43%
q11e. Not felt pressure from manager to come to work when not feeling well enough	75%	69%
q10b. Don't work any additional paid hours per week for this organisation, over and above contracted hours	61%	56%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	81%	78%
q6a. Feel my role makes a difference to patients/service users	81%	79%

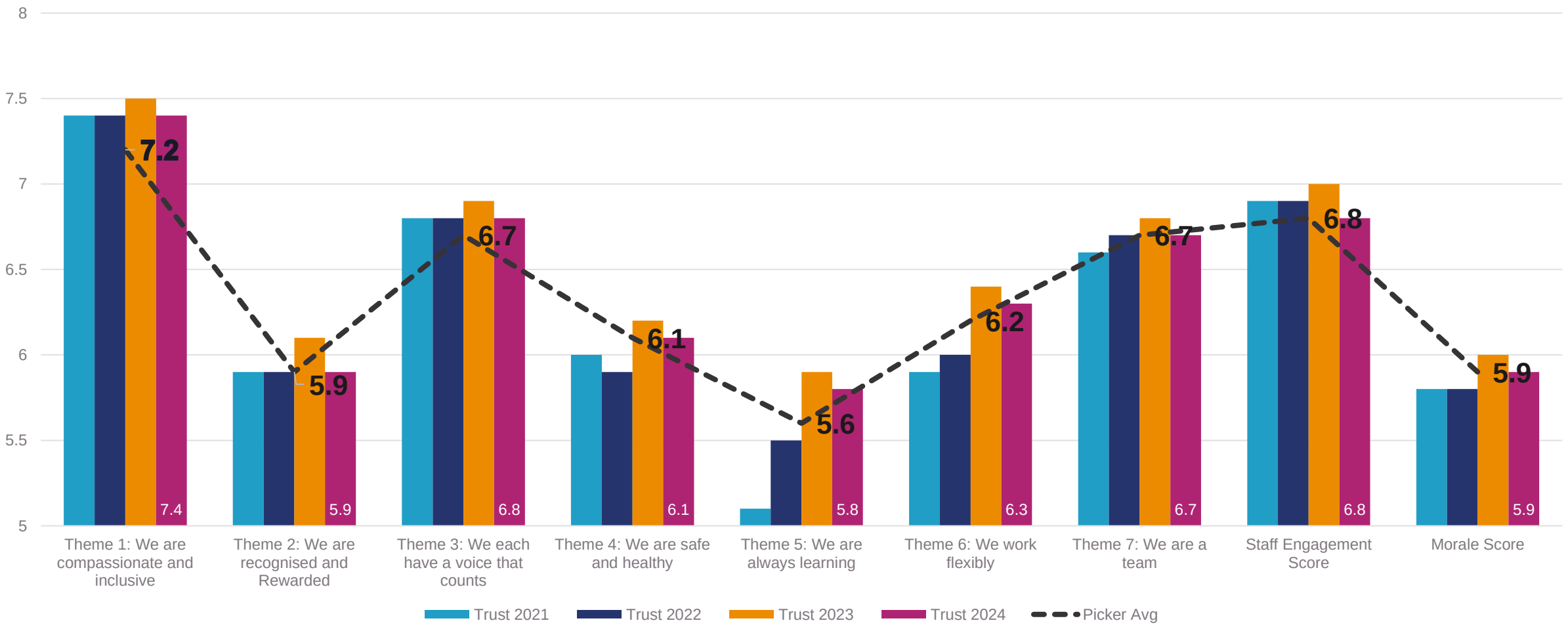
Most declined scores	Org 2024	Org 2023
q4a. Satisfied with recognition for good work	46%	60%
q19d. Feedback given on changes made following errors/near misses/incidents	49%	62%
q11d. In last 3 months, have not come to work when not feeling well enough to perform duties	42%	55%
q9f. Immediate manager works with me to understand problems	60%	71%
q19a. Staff involved in an error/near miss/incident treated fairly	53%	64%

Tables are based on absolute % differences, not statistical significance

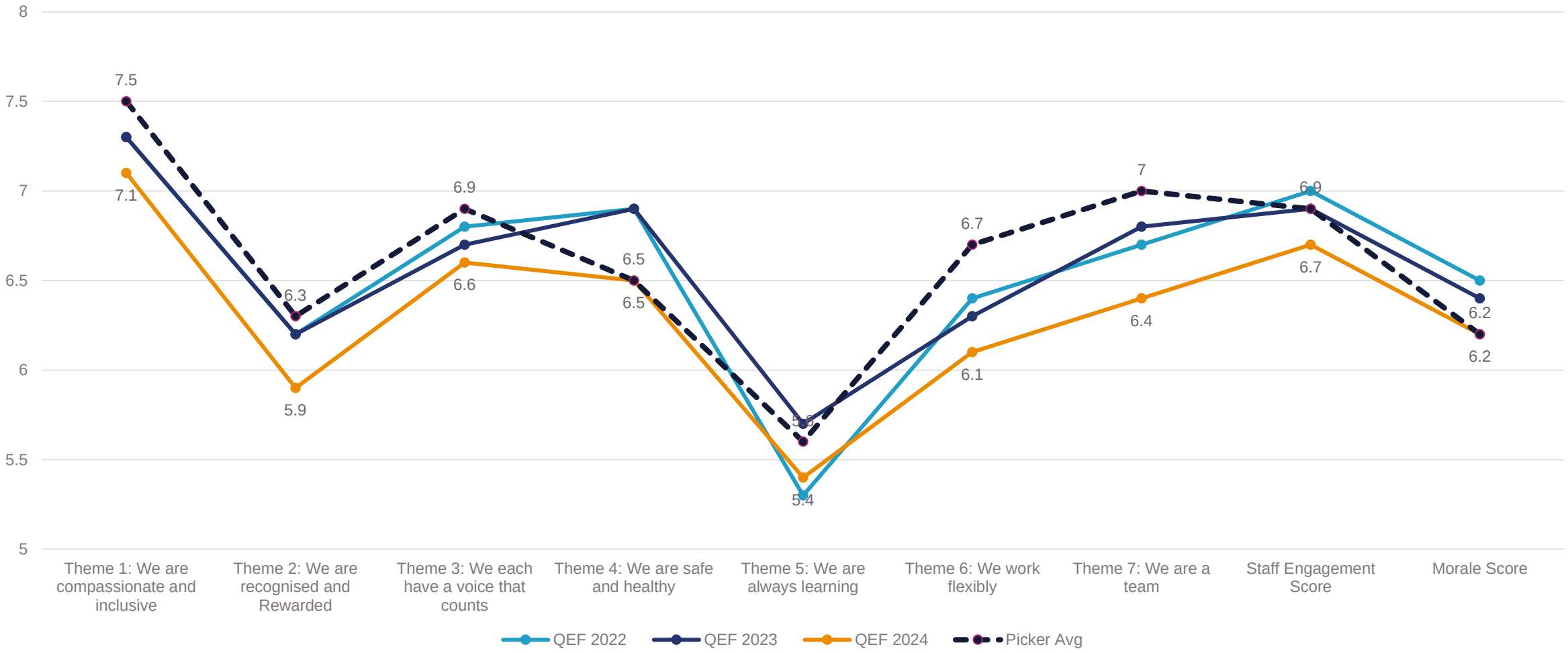
Trust Negative scores - questions where we have declined since last year ***and*** are significantly worse than the average

		Historical					External	
		2020	2021	2022	2023	2024	Average	Organisation
q4b	Satisfied with extent organisation values my work		42%	43%	45%	**40%**	43%	**40%**
q7h	Feel valued by my team		68%	71%	70%	**67%**	69%	**67%**
q8c	Colleagues are polite and treat each other with respect		71%	72%	71%	**67%**	70%	**67%**
q8d	Colleagues show appreciation to one another		67%	67%	67%	**63%**	66%	**63%**
q13a	Not experienced physical violence from patients/service users, their relatives or other members of the public		87%	83%	87%	**84%**	86%	**84%**

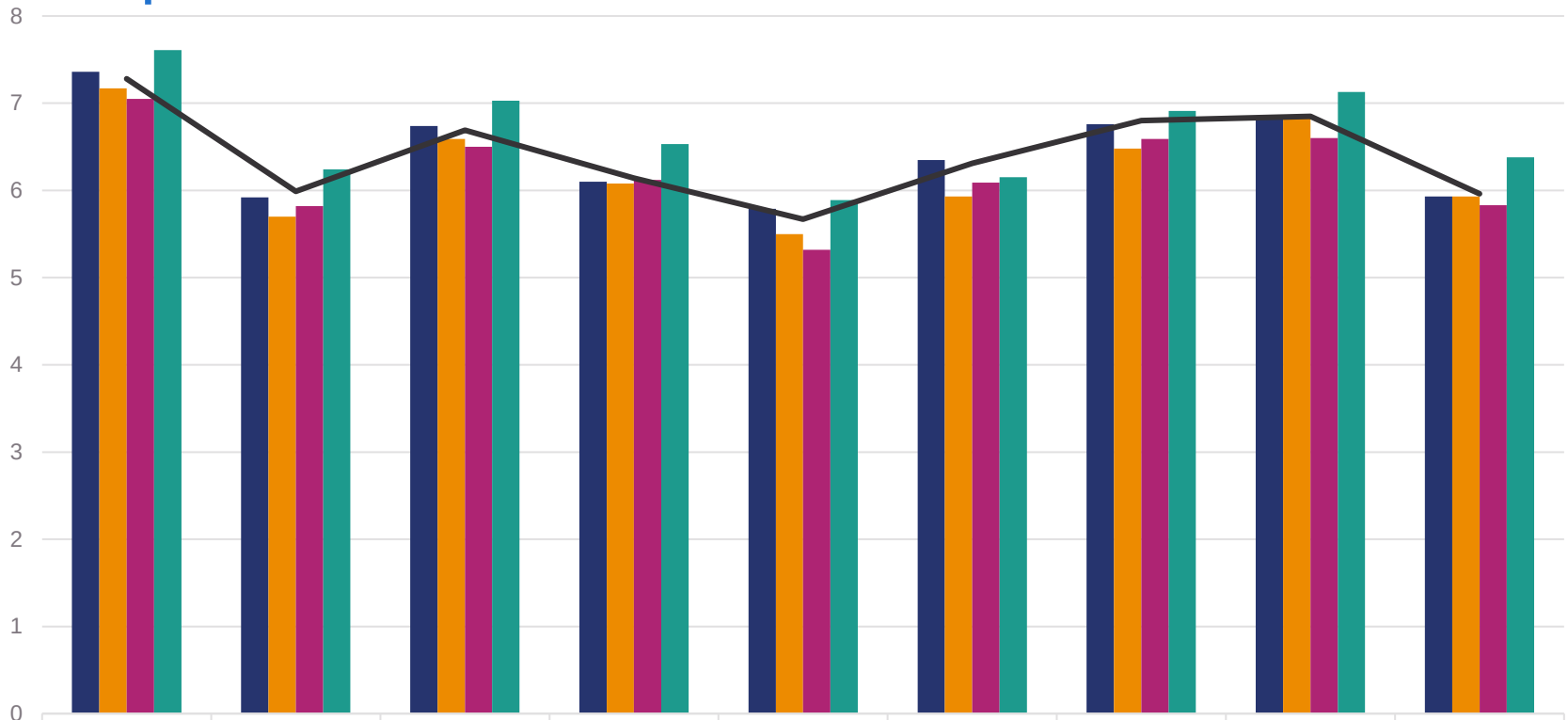
Trust: People Promise 4-year trend



QEF: People Promise 3-year trend



2024 Alliance Group Comparison



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Morale
Gateshead Health NHS Foundation Trust	7.36	5.92	6.74	6.1	5.79	6.35	6.76	6.84	5.93
The Newcastle upon Tyne Hospitals NHS Foundation Trust	7.17	5.7	6.59	6.08	5.5	5.93	6.48	6.83	5.93
North Cumbria Integrated Care NHS Foundation Trust	7.05	5.82	6.5	6.12	5.32	6.09	6.59	6.6	5.83
Northumbria Healthcare NHS Foundation Trust	7.61	6.24	7.03	6.53	5.89	6.15	6.91	7.13	6.38
National Average	7.28	5.99	6.69	6.14	5.67	6.31	6.8	6.85	5.96

Overall positive score: Staff Networks Trust

D-ABILITY STAFF NETWORK

Yes (664)	No (1694)
58%	65%

Heterosexual / straight (2110)	Gay / lesbian, Bisexual, Other (135)	I would prefer not to say (128)
64%	61%	52%

White (2099)	Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/ Caribbean/ Black British, Other ethnic group (262)
63%	67%

Female (1868)	Males (410)	Prefer not to say (89)
63%	64%	47%

Overall positive score: Staff Networks QEF

D-ABILITY STAFF NETWORK

Yes (105)	No (297)
53%	63%

Heterosexual / straight (376)	Gay / lesbian, Bisexual, Other (12)	I would prefer not to say (17)
60%	69%	50%

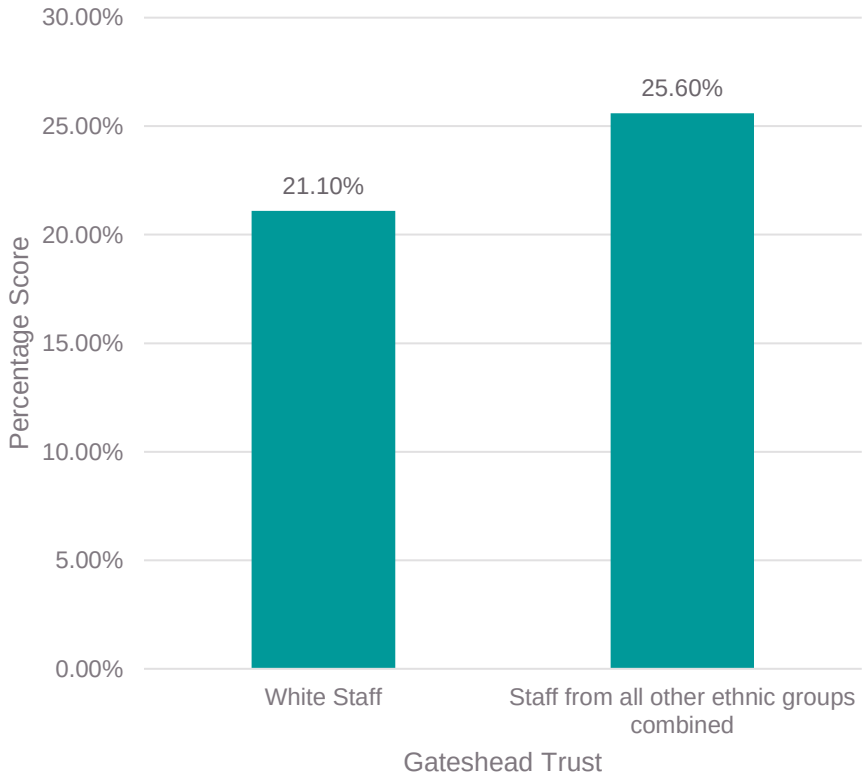
GEM
Global Ethnic Majority

White (388)	Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/ Caribbean/ Black British, Other ethnic group (17)
59%	79%

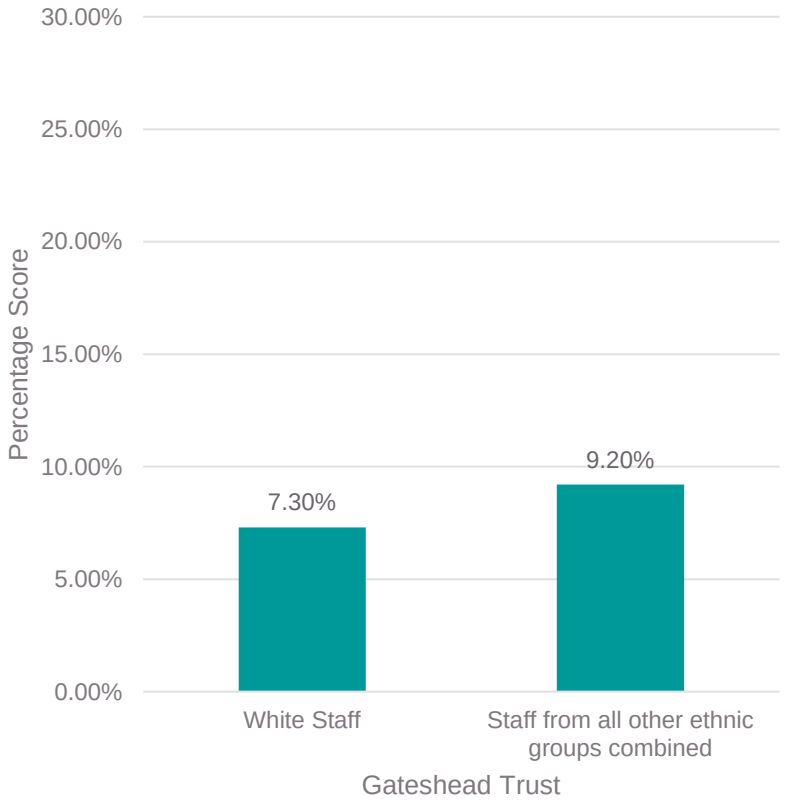
Female (210)	Males (180)	Prefer not to say (10)
59%	63%	50%

Bullying, Harassment or Abuse – WRES

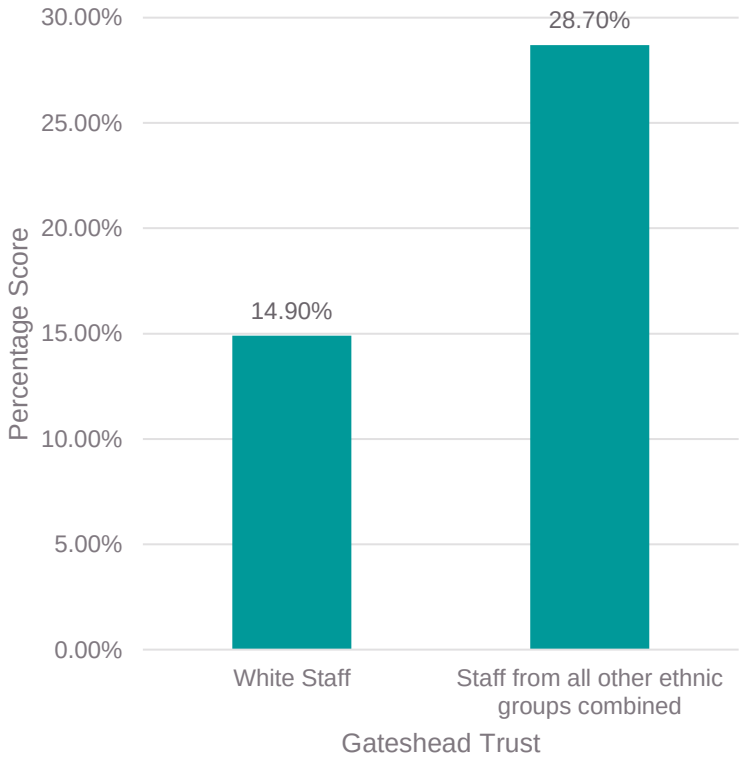
Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public, in the last 12 months, 2024.



Not experienced harassment, bullying or abuse from managers, in the last 12 months. (q14b) 2024



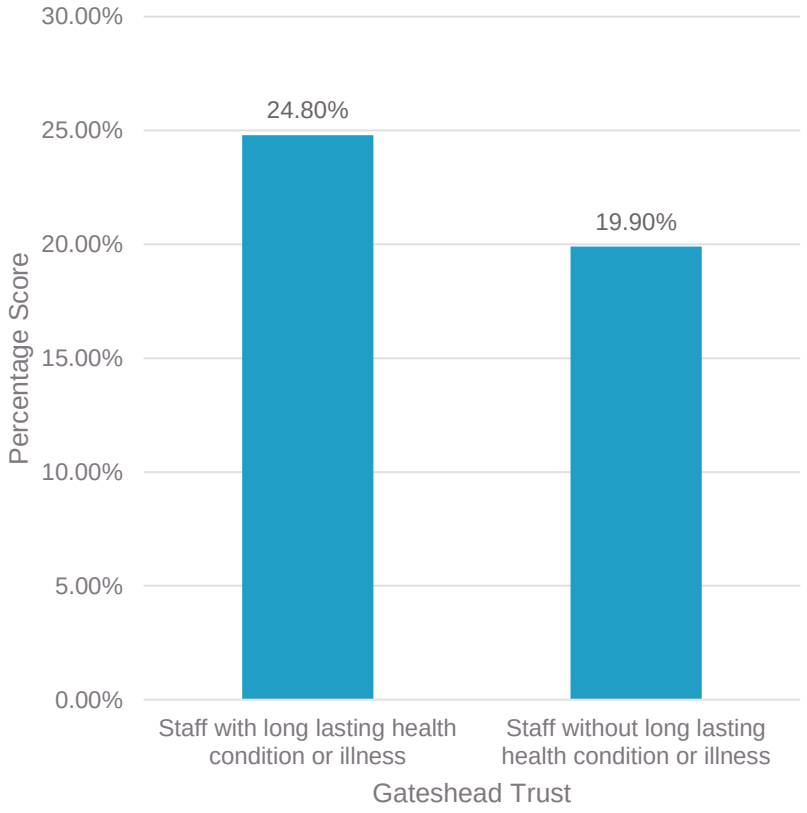
Not experienced harassment, bullying or abuse from other colleagues, in the last 12 months. (q14c) 2024



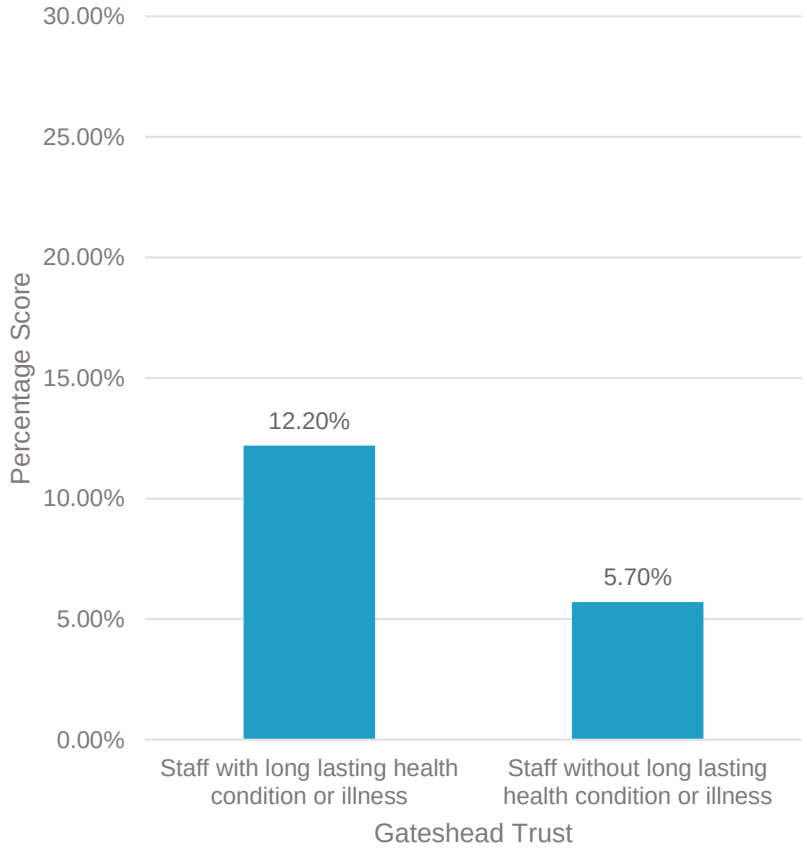
Bullying, Harassment or Abuse – WDES

Gateshead Health NHS Foundation Trust

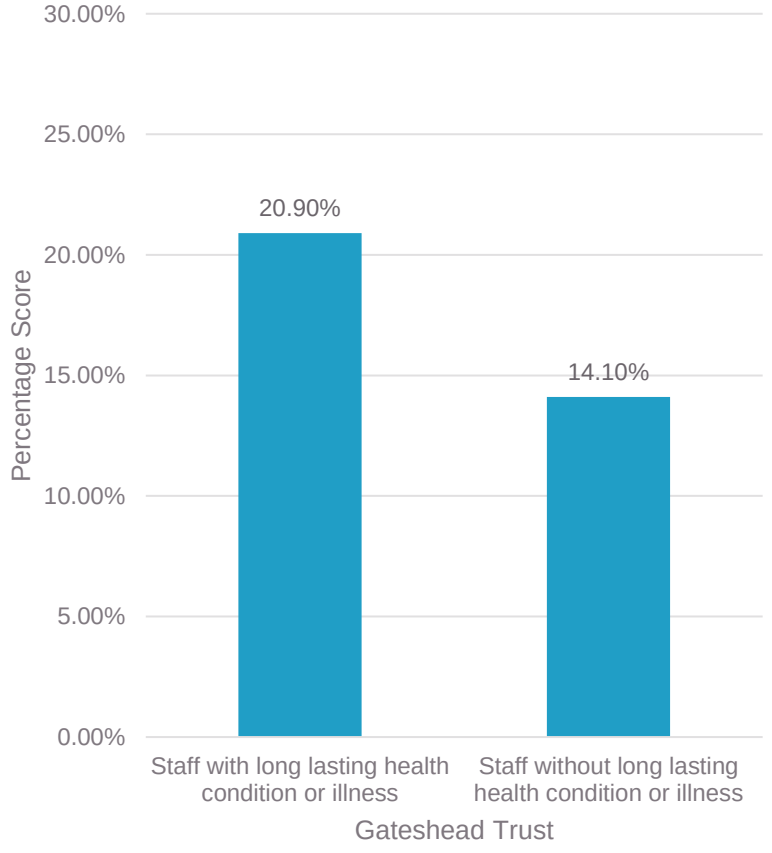
Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public, in the last 12 months (q14a) 2024



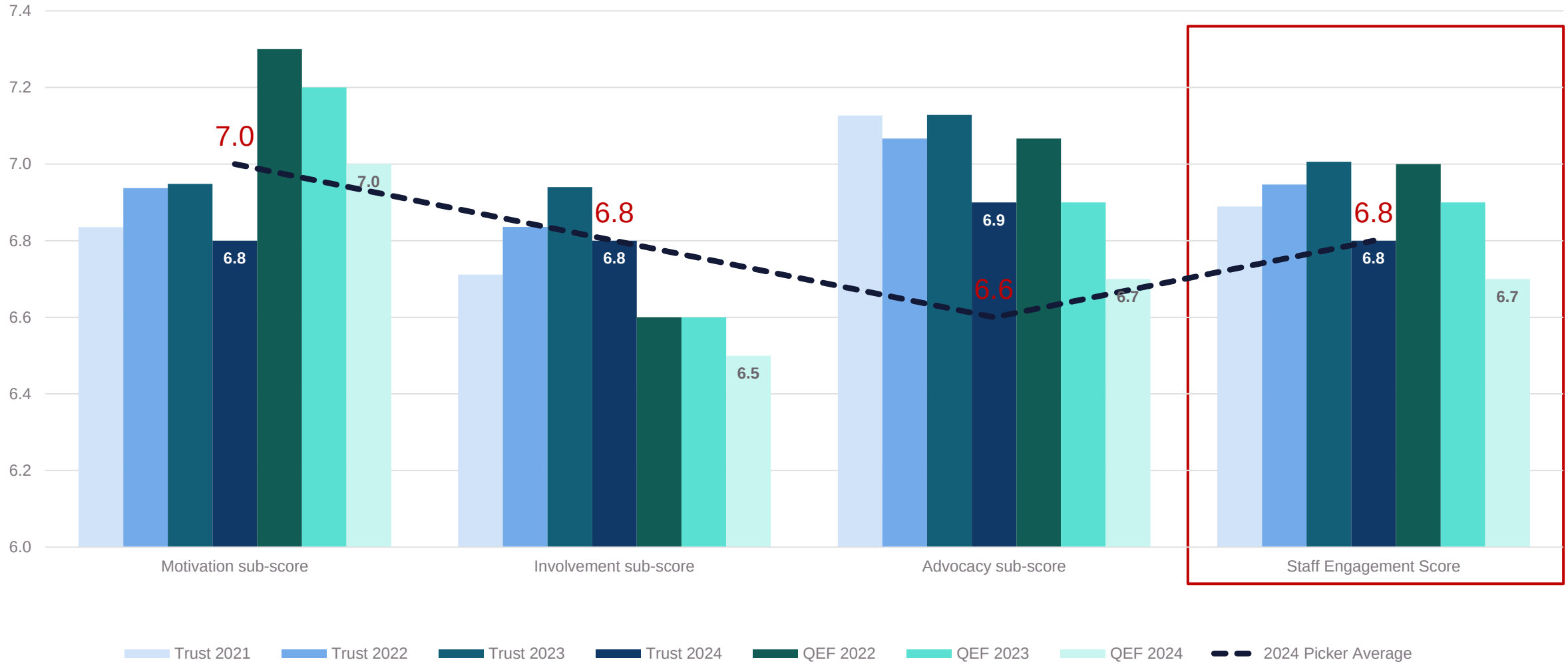
Not experienced harassment, bullying or abuse from managers, in the last 12 months. (q14b) 2024



Not experienced harassment, bullying or abuse from other colleagues, in the last 12 months. (q14c) 2024

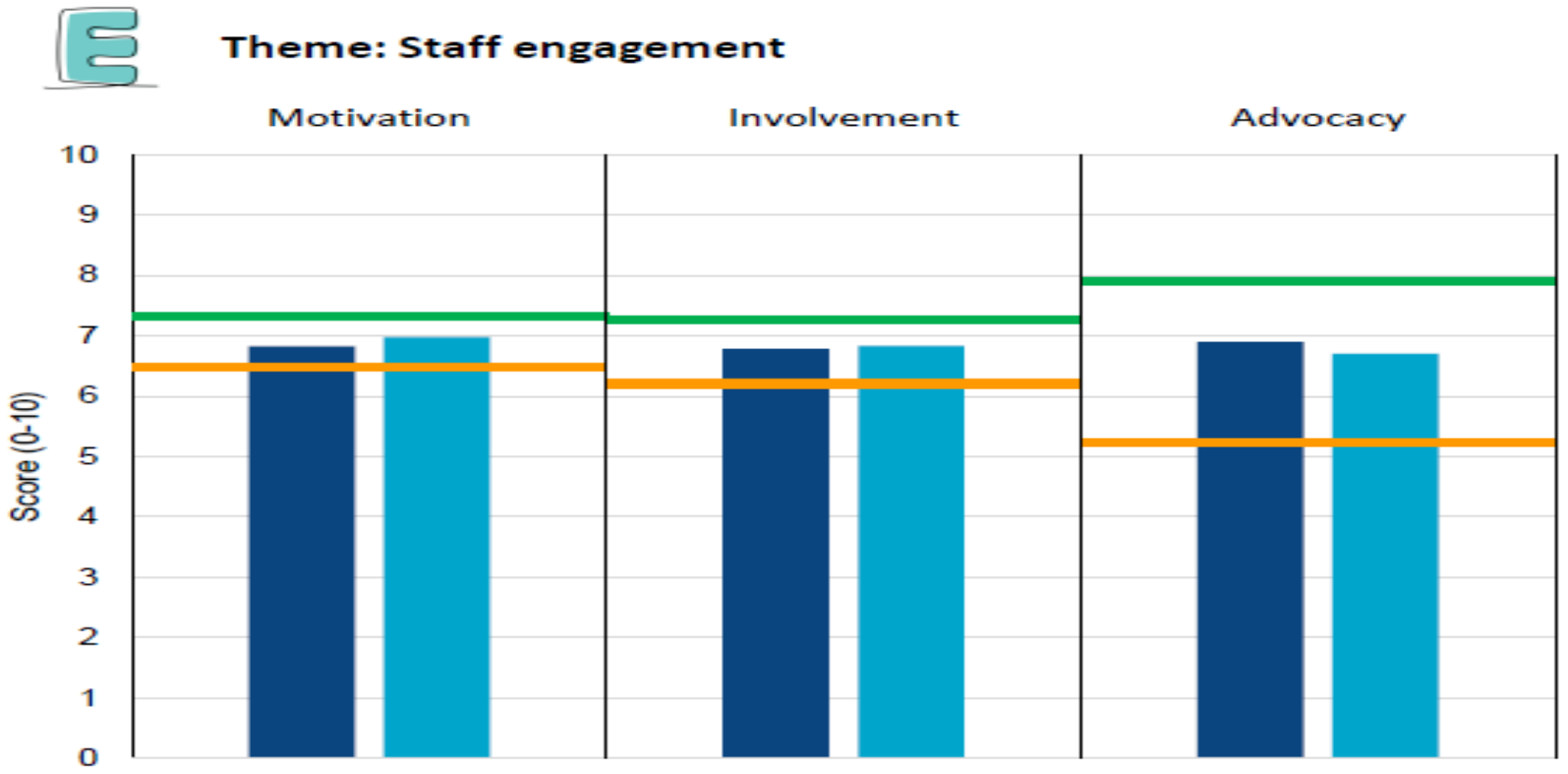


Group 2021 – 2024 engagement scores vs Picker average



Group 2021 – 2024 engagement scores vs Picker average

Gateshead Health NHS Foundation Trust

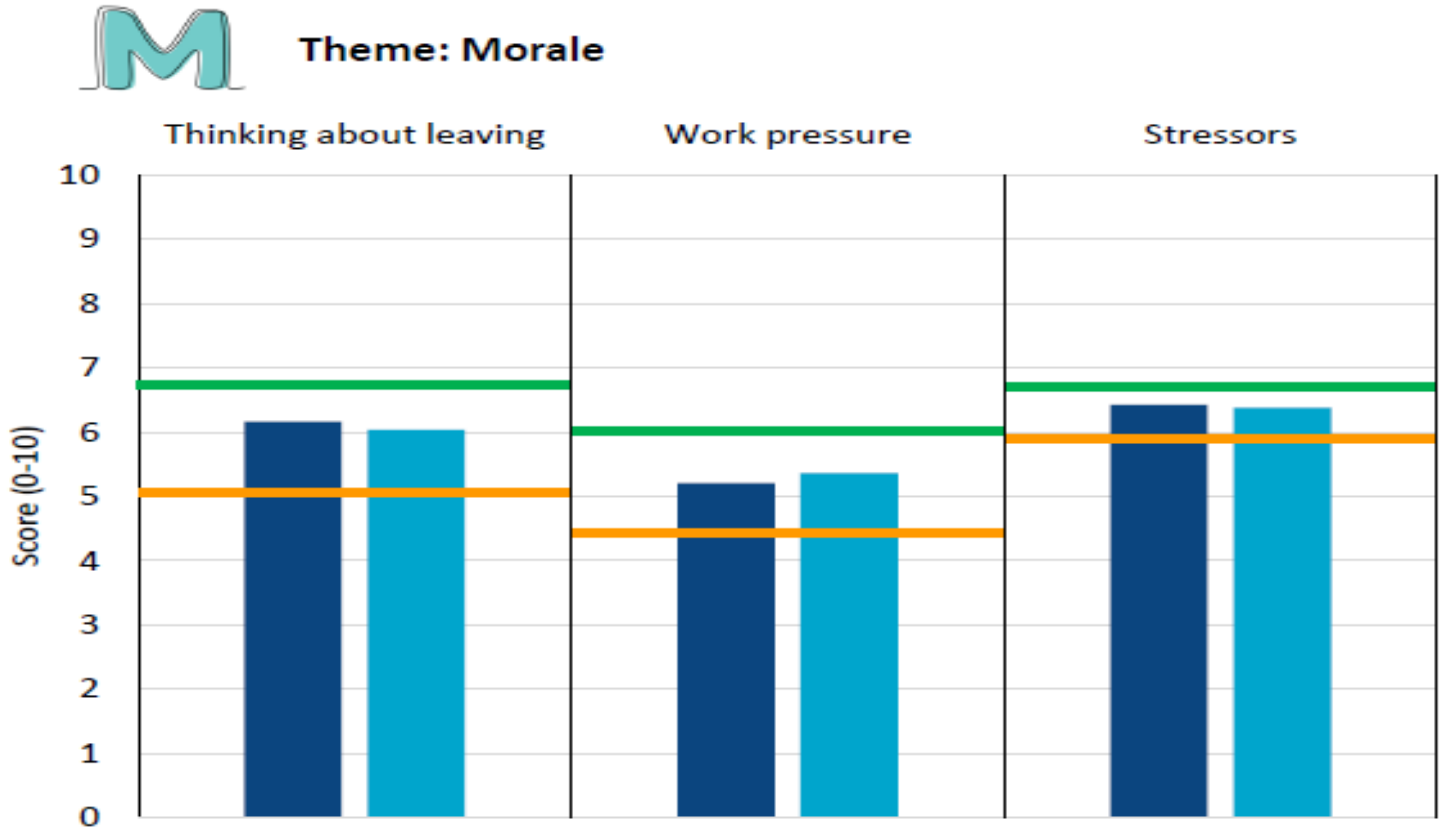


	Motivation	Involvement	Advocacy
Your org	6.83	6.78	6.90
Best result	7.33	7.27	7.90
Average result	6.98	6.83	6.70
Worst result	6.49	6.20	5.24
Responses	2370	2382	2378

Key Highlights:
Motivation
Q2a - Often/always look forward to going to work (decreased & lower than average)
Advocacy
Q25c - Would recommend organisation as place to work (significantly decreased but higher than average)

Group 2021 – 2024 engagement scores vs Picker average

Gateshead Health NHS Foundation Trust



	Thinking about leaving	Work pressure	Stressors
Your org	6.17	5.21	6.42
Best result	6.73	6.03	6.70
Average result	6.04	5.36	6.38
Worst result	5.07	4.42	5.91
Responses	2380	2379	2380

Key Highlights:

Thinking about leaving:

Q26a - I don't often think about leaving this organisation (decreased but higher than average)

Work pressure:

Q3h Have adequate materials, supplies and equipment to do my work (decreased but inline with average)

Stressors

Q3aAlways know what work responsibilities are (lower than average)

Q3e Involved in deciding changes that affect work (decreased but inline with average)

Free Text Themes - Trust Level

There were a total of 884 free text comments**.** These can be categorised / themed as follows:

Theme	Responses	%
Management & Leadership	272	41.15%
Staffing & Workload	171	25.87%
Health & Wellbeing	149	22.54%
Work Environment & Resources	105	15.89%
Patient Care & Safety	86	13.01%
Career Development & Training	58	8.77%
Communication & Engagement	43	6.51%

Local Questions

- Clinical voices of all professions are involved in decision making within the Trust
- Clinical professionals and managers work in partnership to make decisions regarding their services
- The culture in my team aligns to the Trusts ICORE values
- Good behaviour that aligns with the Trusts ICORE values are demonstrated within my team
- Courteous and polite behaviour (i.e., civility) towards colleagues within the workplace is encouraged within Gateshead Health
- Rudeness/inappropriate behaviour (i.e., incivility) within the workplace is appropriately addressed within Gateshead Health

The questions that saw the greatest variance from 2023 were:

- Q06 When good behaviour that aligns with the ICORE values is demonstrated, it is recognised and rewarded
- Q09 How satisfied are you with the overall effectiveness of our corporate internal communication?

What does a great culture look like at Gateshead?

- Supportive and Inclusive Culture - 31.45%
- Patient-Centred Care: - 27.01%
- Communication and Transparency: - 16.93%
- Leadership and Management: - 8%
- Professional Development and Learning Opportunities: - 3.43%
- Recognition and Appreciation: - 3.43%
- Teamwork and Collaboration: - 2.82%
- Work-Life Balance and Wellbeing: - 2.41%

These percentages reflect the frequency with which each theme was mentioned in the comments, highlighting the areas that are most important to the staff at Gateshead Health NHS Foundation Trust.

What next - Trust/Group Level

Gateshead Health NHS Foundation Trust

- We have agreed 2 broad recommendations/key messages to come back to throughout the year to build a consistent narrative….

- **Stop Incivility**
  - Be polite to *each other* and show respect and appreciation
  - Tackle bullying and harassment across all our staff groups, especially those who are under-represented (LGBT, GEM, D-ability)

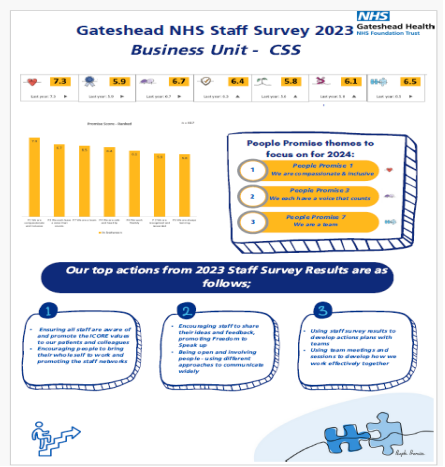
- **Promote and take positive action on engagement**
  - Have wider visibility on our Health and Wellbeing offer – what's needed, what's already available, how do we access it
  - How can we support our own HWB, access support and stay well

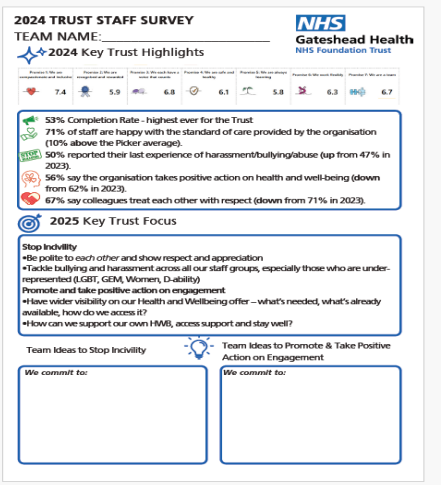
- We need to proactively go and speak to teams about the results – maybe use the CEO roadshows, team brief or similar engagement events to make sense of these.

Next Steps – Divisional Level

The next steps including next data sets are included below:

- **Communicate out group actions** taken since last survey, the impact, and what's next. Managers are asked to utilize posters to identify priorities and actions.
- **Civility**– Work commenced in 2024 regarding incivility and will continue over the next 12 months. This will also be monitored via local questions and Quarterly Pulse survey.
- **Health & Wellbeing** continue to promote health and wellbeing resources, support, materials and opportunities through the on-going campaigns to raise awareness and implementation of initiatives including health need assessments.
- **Zero-tolerance Working Group** will continue to raise awareness around bullying and harassment and enhance policies and procedures and working practices.
- **FTSU** - Tracy Healy will continue to build her profile within the Trust as FTSU guardian to ensure individuals feel safe to speak up and explore mechanisms to report.



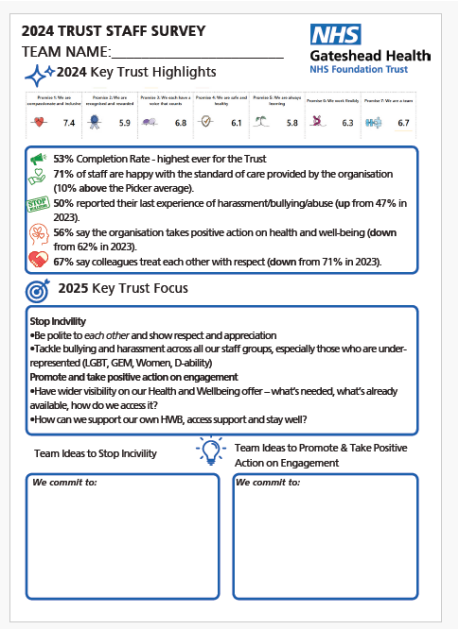


Next Steps – Business Unit Level

The next steps including next data sets are included below:

We would ask that you help to promote the importance of managers sharing their staff survey results with their teams and business units will be asked to utilise the poster to ensure top actions from this survey are identified and actions taken

Teams have been asked to complete the attached posters - business unit posters or equivalent document to flow through POD steering group in April 2025



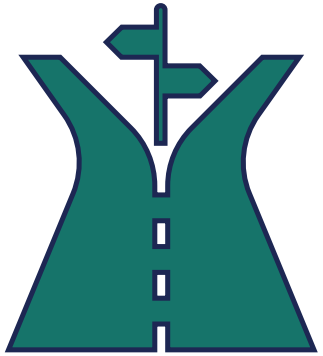
- **Communicate out Business Unit actions** taken since last survey, the impact, and what's next.
- **Local Questions, Free text comments and WRES/WDES Data** will be received and analysed, sharing relevant information with key stakeholders and SME's

Conclusion

Gateshead Health NHS Foundation Trust

What has this year's survey told us?

- More staff than ever have had their say this year – 53%
- There has been a slight decrease in people promise themes across the board, this is in line with Picker average trend.
- We have more to do to show staff the impact of completing the survey
- There are some real differences between the Trust and QEF results



What are we doing?

- Trust focus on two key areas of priority from the staff survey results:
  - **Stop Incivility and Promote and take positive action on engagement**
- Wide cascade of results
- Comms campaign to bring the results to life
- Local teams to discuss and work on bespoke actions for their area

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 17

Report Title:	**Freedom to Speak up Guardian Report 2024/25**			
Name of Meeting:	Trust Board of Directors.			
Date of Meeting:	26TH March 2025			
Author:	Tracy Healy Freedom to Speak Up Guardian (FTSUG)			
Executive Sponsor:	Dr Gillian Findley, Chief Nurse, Professional Lead for Midwifery & Allied Health Professionals. Deputy CEO. Amanda Venner Director of People & OD.			
Report presented by:	Tracy Healy FTSUG			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☒
	To provide an update of FTSU activity for year –2023-2025 to date.			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☒	**Partially assured** ☐	**Not assured** ☐	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Version 1 covering 2023-2025 data presented to QGC 7TH January 2025. Version 2 2023-2025 data Presented to POD Committee 14TH January 2025.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	**April 2023 – April 2024 Period:** • Total of 59 concerns raised, (35 raised the year prior). • A 71.4% increase in reporting from 2022/3 – 2023/4. **April 2024 – Current Position:** • Q1 – 15 Concerns • Q2 – 24 Concerns • Q3 – 28 Concerns • Q4 – Currently to 6/3/25 – 16 **Categorises of Concerns raised in this year period to current 6/3/25 as per NGO Categories:** • 30.1% Inappropriate behaviours / Attitudes • 29% Bullying & Harassment • 21.7% worker safety • 10% Patient Safety • 5% Other / not recorded. • 2.5% Detriment • 1.25% Quality of Patient Care			

	• When staff raise concerns, they are being managed in a variety of ways. Initially being rag rated for current risk and safety for patients and / or staff. Any cases rated high risk to patient or staff safety are escalated immediately to Chief nurse / Deputy CEO and / or Director of People & OD. • Increased the network of FTSU champions from 8 to 30. Currently 28 are fully trained and further 2 to be trained with further 5 awaiting assessment for selection. • In October 2022 it was agreed all Board members would undertake the necessary three levels of FTSU training. At the time of writing 15 out of 15 have completed. 100% Compliance. • FTSU Guardian Service Changes and development. • NGO Self-assessment changes for NHS Trust Boards. • FTSU Policy – compliance with NGO standards since October 2023. • SOP Draft for FTSU policy completed to be authorised. Will go through Governance process and then to Leadership Team for approval. • NGO new guidance requires review for local implementation. • FTSU Audit 1 • FTSU Strategy • Electronic recording	
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	• The committee is asked to receive this report by way of assurance on FTSU concerns and broader culture proactive activity. • The committee are asked to note that due to some of the complexities of cases not all have been resolved in this period but all that remain open are being monitored. • The committee is asked to be cited on future projects and developments for the service to ensure involvement at Board Level for support. • The committee are asked to consider the new NGO new guidance and give any comments for development of local plan.	
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):	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. (This risk currently at score 16). Emerging Risk 3318 - Risk of staff not having an anonymous platform to raise staff or patient safety concerns- mitigation in place and procurement of InPhase App for FTSU now completed. App currently being developed for service. – Now closed as reporting system now live for all staff to access.		
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☒	**Not applicable** ☐

Freedom to Speak Up Guardian Report

1. Executive Summary

1.1 **April 2023 – April 2024** there has been 59 concerns raised via FTSUG. Which was a 71% increase from the previous year.
Current Year April 2024- April 2025 we currently have 64 concerns which have been raised.
Q1 - 15 concerns raised.
Q2 - 24.
Q3 - 25.
Q4 – currently of 6/3/25 – 16.

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

1.3 FTSUG position has now been full time dedicated role for 18 months.

1.4 FTSUG attended the Trust Board development day in October 2023 to present development and changes to the Freedom to Speak Up Service and seek Trust Board members support with action plans for the service. For 2025 the FTSUG will need to be supported by Executive to agree yearly action plan as per new guidance from NGO. The monitoring of action plan will be added to FTSU report moving forward for cycle of business at committees for assurance and transparency.

1.5 FTSUG held roadshows in October 2023 for the National FTSU month this allowed launch of the new FTSUG in full time role and service changes.

FTSU month October 2024 we worked with our communication team and great Northern Alliance colleagues to launch our FTSU month with the lightening of the Millenium Bridge in the FTSU colour green. We undertook several roadshows across all sites to promote FTSU supported by Champions, executives and Non-Executive Lead.

1.6 Over the last 18 months FTSUG has been working collaboratively with POD team and joined the Culture Board program. Currently we are relaunching the membership of the Culture Board Program as well as formalising the governance of the board. FTSUG will support this in deputy chair position.
From the Culture Program the subgroup for Zero Tolerance has undertaken projects including Show Racism the Red Card, with the development of Bystander Training. The “it’s not ok” champaign, and part of this includes sexual safety in the workplace. The trust has signed up to the sexual safety charter to support this, and the FTSUG has supported with the development of a Trust policy for sexual safety in the workplace. Running parallel to this is training program development supported by Northumbria Police, and Kindling services- Active bystander sexual safety training. Several staff are certified trainers for the Trust and will be used to educate and support Trust managers and staff dates have been made available for the next 3 months. Overall, there have been policy changes to 2 other policies to support this alongside the introduction of the new sexual safety policy.
FTSUG was also supported by POD Lead to present these developments to the Patient safety conference. (see summary pg12)

1.7 Completed National Guardians Office Training and is registered as Trusts FTSUG with the NGO. Continues to undertake learning as required by NGO.

1.8 Continue to audit and monitor service delivery for FTSU with external audits completed for ICB and Audit one. Changes made from audits currently include the development of formal feedback process and implementation of FTSU electronic reporting using InPhase to ensure staff have platform to raise concerns both anonymously and in confidence.

1.9 FTSU posters are now being made available for all areas of the Trust to ensure compliance for NGO and CQC.

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

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

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

1.13 The data analysis work has progressed to be able to support “hot spot areas” with reports of key themes allowing action plans to be developed by the different services to improve staff and patient safety and wellbeing.

1.14 Development of data triangulation meeting is being scoped with key stakeholders.

1.15 Several bespoke listening sessions with POD leads have now been undertaken with business unit teams to review historical cases and take forward lessons learnt for future practice supporting change in culture, policies and procedures as well as giving staff who have been harmed assurance of changes made to prevent this occurring in future and supporting the staff with current wellbeing requirements. The report from these sessions has been shared with the executive team and an action plan is under development for further changes to be made.

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

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

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

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

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

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

1.22 FTSU Training Compliance rates for level 1,2, and 3 now required to be reported in all FTSU Reports as first recommendations from Audit 1. See Section 3.

2. Introduction:

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

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

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

2.4 This report provides the Committee with a summary of FTSU activity from April 1-2023 – March 6, 2025. As a new reporting metric, it will also demonstrate to the board the feedback information from staff following raising FTSU concerns.

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

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

3. Key issues / findings

3.1 April 1st, 2023- March 3rd 2025.

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

Table 1 below shows an oversight of the FTSUG cases from 2023-2024, Q1 and up to 6/3/2025 of Q4, with the added information fields from Q3 of 2023 – to date only. (see p14- 21).

- Since changing FTSU to a full-time position and the promotion of the service from both the FTSUG and the executive team we have seen an increase in cases through year 2023-2024 seeing an annual increase of 71%. The current data for 2024 does show a

decrease in Q1 to 15 cases however, there the following two quarters have increased to 24 in Q2 and Q3 further increase to 26, with current Q4 having 16 up to 6/3/24. Benchmarking this against other Trusts nationally we are not outlying with a drop in concerns in Q1 this was the same nationally.

- Since 2023 Q3 data changes have allowed us to have more specific trends, themes and hot spots to not only report but more importantly feed through the culture board program to support changes. The data demonstrates highest trend currently is still unfair treatment of staff from managers or individuals / teams they are working with. The learning from cases mirroring this, identifying highest learning outcomes being incivility.

- The current data demonstrates that there is a split of 11% Patient safety / quality to 83% staff concerns, this has changed within last 6 months from a 20/80% split. Further analysis against national reporting will be undertaken when data is available. Discussions with colleagues from the Great Northern Alliance FTSU services are reporting similar percentages.

- In 2024 we have adapted the data collection further to add learning from concerns, key phrases, cases broken down to department level and added any protected characteristics to gain a better understanding of concerns, specific hotspots, themes, and trends.

3.2 What currently is this telling us?

- Staff with protected characteristics are the group of staff who are less likely to raise concerns currently we have 57 out of the 118 cases (48.3%). However, 16 out of the 57 cases (28%) which staff had recorded having protected characteristics actual concerns they raised was secondary to their protected characteristics overall a 13.5% of cases raised.

- It is telling us we have some key hot spot areas including theatres, midwifery, ECC (a lot of which were historical) and QEF.

- Further interventional work has been undertaken in three areas of the Trust following both number and nature of concerns raised and incidents which have occurred within this financial year. This includes listening sessions in ECC for historic cases, and theatres to support staff following incidents which have occurred and current broader data analysis for theatres to look at incivility, behaviours, and leadership. As well as POD work interventions in both maternity and Paediatric diabetes.

- Other key areas which have had increased reporting in the last quarter include key themes regarding incivility and bullying within QEF this has been raised on individual case basis with appropriate members of leadership team and HR Lead as well as agreement to present paper to QEF POD Committee as well as feeding into QEF Board.

- Other key themes identified are changes in clinical pathways and services which have either been undertaken without all relevant clinical stakeholders or clinical views not been considered or listened too.

- Processes when staff are being appointed to roles were staff feel that "*jobs are being made for people," "people know who is going to be appointed before*

interviews are held," due to nepotism / favouritism and "*clicks*." The recruitment process is being seen to be followed but staff feel this is just to tick a box.

- There are several cases as well which highlight that performance management processes are not been addressed with staff correctly which is leading to staff then feeling they are being bullied and raising concerns.

- There has been an increasing number of cases which are highlighting problems arising for staff who are neurodivergent regarding lack of support and understanding of their condition as well as lack of support for reasonable adjustments to allow them to be able to undertake their role. Including both at local level and Trust level which includes lack of provision for disability sickness / absence due to long term conditions whether this is physical disability or secondary to neurodiversity and mental health conditions. Work is being undertaken to support this through EDI Group and signing of Disability Charter.

- Increased reporting in concerns regarding car parking facilities.

- Although in this report we have seen as predicted and highlighted to Trust board an increase in sexual assault / harassment case numbers rise secondary to some of the bespoke work undertaken collaboratively with POD and FTSU. To assure the board that there is significant work already underway in response to address this and further action plan being put in place from the executive team. (see further updates in report).

- The data bar chart allows us to be able to see where our key areas of improvement are still required. Intimidation, communication, oppression, and verbal abuse, being the highest priority areas. The continued collection of the data has also highlighted the requirement of other categories to be included in the key word findings to support learning which will be incorporated and collected in future reports.

- The subcategories and learning from cases clearly demonstrate significant numbers of cases involving incivility in teams, individuals of all levels this is also demonstrated in our recent staff survey results.

3.3 Staff Stories what are they telling us:
The four cases are from voices of the staff who have given their permission to use in the report. They have varied categories of concerns and can be found in Appendix1.

3.3 Staff members General Comments:

These are direct quotes from discussion I have had with staff members from several area across the Trust and Group. Some of these are part of a concern which has been raised, and these ones have had a level of investigation and feedback. However, the remaining concerns are from staff who just wanted their feelings noted but not raised a separate concern.

- *"My manager is usually bad tempered but currently it is worse. Staff are frightened to raise anything with them."*
- *"Everyone talks about ICORE values, but a lot of people do not practice them, and this is at all levels."*
- *"I have been told I am too nice and need to toughen up if I want to progress in my career".*

- **"***Feel work in Silos and no one wants to support other areas."*
- **"***Narrative of clinically lead and managerially supported does not apply to everyone and things raised by clinicians are not been listened to or they are not involved in the service decision making."*
- *"Bad behaviours are ignored even when highlighted to Matron or SLM as they are always busy and feels like to difficult to have to tackle."*
- *"Some People need to practice what they preach about incivility and behavioural frameworks."*
- *"The difficult discussions are not always had and concerns not always addressed."*
- *"There are different rules for some staff and departments when it comes to employment, being able to advertise jobs, jobs roles being made for people, favouritism / nepotism, and lack of openness and transparency."*
- *"When concerns are raised some responses are bias or subconsciously bias towards managers."*
- *"HR leads work with managers and do not support the staff members, feels like they are out to get people and just believe what managers say."*

3.5 Local Update: What are we doing to improve this / Future developments:

- Since starting in Q3 2023 the new FTSUG has had over 1000 meetings / contacts / interactions and delivered virtual and face to face training. Including all corporate induction sessions as well as developing a virtual training package for staff who are undertaking remote training.

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

- The introduction of increased number of FTSU Champions (30) will also support the service being able to in reach to as many departments as possible. Development of Microsoft teams' site for education and training for FTSU champions as well as a discussion forum for the Guardian and Champions.

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

- This work then leading to now have policies which support the changes we are making in line with zero tolerance and "it's not ok" to support staff from being verbally or physically abused will allow appropriate actions to be taken and give staff increased confidence. The launch of the new policy for sexual safety as well as changes to key other people policies has now been completed and educational awareness is being undertaken.

- Work is required to educate staff and managers in the use of the behavioural framework and how this should be used as one of the ways in which we improve Culture and reduce incidents of incivility.

- The development of a group to support sharing of data for triangulation will also support future improvement programs. We have started this work already comparing our staff survey results with our FTSU concerns and the “So what” actions as per pg12 table showing work being collaboratively undertaken.

- All cases have been discussed with the appropriate Senior Manager and Deputy CEO / Chief Nurse. As well as being escalated to line managers / business unit leads to be investigated and resolved.

- Road map for raising concerns has been completed and shared with Staff in Weekly Newsletter. See Appendix 3

- Scoping with POD leadership team the review of how and who is making decisions on how concerns are responded to ensuring equity for staff and support for managers in this decision making.

- Collection of feedback on all areas of FTSU processes to ensure we can give assurance that staff are satisfied their concerns are being appropriately responded to.

- Further departmental deeper dive analysis reviews with business units to allow for change, quality improvement, changes to processes and management of conduct.

- Continued review of feedback from staff who are raising concerns to allow identification of any areas which require improvement.

- The introduction of InPhase app allowing different reporting options including anonymous reporting.

- Yearly self-assessment and action planning at executive team level for transparency and oversight.

- The relaunch of culture board program to ensure wider team representation and continued collaboration of FTSUG with the culture board program by taking vice chair position.

- FTSU policy SOP requires to be approved by appropriate governance pathways. Draft copy for awareness included See Appendix 1.

- Development FTSU Trust strategy which will need to be undertaken alongside the Trust strategy to ensure alignment.

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

- 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.

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

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

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

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

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

- Supported local response to the national civil unrest and continue to link with all staff forums to have collaborative working.

- To monitor Thurwell investigation updates and further criminal case to ensure any learning which is being identified can be actioned prior to completion of report to reduce any risks if waiting for formal guidance to be published.

- Working with EDI committee to support development of work improvement for neurodivergent staff.

- Support education program for Hate Crimes with Northumbria Police and consideration of Trust being identified as a place for safe reporting.

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

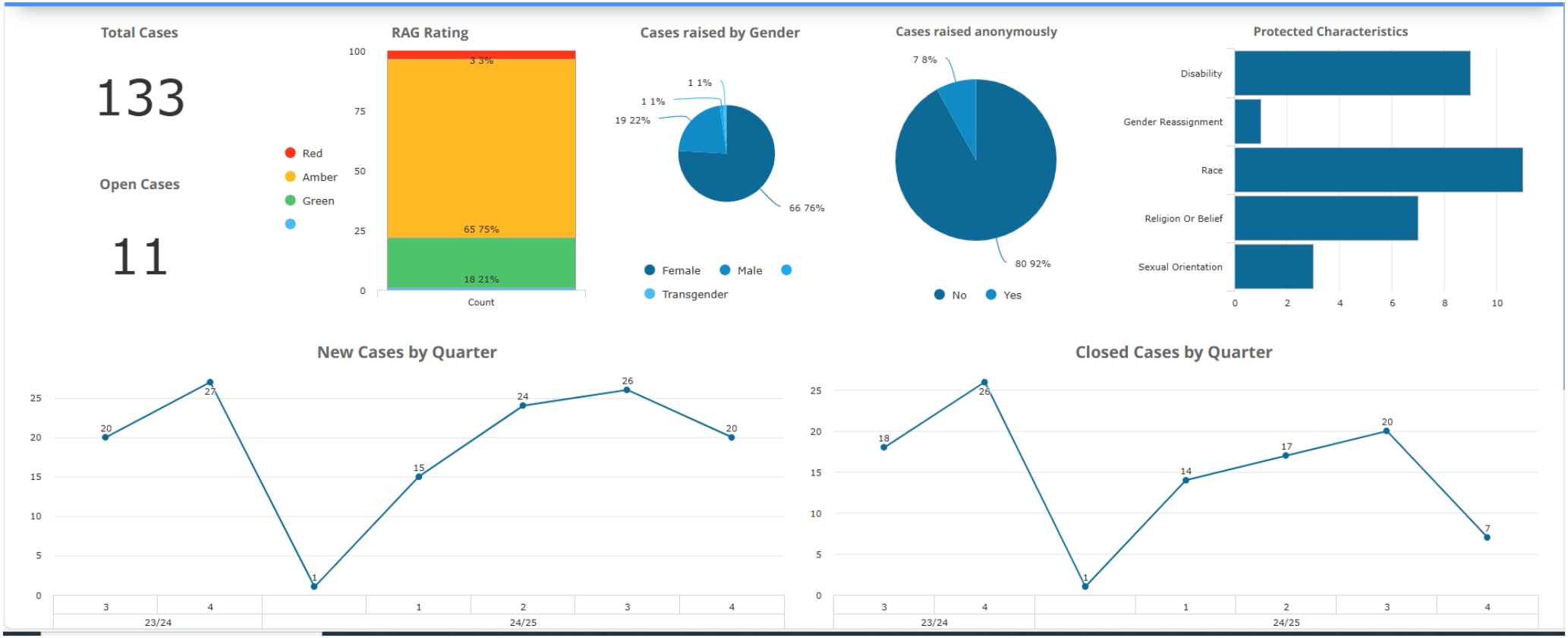
- Development of Microsoft teams' site for education and training for FTSU champions as well as a discussion forum for the Guardian and Champions

Staff Training Compliance for level 1 and 2:

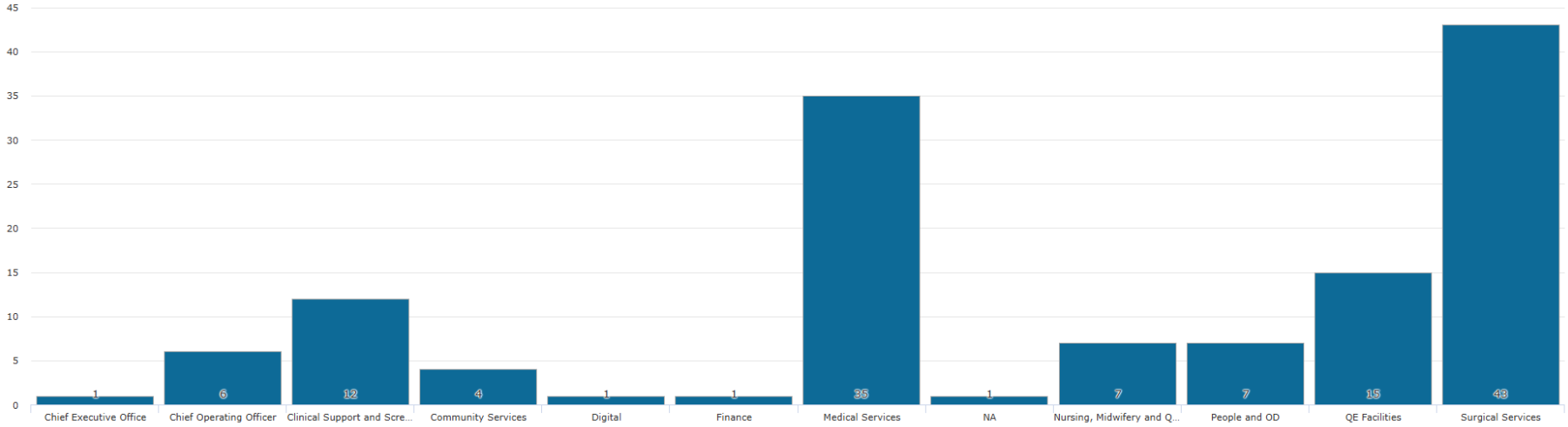
Org L1	Org L2	NHS|MAND|Freedom to Speak Up - All Workers - 3 Years|	NHS|MAND|Freedom to Speak Up - Managers - 3 Years|
297 Gateshead Health NHS Foundation Trust	297 DIVISION - Chief Executive	97.56%	100.00%
297 Gateshead Health NHS Foundation Trust	297 DIVISION - Chief Operating Officer	95.78%	93.79%
297 Gateshead Health NHS Foundation Trust	297 DIVISION - Finance & Digital	99.06%	96.77%
297 Gateshead Health NHS Foundation Trust	297 DIVISION - Medical Director	97.83%	60.00%
297 Gateshead Health NHS Foundation Trust	297 DIVISION - Nursing & Midwifery	95.92%	95.65%
297 Gateshead Health NHS Foundation Trust	297 DIVISION - PFMC	86.93%	85.42%
297 Gateshead Health NHS Foundation Trust	297 DIVISION - People & Organisational Development	100.00%	95.65%

Summary:

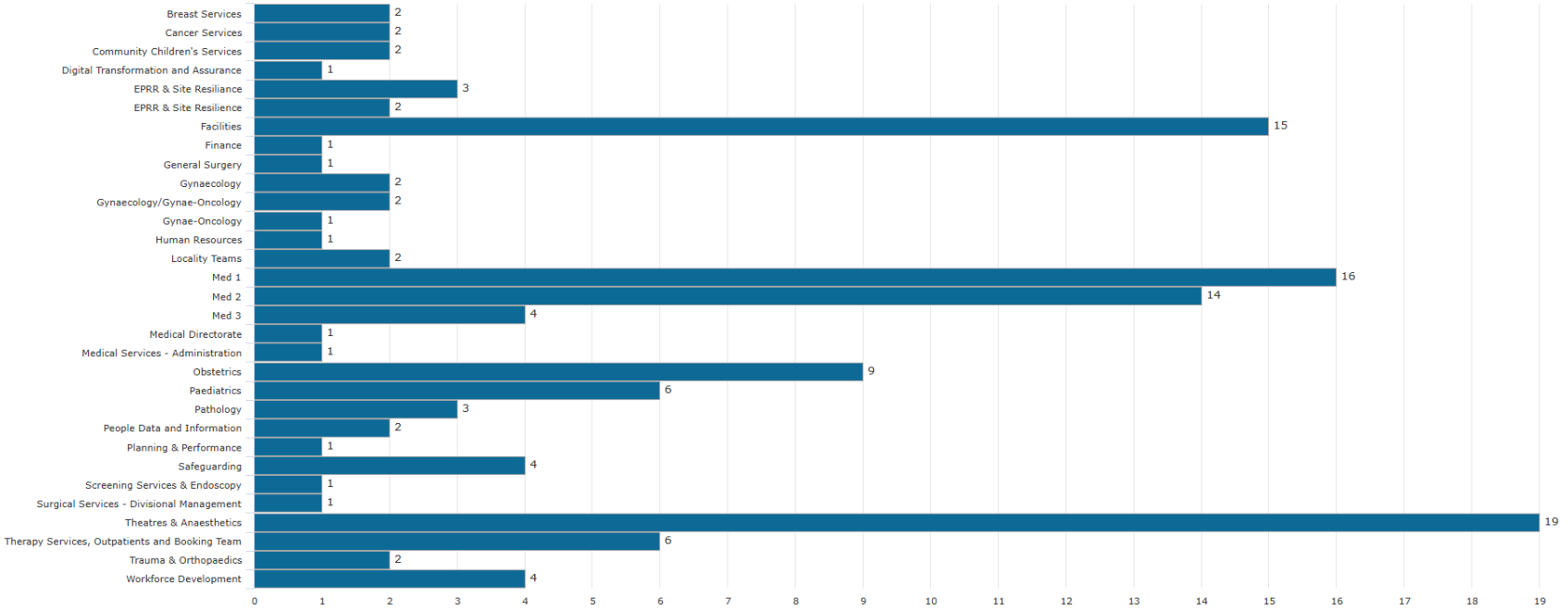
Guardian Data.



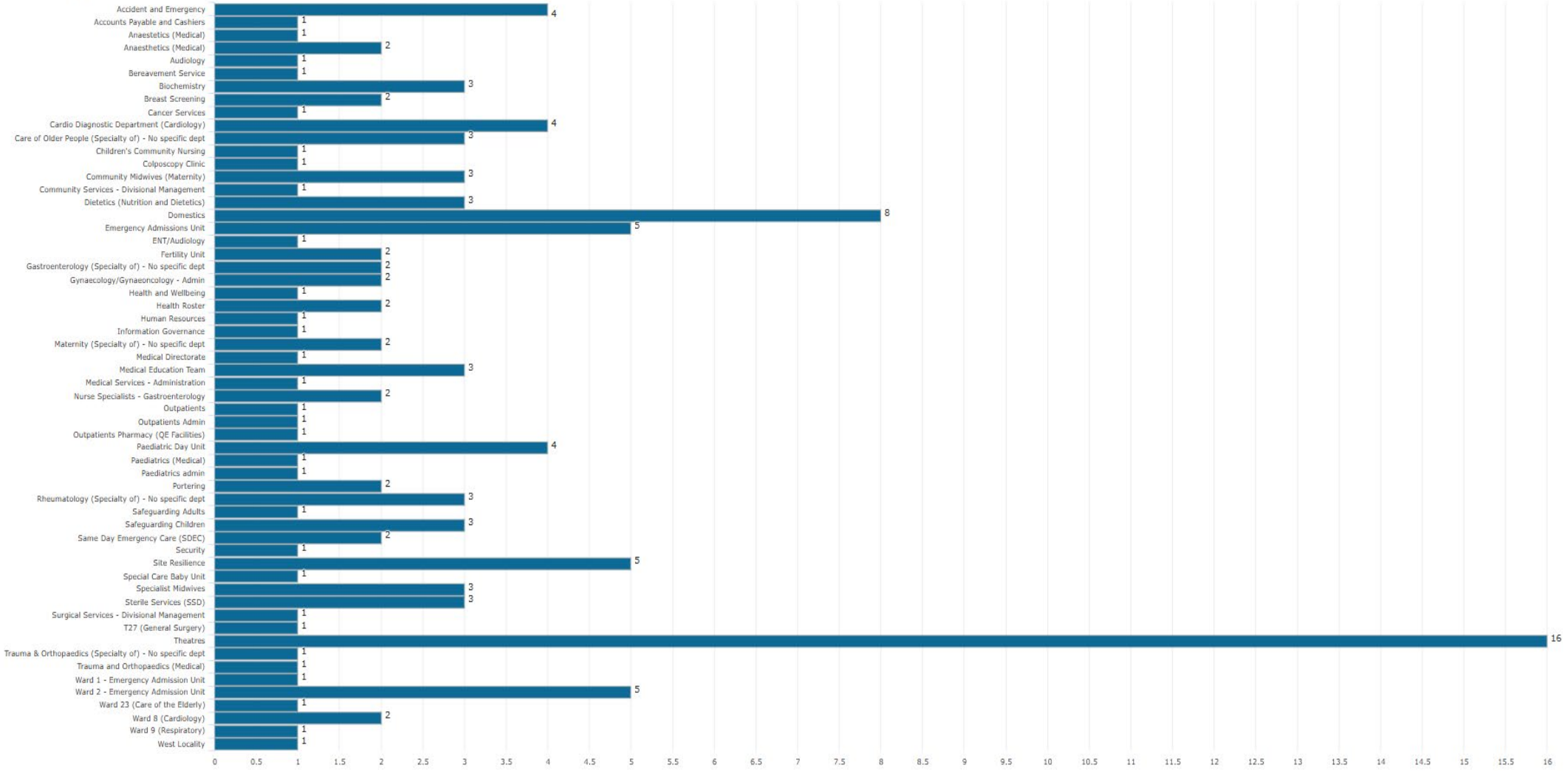
Cases by Business Unit

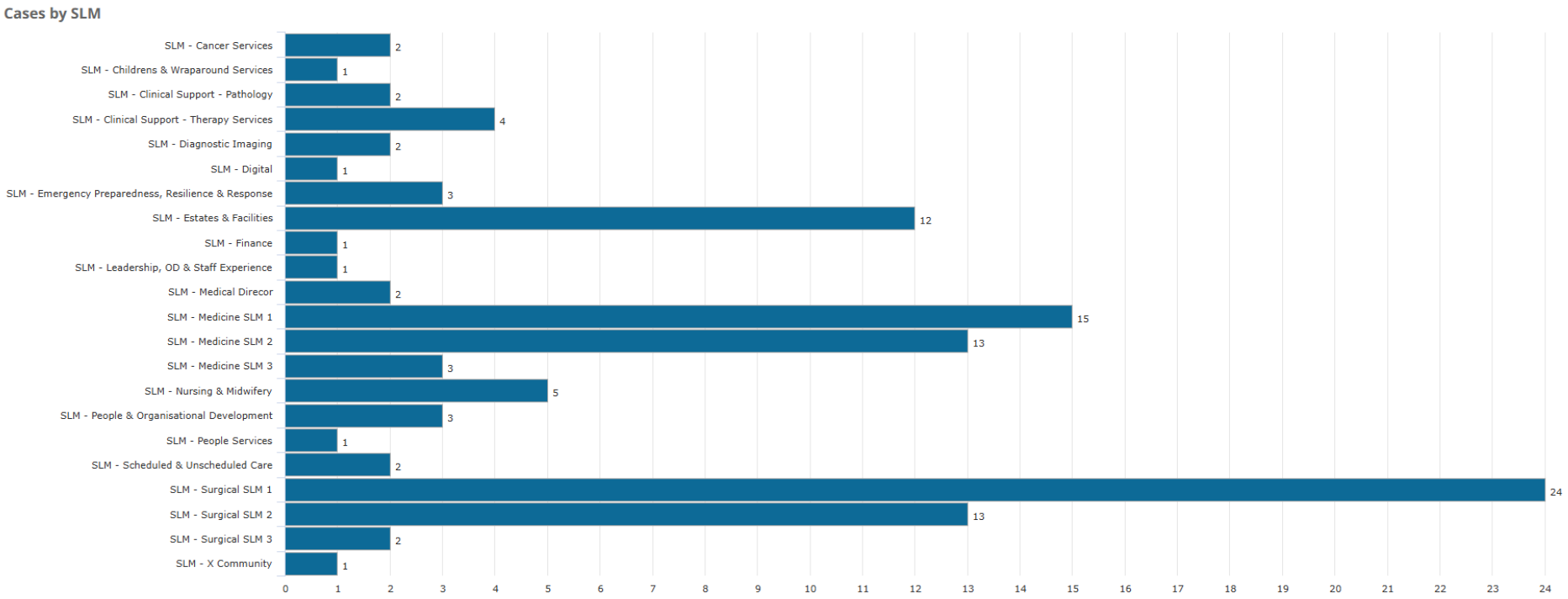


Cases by Service



Cases by Department




Cases by SLM
SLM - Cancer Services
SLM - Childrens & Wraparound Services
SLM - Clinical Support - Pathology
SLM - Clinical Support - Therapy Services
SLM - Diagnostic Imaging
SLM - Digital
SLM - Emergency Preparedness, Resilience & Response
SLM - Estates & Facilities
SLM - Finance
SLM - Leadership, OD & Staff Experience
SLM - Medical Direcor
SLM - Medicine SLM 1
SLM - Medicine SLM 2
SLM - Medicine SLM 3
SLM - Nursing & Midwifery
SLM - People & Organisational Development
SLM - People Services
SLM - Scheduled & Unscheduled Care
SLM - Surgical SLM 1
SLM - Surgical SLM 2
SLM - Surgical SLM 3
SLM - X Community
2
1
2
4
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12
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13
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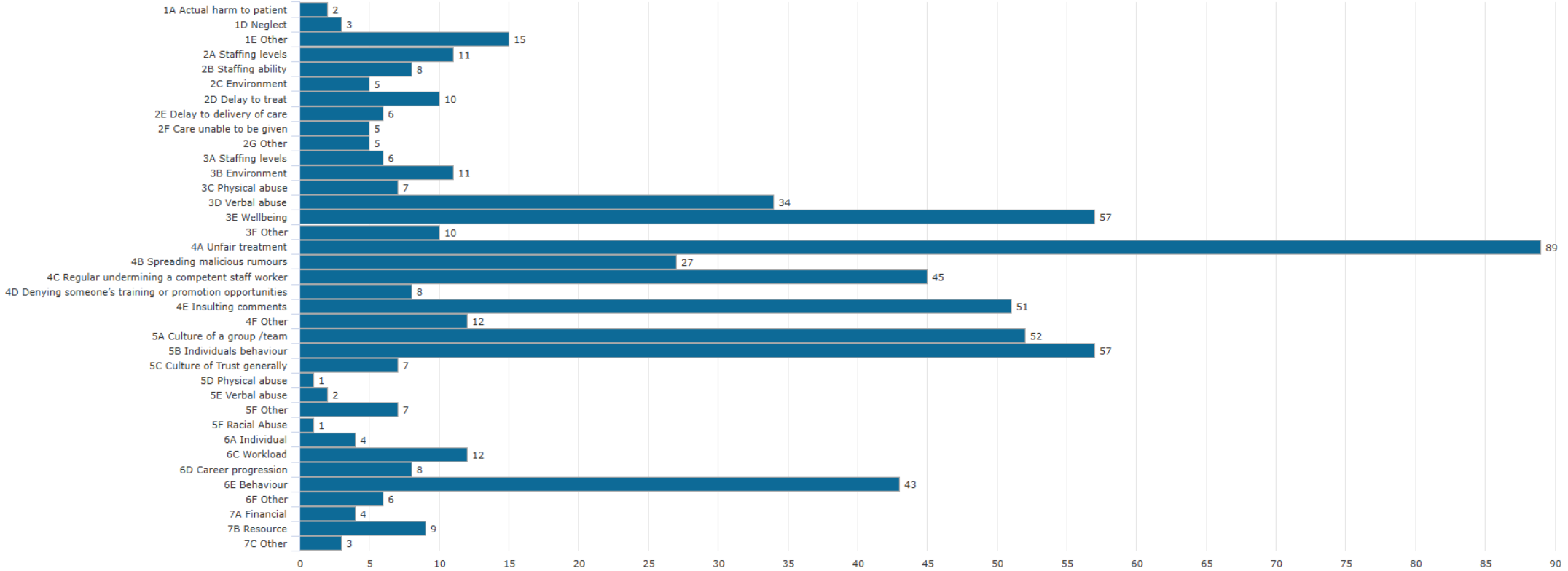
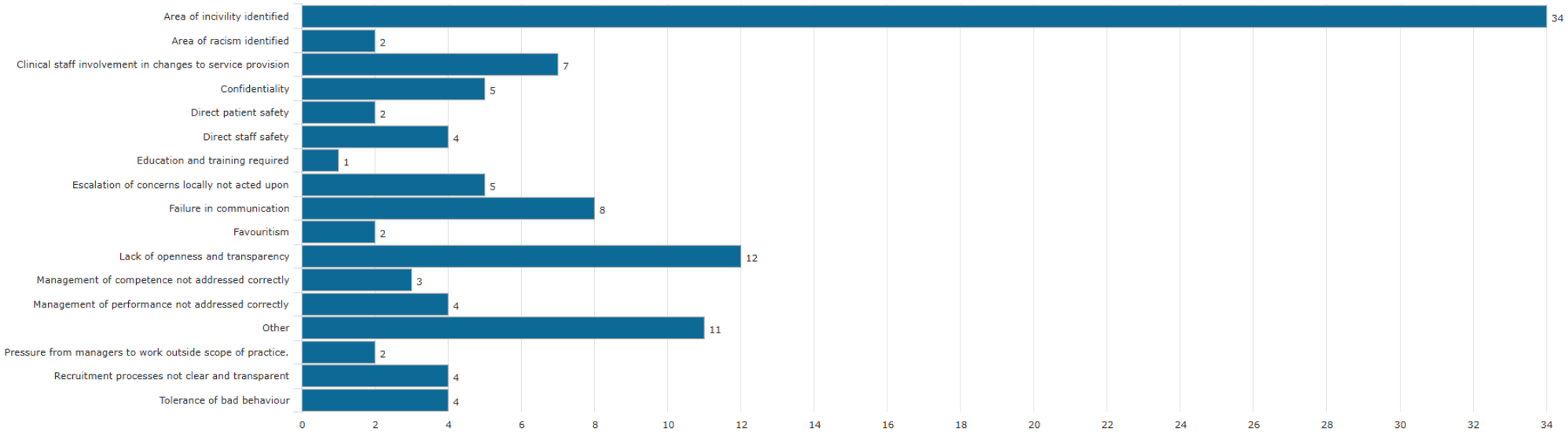
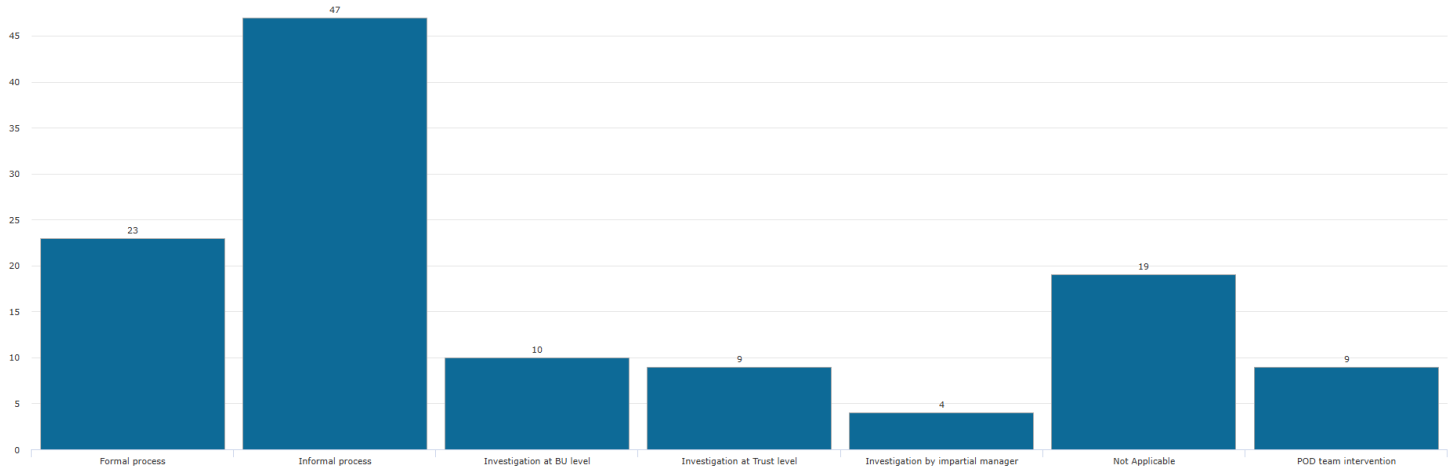
Concern Sub Category

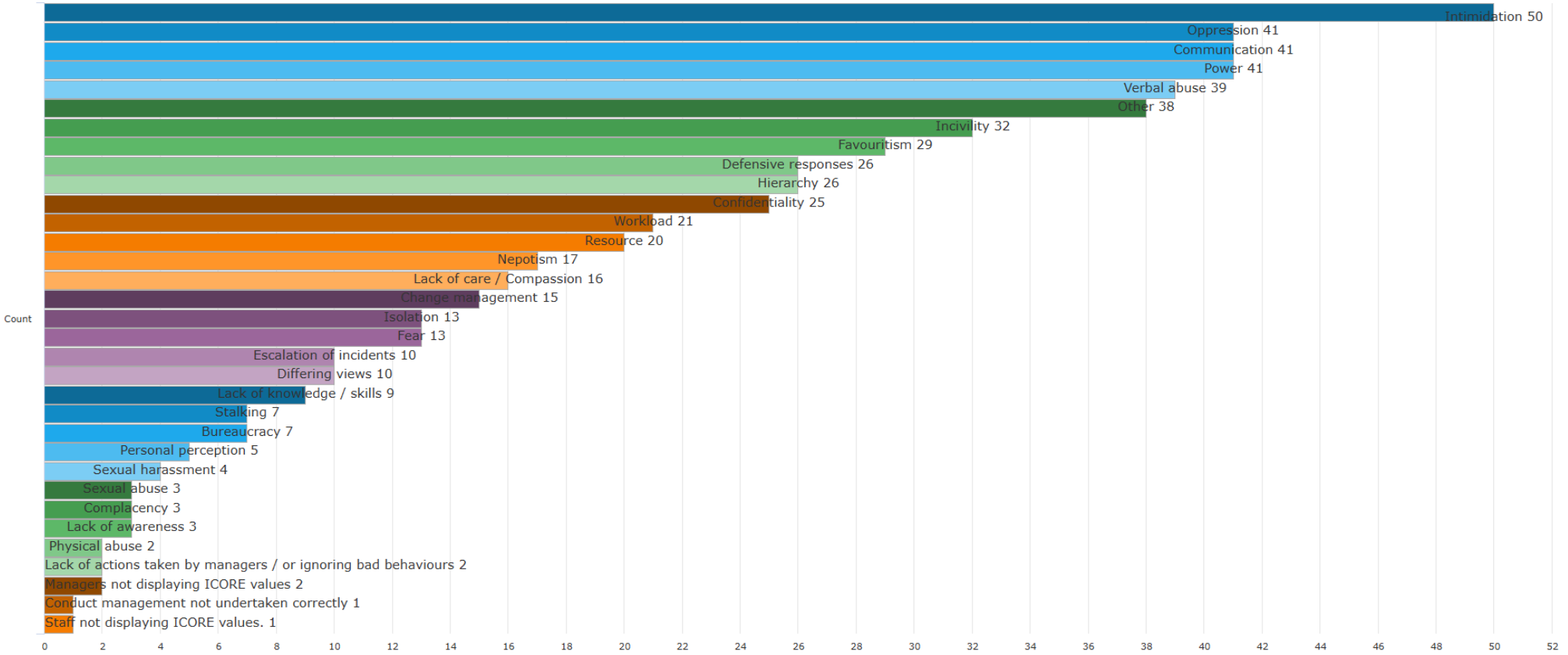


Concern Learning



Cases by Investigation Category




Count
Intimidation 50
Oppression 41
Communication 41
Power 41
Verbal abuse 39
Other 38
Incivility 32
Favouritism 29
Defensive responses 26
Hierarchy 26
Confidentiality 25
Workload 21
Resource 20
Nepotism 17
Lack of care / Compassion 16
Change management 15
Isolation 13
Fear 13
Escalation of incidents 10
Differing views 10
Lack of knowledge / skills 9
Stalking 7
Bureaucracy 7
Personal perception 5
Sexual harassment 4
Sexual abuse 3
Complacency 3
Lack of awareness 3
Physical abuse 2
Lack of actions taken by managers / or ignoring bad behaviours 2
Managers not displaying ICORE values 2
Conduct management not undertaken correctly 1
Staff not displaying ICORE values. 1
0 2 4 6 8 10 12 14 16 18 20 22 24 26 28 30 32 34 36 38 40 42 44 46 48 50 52

4.1 **National Update**:


Detriment-guidanc
e NGO.pdf


Protect-Whistleblo
wer-Risk-Assessmen

Both of these guidelines will need to be scoped with keystakholders and adapted for Local use and then need to get sign off by Eexcutive Management Team.

5. **Recommendations:**

5.1 Previously the Board has been asked to receive the report as partial insurance of FTSU services however due to improvements in both reporting, data analysis and processes the committee is asked to receive this report as assurance.

5.2 The Board is asked to acknowledge development work which is ongoing.

5.3 The Board is asked to continue to support the Freedom to Speak Service and the promotion of open and honest culture across the Trust.

Appendix 1

Case 1:
"I raised a concern about the lack of understanding of my manager and team of the impact of an individual who had formally reported untrue concerns about my behaviour and professionalism.
I contacted FTSU after, unknowingly, speaking with a champion who advised me to make contact.
I found the process reassuring and I felt listened too. This was the initial issue with my department that I did not feel listened to and consequently felt worthless.
I had regular feedback and updates. It was great to be listened to without bias.
The guardian acted as a conduit between management and me. For which I was thankful for as I did not know what to do.
Overall, it was a positive experience for me. And the outcome, I feel benefited all sides."

This case was having significant impact on the staff members health and mental wellbeing as there was a breakdown in communication and confidence between manager and staff member following several months. The situation was regarding incivility within team and behaviours of staff towards each other. An escalation within service line allowed for mediation and resolution for both staff members.

Case 2:
"When I was first directed to the service, I was in a place of fear and distress, and it was difficult for me to find my voice to express my experiences. I appreciated the personal approach that was taken towards myself and my difficulties. The FTSUG caring and empathetic nature helped ease my anxieties and the time she took to allow me to take my time, ensured it felt safe to share and express myself; whilst feeling supported talking through such difficult issues. I felt heard and understood and I was not left to feel alone with my pain and distress, this was comforting and reassuring. The FTSUG helped with my concerns being raised to the appropriate people, and helped ease the overwhelming process of expressing myself for the first time. This was the opening of connecting with services/ organisations to enable me to begin the difficult processing of my trauma".

This case was an historical case which was previously part of a wider investigation which sis not at the time allow the member of staff to feel they could be open and honest about their concerns and experience sue to processes and policies we had in place as well as fear, intimidation and bullying they had endured to try to silence the member of staff. There were also concerns raised by several other staff over a long period of time which were not responded to appropriately and allowed behaviours of sexual harassment, bullying and assault to occur.

Case 3:
"I was a bit nervous at first reaching out to the speak up team but was put at ease straight away by the guardian, which really helped. As a manager I had a concern within my department that I knew could affect the trusts reputation and posed a critical and financial risk to our day-to-day operations for the whole trust, which may have caused patient care to be compromised and could have even impacted the wider NHS. The Guardian was incredibly supportive and understanding and took time to listen to the issues so she could understand herself and deal with the information in the proper manner. It was also reassuring to get feedback at the end from the guardian knowing that my concern and voice had been heard and taken seriously, I never once felt like my confidentiality had been compromised."

This case was of significant risk to patient, staff and Trust safety and confidentiality that it was raised immediately for investigation. A formal investigation was undertaken, and the case was heard under the disciplinary policy with outcome of the staff member being found in breach of conduct and termination of contract.

Case 4:
"Receiving a Neurodivergent diagnosis during COVID, I started to understand me and how my Autism may have been impacting on my management communication difficulties, but how managers choosing not to seek an understanding how they could improve communication between their Neurodivergent staff is what I saw was the biggest problem. So, when my new manager started to make changes in my service this triggered me. However, I knew how to have a voice now that could be heard in the trust after being aware of FTSU Service. I now also had the courage to ask for help. Having a FTSUG that is visible and approachable to enable people to speak to can act as their advocate so every member of staff can remove any fear to speak up and enabling everyone to be heard will avoid us in Gateshead not being a News article.
This also led to staff and managers having a greater understanding of people who are Neurodivergent and having training available for greater awareness. This more importantly helped having the staff voice heard for changes to clinical pathways for patients ensuring a safer and more quality service for the patients."

This case was raised and managed informally for local investigation and as described with support from another manager allowed changes to be clinically driven for service change with managerial support, leading to improved patient pathways and improving staff experience.

Appendix 2:


FTSU Policy SOP Draft 1.docx

Appendix 3

It's not okay - I want to raise a concern about...

NHS Gateshead Health NHS Foundation Trust

My role, my working environment/equipment, my health, or patient safety

The behaviour of others

Everyone's different. Adapt these steps to your situation (you don't need to go through them all), and remember to complete the InPhase reporting where it is indicated.

My job

Have a conversation with your line manager/clinical supervisor or lead as soon as possible

If not resolved:

If flexibility is required, refer to the Flexible Working Policy or use a Passport document to assist conversations with your manager, who will review the request in line with service requirements.

If you have concerns about policies or procedures, refer to the Grievance Policy or consult a staff-side representative.

Raise Development Needs or discuss elements of your role with your line manager/clinical supervisor or lead

My working environment/equipment

Inform your line manager/clinical supervisor or lead

Report on In Phase

If not resolved:

Inform your Health & Safety representative

Review Risk Management Policies

If required, escalate to appropriate lead for action

Feedback learning to individual and update In Phase to inform organisational learning

My health

Discuss with your line manager/clinical supervisor or lead if you feel comfortable

If required, refer to Occupational Health Services (Management referrals, Counselling, Health and Wellbeing team, Physiotherapy, Ergonomics)

If not resolved:

Speak to a Health and Wellbeing Ambassador or a Mental Health First Aider

Review your Wellbeing Plan and the Signposting Toolkit

Discuss a Health passport and the resources and support available on the Wellbeing Website

Patient safety (e.g. patient falls/unsafe staffing/safeguarding)

Speak to your line manager or matron/clinical lead or manager's manager if appropriate

Report on In Phase

If not resolved:

Speak to Freedom to Speak up Guardian and/or Patient Safety Team and/or safeguarding team

Review and investigate the incidents on In Phase in line with relevant policies

If required, escalate to appropriate lead for action

Feedback learning to individual and update In Phase to inform organisational learning

Incivility from a colleague or manager

Speak with the person directly to resolve if you feel able to do so. If not, raise with your line manager/clinical supervisor/their manager. You may also wish to consider Mediation as an option to find resolution

If not resolved:

Review Zero Tolerance Hub for guidance and support, you may prefer to report the incident to the Freedom to Speak Up Guardian, the EDI Manager, a People & OD colleague, a Staffside representative, or a professional lead

Attempt to resolve informally in line with Harassment and Bullying Policy

Contact POD Advisory if unable to resolve informally to progress to formal stage. Ensure to feedback to the individual who raised concerns as appropriate

Violence/discrimination/ harassment from a colleague or manager

Report the incident(s) to your line manager, clinical supervisor/lead or senior manager

If not resolved:

Review Zero Tolerance Hub for guidance and support, you may prefer to report the incident to the Freedom to Speak Up Guardian, the EDI Manager, a People & OD colleague, a Staffside representative, or a professional lead

Seek advice from POD Advisory (ghnt.podservicesadvice@nhs.net) regarding appropriate next steps

Review immediate support for individual raising concern, refer to OH if required

Proceed in accordance with Harassment and Bullying Policy. If applicable, review in line with Group Sexual Safety Policy. Keep individuals informed of progress

Violence/discrimination/ harassment from a patient or visitor

Report the incident(s) to your line manager or senior manager. You may also wish to contact Security on Vocera or **0191 445 2039** if required

Report on In Phase

If not resolved:

Investigate In Phase Incident, if required, escalate to appropriate lead for action

Review immediate support for individual raising concern, refer to OH if required

Feedback to individual. Learning to inform Trust's Violence Prevention and Reduction (VPR) Action Plan

Fraud

Make a record of the concerns and review the Fraud Intranet page

If not resolved:

Contact the Trust's Counter Fraud specialist: Fraud Hotline: 0191 441 5936 Email: **counterfraud@audit-one.co.uk**

You can also report suspicions of fraud to the Executive Director of Finance Kris.Mackenzie@nhs.net

Alternatively, you can phone the National Fraud and Corruption reporting line: **0800 028 40 60** You can also report allegations of fraud online directly to the NHS Counter Fraud Authority at **https://cfa.nhs.uk/reportfraud**

Key policies:

- Flexible Working Policy.docx
- Freedom To Speak Up Policy.docx
- Group Grievance Policy.docx
- Group Harassment and Bullying Policy.docx
- Group Investigation and Disciplinary Policy.docx
- Group Sexual Safety Policy.docx

Remember:

- FTSU Guardian: Tracy.Healy@nhs.net
- HR Advice: ghnt.PODServicesAdvice@nhs.net
- Trade Union Members: ghnt.staffside@nhs.net
- Staff Networks and EDI Manager: Kuldip.Sohanpal2@nhs.net
- Other Support: Cultural Ambassadors, Professional Nurse Advocates, Staff Governors, Professional Leads

Action to be taken by:

Employee

Manager

Route map for raising concerns #GatesheadHealth

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 18

Report Title:	**Board Walkabout Feedback**			
Name of Meeting:	Board of Directors			
Date of Meeting:	26 March 2025			
Author:	Dr Gill Findley, Chief Nurse / Deputy Chief Executive Dr Gerry Morrow, Non-Executive Director Dr Carmen Howey, Medical Director Maggie Pavlou, Deputy Chair			
Executive Sponsor:	Dr Gill Findley, Chief Nurse / Deputy Chief Executive			
Report presented by:	Dr Gill Findley, Chief Nurse / Deputy Chief Executive			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To provide Board Members with an overview of observations and reflections from Board walkabouts, supporting triangulation with other sources of information and assurance			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☒
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	-			

Key issues:
Briefly outline what the top 3-5 key points are from the paper in bullet point format
 	
Consider key implications e.g.
• *Finance*
• *Patient outcomes / experience*
• *Quality and safety*
• *People and organisational development*
• *Governance and legal*
• *Equality, diversity and inclusion*
	• This report seeks to formally share the feedback from Board Member walkabouts at public Board.
	• This supports Board Members in their triangulation of information from different sources and will feature on every Board agenda.
	• Over time this will enable key themes and trends to be identified, as well as any material actions from visits.
	• This report covers two visits:
	  • Ward 8 Cardiology – 30th January 2025; and
	  • Maternity – 27 January 2025 to discuss the Maternity Incentive Scheme (i.e. non-patient-related areas).			

	Maternity • The Maternity visit was specifically focussed on the Maternity Incentive Scheme (MIS) compliance data and therefore differs from typical Board walkabouts. • Consistent with previous visits to Maternity, Board Members were knowledgeable and could quickly find additional information to support the MIS submission, giving confidence in their understanding of the service. Colleagues expressed no concerns, other than in relation to the maternity estate. This is an area which the Board has previously discussed at length and is reflected in the risk registers. • The visit identified an engagement opportunity for Maternity Voices Partners to join the Patient Experience Group. **Ward 8 Cardiology** • Previous Board walkabout reports have tended to reflect positive feedback regarding the environment (with the exception of the maternity estate). The feedback for Ward 8 reflected a different position – not with regards to cleanliness but in relation to clutter and layout. • The physical environment was highlighted as the greatest concern in relation to its potential impact on colleagues, patients and their families. • The matron's knowledge of the ward and enthusiasm was particularly noted as a positive, with low turnover of nursing staff. • Feedback from staff on the ward indicated opportunities for enhancing team relationships across disciplines. • It is noted that feedback from patients who were being surveyed by the Patient Experience team was very positive, which is recognition of the hard work of the team. Following discussion at the last Board meeting the process for planning Board walkabouts has been revised to ensure that time is protected in the diaries for this important activity. There will be an identified slot in the week when all Directors will go out to meet the various teams across all sites including corporate teams.
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	Board Members are requested to review the feedback from the walkabout process and consider this in the context of other items on the Board's agenda for consistency and triangulation.

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:	Full delivery of the actions within the Quality Improvement Plan leading to improved outcomes and patient experience with particular focus on improvements relating to mental health, learning disabilities and cancer. Evidence an improvement in the staff survey outcomes and increase staff engagement score to 7.3 in the 2025 survey					
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒	
Risks / implications from this report (positive or negative):						
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	None					
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒			

Board of Directors' Walkabout Feedback

Board Members in attendance:	Gill Findley – Chief Nurse and Deputy Chief Executive Gerry Morrow – Non Executive Director
Area visited:	Maternity
Date of visit:	27.1.25
Observations about the environment visited if applicable (e.g. clean, tidy, welcoming, health and safety considerations, colleague wellbeing or patient wellbeing considerations)	We visited the maternity department to discuss the MIS compliance. On this visit we did not go to patient related areas, other than the education room and the main entrance
What were you impressed by?	We discussed the MIS compliance data and saw copious amounts of evidence, systematically filed. The staff were able to quickly find any supplementary information that we requested and therefore we felt assured to be able to sign off the submission on behalf of the board. We spoke to the Head of Midwifery, the Labour Ward Lead Obstetrician and the Risk and Safety Midwife. All were happy to answer our questions and expressed no concerns in relation to maternity other than the issues with the building which are well documented.
Any areas of concern / things to follow up?	Agreed to ask maternity Voices Partners to join the Trust's Patient Experience Group.
Overall summary	We approved the submission of the Q3 MIS data set.

Board Members in Attendance	Maggie Pavlou NED Carmen – Group Medical Director
Area Visited	Ward 8 – CARDIOLOGY We also bumped into two of the Patient Experience Team whilst we were there so had a few minutes with them relating to their overall view, and then specifically Ward 8
Date of Visit	30th January 2025
Observations about the environment visited if applicable (e.g. clean, tidy, welcoming, health & safety considerations, colleague wellbeing or patient wellbeing considerations)	**Physical environment** On entering the ward we moved through a very narrow corridor/main thoroughfare which had chairs and equipment "parked" in it making access more difficult and notably making it difficult for the domestic to effectively and safely clean the floors. The nursing desk/reception area is in the middle of the ward and access by the above corridor. There was lots of movement around this area and the area presented as being busy, the desk space too small and being utilised by a number of different members of staff/different professional groups but each focussed on their own task. The adjacent telemetry area added to the busyness and the noise/distraction to staff. In general there was lots of movement around the ward reception area and the corridors. The Fire Exit was noted to be blocked with chairs and wheelchairs. We observed blue tacked notices on walls, duplicating/overlying existing formal signage. This included negative notices such as 'ward staff ONLY' etc We went into a small room used by staff for a break which is also used as a storage cupboard. This is at the opposite end to the kitchen. Staff had personalised and decorated a wall of this room with a noticeboard with photos and positive messaging. **Clinical team** Ward nursing team were polite. The Matron attended the ward for the walkabout. Matron was very passionate about the service and quality of care provided to patients.

	Limited feedback on working on the ward was shared by the medical staff during the visit. Feedback indicated further opportunities for the team to work together to develop relationships across disciplines and strengthen dynamics. **Patient Experience team** Two members of the patient experience team were on the ward actively seeking feedback from patients. They described that the feedback they had received from patients on the day of the walkabout was very positive and this was typical of feedback from patients on Ward 8.
What were you Impressed by?	Matron's level of knowledge of the ward, the cardiology service and her enthusiasm for improving care and patient and staff experience. Reported low turnover of nursing staff and development opportunities for staff.
Any areas of concern / things to follow up ?	Opportunities to develop relationships and enhance dynamics across disciplines. Use of space and lack of storage which impacts on staff wellbeing and patient experience. Opportunities to increase medical presence on the ward round. There is no space anywhere on the ward to hold private discussions with patients or their families including breaking bad news, however there are two spaces just outside the ward which are under used. They are a waiting area for visitors to critical care and a relatives room. The Matron is investigating the possibility of repurposing at least one of these / co-use with critical care however this is taking time to reach a conclusion.
Overall Summary	In general the team seems to be working well and whilst there is an ongoing narrative of being short staffed that does not appear to be impacting on patient care. The greatest concern on the ward is the impact of the physical environment on staff and patients.

Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 19

Report Title:	**Consolidated Finance Report – Part 1**			
Name of Meeting:	Trust Board			
Date of Meeting:	25th March 2025			
Author:	Mrs Wendy Griffiths, Associate Director of Finance Strategic Finance			
Executive Sponsor:	Mrs Jane Fay, Interim Group Director of Finance			
Report presented by:	Mrs Jane Fay, Interim Group Director of Finance			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	The purpose of this paper is to provide assurance against corporate objectives and address financial risks			
Proposed level of assurance – to be completed by paper sponsor:	**Fully assured** ☐ **No gaps in assurance**	**Partially assured** ☒ **Some gaps identified**	**Not assured** ☐ **Significant assurance gaps**	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	**Not applicable**			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity, and inclusion*	The Trust had an original approved 2024-25 planned deficit of **£12.650m** before adjustments for donated asset depreciation, and **£12.405m** after. Following the allocation of non-recurring deficit support funding to North East and North Cumbria Integrated Care System to deliver breakeven across the System, the Trust has been allocated **£5.317m** (Sep-24) and **£4.896m** (Jan-25) non-recurring funding and revised its planned deficit to **£2.437m** before adjustments for donated asset depreciation, and **£2.192m** after. As of February 2025, the Trust has reported an actual deficit of **£2.301m** after adjustments for donated asset depreciation. This is a favourable variance of **£0.167m** from the year-to-date target for reasons detailed in the body of this report.			

	The Trusts updated approved annual 2024-25 capital plan excluding IFRS16 right of use assets totals **£17.747m**, including **£7.771m** PDC supported. As of February 2025, the Trust has reported net capital spend on schemes totalling **£13.781**, which is **£3.966m** less than planned. As of February 2025 the Trusts is forecasting achievement of its planned deficit totalling **£2.192m** for the reasons detailed in the body of this report. The Trust also continues to forecast delivery of its capital programme totalling **£17.747m** for the reasons detailed in the body of this report. Cash balances are forecast at **£18.538m** at 31st March 2025 informed by the delivery of the forecast deficit, capital programme and known working capital movements.				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper.*	The recommendation to the Committee is to receive the report, discuss the potential implications and record partial assurance for the achievement of the 2024-2025 planned deficit as a direct consequence of the reported year-to-date, financial risks and forecast scenario modelling. To note the summary of performance as of February 2025 (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:	Ensuring robust governance structures to enhance our productivity and efficiency to make the best use of resources				
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)	Overall risk of not meeting financial plan, with contributing risks relating to, achievement of cost reduction and other mitigation targets alongside overspend against delegated budgets.				

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

1 Introduction

1.1 The purpose of this report is to provide a summary of financial performance for April 2024 to February 2025 for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds).

1.2 The Trusts 2024-2025 financial plan reports a deficit of £12.405m inclusive of the achievement of £22.806m cost reduction programme (CRP) target, Elective Recovery Fund (ERF) income totalling £2.721m and other internal mitigations totalling £15.689m.

1.3 Following the allocation of non-recurring deficit support funding to North East and North Cumbria Integrated Care System to deliver breakeven across the System, the Trust has been allocated **£5.317m** (Sep-24) and **£4.896m** (Jan-25) non-recurring funding and a revised planned deficit of **£2.437m** before adjustments for donated asset depreciation, and **£2.192m** after.

2 Key Financial Performance Indicators

2.1 Performance against key performance indicators is detailed in Table 1

Finance KPIs	Feb-25				Apr-24 to Feb-25			
	Plan	Actual	Variance	RAG	Plan	Actual	Variance	RAG
I&E (Surplus) / Deficit (adjusted perf.) £m	(0.3)	(0.3)	(0.1)		2.5	2.3	(0.2)	
Operating Income £m	(34.6)	(38.3)	(3.7)		(378.4)	(387.8)	(9.4)	
Pay Expenditure £m	21.9	25.4	3.5		247.2	254.4	7.2	
Non Pay Expenditure £m	12.0	12.2	0.1		129.2	131.6	2.4	
Non Operating Income £m	(0.1)	(0.1)	(0.0)		(1.1)	(1.7)	(0.5)	
Non Operating Expenditure £m	0.5	0.5	(0.0)		5.8	6.1	0.2	
Agency Expenditure £m	0.3	0.1	(0.2)		4.2	1.7	(2.5)	
CRP Delivery £m	(2.7)	(7.9)	(5.2)		(20.1)	(20.0)	0.1	
Capital Expenditure £m	0.9	1.4	0.5		15.9	13.8	(2.2)	
Cash position £m	(1.1)	6.2	7.2		7.7	28.4	20.7	
Liquidity (days)	(13.9)	(3.3)	10.6		(13.9)	(3.3)	10.6	
Better Payment Practice Code (BPPC)								
NHS Number of Invoices	95.0%	88.8%	-6.2%		95.0%	92.2%	-2.8%	
Non NHS Number of Invoices	95.0%	95.7%	0.7%		95.0%	93.8%	-1.2%	
Aged Debt								
Receivables over 90 days NHS	10.0%	21.2%	11.2%		10.0%	21.2%	11.2%	
Receivables over 90 days non NHS	10.0%	41.4%	31.4%		10.0%	41.4%	31.4%	

Table 1: Finance KPIs

2.2 For the period of February 25 only the Trust has reported a deficit of **£0.342m** after the adjustment for donated asset depreciation which is a **£0.067m favourable** variance against plan.

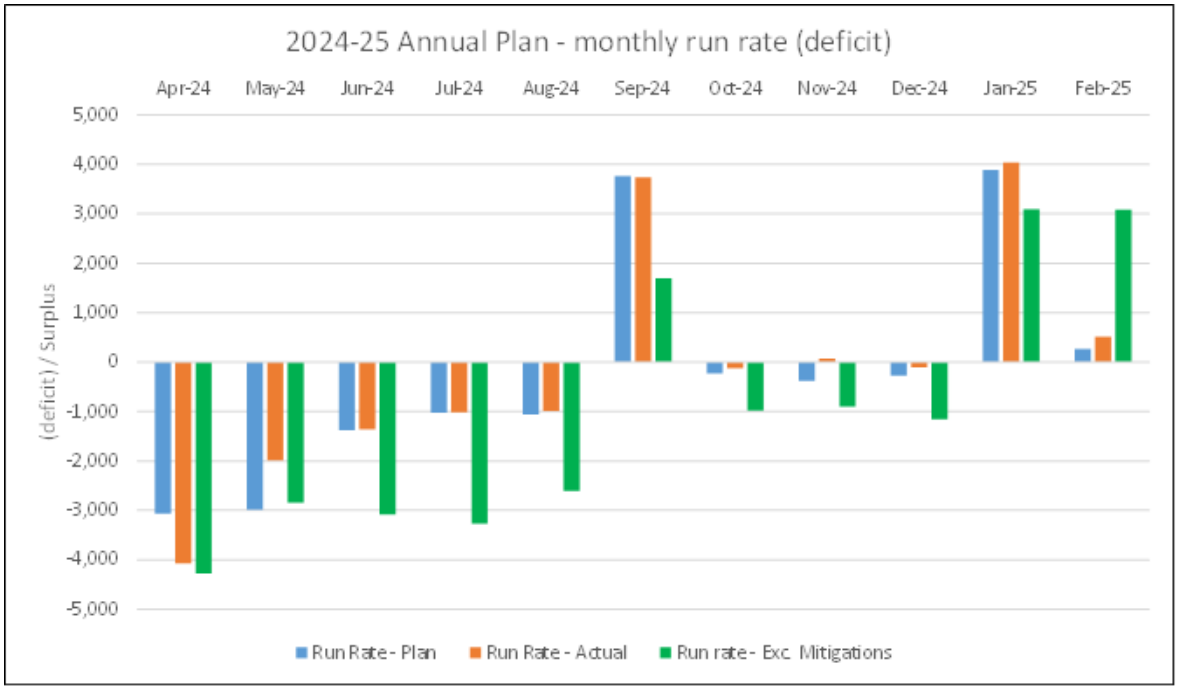
2.3 Year-to-date the Trust has reported a deficit of **£2.301m** which is a favourable variance of **£0.167m** against plan.

3.1.3 The year-to-date variance of **£0.167m** arises as a result of number of key drivers pressures including :

- The use of escalation beds above core funded beds, including overnight boarders in the EAU escalation area, in response to increased admissions, and high numbers of patients not meeting the medical criteria to reside.
- Management of operational pressures and elective recovery performance means higher than planned medical workforce costs across all Divisions totalling **£3.753m** of which medicine **£3.332m** and surgical business units **£0.519m** driven by approved junior medical rota's, premium rate payments on bank, agency and WLI to cover sickness and elective recovery.
- Clinical supplies pressures totalling **£2.596m** due to growth in adult and paediatric diabetes devices above funded budgets **£1.044m** and elective recovery activity.
- Under achievement of the year to date CRP target totalling **£5.268m** excluding schemes not yet transacted.

2.5 Offsetting the key issues and risks include additional system support **(£4.50m),** overachievement of internal flexibilities **(£2.531m),** variable clinical income over performance **(£3.534m**) inclusive of **(£0.502m),** relating to 2023-24, depreciation underspend **(£1.578m)** and higher than planned interest receivable **(£0.547m)**.

2.5 Graph 1 details monthly plan and actual performance including and excluding internal flexibilities, which are driving the reported financial position.



Graph 1: Financial Performance against 24-25 plan

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

STATEMENT OF COMPREHENSIVE INCOME

February 24-25

	NHSE APRIL - MARCH 25 FINAL PLAN							
	Annual Plan	Plan In Month	Actual In Month	Plan to Date	Actual to Date	Variance (Actual - Plan)	Previous Month Variance	Movement in Month
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Operating								
Operating Income from Patient Care activities								
Income From NHS Care Contracts	(354,848)	(31,389)	(34,372)	(341,701)	(349,244)	(7,543)	(3,857)	(3,686)
Income From Local Authority Care Contracts	(90)	(34)	(39)	(280)	(303)	(23)	(18)	(5)
Private Patient Revenue	(684)	(57)	(34)	(628)	(719)	(91)	(114)	23
Injury Cost Recovery	(504)	(42)	(19)	(458)	(308)	150	127	23
Other non-NHS clinical revenue	(1,700)	(19)	(13)	(205)	(157)	48	42	6
Total Operating Income From Patient Care activities	**(357,826)**	**(31,540)**	**(34,476)**	**(343,273)**	**(350,732)**	**(7,459)**	**(3,820)**	**(3,639)**
Other Operating Income								
Education and Training Income	(11,257)	(1,033)	(1,307)	(11,452)	(11,760)	(308)	(35)	**(274)**
R&D Income	(564)	(30)	(43)	(985)	(1,036)	(51)	(38)	**(13)**
Funding outside of System Envelope	0	0	0	0	0	0	0	-
Other Income	(21,790)	(2,004)	(2,461)	(22,611)	(24,314)	(1,703)	(1,254)	**(449)**
Donations & Grants Received	0	(8)	0	(92)	0	92	83	**8**
Cost Improvement Programme - Income	0	0		0	0	0	0	-
Total Other Operating Income	**(33,611)**	**(3,076)**	**(3,811)**	**(35,139)**	**(37,110)**	**(1,971)**	**(1,243)**	**(728)**
Total Operating Income	**(391,437)**	**(34,615)**	**(38,287)**	**(378,411)**	**(387,842)**	**(9,430)**	**(5,064)**	**(4,367)**
Operating Expenses								
Employee Expenses - Substantive	242,176	21,006	24,169	234,601	242,665	8,064	4,901	**3,163**
Employee Expenses - Bank	7,502	507	1,030	7,389	8,821	1,432	910	**522**
Employee Expenses - Agency	3,993	310	132	4,160	1,667	(2,492)	(2,315)	**(178)**
Employee Expenses - Other	1,104	92	111	1,040	1,257	217	197	**20**
Cost Improvement Programme - Pay	0	0		0	0	0	0	-
Total Employee Expenses	**254,775**	**21,915**	**25,442**	**247,191**	**254,411**	**7,221**	**3,693**	**3,527**
Purchase of Healthcare - NHS bodies	8,172	681	554	7,472	8,116	644	771	**(127)**
Purchase of Healthcare - Non NHS bodies	3,300	271	156	3,130	3,302	172	287	**(115)**
Purchase of Social Care	0	0	0	0	0	0	0	-
NED's	192	16	15	171	166	(6)	(5)	**(0)**
Supplies & Services - Clinical	37,782	3,864	3,787	38,530	41,124	2,594	2,674	**(80)**
Supplies & Services - General	2,943	240	225	2,759	2,813	53	68	**(15)**
Drugs	24,772	2,029	2,090	22,986	22,988	2	(60)	**62**
Research & Development expenses	0	0	0	1	(1)	(1)	(2)	**0**
Education & Training expenses	1,488	138	105	1,682	1,571	(110)	(77)	**(33)**
Consultancy costs	276	23	73	289	677	388	339	**50**
Establishment expenses	4,344	372	275	4,055	3,804	(251)	(154)	**(97)**
Premises	19,123	1,475	1,969	16,873	18,423	1,550	1,056	**494**
Transport	1,545	109	141	1,454	1,408	(45)	(77)	**32**
Clinical Negligence	9,120	760	755	8,345	8,034	(311)	(306)	**(5)**
Operating Leases	1,212	217	75	2,386	1,290	(1,096)	(954)	**(141)**
Other Operating expenses	5,513	646	794	6,090	6,987	897	41	**856**
Cost Improvement Programme - Non Pay	0		0		0	0	0	-
Reserves	0	0	0	0	0	0	0	-
Operating Expenses included in EBITDA	**119,782**	**10,840**	**11,015**	**116,221**	**120,702**	**4,480**	**3,601**	**4,407**
Depreciation & Amortisation - Purchased / Constructed	10,287	864	863	9,428	8,011	(1,416)	(1,415)	**(1)**
Depreciation & Amortisation - Donated / Granted	245	19	24	214	262	48	43	**4**
Depreciation & Amortisation - Finance Leases	3,540	295	261	3,245	3,035	(210)	(177)	**(34)**
Impairment & Revaluation	96	8	(3)	92	(418)	(510)	(499)	**(11)**
Operating Expenses excluded from EBITDA	**14,168**	**1,187**	**1,146**	**12,978**	**10,890**	**(2,088)**	**(2,047)**	**(41)**
Total Operating Expenses	**388,725**	**33,943**	**37,604**	**376,390**	**386,003**	**9,612**	**5,247**	**4,366**
(Profit)/Loss from Operations	**(2,712)**	**(673)**	**(684)**	**(2,021)**	**(1,839)**	**182**	**183**	**(1)**
Non Operating								
Non-Operating Income								
Finance Income	(1,220)	(102)	(133)	(1,122)	(1,669)	(547)	(515)	**(31)**
Total Non-Operating Income	**(1,220)**	**(102)**	**(133)**	**(1,122)**	**(1,669)**	**(547)**	**(515)**	**(31)**
Non-Operating Expenses								
Finance Costs	824	69	60	755	651	(104)	(95)	**(9)**
Gains / (Losses) on Disposal of Assets	0	0	0	0	0	0	0	-
PDC dividend expense	4,420	368	302	4,052	3,986	(66)	(0)	**(66)**
Total Finance Costs (for non-financial activities)	**5,244**	**437**	**362**	**4,807**	**4,637**	**(170)**	**(95)**	**(75)**
Other Non-Operating Expenses								
Misc. Other Non-Operating expenses	0	0	0	0	0	0	0	
Total Non-Operating Expenses	**5,244**	**437**	**362**	**4,807**	**4,637**	**(170)**	**(95)**	**(75)**
(Surplus) / Deficit Before Tax	**1,312**	**(338)**	**(455)**	**1,663**	**1,129**	**(534)**	**(427)**	**(107)**
Corporation Tax	1,125	94	137	1,031	1,434	403	360	**43**
(Surplus) / Deficit After Tax	**2,437**	**(244)**	**(318)**	**2,693**	**2,563**	**(130)**	**(66)**	**(64)**
(Surplus) / Deficit After Tax from Continuing Operations	**2,437**	**(244)**	**(318)**	**2,693**	**2,563**	**(130)**	**(66)**	**(64)**
Remove capital donations / grants I&E impact	(245)	(20)	(24)	(225)	(262)	(37)	(34)	(3)
Adjusted Financial Performance (Surplus) / Deficit	**2,192**	**(264)**	**(342)**	**2,468**	**2,301**	**(167)**	**(100)**	**(67)**

Table 2: Statement of Comprehensive Income

3 Cost Reduction Programme

3.1 Included in the Trusts 2024-25 financial plans is an annual CRP requirement of **£22.800m**. As of February £16.472m is forecast to be achieved which is a shortfall of £6.328m.

Business Unit	2024-25 Annual Target £000	2024-25 Annual Achieved £000	2024-25 Updated Forecast Schemes £000	2024-25 Shortfall £000	RECURRING ACHIEVEMENT Recurring Achieved £000	Recurring Forecast £000	Recurring Shortfall £000
Chief Executive	138	0	10	(128)	0	0	(138)
Chief Operating Officer	138	292	292	154	0	0	(138)
Clinical Support & Screening Services	4,307	1,782	3,058	(1,249)	43	82	(4,225)
Community Services	1,475	898	1,028	(447)	187	207	(1,268)
Estates & Facilities	233	300	300	67	0	0	(233)
Finance and Digital	800	943	943	143	213	213	(586)
Medical Director	58	59	59	1	4	4	(55)
Medicine & Elderly	3,861	142	142	(3,718)	115	115	(3,746)
Nursing & Midwifery	239	146	211	(28)	86	151	(88)
People & Organisational Development	251	188	214	(37)	87	87	(164)
Surgical Services	4,231	3,412	3,412	(820)	679	576	(3,655)
Trust Financing	4,069	2,654	3,804	(265)	276	276	(3,793)
Sub-total Trust Performance	19,800	10,815	13,472	(6,328)	1,690	1,711	(18,089)
QEF	3,000	2,989	3,000	0	3,000	3,000	0
Sub-total QEF Performance	3,000	2,989	3,000	0	3,000	3,000	0
Total Group Performance	**22,800**	**13,804**	**16,472**	**(6,328)**	**4,690**	**4,711**	**(18,089)**

Table 3: Cost Reduction Target Performance

4 Capital

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

4.2 Variations to the approved programme in February 2025 include an additional PDC award totalling **£0.634m** relating to Digital Diagnostics, Frontline Digitalisation **£0.500m**, Cyber Security of **£0.075m**. The PDC award in respect of the CDC has been reduced to **£6.562m** from **£6.737m** due to a revised valuation of the scanner which has been transferred from Bolton. Charitable funded schemes now totalling **£0.156m**, resulting in available capital funding of **£17.747m** as summarised in Table 8 below.

Capital Funding	£'000s	£'000s
Net Depeciation*		9,324
Cash		486
PDC Funded Schemes		
- CDC	6,572	
- Digital Diagnostics	634	
- Frontline digitalisation	500	
- Cyber Security	75	7,781
Charitable Funds		156
Total		17,747

* After principal loan repayments

Table 4: Capital

5 Cash and Liquidity

5.1 Group cash as of 28th February totalled £28.419m, an increase of £6.175m from January (£22.244m). This is the equivalent to an estimated 26.69 days operating costs (January 20.89 days) and is £20.723m above plan year-to-date

5.2 The liquidity metric for February was (3.26) days; 10.62 days better than plan of (13.88) days due to improvements in working capital balances, non-recurring deficit support and capital programme slippage.

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

Statement of Position - February 2025

	2024/2025 January 2025 Group	2024/2025 February 2025 Group	Movement from Prior Month	2024/2025 February 2025 QEF	2024/2025 February 2025 FT
	£000's	£000's	£000's	£000's	£000's
Assets					
Non-Current Assets					
Investments	80	80	0	80	16,824
Property, Plant and Equipment, Net	166,961	167,958	997	1,086	166,872
Right of Use Assets	6,298	6,041	(257)	3,443	2,598
Trade and Other Receivables, Net	2,307	2,273	(34)	664	1,609
Finance Lease - Intragroup				40,579	0
Trade and Other Receivables - Intragroup Loan	0	0	0		2,988
Total Non Current Assets	175,646	176,353	706	45,853	190,892
Current Assets					
Inventories	5,121	5,116	(5)	2,766	2,350
Trade and Other Receivables - NHS	1,788	2,425	636	170	2,255
Trade and Other Receivables - Non NHS	10,156	8,753	(1,404)	4,501	4,252
Trade and Other Receivables - Intragroup				10,366	14
Trade and Other Receivables - Other	0	0	0	0	0
Prepayments	6,038	5,638	(400)	827	4,811
Cash and Cash Equivalents	22,244	28,419	6,175	7,447	20,972
Other Financial Assets - PDC Dividend	0	0	0	0	0
Accrued Income - NHS	13,798	9,736	(4,062)	838	8,899
Accrued Income - Other	1,650	1,804	154	968	836
Finance Lease - Intragroup				63	0
Trade and Other Receivables - Intragroup Loan					374
Total Current Assets	60,796	61,892	1,096	27,945	44,763
Liabilities					
Current Liabilites					
Deferred Income	8,131	6,034	(2,097)	23	6,011
Provisions	3,779	3,678	(101)	612	3,066
Current Tax Payables	5,326	5,236	(90)	476	4,760
Trade and Other Payables - NHS	1,949	1,630	(319)	0	1,630
Trade and Other Payables -Intragroup				14	10,366
Trade and Other Payables - Other	11,571	12,561	990	3,510	9,052
Lease Liabilities	1,293	1,044	(249)	395	649
Trade and Other Payables - Capital	616	2,241	1,625	0	2,241
Other Financial Liabilities - NHS Accruals	5,553	5,461	(92)	870	4,591
Other Financial Liabilities - Accruals	20,124	21,641	1,517	10,855	10,786
Other Financial Liabilities - Borrowings FTFF	499	499	0	0	499
Other Financial Liabilities - PDC Dividend	1,473	1,776	302	0	1,776
Other Financial Liabilities - Intragroup Borrowings	0	0		374	0
Finance Lease - Intragroup	0	0		0	63
Total Current Liabilities	60,316	61,802	1,486	17,128	55,490
NET CURRENT ASSETS (LIABILITIES)	480	90	(390)	10,817	(10,727)
Non-Current Liabilities					
Deferred Income	1,996	1,995	(0)	1,719	277
Provisions	2,445	2,445	0	0	2,445
Trade and Other Payables - Other	24	36	12	0	36
Lease Liabilities	5,823	5,823	0	3,564	2,259
Other Financial Liabilities - Accruals	0	0	0	0	0
Other Financial Liabilities - Intragroup Borrowings	0	0	0	2,988	0
Other Financial Liabilities - Borrowings FTFF	11,013	11,013	0	0	11,013
Finance Lease - Intragroup				0	40,579
Total Non-Current Liabilities	21,301	21,312	12	8,270	56,609
TOTAL ASSETS EMPLOYED	**154,825**	**155,130**	**305**	**48,399**	**123,555**
Tax Payers' and Others' Equity					
PDC	170,535	170,535	0	0	170,535
Taxpayers Equity	0	0	0	0	0
Share Capital	0	0	0	16,824	0
Retained Earnings (Accumulated Losses)	(28,989)	(28,684)	305	31,575	(60,258)
Other Reserves	0	0	0	0	0
Revaluation Reserve	13,180	13,180	0	0	13,180
Misc Reserve	99	99	0	0	99
TOTAL TAXPAYERS EQUITY	154,825	155,130	305	48,399	123,555
TOTAL ASSETS EMPLOYED	**154,825**	**155,130**	**305**	**48,399**	**123,555**

Table 5: Statement of Financial Position

6 Conclusion

6.1 Following the allocation of an additional **£5.317m** in September, and a further £4.896m notified in January non-recurring deficit support the Trust has a revised planned deficit of **£2.437m** before adjustments for donated asset depreciation, and **£2.192m** after.

6.2 The Trust has reported an adjusted deficit of **£2.301m** for the period up to February 2025, which is a favourable variance of **£0.167m** from its year-to-date target

6.3 The Trust has reported externally the achievement of cost reduction programme totalling **£20.031m** and is forecasting to achieve **£22.800m.** On a recurring basis the Trust is forecasting a total of £5.420m, equivalent to 25%, with a total unachieved target of £17.380m to be carried forward to 2025-26.

6.4 The Trust is forecasting delivery of its planned deficit totalling £2.192m partly as a result of non-recurring benefits including technical adjustments totalling £14.965m, system deficit support of £10.213m and system pressure support totalling £6.000m.

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

6.6 The Trust is forecasting delivery of its capital programme within its Capital Delegated Expenditure Limit, after the declaration of £4.489m IFRS16 slippage.

Jane Fay, Interim Group Director of Finance
March 2025

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 20

Report Title:	Strategic Objectives & Constitutional Standards			
Name of Meeting:	Board of Directors			
Date of Meeting:	26th March 2025			
Author:	Deborah Renwick			
Executive Sponsor:	Kris Mackenzie/Jane Fay			
Report presented by:	Kris Mackenzie/Jane Fay & Joanne Halliwell			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☒
	This report presents progress, risk and assurance in relation to our Strategic Objectives for M11 2024/25.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Finance and Performance Committee – 25 March 2025			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal*	**We will continuously improve the quality and safety of our services for our patients**. **Maternity:** Continues on an improvement trajectory: Compliance with Ockenden and Maternity Incentive Scheme recommendations are now both at 100% compliance. Delivery of the **Quality Improvement Plan** compliance with actions on track for delivery in month fell 68% to 64%. Key delivery areas for improvement remain in: Daily resus checks & safe storage of COSHH, appraisal rates and implementation of the PSIRP workstream plans. **PSIRP**: The volume of falls and falls harm rates have increased in month, with two NAIF (head injury falls) reportable falls. **QA**: The Trust has reported four cases of C. difficile in M11 and a total of 38 year to date against our annual threshold is 37. In month rates per 100k bed days have increased to 31.4.			

• *Equality, diversity and inclusion*	**QA**: Performance against learning disability and autism training remains below target levels of 85%, although improving in month from 61.8% to 64.2%. Discussions continue re: regional hub delivery model and issues in digital updates to monitoring systems. Mental Health Act Policy training remains static at 83% and below target levels of 90%. Training and delivery challenges are evident with releasing Ward staff and time to train coupled with rotational allied health professionals. Additional training dates are being released. Medicines management indicators remain under review to support high impact SMART and measurable KPI's. The **agreed strategic approach to EPR** and the outline business case (OBC) is in draft and being reviewed through Trust governance routes. The current timetable requires Board review of the strategic approach in March 25. Work is continuing to align plans with a shared Digital Alliance Strategy and establish core digital standards. **Development & implementation of an Estates strategy** has now been deferred, awaiting further clarity on the direction of the GNHA Big Build. The headline metrics underpinning and related to the development of the strategy are detailed below: • Baseline risk assessments from Inphase has been undertaken. In M11 there are 21 estate risks with a combined risk score of 252 a reduction from 256 in M10. • At the end of M11, the Trust is above the target reduction of safety incidents reported linked to estate issues. There were 5 estates related safety incidents reported in February, 2 incidents were related to the same area of the estate. • Multi-disciplinary PLACE audits have taken place in three areas across the Trust in February. No major concerns were raised, the lifecycle of decorating / general paint work is being reviewed. Scoring systems remain outstanding as the Team continue to work on implementing PLACE Lite. • A reduction in the value of backlog maintenance score will be heavily influenced by the work ongoing to rationalise aging estate. A clinically prioritised plan to review backlog maintenance programme is in place. **We will be a great organisation with a highly engaged workforce.** • Vacancy rates continue on an upward trajectory, increasing 0.2% in month from 5% to 5.2% with tighter controls in VCF process. • Staff engagement score decreased from 6.63 to 6.2 in the Quarterly Pulse survey, remains below target levels of 7.3.

	The completion rate was 9.3%. Targeted work is on-going to improve rates via multiple routes. • Turnover rates remain above target levels of 9.7% with M11 performance at 11.3%. • Sickness absence rates of 5.7% remain above target levels of 4.9%. • Temporary staffing spend as a proportion of pay bill is at 0.5% and remains below the planning target of 2.3%. **We will enhance our productivity and efficiency to make the best use of our resources.** **Improve the quality-of-care delivery and accessibility for patients by meeting locally agreed stretch targets.** Despite Urgent and Emergency care pressures continuing during the winter, improvements are evident in February and being maintained in Q4. • The ED 4-hr standard improved in month from 71.2% in M10 to 73.6% in M11, although still below national target level of 78% and planned improvement levels. • Time in Department metrics improved again in month with 2.5% of patients in ED over 12 hours in the department, huge improvements from 10% in M9 and a 50% improvement on the same period last year. • There were zero reportable 12-hr delays for admission. • The Trust remains a top performer in Ambulance Handover times with average hand-over time of 13mm:34ss in February against the national standard of < 15mins. • The number of ambulance conveyances were comparable to the same period last year. Improvement activities are underway to support recovery in Q4, focusing on triage, reducing total time in department and a wider Trust wide plans to improve flow and discharge. • Outbreaks of norovirus/Covid in the hospital have also impacted on the ability to create flow. • Average NEL length of stay reduced in month to 7.31 days in February. • Discharge remains problematic, the daily average of patients no longer meeting the criteria to reside increased to 46 in February. • In February there were 452 beds open, on average 23 beds less than previous month and 18 beds less per day open than last year.

	The waiting list increased to 13,096 representing an increase in month of +228 (1.8%) and 11% growth from April. Inpatient waiting list remains static, whilst outpatient waiting list increased by 2%. A deep dive into the drivers behind the Waiting lists position is underway via Operational Oversight Group. February's RTT performance is at 71.3% (improving from 70.6% M10). 52 week waiters are over planned for levels at 66 in February. Forecast modelling is ongoing, tracked to key recovery delivery areas in support of minimising year end risks. • Current waiting list is over year end projections. • Focus remains on achieving zero over 52 weeks and reducing outpatient waiting times and increased validation. • Key Waiting list pressures remain in Gynaecology, Urology, COTE, Cardiology, Gastroenterology, Rheumatology and Respiratory. • RTT performance is forecast ~ 72% by year end. The Trust has recently been highlighted nationally as one of the top 20 Trusts for RTT performance and selected for the Going Further Faster Programme. Sustained improvements have been maintained across all key cancer measures and are planned to continue. Diagnostics: Waiting List is at 6,571 representing an in month increase of +87 waiters and 9% growth from April. January's DM01 performance is at 86.4%, below H2 revised planned for levels of 91%, representing a positive performance variance of + 5% from last month. Modalities posing the greatest risk to year end forecasts are Non-obstetric ultrasound, echocardiology and audiology. Recovery support is in place to support year-end improvements in performance. Current year end projections for the DM01 are ~90% against a revised H2 plan of 93% and the projected year end waiting list remains over 6,000. **Evidence of reduction in cost base & an increase in patient care related income by the end of March 2025 to a balanced financial plan for 2025/26.** **Plan:** At the end of M11 the Group are reporting a deficit position of £2.301m against revised planned levels of £2.468m representing a positive variance of £170k Risks remain around achieving the year end plan due to overspending against delegated budgets largely in medical and nursing workforce and non-delivery against recurrent CRP targets.

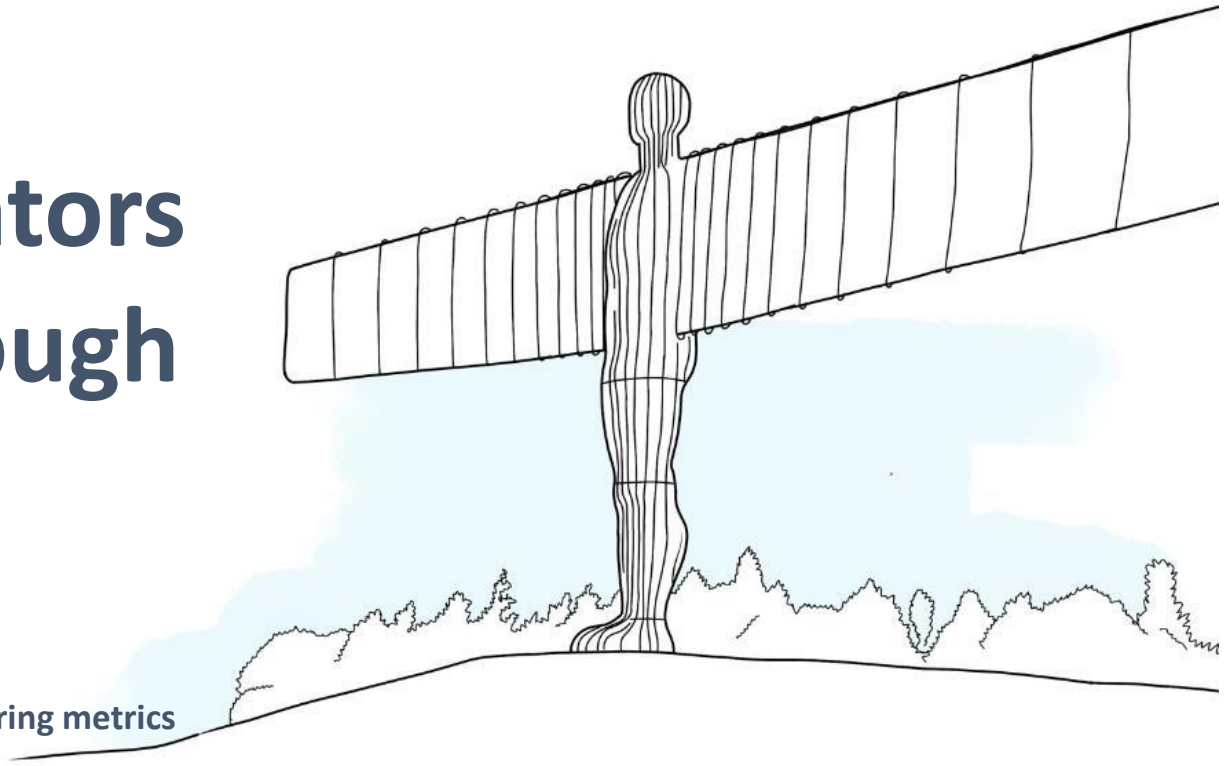
	Cost Reduction Plan (CRP) is behind plan with a negative variance of £73k. £20.031m CRP was transacted at M11 against a plan of £20.104m Risks remain in the proportion of non-recurrent savings made to date. The focus going forward remains in delivering long term improvements to deliver recurrent savings to support financial sustainability. The Trust is planning to deliver a revised forecast outturn deficit position of £2,192m, aided by an additional £5.3m non-recurrent deficit support funding in September and £4.9m in January. The Trust is planning to achieve £15m cash forecast at the end of March. **We will be an effective partner and be ambitions in our commitment to improving health outcomes.** Our fragile services review will feed into the annual planning cycle and inform provider collaborative sustainability. Improvements in health inequalities will be driven by the Health Inequalities Strategy and plan – further work is ongoing in the group to revise the delivery plan. Digital teams will continue to support efforts to reduce digital exclusion by repurposing hardware in 2024/25 and have achieved target levels of recyclable hardware to date. Gynaecology outpatient median waiting times reduced from 37 to 32 weeks in month. Service plans to support recovery are in development to improve waiting times. Paediatric autism assessments and diagnosis waiting times have reduced in-month to a median of 65 weeks. **We will develop & expand our services within and beyond Gateshead.** Plans to increase QEF externally generated income by 0.5% are ahead of schedule with Month 11 cumulative delivery at 6%.	
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The recommendations to the Board are to receive this report, discuss the potential implications and note the improvement or challenge in key areas.	
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 Strategic Objectives.				
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
	Key areas to establish reporting: • PLACE audit scores not yet generated from PLACE Lite • Medication updates are included in the narrative section. No movement in key areas: • Fragile & vulnerable service review: Planned reviews align with strategy discussions. • Health Inequalities: Review of strategy, plan and realignment of key determinants of health, supported by Public Health. Areas requiring attention: **Quality & Safety:** • Quality Improvement Plans • Harm rates from falls • Safety incidents linked to Estates • Mental Health Act & Disability & Autism Training **Workforce:** Staff engagement, turnover rates, vacancy & sickness absence rates. **Productivity & Efficiency:** Increasing RTT & Diagnostic waiting lists Year end achievement of DM01 95% standard: Non-obstetric ultrasound, audiology & echocardiology. Winter and region wide pressures are impacting on bed availability and flow across the Trust and impacting on Urgent and Emergency Care metrics and 4hr A&E target. Risk in achieving financial plan & reducing expenditure and achieving CRP. Risks remain in reducing waiting times in gynaecology and autism assessment pathways with current workforce pressures.				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

NHS
Gateshead Health
NHS Foundation Trust

Strategic Objectives 2024/25

Leading Indicators and Breakthrough Objectives



Including Constitutional standards monitoring metrics

Reporting Period: February 2025

Our patients Our people Our partners

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

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

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

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

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

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

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

Our Strategic aims:

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

Our strategic intent:

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

Strategic Objectives 2024/25

Executive Summary

NHS Gateshead Health NHS Foundation Trust

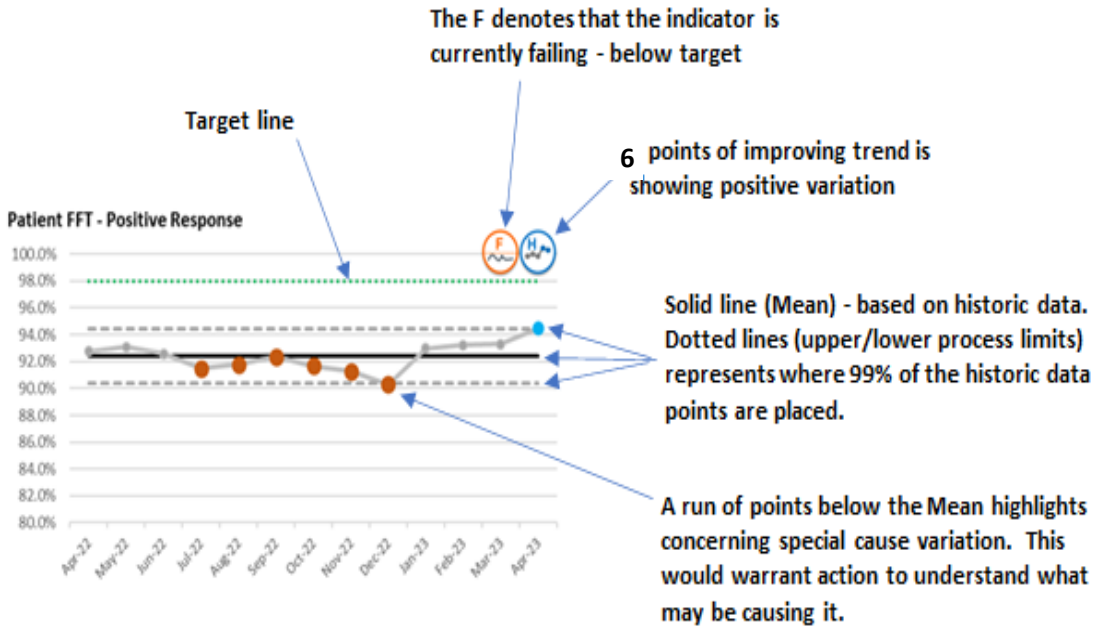
Improved	No Change	Needs further attention
We will continuously improve the quality and safety of our services for our patients		
Compliance with Level 1 training plans for learning Disability & Autism training improved to 64.21%	Scoring in domains in areas of PLACE inspection not available	Strategic approach to development of EPR is behind schedule
Ockenden recommendations are fully compliant at 100%		Mental Health Act Training requires a training package for all registered staff dropped slightly to at 83%
Maternity Incentive Schemes are fully compliant at 100%		Severity of risk scores linked to estates has decreased to 252 however remains high
		Quality Improvement Plans decreased to 64% compliance but remains below target
		Harm rate from falls increased to 3.89
		C.Difficile rate has increased to 31.4
		Reduction in patient safety incidents linked to estate issues: decreased to 5
We will be a great organisation with a highly engaged workforce		
	Improve the staff engagement score to 7.3 (currently at 6.2)	Achievement of the internal turnover standard of 9.7% (currently at 11.3%)
	Reduction in temporary staffing spend 0.5% of pay bill.	Internal sickness absence standard at 5.7%
		Maintain the vacancy rate at <=2.5%, currently at 5.2%
We will enhance our productivity and efficiency to make the best use of our resources		
	Review and revise 2022/25 Green Plans: Align governance to group structure - Meetings underway	Average non-elective length of Stay < 4 Days
	Increase in New & Follow up value added activity to 33% (decreased slightly to 32.4% in February)	Achievement of Zero 52 weeks.
		Reduce the number of patients with no Criteria to Reside (February - 46)
		Achievement of 4-hr A&E target (Below planned trajectory and target)
		Achievement of the trajectory to achieve 60% RTA to Bed within 1 hour
		Risk in achievement of financial plans including CRP
		Reduce >12 hour total time in Emergency Department
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	Reduction in the wait for gynaecology outpatients to no more than 26 weeks by March 2025.
	Evidence in an improvement in health inequalities in the key focus areas linked to the determinants of Health for Gateshead	Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 weeks by March 2025
	No further change in the number of digital devices repurposed to the local community	Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients by March 2025
We will develop and expand our services within and beyond Gateshead		
	Increase in QEF externally generated turnover 4%	

How to interpret the SPC icons and charts

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

What are Statistical Process Control (SPC) charts

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



SPC Rules

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

Icon Colours Explained

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

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

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

NHS Gateshead Health NHS Foundation Trust

	P	?	F	
Improving		Increase % of Outpatient % with procedures	Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 by March 2025 Achievement of the internal turnover standard of 9.7% Ockenden Recommendations % compliance with Total Recommendations	
Neither improving or deteriorating		Harm falls rate per 1000 bed days Achievement of the 4 hours trajectory C.Diff Healthcare associated rate per 100,000 occupied bed days Reduction in the wait for gynaecology outpatients to no more than 26 weeks Reduction in patient safety incidents related to estates issues Achievement of the trajectory to reduce >12 hour total time in Emergency Department Achievement of the % to reduce >12 hour total time in Emergency Department	Reduce the number of patients with no Criteria to Reside Achievement of the 52 week RTT standard Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients by March 2025 Achievement of the internal sickness absence standard of 4.9%	
Deteriorating		Maintain the vacancy rate at <=2.5% 90% of staff to complete Mental Health Act training	Average Length of Stay Non-Elective <4 days Achievement of the trajectory to achieve RTA to Bed within 1 hour Compliance with the quality improvement plan indicated by the % of actions on track	
	Consistency in PASSING the target	**Inconsistency in HITTING, PASSING and FALLING SHORT of the target**	**Consistency in FAILING the target**	

Strategic Objectives 2024/25

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

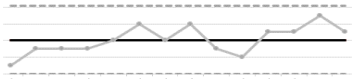
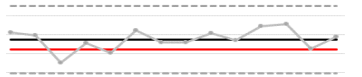
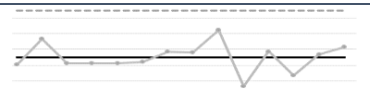
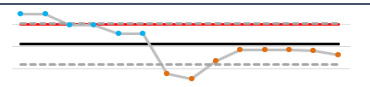
NHS Gateshead Health NHS Foundation Trust

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

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

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

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

Metric	Target	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Ass/Var	Trend
LEADING INDICATORS																	
Ockenden Recommendations % compliance with Total Recommendations	100%	77.7%	77.7%	77.7%	78.0%	78.0%	74.0%	74.0%	89.0%	90.0%	95.2%	97.4%	98.0%	100.0%	100.0%	H F	
Maternity Incentive Schemes % compliance with Total Recommendations	100%				62.9%	70.8%	76.4%	77.5%	83.0%	89.0%	89.0%	89.0%	96.0%	96.0%	100.0%		
Reduction in patient safety incidents linked to estate issues	<=4	1	3	3	3	4	6	4	6	3	2	5	5	7	5	?	
Compliance with the quality improvement plan indicated by the % of actions on track	100%	84%	88%	88%	88%	88%	76%	84%	88%	84%	72%	68%	56%	68%	64%	L F	
BREAKTHROUGH OBJECTIVES																	
Scoring in domains in areas of PLACE inspection composite score > 95%	> 95%																
Reduction in severity of risk score linked to estates	TBA				252	252	252	267	279	284	280	280	272	256	252		
Harm falls rate per 1000 bed days (5% reduction)	3.2	4.10	3.96	2.51	3.53	3.03	4.21	3.57	3.57	4.06	3.69	4.44	4.55	3.24	3.89	?	
C.Diff Healthcare associated rate per 100,000 occupied bed days	<=3.20	20.1	36.5	21.0	21.1	20.9	22.1	28.4	27.8	42.0	6.7	28.6	13.2	26.7	31.4		
90% of staff to complete Mental Health Act training.	90%	92.2%	92.2%	89.7%	89.7%	87.9%	87.9%	78.9%	77.6%	81.8%	84.2%	84.2%	84.2%	84.0%	83.0%	L ?	
85% of staff to complete GHFT Level 1 learning disability and autism training from April 2024. Develop plans for Level 1 Face to face interactive training as part of mandatory training offer.	85%						33.72%	41.53%	46.93%	50.76%	54.95%	57.36%	59.97%	61.80%	64.21%		

Strategic Objectives 2024/25

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

NHS Gateshead Health NHS Foundation Trust

An agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.
Development & implementation of an Estates strategy that provides a 3 year capital plan to address the key critical infrastructure and estates functional risks across the organisation by March 2025

Measures requiring focus this month

	Measure	Summary
1	Ockenden recommendations % compliance with total recommendations	February compliance 100%, MIS compliance with all elements of Saving Babies Lives Care Bundle confirmed Audits complete for IAEs 5&7, continue to monitor compliance.
	Maternity incentive schemes % compliance with total recommendations	The Trust is reporting compliance at 100%. Annual LMNS assurance report received, Q3 LMNS assurance meeting completed, MIS compliance reporting period ended 30/11/2024 Final ratification of updated Maternity Risk Management Guideline completed – January Safecare - Safety action 7. Update of maternity governance structure in line with Trust, recruitment to midwifery and consultant vacancies.
2	Compliance with the quality improvement plan indicated by the % of actions on track.	Latest reported data relates to February 2025 with 64% of the Improvement Plan actions on track to deliver. The newly developed Quality Improvement Plan monitors 25 leading indicators covering Patient Safety, Patient Experience and Quality. February's performance shows progress is not where would plan to be at this stage in the year. Plans are in place with the relevant action owners for actions that are reporting risk of non achievement. Non compliance areas: Resus daily checks and safe storage of COSHH as part of the 2019 CQC action plan, Trustwide appraisal rates, Implementation of falls PSIRP workstream plan, Reduction of harm from falls of 5% by end Q4,Mental Health Act, Embed the action plan from the newly developed MH strategy, Develop a robust monitored audit programme in Maternity and Complaints process. The following actions have now been fully implemented: Medicine Management: Establish a Diabetes and Insulin Safety Forum, Medicine Management: Establish a Specialist Pharmacist Prescriber within Women's Health and Children's services, Quality Strategy: Establish a violence reduction group Challenges continue for resus checks daily checks taking place and COSHH files being up to date. The Chief Matrons are working with the matrons and Health and Safety Team to improve the continuous low compliance against both of these. To note there has been a marked improvement in both areas over the past two months. Low compliance with trustwide appraisal rates, local induction rates and staff retention rates are being monitored via Tier, 1,2 and 3 POD meetings. Current Flu vaccine uptake rates remain significantly below the target of 75% of all staff by April 2025, work continues to drive the flu campaign however to note there is a risk of non-achievement against this indicator.
	85% of staff to complete GHFT Level 1 learning disability and autism training from April 2024. Develop plans for Level 1 Face to face interactive training as part of mandatory training offer.	Ongoing discussions continue regarding next steps with regards to LD and Autism awareness training, scoping delivery models when national guidance produced. Ongoing discussions within the alliance to the delivery model approach. Challenge remains regarding regional hub where e-learning is hosted which at times is impacting completion being noted in the system, discussions ongoing regarding a fix for this, however the team are supporting to update compliance as required as compliance is increasing month on month
	Improve Mental Health Act Policy Training Compliance to 90% for all *registered* staff via training and audit.	Performance decreased slightly to 83.0%, the percentage has been negatively affected by new staff coming into post who require training. CPN team and Memory Hub staff are 100% compliant with training, 39 acute staff have been trained. Additional training sessions for all MH staff are offered in addition to pre-arranged sessions on ESR. As yet there has been no uptake for additional sessions in 2025. Training for RMN's in Feb was unable to go ahead as delegates booked onto the session did not attend. Training for RGN's in Feb was cancelled as a result of no delegates booking onto the session. Training for mental health HCA's/ support workers was cancelled in Jan 2025 due to no delegates booking onto the session. One member of staff has booked onto the training session for March. Ward managers have been emailed to see if there are any staff able to be released to attend but advised no staff are available to be released. It is identified that 40 mental health staff will drop out of compliance with MHA training in 2025. All training dates for mental health staff and general nursing staff have been arranged and available to book on ESR. Additional training sessions are able to be arranged upon request to support with improving compliance outside of scheduled training dates. Mental health team managers are emailed monthly updates on staff training figures. Mental Health link identified for Cragside to support with improving application of the MHA on inpatient MH wards. Initial supervision session held to map out role. Link for Sunniside yet to be identified. Matrons have been emailed to advise that ward managers and site resilience team members should receive MHA training to support the ward staff and act as a point of contact. Ward managers and site resilience team have been identified and emailed by the Safeguarding Training Administrator. Following this email, 7 Staff have booked onto the next training session.
	Improve our IPC C.Difficile infection rates per 100 000 occupied bed days.	The Trust's C-diff threshold for 24/25 is 37, year to date we are reporting 38 cases. A rate of 31.4 per 100,000 occupied bed days is observed in February 2025, resulting from 4 cases (compared to a rate of 26.7 last month). A 10 point C-diff reduction plan is in place, with a drive to 'back to basics' for clinical areas particularly around hand hygiene, AMP and learning. Community prevalence continues to be higher than normal levels, reflecting national and local elevated levels of C.Diff.
	Medicines	The Women's Health and Childrens Services Pharmacist has been in post since April and is now well established, presenting the role to the Great North Pharmacy Conference in July. Work to review IV iron infusions is ongoing this financial year and guidelines implemented in December 24. Further development of mandatory e-Learning for syringe drivers and the development of a Palliative Care presentation for preceptorship training are hoped to be implemented for the next financial year.
	Harm related falls will reduce by 5% by March 2025.	Falls have increased slightly this month. Staffing has been very challenging and thought to be a possible factor in the increase in patients falling. There have been 2 NAIF audit reportable falls (both head injuries) with very little learning. There is work planned to revamp the falls group/workstream. This includes it changing to a bimonthly meeting. Staff were in agreement to this and a suitable day/time will be agreed. There remains a significant gap in the resource for the falls work, and it is hoped this will be address through the falls work/group/workstream. Continued focus within the falls group/ward staff on falls and falls prevention. Training provided to ward 14 following an increase in falls on the ward.
3	Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.	Outline Business Case is in draft and is currently being socialised throughout the organisation. Benefit Profiles are being developed specifically regarding potential cash releasing and cost avoidance benefits and activity is underway to ensure alignment with alliance plans. Capacity and capability issues are impacting the start of the development of the Output Based Specification which would be required for the procurement activity. Progression with alliance discussions, while positive, have impacted the delivery date of the OBC. The target date to get to Trust board is now Mar 2025 Initial discussions have taken place with the Cabinet Officer and EPR Investment Board to establish process for approvals/controls Current drivers are due to the contractual limitations of the existing provision decision regarding strategic route will be required in Mar 2025 to allow sufficient time for procurement of a solution, including due diligence. It has therefore been agreed that the case will be considered at the January Trust board. There is a risk associated with the current timescales for the existing PAS contract which expires in Dec 2027 - delays to the programme could mean that this is extended beyond the required timescale. Uncertainty of alliance digital strategy and plans could impact on the programme delivery, there is no current external funding stream available to support this programme, due to previous funding received.
4	Reduction in risks and severity of scores linked to estate issues	February position, 21 Risks with combined critical infrastructure risk score of 252 (reduced from 256 in January) No new risks identified. 1 risk reduced (4529)-Ventilation failure in QEH mortuary due to age of system. Score reduced from 16 to 12.
	Reduction in patient safety incidents linked to estate issues	5 patient safety incidents related to estates issues in February 2025. These figures currently exclude incidents related to pressure damage and incidents reported as Harm not related to Gateshead on Inphase. 2 of the 5 incidents relate to the noise levels in audiology and the impact of this on the ability to perform hearing tests.
	Scoring in domains in areas of PLACE inspection composite score > 95%	PLACE lite implementation is still awaited to produce percentage scores. In February the chapel, communal areas and SC reception have been reviewed. No areas raised any concerns except the chapel is looking tired and is need of decorating, estates are aware and are looking at life cycle of the area. The toilet was locked and used as a storage facility.
	Reduction in value of backlog maintenance score as reported via the ERIC return	There is now a clinically prioritised plan to review and deliver the backlog maintenance programme. The challenges are limitations on capital available to support the plan & CDEL allocation. Rationalisation of our existing aging estate is required to meet the 25% reduction target (equating to £3.5m reduction). The capital programme has been confirmed and an update will be available when capital projects are completed.

Strategic Objectives 2024/25

We will be a great organisation with a highly engaged workforce

NHS Gateshead Health NHS Foundation Trust

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

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

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

Metric	Target	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Ass/Var	Trend
LEADING INDICATORS																	
Maintain the vacancy rate at <=2.5%	<=2.5%	2.3%	2.2%	2.4%	1.7%	1.7%	1.6%	3.2%	3.1%	2.7%	3.4%	3.2%	3.5%	5.0%	5.2%		
Improve the staff engagement score to 7.3	>=7.3	6.60			6.60			6.63						6.20			
BREAKTHROUGH OBJECTIVES																	
Achievement of the internal turnover standard of 9.7%	<=9.7%	12.8%	12.9%	12.5%	12.0%	11.8%	12.1%	11.7%	11.7%	11.7%	11.2%	11.4%	11.5%	11.7%	11.3%		
Achievement of the internal sickness absence standard of 4.9%	4.90%	6.3%	5.6%	5.2%	5.5%	5.7%	5.8%	5.8%	5.7%	5.6%	5.6%	5.6%	5.7%	5.7%	5.7%		
Reduction in temporary staffing spend of pay bill evidenced month on month	<=2.3%				1.4%	1.0%	0.9%	0.4%	0.5%	0.4%	0.6%	0.5%	0.4%	0.5%	0.5%		

Measures requiring focus this month

Measure	Summary
Maintain the vacancy rate at <=2.5%	Vacancy rate is at 5.2%, a 0.2% increase compared to January 24. Both contracted WTE and Budgeted WTE decreased from January to February 2025. Vacancies add pressure to the group and our ability to provide a safe and high-quality service. Our current vacancy rate is above the target, this could include critical vacancies that are causing operational pressure and additional work spend. A review of the VCF process is in place to ensure there is tighter scrutiny in place for all vacancies.
Improve the staff engagement score to 7.3	Annual Engagement score had been declining since 2018, 2023 saw engagement raise to 7.0 from 6.9 in 2022. So this is slightly increasing. The quarterly pulse survey result for January 25 was 6.2, with a 9.3% completion rate for the group. January 25 people pulse survey scores have been added to this month's report, engagement decreased to 6.2 from 6.6 in July24 and 6.8 in the October 24 Staff Survey. Low levels of engagement with both Annual and Pulse Survey Results bring validity of measure into question. A refreshed approach to increasing completion rates will take place for the July quarterly people pulse, with an aim to increase completion which will better allow the Trust to measure engagement on a quarterly basis. Number of actions in place to address staff engagement such as L&D, FTSU, improved comms, revised appraisal process.
Achievement of the internal turnover standard of 9.7%	Turnover decreased by 0.4% to 11.3% in February 25. Staff are leaving the NHS across all providers given the significant work pressures and burnout. Turnover adds pressure to the group and our ability to provide a safe and high-quality service. Recruitment costs of backfilling as well as additional temporary staffing on an interim basis add to the costs. Conversely our significant WTE growth is positively impacted (reduced) with turnover, however the challenge lies in where this turnover occurs in the Group. The people promise exemplar programme is now underway, and as part of this work there are working groups in place for induction, stay conversations, flexible working and self-rostering. This work is being monitored via the ICB - good feedback received from ICB on the robust and clear project plan. Deep dive presented to People and OD committee and a clear plan in place for targeted interventions for those teams with high turnover.
Achievement of the internal sickness absence standard of 4.9%	High levels of deprivation and external factors along with challenging roles are driving some of our sickness absence. Sickness remained at 5.7% for a rolling 12 months in February 25. Absence adds pressure to the group and our ability to provide a safe and high-quality service. Not managing sickness absence results in staff being off work for longer periods of time. Continue with monthly case management approach of all long-term absence cases. Business Units provided with monthly short term absence reports highlighting all employees who have triggered short term absence procedure. Ongoing training and development on the new absence management policy.
Reduction in temporary staffing spend evidenced month on month reduction and no higher than 2.3 % of pay bill.	Temporary staffing spend remains under target at 0.5%. Off framework agency usage has dramatically decreased but additional pay spend remains high. Off framework agency usage has dramatically decreased but additional pay spend remains high. Challenges in that temporary staffing spend is continuing, further controls to be put in place for the Bank and Agency reduction monitoring group. The bank and agency reduction monitoring group has extended the metrics reported through this group to include all temporary staffing figures.

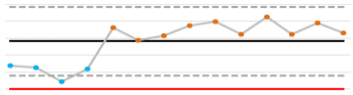
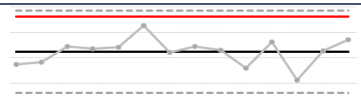
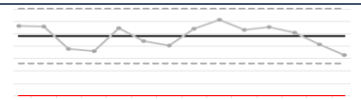
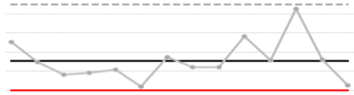
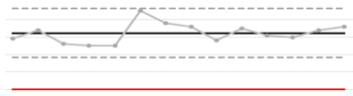
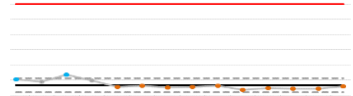
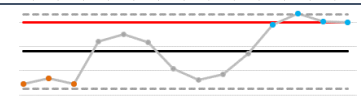
Strategic Objectives 2024/25

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

Gateshead Health NHS Foundation Trust

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

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

Metric	Target	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Ass/Var	Trend
LEADING INDICATORS																	
Average Length of Stay Non-Elective <4 days *Revised to align with operational guidance definitions*	<=4	5.38	5.26	4.46	5.19	7.62	6.87	7.17	7.73	7.96	7.24	8.26	7.24	7.88	7.31	H F	
Achievement of the 4 hours trajectory	≥78% (Local ≥80%)	68.6%	69.0%	72.2%	71.8%	72.0%	76.3%	71.0%	72.2%	71.4%	67.8%	73.0%	65.6%	71.2%	73.6%	?	
Achievement of the 52 week RTT standard	Apr 24 - 58 May 24 - 42 Jun 24 - 18 Jul 24 - 0	113	112	76	72	109	88	81	108	123	106	111	102	83	66	F	
Achievement of 2024/25 financial Plan - Variance (£k)	Figure in brackets favourable				2,312	2,609	0.009	(0.004)	(0.073)	(0.042)	0.026	(0.143)	(0.1)	(0.1)	(0.167)		
Finance - Forecast Out-turn Deficit (Plan)	12,650 (R)7,088 (R) 2,192				12,650	12,650	12,650	12,650	12,650	7,088	7,088	7,088	7,088	2,192	2,192		
BREAKTHROUGH OBJECTIVES																	
Achievement of the trajectory to reduce >12 hour total time in Emergency Department	0	692	458	362	358	413	225	531	391	395	749	495	1036	466	208	?	
	2.0%	7.0%	4.9%	3.6%	3.8%	4.1%	2.3%	5.4%	4.4%	4.4%	7.6%	5.1%	10.5%	5.2%	2.5%	?	
Reduce the number of patients with no Criteria to Reside	<10	39	44	36	35	35	55	48	46	38	45	41	40	44	46	F	
Achievement of the trajectory to achieve RTA to Bed within 1 hour	60.0%	10.6%	8.8%	13.6%	9.7%	5.5%	6.1%	5.2%	5.6%	6.3%	3.7%	4.7%	4.2%	4.3%	5.7%	L F	
Increase % of Outpatient % with procedures	>=33%	27.9%	28.4%	27.9%	30.9%	31.6%	30.9%	28.7%	27.9%	28.3%	30.0%	32.4%	33.5%	32.9%	32.4%	H ?	
2024-25 CRP Delivery Variance	Figure in brackets favourable				0	0	98	0	(570)	680	1,157	2,539	2,994	2,082	73		
No less than £5m cash as per forecast at March 2025	>=£5m				£5m	£5m	£5m	£5m	£5m	£5m	£5m	£5m	£5m	£5m	£5m		

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

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

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

Measures requiring focus this month

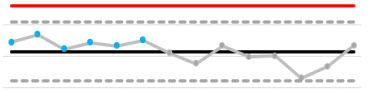
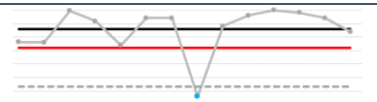
Measure		Summary
1	**Average Length of Stay Non-Elective <4 days**	Length of stay decreased during February but remains out with the target for the year. This reduction was despite the challenges in using Intermediate Care beds which occurred mid month. Ongoing work targeting those with no criteria to reside and ensuring they are discharged appropriately as well as focusing on those with a stay of 7, 14 or 21 days continues to be the focus of improvement work to further reduce this target.
	Achievement of the 4 hours trajectory	Performance at 73.6 % shows an improvement but remains below the required 78% standard. Availability of beds on EAU and back of house is key to achieving this objective. Focus on ensuring flow earlier in the day, use of the discharge lounge, estimated date of discharge and actual date of discharge enable this to be reviewed. Patient discharge early in the day, achieving this would enable us to ensure that patients did not remain within ED. Also reviewing non admitted waits to understand times of day and improvements required. The discharge improvement project is focusing on measurably improving discharges. Further changes to the Dashboards have been implemented and a review at all patient flow meetings is now in place. Further enhanced patients flow meetings have been introduced to support better flow and improve this target.
	Achievement of the trajectory to reduce >12 hour total time in Emergency Department	Performance at 2.5 % showed an improvement on January's figures. To achieve the planned reduction availability of beds on EAU and back of house is key. Focus on ensuring flow earlier in the day, use of the discharge lounge, estimated date of discharge and actual date of discharge enable this to be reviewed. Patient discharge early in the day, achieving this would enable us to ensure that patients did not remain within ED. Also reviewing non admitted waits to understand times of day and improvements required. The discharge improvement project is focusing on measurably improving discharges.
	Achievement of the trajectory to achieve 60% RTA to Bed within 1 hour	Performance of 5.7%. This is driven by late bed availability in the day, specifically EAU. Appropriate streaming to SDEC. Discharge profile is later in day, address planning for tomorrow's discharges today. Discharge work and review of mechanism to alert Patient Flow team to timeframe.
	Reduce the number of patients with no Criteria to Reside	Average number of patients per day who do not meet the criteria to reside was 46. There has been a significant push on reducing these numbers but they remain higher than anticipated. Availability of services in the Community to support patients who no longer need acute hospital care and ensuring that we are maximising our use of our own services is a key risk. Challenge in improving the process and outcomes for patients who do not need a hospital bed but do need support in the Community. Daily review with Social Care, review by Discharge Co-ordinators, service improvement plan developed.
	Achievement of the 52 week RTT standard by end Q1 and delivery of the trajectory for 40 weeks	We continue to see a reduction in the number of patients waiting over 52 weeks for treatment and are on track to achieve 0 by the end of March 25. Challenges remain in two specialties; T&O and Gynaecology due to capacity and demand imbalances and challenged shared pathways in key service areas, this is being managed through the access and performance weekly meeting and weekly service meetings. Review of waiting lists by consultant, pooling and alternative ways of releasing capacity remain underway. Additional theatre lists where possible and ongoing validation of pathways.
	Increase in New Outpatient activity	We have achieved the target of 33% consistently since Dec 24 and on track to maintain this at year end.
2	**Evidence achievement of the 24-25 financial plan**	The Trust has a planned deficit at M11 of £2.468m and actual performance of £2.301m deficit which is a favourable variance of £0.17m. In month 6 (£5.317m) and month 10 (£4.896m) the Trust received notification of non-recurrent deficit support funding resulting in a revised outturn deficit of £2.192m anticipated at the financial year-end, and forecasts to achieve this position. However, risks remain around overspending against delegated budgets and identification and delivery of recurrent CRP targets. The Trust has a planned CRP target at M11 of £20.104m and actual performance of £20.031m which is a negative variance of £0.073m. There is £5.040m delivered recurrently which is £7.251m less than planned. Focus remains on identifying recurrent savings schemes to support future financial sustainability. As the trust is forecasting to achieve its planned deficit, including the receipt of additional system support funding, cash is forecast to be c. £15m which is £10m ahead of plan, and will not be less than the £5m target at the financial year end.
3	**Review & revise the 2022/25 green plan & align with the group structure by the end of Q2.**	Q1 - Q2 plans to embed the Green plan governance structure and align with group governance. The first sustainability was held in June, where 10 workstreams will provide update reports aligned to our sustainability objectives. Work plan priorities include: waste, active travel, fleet, procurement, estates & facilities, workforce/communications, sustainable care, medicine, digital transformation and adaptation. Q4 plans include a survey of understanding across the Board/EMT and Senior Leadership Group members.

Strategic Objectives 2024/25

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

NHS Gateshead Health NHS Foundation Trust

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

Metric	Target	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Ass/Var	Trend
BREAKTHROUGH OBJECTIVES																	
Increase in the number of digital devices repurposed to the local community	>300				100	100	50	58	0	0	10	0	0	0	0		
Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients by March 2025	>=98%	92.2%	93.4%	91.1%	92.1%	91.6%	92.5%	90.5%	88.8%	91.6%	89.9%	90.0%	86.5%	88.4%	91.7%		
Reduction in the wait for gynaecology outpatients to no more than 26 weeks	<=26	28.1	28.0	39.7	35.9	27.0	37.0	37.0	8.0	34.0	38.0	40.0	39.0	37.0	32.0		
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 by March 2025	<=30	77	76	78	80	81	83	85	82	78	78	72	64	66	65		

Measures requiring focus this month

Measure	Summary
Evidence a reduction in the number of 'fragile' and 'vulnerable' services as a direct outcome of Alliance working	This will be reviewed quarterly as part of the Provider Collaborative Sustainability review. Outputs and products from this work will be reviewed to inform the annual planning process and is contained in the Project Plan for 2024/25 to support planning for 2025/26.
Evidence in an improvement in health inequalities in the key focus areas linked to the determinants of Health for Gateshead	Key determinants of Health for Gateshead are to be defined through the Health Inequalities Group workstream. Evidence/measures and controls will be implemented as part of the focused work to progress in 2024/25.
Increase in the number of digital devices repurposed to the local community	Digital exclusion is where members of the population have inadequate access and capacity to use digital technologies that are essential to participate in society. The risk to this target is that the quantity of devices being made available for recycling and repurposed is dependant on Trust usage and need. This is therefore entirely variable throughout the course of the year. To date in 24/25 318 devices have reached end of life and the Trust will continue to recycle equipment as swiftly and efficiently as possible.
Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients by March 2025	In 2022 the Trust moved from recording smoking status at discharge to recording smoking status on admission (within 6 or 24 hours). This helps care workers understand and support patient needs in managing withdrawal from tobacco and identifying target cohorts of patients who require support from the tobacco dependency treatment service. Smoking status recording on admission increased to 91.7% (1418/1547) from 88.4% (1551/1755) last month. February 2025: 63 patients without a smoking status recorded; 62 patients recorded as unknown / not recorded; 3 patients declined to provide a response.
Reduction in the wait for gynaecology outpatients to no more than 26 weeks by March 2025.	The median wait has continued to decrease since Nov 24 and currently at 32 weeks. Work continues with the clinical team to review OP pathways to maximise opportunity for additional new appointments. New consultant started Jan 25 but we have since received a notice from another consultant leaving in April 25. We are hopeful to appoint into this vacancy but will likely have a gap before commencing employment. Working to mitigate and understand any additional opportunities to manage OP demand. Job plans have been reviewed and signed off with changes enacted to clinic templates and structures to provide additional OP capacity.
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 weeks by March 2025	Current median wait reduced to 65 weeks for February 25 for autism assessment pathways. Slight loss in capacity Jan 25 due to short term absence. Monitoring trajectory on monthly basis. Increase in referrals over recent years for Paeds ASD service which has led to a Capacity and Demand challenge and significant backlog. Overall waiting list size continues to decrease.

Strategic Objectives 2024/25

We will develop and expand our services within and beyond Gateshead

NHS Gateshead Health NHS Foundation Trust

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

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

Metric	Target	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Ass/Var	Trend
LEADING INDICATORS																	
0.5% increase in QEF externally generated turnover	>=0.5%				0.2%	0.0%	0.0%	0.6%	1.0%	0.4%	0.8%	1.0%	1.0%	1.0%	0.0%		

Measures requiring focus this month

Measure	Summary
0.5% increase in QEF externally generated turnover	Current cumulative performance is 6% which is ahead of target plan. Performing well at engagement, VAT consultancy and target more than exceeded. Work ongoing across other areas to increase performance. Additional income received YTD re: VAT consultancy and new NUTH Transportation contract. Work ongoing around additional VAT consultancy and a bid for NUTH transportation services was successful. Discussions ongoing on current contracts to agree extensions where appropriate.

NHS
Gateshead Health
NHS Foundation Trust

Constitutional Standards 2024/25

Reporting Period: February 2025

Constitutional standards 2024/25	Constitutional Standards metrics Assurance Heatmap	

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

Constitutional Standards

Metrics

NHS Gateshead Health NHS Foundation Trust

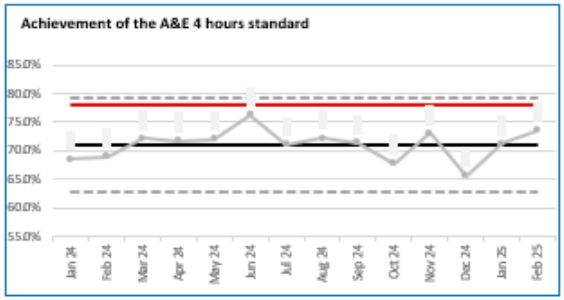
Metric	Target	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Ass/Var
Achievement of the A&E 4 hours standard	>78%	68.6%	69.0%	72.2%	71.8%	72.0%	76.3%	71.0%	72.2%	71.4%	67.8%	73.0%	65.6%	71.2%	73.6%	
12 hour trolley waits (DTA to left department)	0	1	0	0	1	4	0	3	0	0	3	1	30	0	0	
% of ED attendances > 12 hours in department	<2%	7.0%	4.9%	3.6%	3.8%	4.1%	2.3%	5.4%	4.4%	4.4%	7.6%	5.1%	10.5%	5.2%	2.5%	
Ambulance handover delays 30-60 minutes	0	25	1	0	0	2	1	10	4	3	3	10	43	21	4	
Ambulance handover delays 60 minutes +	0	2	0	0	0	0	0	13	0	0	0	1	51	14	0	
Achievement of the RTT 18 week standard	>92%	68.3%	67.8%	67.9%	68.9%	70.6%	70.6%	70.3%	69.2%	68.6%	68.5%	69.2%	69.8%	70.6%	71.3%	
Achievement of the 52 week RTT standard	0	113	112	76	72	109	88	81	108	123	106	111	102	83	66	
Achievement of the 6 week diagnostic standard	>95%	90.0%	92.1%	91.2%	88.8%	86.0%	83.8%	84.7%	84.3%	86.4%	88.3%	86.8%	83.3%	81.4%	86.4%	
Achievement of the Cancer 28 day standard	>77%	75.9%	83.0%	81.1%	79.7%	82.1%	80.7%	80.5%	79.7%	77.7%	82.0%	83.8%	84.8%	77.6%	81.0%	
Achievement of the Cancer 31 day standard	>96%	99.6%	100.0%	97.9%	99.1%	100.0%	100.0%	98.9%	99.8%	100.0%	99.1%	98.5%	98.9%	99.4%		
Achievement of the Cancer 62 day standard	>70%	72.4%	71.2%	73.9%	75.7%	67.6%	71.4%	69.8%	74.7%	67.3%	81.0%	74.8%	75.4%	79.8%		

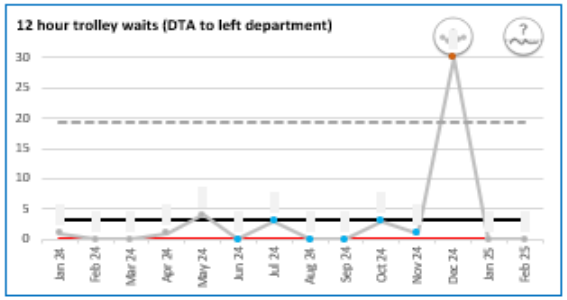
Validated data unavailable at time of report

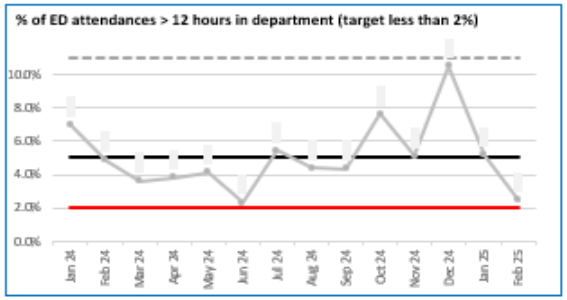
Constitutional Standards

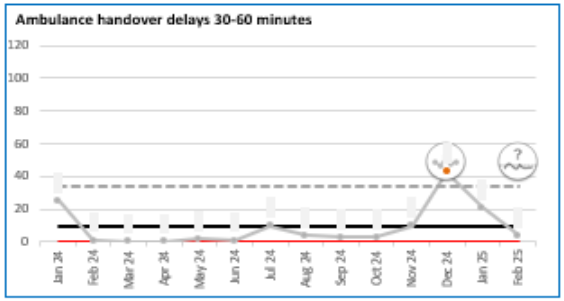
Metrics (SPC)

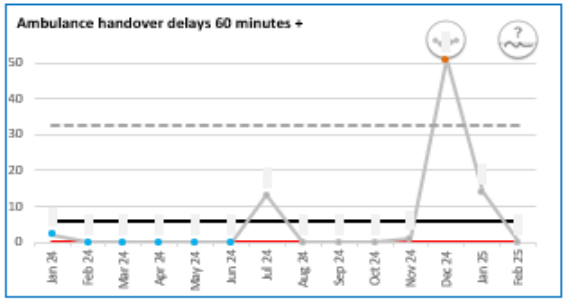
Gateshead Health NHS Foundation Trust

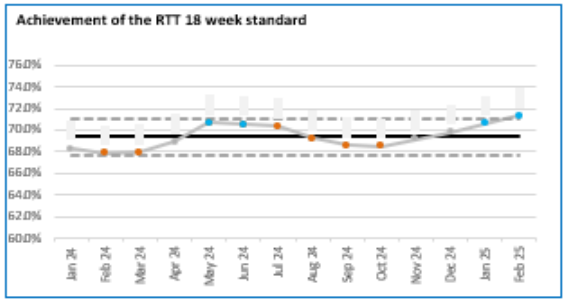


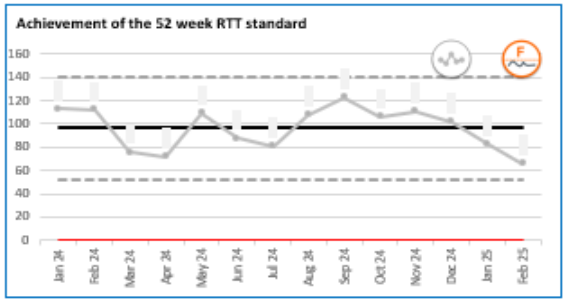


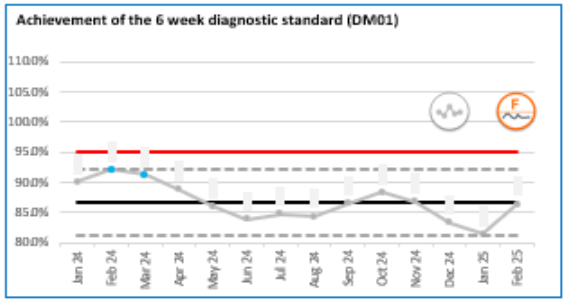


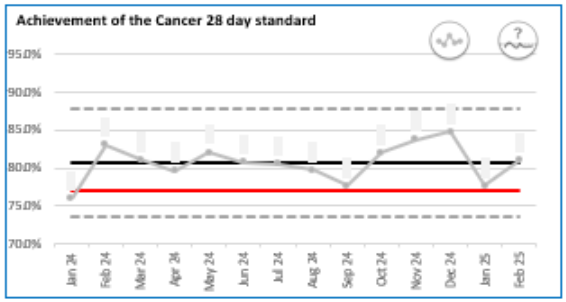


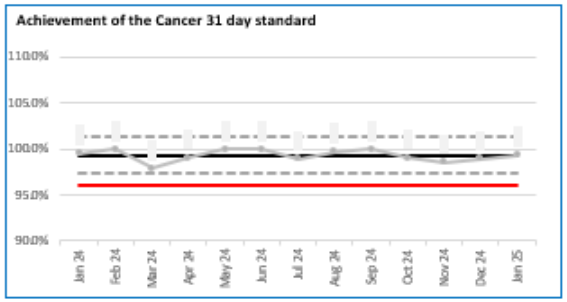


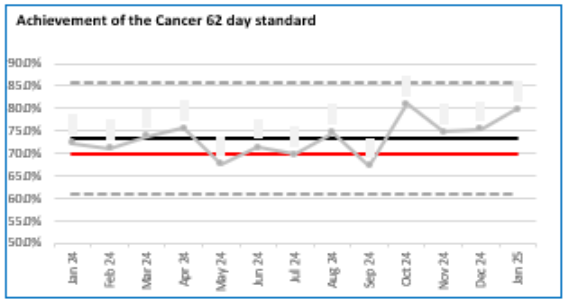












Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 21

Report Title:	**Learning from Deaths – Quarter 3 2024-25**			
Name of Meeting:	Trust Board			
Date of Meeting:	Wednesday 26th March 2025			
Author:	Wendy McFadden – Strategic Lead Clinical Effectiveness			
Executive Sponsor:	Dr Carmen Howey – Group Medical Director			
Report presented by:	Dr Carmen Howey – Group Medical Director			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To provide an overview to the Trust Board of the organisational learning from deaths for quarter 3.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	NA			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	The paper outlines the process for review of deaths within the organisation and the way in which those review processes enable learning from good practice and learning where there is evidence that care could be improved. It should be read together with the Mortality Data report for Q3 and the Medical Examiner report for Q3 to an ensure an understanding of the context and an overview of the mortality related activity within the Trust. There have been recent difficulties with the scheduling of the Mortality Council meetings meaning that review of deaths in that forum has been delayed. Good progress has been made in the review of the deaths of patients with Learning Disability but due to challenges			

	described above re the Mortality Council meetings those cases have not yet received scrutiny in that forum. There remain a significant number of deaths for patients with Serious Mental illness which require review and the plan for this is described. The report describes how other sources of data are triangulated with the information from the mortality review processes to ensure a joined-up understanding of any issues related to patient deaths which would cause us concern. The paper provides partial assurance regarding our internal processes due to the limited number of deaths which have been reviewed through Mortality Council and the number of outstanding SMI deaths which still require specialist review.				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	To receive the paper 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:	*List corporate objective reference and headline – e.g., 1.4 Maximise the use of Nervecentre to improve patient care*				
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)	NA				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Learning from Deaths Report – Quarter 3 2024/25

1 Introduction:

Quarterly board reporting of certain Learning from Deaths mortality data is mandatory. The board should understand the Trust's investigations, learning, and actions implemented in response to deaths. Particular attention should be paid to the deaths of autistic children and young people with a learning disability or mental health condition (*NHS England, The insightful provider board – supporting guidance, December 2024)*.

The Trust's Learning from Deaths policy explains the agreed process for reviewing and learning from deaths across the organisation. The reviews following a three-step process as outlined below:

1. **Medical Examiner review - First level**
   The Medical Examiner team will conduct a first stage review. They will identify whether there is any reason to conduct a more in-depth ward level review by the clinical teams. They will also highlight cases for a Structured Judgement Review by the Mortality Council.

2. **Ward level case note review – Second Level**
   If the first stage review has considered that a clinical or staff incident, a relative enquiry, an element of preventability, (with or without a decrement in care), or any combination of all these, a more in-depth case record review is required. It is expected these reviews will be referred to the relevant specialty team for review. Ideally, these should be carried out within six weeks of notification by the Medical Examiner Team.

3. **Mortality Council Structured Judgement Review**
   The Mortality Council will undertake a structured judgement review of the deaths that are mandated within the National Quality Board guidance:

   - Deaths of people with a learning disability - was autistic and was over 18 years old or had a learning disability and was over 4 years old
   - Deaths of people with severe mental illness (SMI) - all inpatient, outpatient and community patient deaths of people with severe mental illness (SMI) should be subject to case record review. In relation to this requirement, there is currently no single agreed definition in the Learning from Deaths framework which conditions/criteria would constitute SMI. The term is generally restricted to the psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder. It is acknowledged that there is substantive criticism of this definition; personality disorders can be just as severe and disabling, as can severe forms of eating disorders, obsessive compulsive disorder, anxiety disorders and substance misuse problems. The purposes of this policy this apply to the psychoses.
   - Infant or child deaths – these deaths come to the Mortality Council to ensure that Trust have oversight of infant or child deaths, however, they are subject to the child death review process as per the Management of Sudden Unexpected Deaths in Neonates and Children Policy.

- Stillbirths – are reviewed using the Perinatal Mortality Review Tool as per the Maternity Services Risk Management Operational Policy. A quarterly assurance/learning report is provided to the Mortality & Morbidity Steering Group.
- Maternal deaths.
- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision –a significant concern is defined as a formal complaint or a concern raised via the Patient Advice and Liaison Services (PALS) Team.
- All deaths in a service specialty, particular diagnosis or treatment group where an 'alarm' has been raised with the provider through whatever means (for example, via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the Care Quality Commission or another regulator).
- All deaths in areas where people are not expected to die – for example, in certain elective procedures.
- Deaths where learning will inform the provider's existing or planned improvement work.

The deaths are reviewed using the Hogan PRISM 2 level of preventability scale:

Hogan 1 - Definitely not preventable
Hogan 2 – Slight evidence of preventability
Hogan 3 – Possibly preventable less than 50:50
Hogan 4 – Probably preventable more than 50:50
Hogan 5 – Strong evidence preventable
Hogan 6 – Definitely preventable

Also used to assess the quality of care is the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) grading system for case review :

NCEPOD 1 – Good practice
NCEPOD 2 – Room to improve clinical care
NCEPOD 3 – Room to improve organisation of care
NCEPOD 4 – Room to improve clinical care and organisation of care
NCEPOD 5 – Less than satisfactory
NCEPOD 6 – Insufficient data

This newly developed quarterly Learning from Deaths report should be read in conjunction with the Mortality Data Report Quarter 3 2024/25 and the Medical Examiner Report Quarter 3 2024/25.

This report includes learning from ward level reviews an update on the progress with the review of Learning Disability and Severe Mental Illness deaths and learning from Mortality Council review.

2 Learning from Ward Level Reviews:

30 ward level reviews took place in quarter 3, 28 were 'Definitely not preventable' and 2 had 'Slight evidence of preventability', these have been referred by the ward team and the Medical Examiner for a Mortality Council review.

From the quality of care review perspective, 20 deaths were deemed to be 'Good Practice', 5 'Room to improve in clinical care', 3 'Room to improve in the organisation of care' and 2 'Room to improvement in both clinical and organisational care'.

2.1 Themes of good practice identified through Ward Reviews:

- Good communication with families, patient wishes were respected.
- Appropriate discussions with multiple specialities.
- Valuable communication and input at end of life with palliative care team.
- Good family involvement with various specialities.
- Effective discussions around most appropriate place for care and also ceiling of care.

2.2 Learning from Ward Reviews

Reviewing the narrative from ward level reviews did not identify any thematic trends, only the specifics of individual cases shared below. These have been identified and acted on by the wards within their remit at department level.

- **Lengthy waiting time in Emergency Department**

Lengthy waits in the Emergency Department resulted in a poor experience in relation to continence and barriers to using the toilet facilities. This is reflective of the Risk 2969 on our organisational risk register "Risk of a 12 hour wait in ED due to organisational pressures resulting in sub optimal patient care and patient harms".

The following actions are agreed and will be taken forwards within the Urgent and Emergency Care Service Line (Med 1).

- Emergency department team will use an existing screen within the corridor for signage to let patient's /families know that support is available for them should they require toilet / washing facilities during their stay in the department and who is the best person to seek help from.
- Good practice and learning from mortality reviews is already shared with the team via the Band 6 and 7 nursing quality and safety leads. To enhance this the team will create of a SharePoint site to act as a central space to share learning for the team

The following actions are agreed and will be taken forwards within the Medicine & Community Division utilising expertise from corporate partners eg BI and Patient Experience

- Nurse staffing levels in ED are to be triangulated with 4 hour performance data and 12 hour total time in department to give a better understanding of the departmental pressures at time of high demand. This work will feed into the wider organisation activity around the model of care delivery across our front of house services.

- Review of Friends and Family data for trends and narrative regarding patient experience in ED and consider any other means of capturing this information to ensure a greater understanding of how long waits and transformative change to address these impacts on patient experience.

- **Communication and documentation**

A family felt that the update provided to them by the medical team did not give the full picture of what was happening with their loved one. The discussion was not documented with the patient's notes. DNACPR discussions should take place with patients and families on admission when possible and relevant and should be appropriately documented.

Actions agreed:

- The individual team plan to discuss this with the relevant staff to confirm the importance of documenting discussions with families.
- Discussion regarding DNACPR discussion and documentation to continue as part of local and Trust induction.

- **Consent**

Detail on consent form was very limited, did not include record of conversation with relatives or risk of death.

Actions agreed:

- The clinical team have been reminded of the importance of the inclusion of all relevant information on consent forms and the importance of this being accurate and legible.
- Work continues in the Division of Surgery with regard to strengthening the process of informed consent. This will be shared with the Medicine & Community and CSS Divisional SafeCare meetings as consent documentation is relevant for some services within those Divisions.

- **Care and treatment**

Bedside ascitic drain was attempted for symptom improvement however was abandoned due to faeculent aspirant caused by bowel perforation. Bowel perforation did not contribute to death as patient already dying. It was agreed that bedside ascitic drains should only be undertaken for tense ascites. Otherwise, ultrasound guided drains should be considered to avoid the complication seen in this patient

Actions agreed:

- Learning has been shared within the clinical team and will be shared at the next at Divisional Safecare meeting.

Chest x-ray was requested during working hours, carried out in the evening after 5pm and was not reviewed. The report was not made available until after the patient was deceased, however the chest x-ray was available for viewing. This demonstrated air under the diaphragm consistent with perforation of the gastrointestinal tract. The patient would not

have been for surgical intervention but if seen sooner, palliative measures would have been able to be put in place sooner.

Actions agreed:

- The ward is implementing a 17:00 handover between doctors and nursing staff as a safety net for outstanding results that need to be chased. This will allow nurses to escalate to doctors on call if they have not had any communication regarding outstanding results.

Learning from the two Hogan 2 cases will be included in a future report on completion of the Mortality Council review.

3 Learning from Mortality Council

The Mortality Council is the designated group with delegated responsibility from the Mortality & Morbidity Steering Group to undertake – Enhanced Mortality Structured Judgement Reviews. It is chaired by the Associate Medical Director for Quality & Safety and is attended by a range of senior clinicians, including SafeCare Leads and Medical Examiners. The Council is also supported by clinical effectiveness, patient safety, safeguarding and legal team representatives.

For the period 1st October to 31st December 2024, one Mortality Council meeting took place in October 2024. The meetings scheduled for November and December 2024 were stood down due to the unavailability of the chair, as a result of annual leave and sickness. The meeting planned for January 2025 was also cancelled as the Associate Medical Director for Quality and Safety stood down from the role, the process for the replacement is currently underway. Several other options were explored in an effort to proceed with the meeting; however, these were all unsuccessful.

Seven deaths were reviewed at the October meeting, the outcomes of which are below:

Hogan 1 – Definitely not preventable	6
Hogan 4 – Probably preventable – more than 50:50	1

NCEPOD 1 – Good practice	5
NCEPOD 4 – Room to improve clinical and organisational	2

3.1 Summary of Hogan 4 / NCEPOD 4:

This patient was referred to the Mortality Council by the Medical Examiner and also flagged due to being entered as a ‘fatal’ patient safety incident on Inphase.

The patient was admitted with reduced urinary output and was thought to be in urinary retention with a background of metastatic lung malignancy. Patient was on EAU and was felt to be intravascularly dry and so intravenous fluid were prescribed. They were also felt to be slightly constipated and so laxatives also prescribed. On day two they were found to have haematuria and an Hb drop from 126 on admission to 76.

The following day they deteriorated clinically and at the time of medical review had a Hb of 54 and a lactate above 10. There was had no overt evidence of gastrointestinal bleeding

but did have ongoing haematuria however it was not felt enough to explain the drop in Hb. They were too unwell to be transferred for a CT scan at the time and passed away not long after the clinical deterioration. As the cause of death was unclear, the patient was referred to the coroner.

- Issues were identified with relation to missed opportunities to acknowledge and act on significant blood results.
- Escalation of the patient's deterioration was not recognised or acted on appropriately and concerns were raised around the interactions with NerveCentre.
- Issues were raised with regard to reduced medical staffing levels creating vulnerability out of hours.
- The outcome from the Mortality Council was shared at the Executive Safety Panel where the decision to commission a Patient Safety Incident Investigation (PSII) was made.
- The family are being supported through the PSII by Family Liaison Officers and this will come back to Executive Safety Panel for sign off.

3.2 Thematic Learning from Mortality Council Reviews

- **Documentation** - being recorded in multiple places has been identified as a theme in multiple Mortality Council discussions. Care is documented on paper in the green notes, on electronic system such as Careflow, NerveCentre. There is no consistency across the organisation. Some areas only using NerveCentre, some only using paper notes, some using both. This may adversely impact patient outcomes as the primary purpose of a patient record, whether handwritten or digital, is to support direct patient care. All records must be clear, complete, accurate, up-to-date, and legible. This reflects the impact of the organisational Risk 4402 "Risk of breaching legislative requirements due to lack of long-term strategic approach to the management and storage of health records (both paper and digital) which could lead to regulatory and reputational harm" in relation to patient care and the broader organisational review of deaths.

- **Emergency Health Care Plans (EHCP)** – it was identified that increasingly patients are admitted to hospital contrary to their wishes expressed within their EHCP for various reasons. The admissions are potentially avoidable, and patients are not remaining in their preferred place of care. This was shared with the Emergency Health Care Plan Programme via one of the members of the Mortality Council. The summary and key pieces of work within this programme are:

  "Gateshead is seeing multiple patients with repeated emergency admissions in their last year of life. Patients are dying with greater complexity. Multiple systematic reviews have demonstrated that residential and palliative care input, are able to significantly reduce unplanned readmissions. The aim of the programme is to reduce avoidable hospital admissions to hospital and allow the patient to remain in their preferred place of care. A number of key deliverables have been identified:-

  - Stakeholder events to review challenges and barriers in this area
  - Targeted intervention with specialist input in community
  - Promote palliative care register and palliative care GP meetings
  - Reduce the number of deaths in hospital from care home admissions
  - Reduce numbers of unplanned admissions to hospital
  - Increase in numbers having preferred place of care/death recorded and achieved

- Increase in number and quality of EHCPs
- Develop a multi-agency EHCP education plan

The Emergency Health Care Plan Programme is being led by the Transformation Team with Jo Halliwell as the SRO and clinical leadership provided by Dr Anna Porteous Palliative Care Consultant and Dr Helena Maddock Care of the Elderly Consultant. This programme is due to complete by April 2025.

3.3 Good Practice Identified from Mortality Council Reviews

- Good practice was identified for reasonable adjustments made for patients with learning disabilities from a case discussed in October 2024;
    - A mother and daughter were both in hospital at the same time, the daughter was very poorly, it was made possible for them both to be moved to the same ward in the same room, to be together at the daughter's end of life.
    - There was quick recognition of a patient's deterioration, as a result good discussions took place with the family about the treatment options available.

3.4 Learning Disabilities deaths

The Mortality Data report highlights that the deaths of 16 patients with a learning disability are to be reviewed. All of these reviews have now been completed by the Learning Disability Lead Nurses, however, have not been reviewed by the Mortality Council due to lack of meetings. They will be scheduled onto agendas commencing in February 2025.

3.5 Severe Mental Illness deaths

The Mortality Data report also highlighted that the deaths of 20 patients with a Severe Mental Illness diagnosis are to be reviewed. Three of these have since been reviewed by the Older Person's Mental Health Team, however, have not been reviewed by the Mortality Council due to lack of meetings. The three reviewed are scheduled for review at the April meeting which is the next time the mental health specialist is available to attend. The remaining 17 will be worked through with a view to adding three to each Mortality Council from April onwards.

4 Triangulation of mortality data and learning

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

- Any potential patient safety incidents identified during the course of the medical examiner scrutiny are highlighted either to the treating team to report an incident via Inphase or in some cases the Inphase is completed by the Medical Examiner Office.
- The Patient Safety Team is represented on the Mortality Council to ensure that any deaths deemed to be a Hogan 4 are managed appropriately in terms of commissioning a PSII.
- Deaths referred to the coroner which have the potential to progress to an inquest are shared with the Legal Team by the Medical Examiner Office.
- For deaths reviewed by the Mortality Council, information is obtained in advance of the meeting in relation complaints/PALs, patient safety, legal and safeguarding, to ensure that the full picture is available for the discussion.

- Formal Complaints received from relatives/carers of the deceased are shared by the complaints team for discussion at the Mortality Council.
- Outcomes and learning from Inquests for individual patients are presented to the Mortality Council.
- A quarterly learning summary from the Mortality Council is developed and shared throughout the organisation.
- Learning from Mortality Council is also shared via Divisional SafeCare Meetings and the Learning Panel.

It is notable that some of the themes from Ward Level reviews and Mortality council Reviews reflect risks already recognised in our organisational risk register, namely Risk 2969 on our organisational risk register "Risk of a 12 hour wait in ED due to organisational pressures resulting in sub optimal patient care and patient harms" and Risk 4402 "Risk of breaching legislative requirements due to lack of long-term strategic approach to the management and storage of health records (both paper and digital) which could lead to regulatory and reputational harm"

5 Summary

This paper gives partial assurance in relation to the organisation's infrastructure for reviewing and learning from deaths.

It has been challenging to conduct Mortality Councils throughout quarter 3 and has continued into quarter 4. This has been caused by the inability to secure a chair for the meeting. This generates a backlog of cases to be reviewed and opportunities to identify learning and escalate any relevant cases into other governance processes e.g. patient safety and patient experience.

A Hogan 4 was identified by the Mortality Council in quarter 3, the detail in the paper provides assurance that this was acted on and escalated through the organisation's governance processes appropriately.

Good practice in both ward level mortality reviews and Mortality Council reviews has been identified. Learning from Ward Level reviews is actioned and shared within Division and across Divisions where this is appropriate.

Learning arising from the Mortality Council reviews is already known to the organisation and actions are in progress.

6 Recommendation

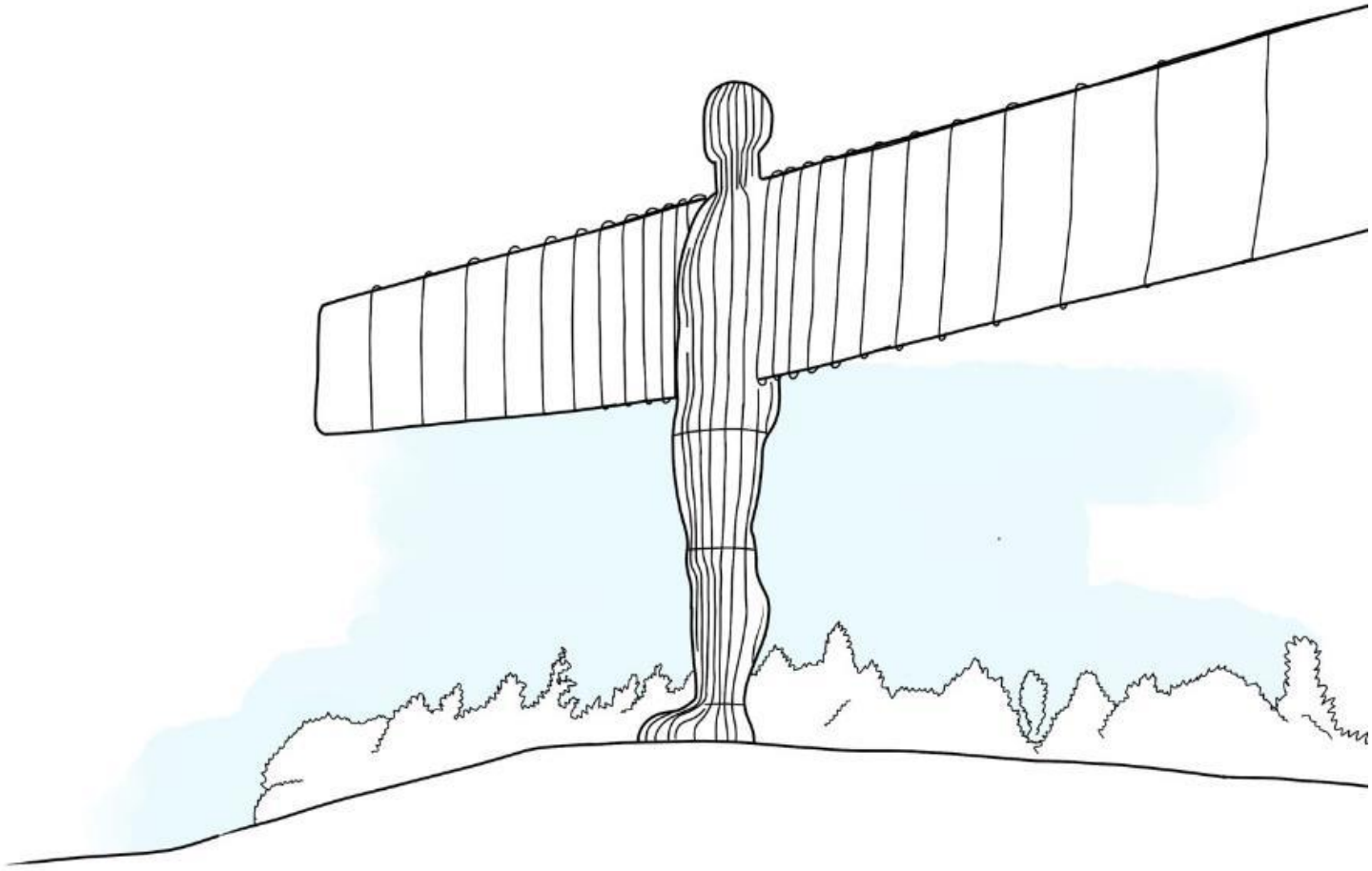
The Steering Group is asked to receive this paper for information and assurance.

NHS
Gateshead Health
NHS Foundation Trust

Mortality Data Report

Quarter 3 2024-25

This report should be read in conjunction with the Learning from Deaths Report



How to interpret the SPC icons and charts

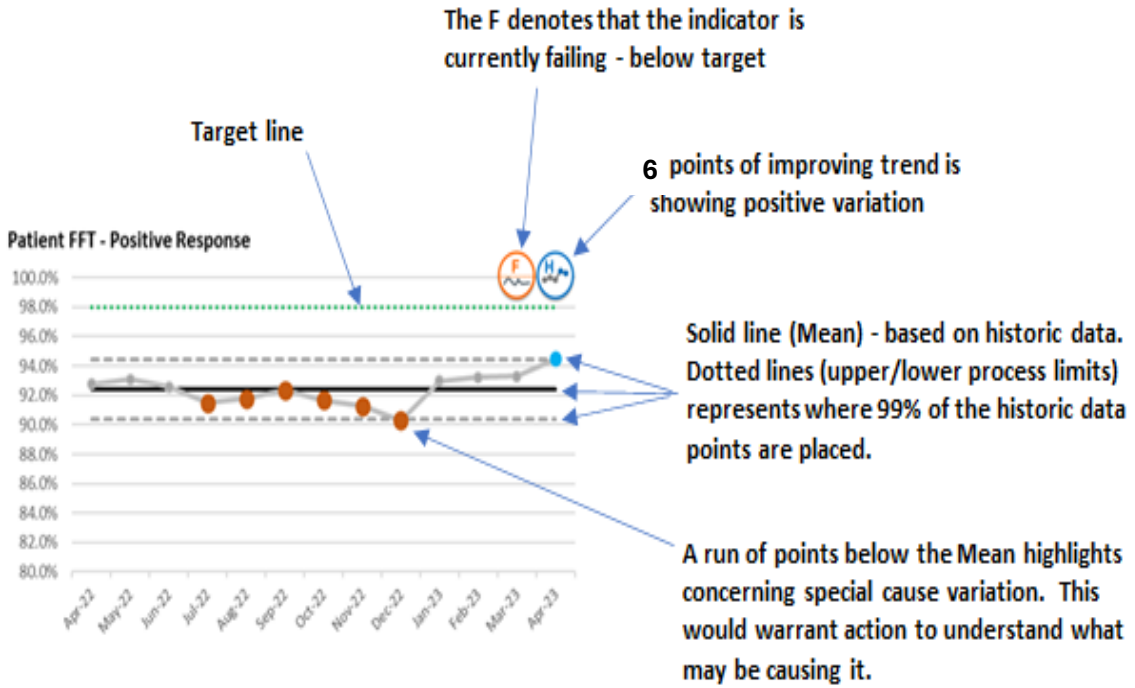
NHS Gateshead Health NHS Foundation Trust

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

What are Statistical Process Control (SPC) charts

This report should be read in conjunction with the Learning from Deaths Report

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



SPC Rules

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

Icon Colours Explained

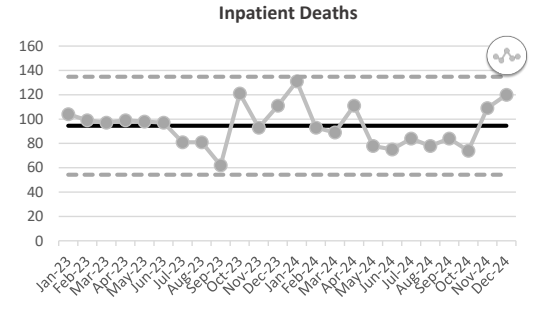
Variation icons: Orange indicates concerning special cause variation requiring action. Blue indicates where improvement appears to lie, and Grey indicates no significant change (common cause variation).

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

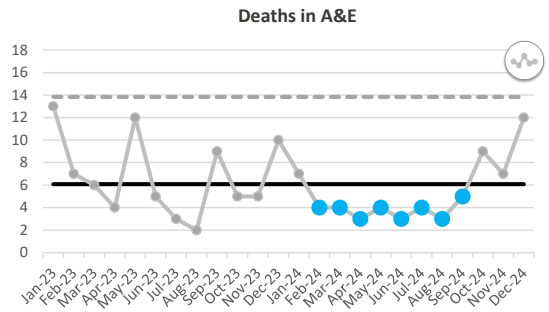
Mortality Data Report - Quarter 3 2024-25

NHS Gateshead Health NHS Foundation Trust

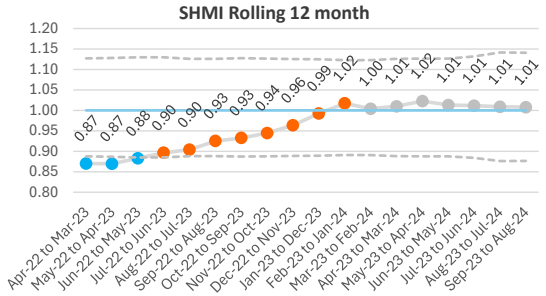
303 inpatient deaths in Q3 2024-25 compared to 325 for the equivalent period last year. Common cause variation observed.



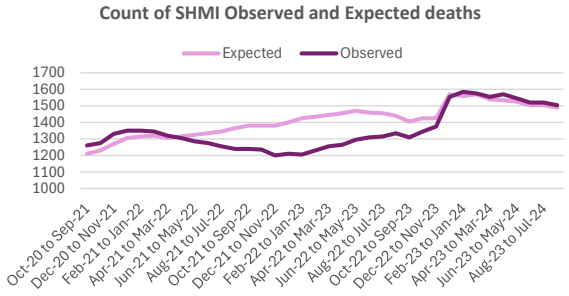
28 deaths in the A&E department in Q3 2024-25 compared to 20 for the equivalent period last year. Common cause variation observed in Q3 following a period of low volumes of A&E deaths between April and September 2024.



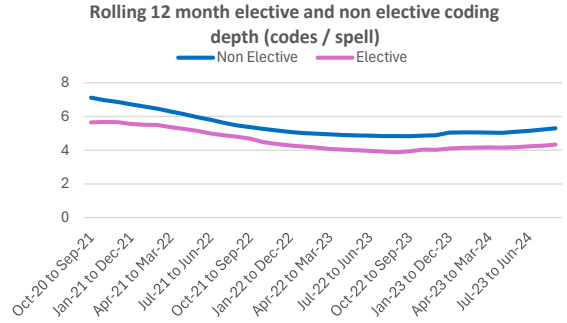
The SHMI remains stable since the period ending February 2024. Prior to this the SHMI had been lower than expected followed by an increasing trend.



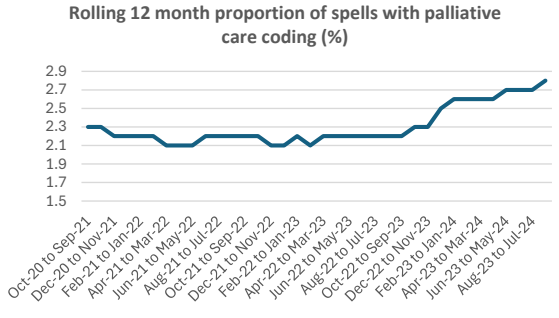
Observed mortality is closely aligned to the expected mortality in recent months (hence the SHMI score close to 1.00). The number of expected and observed deaths shows a general decline as SDEC activity is removed progressively from the rolling 12 month period from May 2024.



A general decline is noted in the coding depth for both elective and non elective admissions. The Trusts coding depth is lower than the England average.



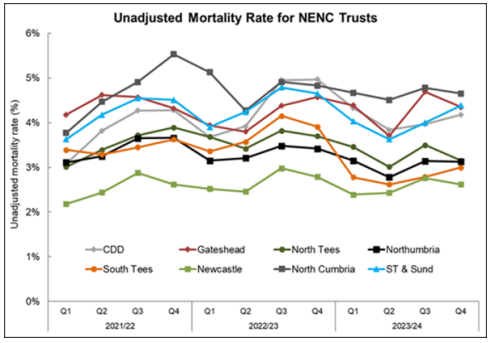
A general increase is observed in the proportion of spells with palliative care coding recorded. 2.8% of spells had a palliative care code compared to 2.1% for England.



Mortality Alerts from HED remain for the cancer diagnostic groups that the Trust routinely alerts. Patients with a cancer diagnosis receive curative treatments at neighbouring Trusts. In addition, the SHMI does not risk adjust for palliative coding which may account for Gateshead having higher observed figures compared to expected. The majority of cases have been scored and all those scored were recorded as 'Definitely not preventable' and' Good Practice'.

	Alert	CCS Diagnostic Group	Period	Observed Deaths	Expected Deaths	Obs -Exp	SHMI CUSUM Score	% Reviewed (where death within Trust)	% Definitely not preventable	% NCEPOD Good Practice
	SHMI	Cancer of the colon	Oct 2023 to Sep 2024	35 (27 in hospital)	18.2	16.8	192.3	92.6%	100%	100%
	SHMI	Cancer of bronchus; lung	Oct 2023 to Sep 2024	69 (50 in hospital)	44.3	24.7	155.8	96.0%	100%	100%

The unadjusted mortality rate varies between trusts and quarters from 2.3% to 5.5% across the period July 2021 to June 2024 with a range of 2.3% to 4.6% in the latest period. The unadjusted rate includes all deaths in hospital plus deaths within 30 days of discharge; the rates are not strictly comparable between trust.

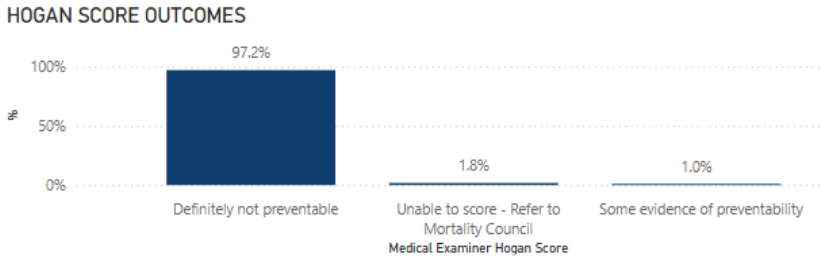


Mortality Data Report - Quarter 3 2024-25

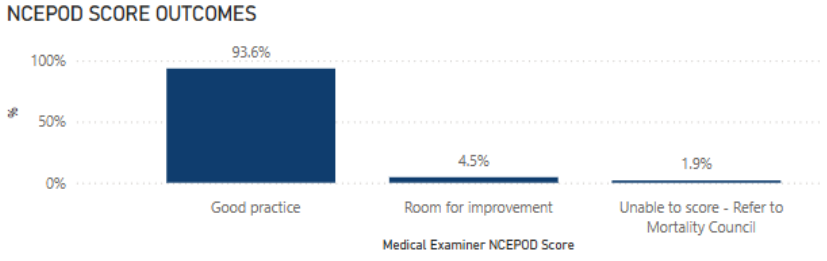
NHS Gateshead Health NHS Foundation Trust

Medical Examiner Scrutiny: January 2024 to December 2024

Medical Examiner Hogan Score	Count
Definitely not preventable	1141
Unable to score - Refer to Mortality Council	21
	17
Some evidence of preventability	12
Total	**1191**

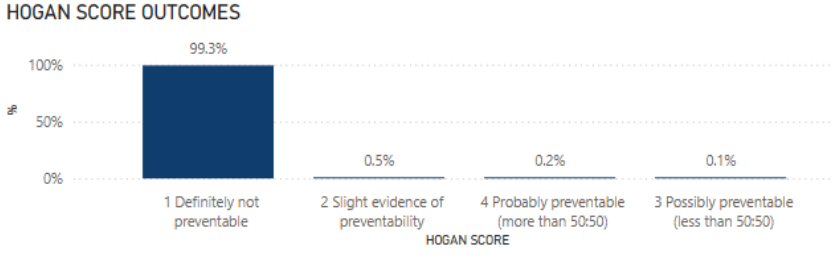


Medical Examiner NCEPOD Score	Count
Good practice	1096
Room for improvement	53
Unable to score - Refer to Mortality Council	22
	20
Total	**1191**

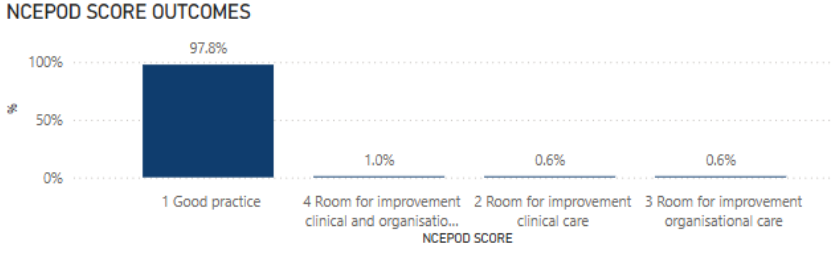


Outcomes from all levels of mortality review (ME Scrutiny, Ward reviews and Mortality Council reviews) in the period:
99.0%Definitely not preventable. 97.2% Good Practice.
2 deaths (0.2%) were identified as possibly preventable (more than 50:50).

HOGAN SCORE	Count
1 Definitely not preventable	1080
2 Slight evidence of preventability	5
3 Possibly preventable (less than 50:50)	1
4 Probably preventable (more than 50:50)	2
Awaiting Mortality Council Review	65
Awaiting Ward Team Review	25
Not reviewed / scored	13
Total	**1191**



NCEPOD SCORE	Count
1 Good Practice	1064
2 Room for improvement clinical care	7
3 Room for improvement organisational care	6
4 Room for improvement clinical and organisational care	11
Awaiting Mortality Council Review	65
Awaiting Ward Team Review	25
Not reviewed / scored	13
Total	**1191**



Mortality Data Report - Quarter 3 2024-25

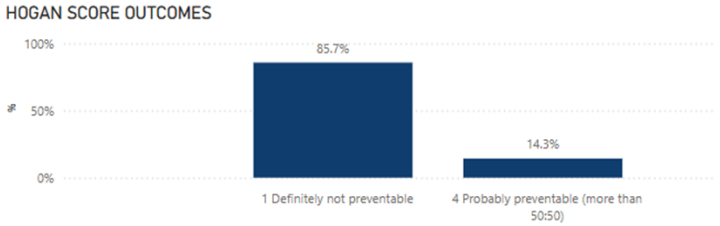
NHS Gateshead Health NHS Foundation Trust

Mortality Council Reviews in Q3

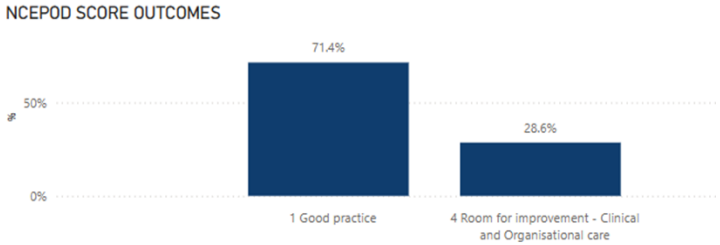
7 cases reviewed and scored by Mortality council in the quarter.

6 cases identified as 'Definitely not preventable' and 1 case identified as 'Probably preventable (more than 50:50)

Mortality Council Hogan Score	Count
1 Definitely not preventable	6
4 Probably preventable (more than 50:50)	1
Total	**7**



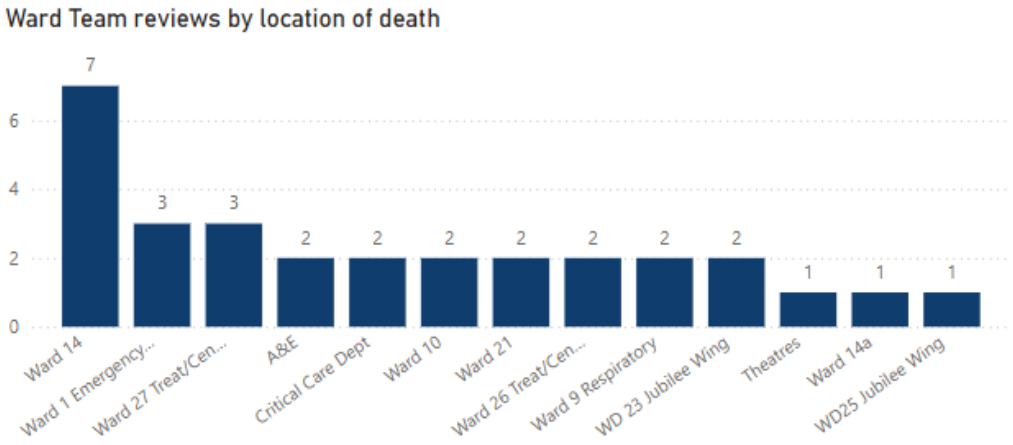
Mortality Council NCEPOD Score	Count
1 Good practice	5
4 Room for improvement - Clinical and Organisational care	2
Total	**7**



30 ward level reviews were underataken in the quarter.

The chart below shows the reviews by location of death, however reviews were undertaken by the appropriate clinical staff.

Ward	Count
A&E	2
Critical Care Dept	2
Theatres	1
Ward 1 Emergency Admission Unit	3
Ward 10	2
Ward 14	7
Ward 14a	1
Ward 21	2
Ward 26 Treat/Centre	2
Ward 27 Treat/Centre	3
Ward 9 Respiratory	2
WD 23 Jubilee Wing	2
WD25 Jubilee Wing	1
Total	**30**

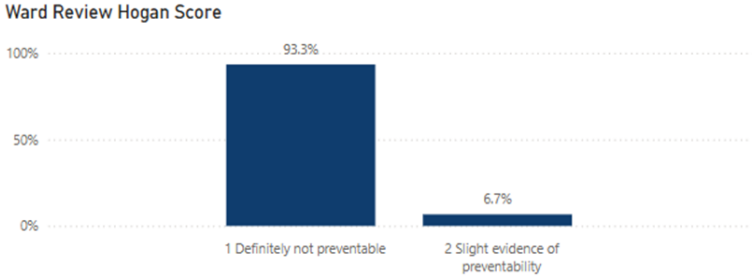


Mortality Data Report - Quarter 3 2024-25

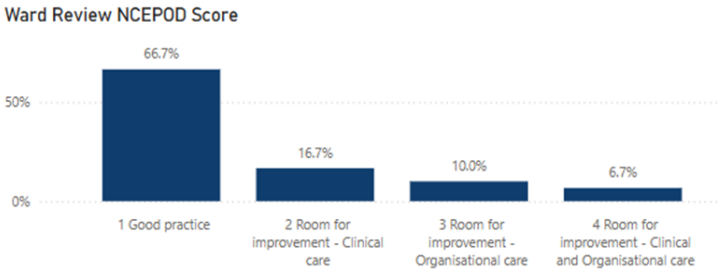
NHS Gateshead Health NHS Foundation Trust

Outcomes from Ward reviews in the period.
30 Ward level reviews in the quarter. Slight evidence of preventability identified in 2 cases, to be escalated to mortality council.
Room for improvement identified in 10 cases.

Ward Review Hogan Score	Count
1 Definitely not preventable	28
2 Slight evidence of preventability	2
Total	**30**

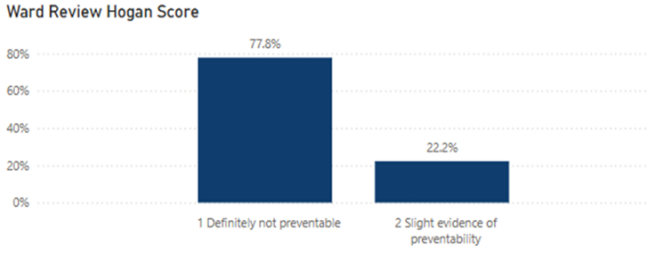


Ward NCEPOD Score	Count
1 Good practice	20
2 Room for improvement - Clinical care	5
3 Room for improvement - Organisational care	3
4 Room for improvement - Clinical and Organisational care	2
Total	**30**

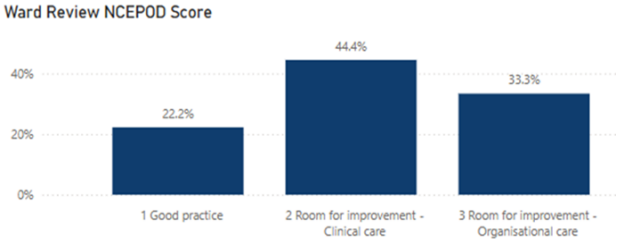


Medical Examiner Referrals to the Ward
9 cases reviewed were as a response to being referred by the Medical Examiner. Slight evidence of preventability identified in 2 cases, to be escalated to mortality council.
Room for improvement identified in 7 cases. 51 cases outstanding to the end of Q3.

Ward Review Hogan Score	Count
1 Definitely not preventable	7
2 Slight evidence of preventability	2
Total	**9**



Ward NCEPOD Score	Count
1 Good practice	2
2 Room for improvement - Clinical care	4
3 Room for improvement - Organisational care	3
Total	**9**



Mortality Data Report - Quarter 3 2024-25

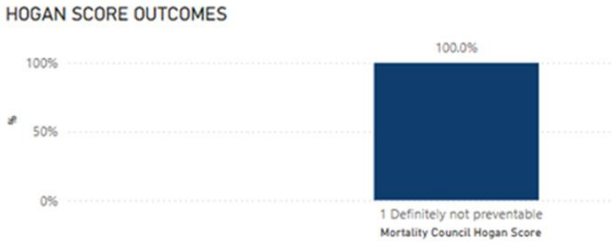
NHS Gateshead Health NHS Foundation Trust

Learning disability deaths

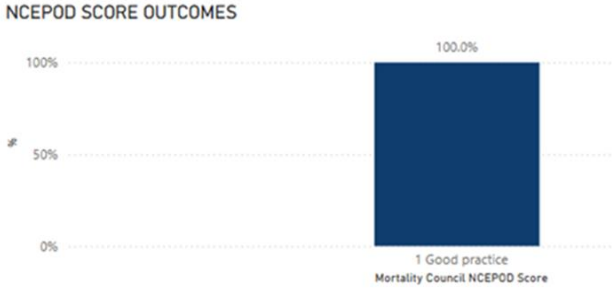
3 Learning disability deaths reviewed in quarter 3 2024-25.

16 cases remain outstanding at the end of quarter 3.

Mortality Council Hogan Score	Count
1 Definitely not preventable	3
Total	**3**



Mortality Council NCEPOD Score	Count
1 Good practice	3
Total	**3**



Severe Mental Illness deaths

Zero SMI deaths reviewed in Q3 2-24-25.

20 cases outstanding at the end of the quarter

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 21ii

Report Title:	**Medical Examiner quarterly report October 24 – January 25**			
Name of Meeting:	Trust Board			
Date of Meeting:	26th March 2025			
Author:	Dr Vanessa Linnett			
Executive Sponsor:	Dr Carmen Howey			
Report presented by:	Dr Carmen Howey			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	1. To provide assurance to GHNT as the host employer in relation to the activity of the Medical Examiner Office in line with legislation and NHSE guidance. 2. To provide information to the Trust of findings from medical examiner scrutiny relating to the care of Trust patients			
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*	• Quality and safety - 7 patients were thought by a Medical Examiner to have had a possibly preventable death whilst in the care of Gateshead NHS Foundation Trust in the period between October 24 and December 2024. • Governance and legal - Gateshead NHS Foundation Trust is breaching NHS England guidance as the host of the Gateshead ME by using Medical Examiner Officer resource to support the delivery of the Bereavement Service.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	Ensure that Gateshead NHS Foundation Trust has robust processes in place for learning from deaths in a timely manner that results in an improvement in knowledge and practice by clinical staff who have been involved in			

<table>
<tr><td></td><td colspan="5">preventable deaths, and those who will be involved in the care of similar patients in the future.

Ensure that Gateshead NHS Foundation Trust is compliant with NHS England guidance that host Trusts should not prescribe budgets or ways of working that adversely affect the operation of the medical examiner office.
Consider how the risk in relation to legislative guidance can be mitigated or fully addressed if possible.
Commit to ensuring that the ME Office is able to operate with independence whilst being part of a wider host organisation.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☐</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☐</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="4">We will 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"></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">Several deaths may have been prevented by earlier diagnosis and treatment
GHNFT is in breach of NHS England guidance as host of the Medical Examiner service.</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>

Medical Examiner Q3 Report

1. Introduction

1.1 The Medical Examiner service

A Medical Examiner service has been in place at the Queen Elizabeth Hospital since September 2020, but prior to 9th September 2024 was a non-statutory process. Since then, it has been a statutory process throughout England, and applies to all deaths not investigated by the coroner.

This report covers the first quarter since the Medical Examiner process became statutory.

1.2 The role of the Medical Examiner

Medical examiners, supported by medical examiner officers, review medical records of deaths not already referred to the coroner and interact with attending practitioners (AP) and bereaved people to address 3 key questions:

- what did the person die from? Ensuring accuracy of the AP Medical Certificate of Cause of Death (MCCD)
- does the death need to be reported to a coroner? Ensuring timely and accurate notification in line with statutory requirements and guidance
- are there any clinical governance concerns? Ensuring the relevant referral is made where appropriate

The responsibilities of medical examiners are governed by the Coroners and Justice Act 2009, the Medical Examiners (England) Regulations 2024, the Medical Examiners (Wales) Regulations 2024 and the Medical Certificate of Cause of Death Regulations 2024.
The regulations require medical examiners to:

1. provide independent scrutiny of the causes of death, in line with statute and this guidance. This means they must carry out a proportionate review of medical records.
2. make whatever enquiries appear to be necessary to confirm or establish the cause of death.
3. send completed MCCDs to register offices, once the cause of death has been established.
4. should they detect concerns about care, refer such cases as appropriate to established clinical governance review processes and/or notify the coroner or police when appropriate. The ME should provide adequate information about what the concerns are for the relevant organisation to investigate, but do not undertake an investigation themselves.

The Trust currently employs a Lead Medical Examiner and 8 other Medical Examiners (some are also employed by the Trust for their other clinical roles, others are only employed by the Trust as medical examiners), providing 8 4-hour sessions a week, and scrutinises all deaths in the Gateshead area which have not already been investigated by the coroner.

1.3 The role of the Medical Examiner Officer

Medical examiner officers manage cases from initial notification by the attending physician following a death, through to completion and communication with the registrar. They are essential for the effective, efficient and consistent operation of the medical examiner system. Medical examiner officers provide a constant presence in the office,

unlike medical examiners who usually work in the role part-time and come from a range of specialties.

Medical examiner officers support medical examiners by obtaining and carrying out a preliminary review of all relevant medical records (and additional details where required) to develop a case file setting out the circumstances of each death. This requires work with coroner's offices, registrars, bereavement services, complaints managers and legal services. Over time, with experience and training, they can support medical examiners in determining causes of death and identifying the need for coroner notification.

Medical examiner officers are well-placed to identify patterns and trends, and to act as a source of expert guidance to all users of the medical examiner system.

Medical examiner officers can carry out the following tasks on behalf of medical examiners:

1. reviewing the causes of death proposed by the attending practitioner and whether the coroner needs to be notified
2. asking bereaved people whether they have questions about the cause of death or concerns about the patient's care before death

The medical examiner officer must keep a written record of all such interactions, and the medical examiner must review this before signing their declaration on AP MCCD or Medical Examiner Medical Certificate of Cause of Death (ME MCCD).

The Trust currently employs a Lead Medical Examiner Officer and 3 other medical examiner officers, currently providing 2.64 whole time equivalent staff.

The Medical Examiner team duties start on receiving a referral from an Attending Practitioner (AP) following a death. It is the duty of the clinical teams to notify the ME team, although for hospital patients this service is supported by the Bereavement Team, who identify hospital deaths and an Attending Physician to complete the MCCD and ME referral.

Once the family have been spoken to by the ME or MEO, their information is passed to the Bereavement Team, who speak to them and provide them with support and information relating to the registration of death, and other legal processes.

In the absence of a member of the Bereavement Team who is able to undertake these Bereavement Team duties, the MEOs have been providing this additional support, although National Guidance advises against this.

2. Activity of the Medical Examiner service for Q3

There were 604 deaths scrutinised by the ME team in quarter 3.

The time taken for completion of ME scrutiny from referral to sending the MCCD was one day on average, compared to a regional average of two to three days.

There were four requests by families for early Medical Examiner scrutiny and issue of MCCD, which was achieved for all requests.

3. Medical Examiner scrutiny findings for Q3

Quarter 3 October – December 24

QE Deaths reviewed by the Medical Examiner Service

	QE deaths - Number scrutinised	QE deaths - Not scrutinised	QE deaths accepted by coroner	Community referrals	Total deaths scrutinised
October	83	0	2	78	165
November	116	0	9	90	206
December	131	0	11	102	233

There has been a high number of deaths in the QE during the months of November and December but this is reflected throughout the hospitals in the region and nationally, and is also reflected in the number of hospital admissions.

All the deaths in this period received scrutiny by a Medical Examiner (although this is not necessary for deaths already reported to the coroner). 22 deaths have been referred to the coroner and accepted by him for investigation. 7 deaths were felt by the Medical Examiner to have possibly been preventable.

Many deaths get referred to the coroner, but a CN1A is issued, which means the coroner does not need to investigate. The reasons for referrals to the coroner where the coroner has decided to investigate are listed below.

Referral to the coroner:

Unknown / self neglect	2
Occupational illness	2
Death due to illegal drug use	1
Unclear cause of death	6
Inpatient #NoF with delayed diagnosis	1
Septic arthritis, delayed diagnosis	1
Possible PE after recent trauma	1
Death after fall and # pelvis	1
Sepsis possibly 2' elective lap chole	1
Unwell, not escalated, unclear cause of death	1
Family concerns about community care neglect	1
Missed diagnosis of myxoedema	1
Anticoagulation and trauma	1
Family concerns	1
Death from complications of necessary surgery	1

Referral to Mortality Council

Where significant concerns have been raised during ME scrutiny, or by the family, or where a mortality review is required for other reasons for example where the death is one which requires review as per the National Quality Board Guidance (see Learning from Deaths report for detail), the following patients death has been referred to mortality council. The medical examiner notes whether they think the death may possibly have been preventable. The table below lists the deaths referred to the mortality council by the medical examiner.

Concern	Preventability of death	Coroner involvement and comments
Missed diagnosis	Possibly	Coroner
Delayed diagnosis	Possibly	Coroner Family concerns
Inpatient #NoF with delayed diagnosis	Possibly	Coroner Family concerns
Escalation of treatment	Possibly	Coroner
Multiple admissions, multiple hospitals, possible delay to treatment	Possibly	Family concerns
Palliated when possibly could have recovered.	Possibly	Family concerns
Escalation of treatment	Possibly, but need PM to know	Coroner
Death after elective surgery	Difficult to say, needs PM and input from surgeons	Coroner
Death after elective surgery	Difficult to say, coroner issued CN1A, (no further investigation)	CN1A
Possible delayed diagnosis and treatment	Difficult to say. Not referred to coroner.	
Multiple admissions with ongoing sepsis	Not preventable	Family concerns
Severe mental illness	Not preventable	
Learning disability	Not preventable	
LD and family concerns	Not preventable	
Unexpected child death	Not preventable	
Status epilepticus management	Not preventable	Referred to coroner due to family concerns

As far as it's possible to identify any theme from the Medical Examiner scrutiny, from the deaths scrutinised in Quarter 3, it is that most concerns about preventability relate to delayed or missed diagnoses and escalation of treatment. Concerns do not relate to treatment that has been given. The concerns do not relate to a particular area or specialty.

In addition to referrals to the mortality council, feedback is often given to clinical teams that have looked after a patient, either via the named consultant or ward manager, depending on what concerns have been raised. This often relates to feedback from families around quality of care, rather than preventability, for example around nursing care.

4. Function of the ME service and compliance with NHS England Guidance

NHS England » National Medical Examiner's guidance for England and Wales

The role of the Medical Examiner service is set out in law. The NHS England National Medical Examiner's guidance (link attached) gives a summary of how the service works, including the role of host organisations.

Of relevance to the host organisation are the following sections:

- *NHS bodies that employ medical examiners and officers must respect and support their independence. They should not prescribe budgets, ways of working or other matters that adversely affect the independent scrutiny provided by medical examiners or the operation of the medical examiner office*

- *NHS bodies that host medical examiner offices and those that may fund them, such as integrated care boards (ICBs) in England, must ensure that resources allocated for medical examiner offices are fully available.*

- *Medical examiners must be able to exercise their professional judgement independently and be seen to do so,*

- *NHS bodies employing medical examiners and officers must not request or require them to carry out other work that conflicts with statutory medical examiner duties or inhibits fulfilment of those duties.*

- *Some NHS trusts have considered combining medical examiner officer duties with other roles. This is not supported. Resources are provided to NHS bodies on the basis that they facilitate medical examiner activity, and operational arrangements at NHS bodies employing medical examiners must support their independent role.*

- *Medical examiners must carefully consider whether any position or office they hold could reasonably be judged to conflict with their duty to provide independent scrutiny of deaths and their responsibility to reach objective decisions about whether to escalate matters such as trends and concerns about care.*

Within Gateshead NHS Foundation Trust there has been a challenge in relation to the staffing of the Bereavement Team and an expectation that Medical Examiner Officers offer support to families that would usually be delivered by the Bereavement Team. Currently the Bereavement Service provides a partial service, which doesn't include phone calls to assist the bereaved with the processes around registration of death. The risk to the organisation of MEOs filling that gap and thus potentially being in breach of the above legislative guidance is one that needs to be highlighted and addressed.

The ME team have funding allocated from NHS England, and need to be permitted to use this funding flexibly for ME team staff when demand is high, within the Medical Examiner budget. Recent discussion with the Group Medical Director has led to agreement that when MEO staff have worked additional hours to meet the peak in demand seen at the end of Q3 and into January 2025 this can be recompensed through TOIL where possible or overtime when that can be paid from within the ME Office budget and without recourse to other organisational funding.

The ME team and Gateshead NHSFT also need to be aware of how conflicts of interest may arise with different roles that MEs fulfil within the Trust, or with local supervising bodies. Medical examiners cannot be involved with mortality reviews for patients they have been the ME for, and need to consider how any Trust governance roles, or external supervision or governance roles, may conflict with the need for independence as MEs.

5.Solutions / recommendations

The Trust must have clear processes in place to undertake learning from deaths in a timely and effective manner, when preventability has been identified as contributing to deaths. This needs to lead to changes in knowledge and practice by clinical teams who have looked after the patient, and those who will look after similar patients in future.

The Group is asked to receive this report with partial assurance that the work of the Medical Examiner's Office is being carried out in accordance with the legislative requirements.

The organisational risk in relation to potential breach of the legislative guidance regarding supporting the gaps in the bereavement team needs to be considered and addressed.

It is important that the function of the ME service is recognised as being independent of other Trust governance processes or activity, to give patients and families the confidence that an ME review is independent. This is of benefit to the Trust as well as the ME service.

Possible solutions would include increased staffing to the bereavement team or a different service model which does not use the time and resource allocated to the function of the ME Office.

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 21iii

Report Title:	**Response to the Medical Examiner quarterly report October 24 – January 25**			
Name of Meeting:	Trust Boad			
Date of Meeting:	26th March 2025			
Author:	Dr Carmen Howey, Group Medical Director			
Executive Sponsor:	Dr Carmen Howey, Group Medical Director			
Report presented by:	Dr Carmen Howey, Group Medical Director			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☒
	This report is provided as response to the Medical Examiner Q3 report			
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 ME Q3 report raises concerns with regard to the following: • Quality and safety - 7 patients were thought by a Medical Examiner to have had a possibly preventable death whilst in the care of Gateshead NHS Foundation Trust in the period between October 24 and December 2024. • Governance and legal - Gateshead NHS Foundation Trust is breaching NHS England guidance as the host of the Gateshead ME by using Medical Examiner Officer resource to support the delivery of the Bereavement Service. This paper seeks to give some assurance to those points.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	Consider the overall picture of Mortality Data and Learning from deaths and be assured that there is a robust process for learning from deaths within the organisation and that our data does not indicate any evidence of outlier status or issues of concern or advise if further action is recommended to give assurance.			

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

Medical Director Response to Medical Examiner Q3 Report

The Medical Examiner report describes concern relating to:

1. The organisational process for Learning from Deaths

Medical Director response:

The Learning from Deaths report presented alongside this gives assurance regarding our organisational process for learning from deaths. It covers the same time period as this report but, due to time delay in cases being referred for review by the ME and then that re happening the deaths considered in each report will represent different patients.

2. That in Q3 the Medical Examiner identified 7 deaths which were possible preventable due to delays in diagnosis or missed diagnosis and failure to escalate treatment.

Medical Director response:

The Learning from Deaths report as above describes one case reviewed in the same time period which was probably preventable with the other six cases reviewed determined to be definitely not preventable although, as referenced above due to time delay in cases being referred for review by the ME and then that re happening the deaths considered in each report will represent different patients.

The Mortality Data report does not give any indication that we are an outlier with regard to our mortality data and does not raise any specific issues of concern,

3. The requirement for the ME Office and work of the Medical Examiner to have independence and that the use of the ME Officers to support the Bereavement Service whilst short staffed has put this at risk.

Medical Director response:

The Medical Examiner Service should be as independent of the wider hosting organisation as possible whilst also being subject to day-to-day management and oversight through local line management arrangements with the employing NHS body. The use of the ME Officer support to the Bereavement Services team does breach relevant national guidance but this is how some Trusts choose to operationalise their services. This breach represents a risk to the independence or a perceived lack independence of the Medical Examiner service. There are a range of options which could be considered to address or mitigate this risk or the Trust may choose to accept this risk.

The recommended action is to agree this risk as follows on the risk register:

There is a risk that a lack of or perceived lack of independence in the Medical Examiners Office as a result of the support offered to the Bereavement Services team could result in reputational harm to the Trust and distress to the bereaved. Likelihood 1 x Impact 4.

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 22

Report Title:	**Maternity Integrated Oversight Report – February 2025**			
Name of Meeting:	Board of Directors			
Date of Meeting:	26th March 2025			
Author:	Ms Abbie McCready, Lead Midwife for Risk and Patient Safety			
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 February 2025			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Maternity Safecare 13/3/2025 SBU Ops Board 26/3/2025 Safecare Steering Group 18/3/2025 Trust Board 26/3/2025			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	**Maternity dashboard:** • In February 2025, there were 151 births, 0 MNSI cases and 0 perinatal losses. • Exceptions reported – positive outlier continues for breastfeeding rates & smoking, high SPC remains for overall caesarean sections. Reduction is seen in maternal readmissions. • Moderate harm incidents – 0 incidents reported **Q3 ATAIN report** **Q3 Friends & Family positive feedback comments** **Exception reporting:** • Delays to Birth reflections appointments • Emerging risk #4695 – Neonatal Badger EPR system support			
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 2025

Maternity IOR contents

- Maternity Dashboard 2024/25:
    - February 2025 data

- Exception reports:
    - Maternity dashboard exceptions
        - Caesarean section rate
        - Breast feeding rates
- Items for information:
    - Perinatal Quality Surveillance minimum dataset
    - Strategic Objectives
    - Summary of performance for NENC LMNS providers as reported in the Maternity Services Survey 2024
    - Family and Friends Feedback
    - Incidents
        - No MNSI cases reported in February 2025
    - Perinatal Mortality and Morbidity
        - 0 perinatal loss in February 2025
    - ATAIN Q3 update
    - Exception Reporting
        - Birth Reflections

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Births	Feb 25	152	-			164	124	204
Spontaneous vaginal deliveries	Feb 25	73	-			76	54	98
Assited births	Feb 25	79	-			88	57	118
Induction of Labour	Feb 25	60	-			60	30	90
Maternity Readmissions	Feb 25	2	-	L		3	-3	9
Neonatal Readmissions	Feb 25	8	-			5	0	10
Smoking at time of booking	Feb 25	5.68%	15.00%		P	7.37%	1.59%	13.15%
Smoking at time of delivery	Feb 25	2.67%	6.00%		?	5.88%	-0.35%	12.10%
In area CO at booking	Feb 25	90.34%	90.00%		?	90.44%	75.86%	105.02%
In area CO at 36 weeks	Feb 25	89.24%	80.00%		?	82.17%	69.98%	94.36%
Admitted directly to NNU (SCBU) (>37 weeks)	Feb 25	8	4		?	8	-2	17
Percentage Admitted directly to NNU (SCBU) (>37 we	Feb 25	5.44%	6.00%		?	4.94%	-0.97%	10.84%
Preterm birth rate <=36+6 weeks at birth	Feb 25	2.65%	6.00%		?	5.70%	-0.28%	11.68%
Continuity of Carer: Percentage placed on pathway (2	Feb 25	18.55%	-			17.22%	8.98%	25.46%
Continuity of Carer: Percentage from BAME backgrou	Feb 25	25.00%	-			26.51%	-0.20%	53.22%
Spontaneous Vaginal Births (%)	Feb 25	48.34%	-			46.80%	35.98%	57.62%
Induction Rate	Feb 25	39.74%	-			37.16%	24.02%	50.31%
Instrumental Delivery Rate	Feb 25	11.26%	-			13.13%	4.67%	21.58%
Elective C Section Rate	Feb 25	20.53%	-			18.27%	9.71%	26.83%
Emergency C Section Rate	Feb 25	20.53%	-			22.00%	13.34%	30.65%
C Section Rate	Feb 25	41.06%	-			40.27%	29.66%	50.88%
3rd or 4th degree tear (Total) Precentage	Feb 25	0.00%	3.00%		?	1.13%	-1.50%	3.77%
Massive PPH >=1.5L (All births)	Feb 25	5	2		?	8	-1	18
Breastfeeding: Percentage of Initiated Breasfeeding	Feb 25	83.22%	66.20%	H	P	76.87%	66.22%	87.52%
Breastfeeding: Breasfeeding at Discharge (Transfer to	Feb 25	62.84%	56.20%	H	?	58.80%	43.80%	73.80%

Safe

Responsive

Maternity

NHS

Gateshead Health

NHS Foundation Trust

Maternity Dashboard 2024/245

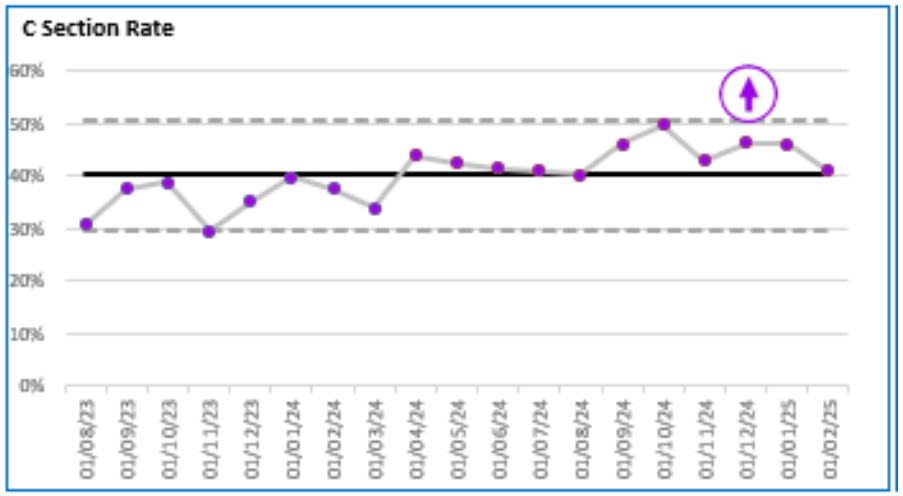
Maternity Dashboard 2024/25

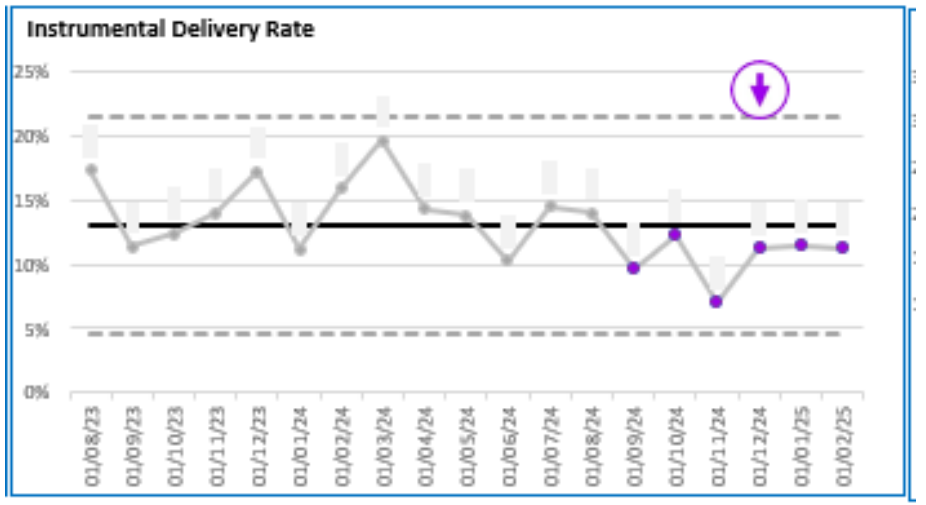
Maternity

Gateshead Health NHS Foundation Trust

Safe

Responsive





- **Background**
  - Slight increase in overall caesarean section rate with reduction in instrumental delivery rate
- **Assessment**
  - EmLSCS rate reducing over last quarter
- **Actions**
  - Continue to monitor
- **Recommendations**
  - Completed audit to review reasons for caesarean section using Robson groups – to be presented in March governance groups

Maternity Dashboard 2023/24

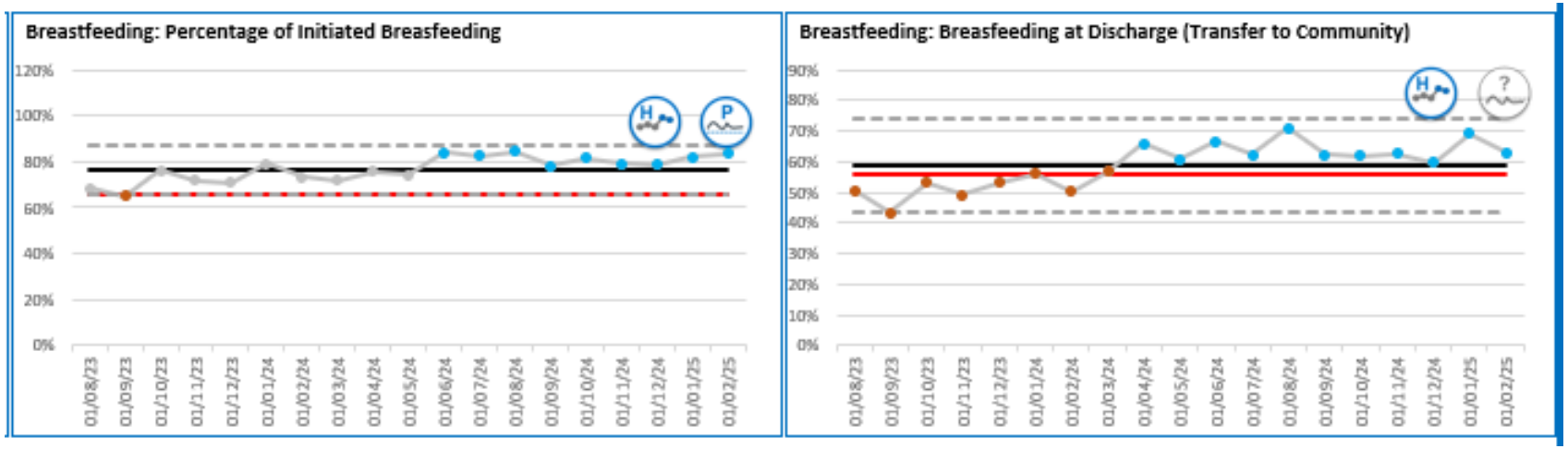
Maternity

NHS

Gateshead Health
NHS Foundation Trust

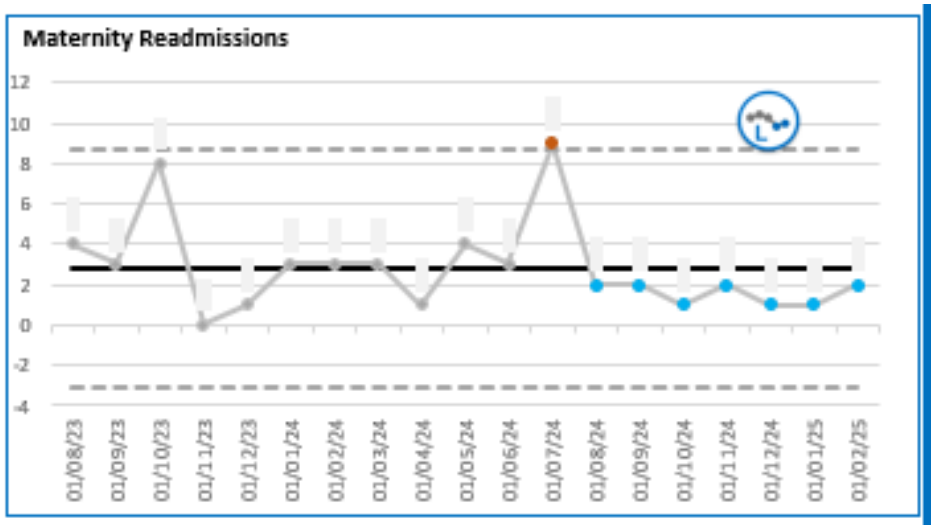
Safe

Responsive



- **Background**
  - Breastfeeding rates are audited as part of the UNICEF standards
- **Assessment**
  - Initiation rates consistent improvement over last 6 months
  - Breastfeeding rates at discharge to community also have a consistent improvement over the last 6 months.
- **Actions**
  - Continue to maintain improvement
- **Recommendations**
  - Continue to audit
  - UNICEF maternity & neonatal accreditation to be recommenced in 2025/26 to be compliant with 3-year delivery plans

Maternity Dashboard 2023/24



- **Background**
  - Postnatal readmissions require reporting via Inphase
  - Following spike in July 2024 – deep dive audit performed, actions put in place to ensure adequate postnatal analgesia, review infection rates – sustained lower rates since then
- **Assessment**
  - Consistence reductions in readmissions
- **Actions**
  - Continue to maintain improvement
- **Recommendations**
  - Continue to Inphase and review postnatal readmissions

2024/25		April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Number of perinatal losses		0	0*	1	0	0	0	1	2	1	0	0	
Number of MNSI cases		1	0*	0	0	0	0	1 (August birth)	0	0	0	0	
Number of incidents logged as moderate harm or above		1	0	0	0	0	2	0	2 plus screening	2	1	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	107.7	110.0%	98.4%	99.3%	100%	97.8%	94.6%	90.0%	89.9%	77.1%	77.6%	
	Night shift	105.2	109.7%	102.8%	103.6%	103.1%	105.6%	99.9%	100.3%	98.1%	103.9%	99.0%	
	CHP PD*	18.3	18.7	18.4	11.9	12.2	10.1	12.2	12.3	12.2	12.4	12.0	
Service user feedback	FFT “Overall how was your experience of our service” – total score for very good and good responses	100%	90%	100%	Reports not received		100%	100%	100%				
	Complaints	2	1	1	3	0	3	1	4	3	4	4	
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	

*CHPPD overall care hours per patient per day

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

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total Areas	9	9	9	9	9	9	9	9	9	9	9	
Areas Not Applicable												
No. Compliant	2	2	4	4	6	5	5	5	7	9	9	
No. Non Compliant	7	7	5	5	3	4	4	4	2	0	0	
Percentage Compliance	78%	78%	74.0%	74%	89%	90%	95%	97.40%	98%	100%	100%	

Areas compliant: (List domains compliant)
1. Enhanced Safety, 2. Listening to families 3. Staff training & MDT working, workforce, 4.Managing Complex Pregnancy, 5. RA throughout pregnancy, 6. Monitoring Guidelines. 7. Informed Consent,

Areas Non compliant: (List domains non-compliant)
None

How are we performing or Progress Made?
MIS compliance with all elements of Saving Babies LIves Care Bundle confirmed
Audits complete for IAEs 5&7

What is driving performance or what are the challenges

What actions is being taken or future risks & planned developments
Continue to monitor compliance

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

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total Areas	89	89	89	89	89	89	89	89	89	89	89	
Areas not Applicable	6	6	6	6	6	6	6	6	6	6	6	
No. Compliant	56	63	68	69	74	79	79	79	80	80	83	
No. Non Compliant / Unassessed	35	26	15	14	15	4	4	4	3	3	0	
Percentage Compliance	63.0%	71.0%	76.0%	78%	83%	89%	89%	89%	96%	96%	100%	

Areas compliant: (List domains compliant) Safety actions 1, 2, 3, 4, 5, 6, 7, 8, 9, 10

Areas Non compliant/Not Assessed: (List domains compliant)
N/A - 6 areas as only required if not compliant

How are we performing or Progress Made?
Annual LMNS assurance report received, Q3 LMNS assurance meeting completed, MIS compliance reporting period ended 30/11/2024
Final ratification of updated Maternity Risk Management Guideline completed – January Safecare - Safety action 7

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

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

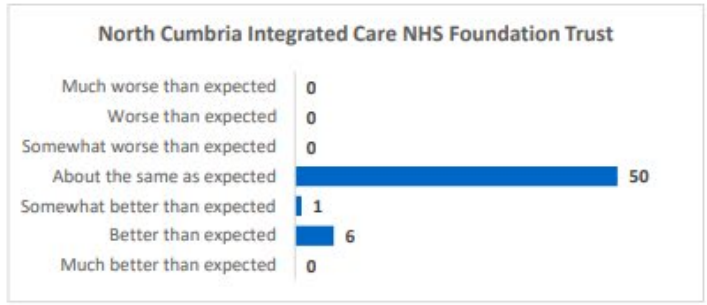
Summary of performance for NENC LMNS

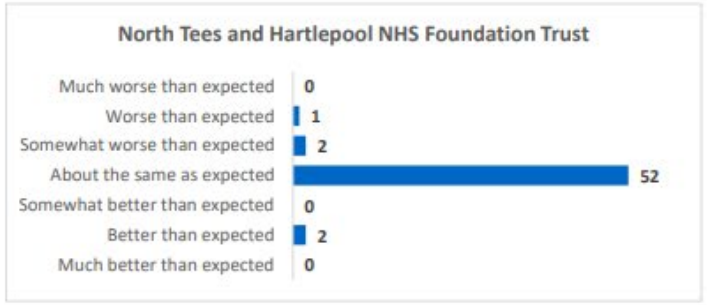
(Maternity Services Survey 2024)

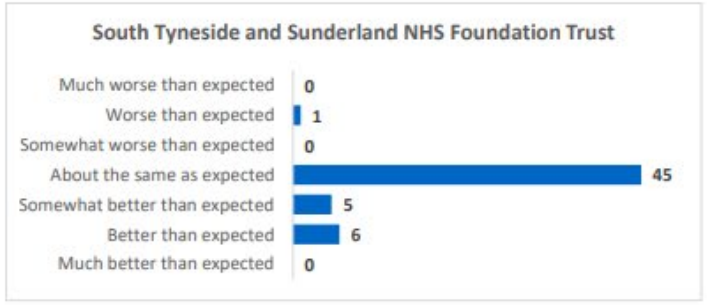
Caring

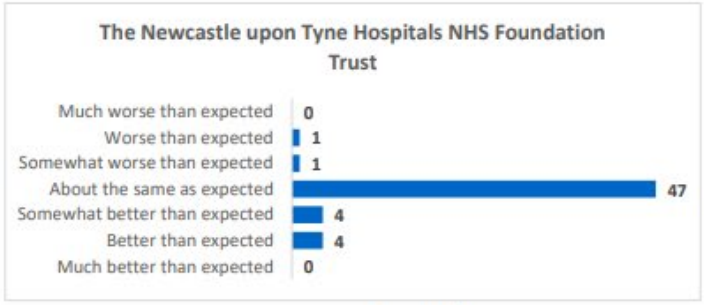
Gateshead Health NHS Foundation Trust

Several trusts performed better and much better than expected compared with most other trusts for several questions in the survey. The specifics of this can be found in the performance tables later in this report.









Friends and Family Feedback

Caring

NHS Gateshead Health NHS Foundation Trust

More information regarding the whole process of discharge and care. After being informed I would be home following 6 hours post birth ended up being 12 hours. Just being updated would help overall the experience was very good from the whole maternity unit

The midwives who I spoke to over the phone and who looked after me were fabulous! Very attentive, answered all of my questions and acted like nothing was a bother which made me and my partner feel at ease. Kept me updated on everything that was going on and I was regularly being checked on for the time I was there. The midwife in the hospital was also engaging with my partner which made him feel included.

The midwife was a good listener and very comforting. She answered all my questions and was very nice. It was the best counseling session of my life whether it was with a doctor, midwife or a nurse.

Maternity antenatal unit - my midwife and student midwife were excellent. They explained all information clearly with care and compassion. All aspects of my care for me and my baby were excellent, I felt I was well informed and looked after. Postnatal ward- all staff were lovely, however I felt like I wasn't very well informed about what was happening with my care/ discharge. I felt I had to keep asking for updates. The support workers were lovely and felt like they tried to support me with aftercare. I am aware that at this time the ward may have been busy etc

All the staff both myself and my husband came across from our first antenatal appointment to discharge following the birth of our son were truly amazing and an absolute credit to the QE team. All staff were caring, compassionate and knowledgeable. Through my pregnancy, I visited the PAU on a couple of occasions due to concerns regarding reduced movement, each staff member was reassuring and although they were busy, I always felt they had mine and the baby health interest at heart of everything they done, I felt I was potentially wasting their time but they reassured me this was definitely not the case and they wanted me to attend whenever I felt this was required. Our baby was breech and there I also underwent an ECV, again the information shared about this process was very informative, all my options and risks discussed to allow me to make an informed decision. My son did successfully turn but unfortunately 2 days later had turned back so again options and risks discussed and it was agreed an elective section could be booked. Again the communication around this was second to none. My husband and I attended the Labour ward on Wednesday 8th January where we were greeted with smiles, again staff we met were approachable and kept us up to date with what to expect. The elective section was calming due to the amazing staff within theatre, they kept both myself and my husband up to date, reassured us and explained everything going on - the staff are worth their weight in gold ! Z the scrub nurse and looked after us in recovery was so friendly, she kept us up to date on what was happening. Y our midwife at delivery and caring for us in recovery was so lovely again explaining what to expect, she took such good care of our son. On moving to the post natal ward again we could not fault any of the staff, from midwifes, nursing assistants, support workers, catering, domestics were all very approachable and willing to do whatever was needed for the comfort and care of not just me and my baby but also ensuring my husband felt included and updated. Although I could not fault any of the staff I would like to personally thank the Midwife X who cared for us on Thursday 9th, I was personally struggling on this date, with trying to breastfeed, for the first time ever I had significantly hight blood pressure which made me feel dreadful along with all the hormones, I ended up having a panic attack. X was like an angel during this whole time, she stayed with me until I was settled, she offered to explore options which could potentially allow my husband to stay (although not needed in the end as she helped me recover). X is not just a credit to QE but to the midwife profession. Please could personally thanks be provided and acknowledgement given to X (sorry I can't recall her surname but I assume this will be on my record). Going into pregnancy was an anxious time for both myself and my husband following a previous miscarriage and accessing IVF again via the Trust (again amazing experience due to staff) but our experience has truly shown what the NHS is about, care and compassion, putting the patient first and again everyone a credit to the Trust and their professional registration.

ATAIN- Avoiding term admissions to SCBU

Q3 2024/25 Total births >37 weeks	Total term admissions	Reasons for admission
442	12 babies 2.7% (5.24%)	67% respiratory 17% observation/monitoring 8% Sepsis 8% Capacity

Maternity

Gateshead Health NHS Foundation Trust

Responsive

Safe

Item No	Link to ATAIN admission criteria	Learning	Action
1	**Escalation process for baby review**	• Delays to review babies/repeated requests for review	• Develop clear pathway for escalation when neonatal concerns. • Staffing improved on SCBU, increased availability of ANNP's.
2	**First feed within 1 hour of birth.**	• Only 58%of babies were fed within 120 minutes of birth • Only 8% babies fed within 60 minutes of birth	• Audit time of first feed with aim to feed within 60 minutes of delivery. • Promote colostrum harvesting at point of contact: Pre-Op for ELCS, admission for IOL, AN clinic. • Support for golden hour from both MSW and HCA's when available. • Facebook post and poster developed to raise profile of Golden Hour and Colostrum Harvesting. • Maternity Masterclass training for support workers for golden hour and feeding.
3	**Neonatal Observations at birth and for at risk babies**	• Full set of observations not completed every time observations are required.	• Review current guidelines to ensure following national/local recommendations.
4	**Documentation**	• Systematic review tool not used for CTG analysis • SBAR on Badgernet not completed in baby notes	• CTG review – remind medical staff to use Badger review tool. • SBAR for mother and baby separately. • Documented plan of care/handover when babies stepped down from SCBU.

Exception reporting

Maternity

NHS Gateshead Health NHS Foundation Trust

Caring

Responsive

Birth Reflections Service

- Birth reflections is an unfunded service, provided predominantly by PMAs
- NHSE good practice guide recommends services provide an opportunity for women to discuss their birth & NICE guidance includes an offer to women to discuss their experience.
- The LMNS has produced guidance (2024) to provide a standard across NENC to improve care and outcomes for those women who may need to access a birth reflections service – this is currently being reviewed by our PMA team to align our service including annual audit of referrals and outcomes.
- Due to our current midwifery staffing capacity, we are currently experiencing longer waits than normal for a Birth Reflections appointment.
- There are 22 outstanding Birth Reflection referrals at the moment.
- Therefore we are placing a pause on taking any new referrals for 3 months to enable us to address the backlog.
- Discussed & shared with MNVP to keep service users informed.
- Additional support being identified from ward managers & senior team.

Exception reporting

Maternity

NHS Gateshead Health NHS Foundation Trust

Safe

Emerging Risk #4695

- From 1 April 2025, there will no longer be a system administrator for Badger Neonatal EPR
- Result – user support, system testing & development, data quality checks & security/governance assessments will no longer be available, Clinical Safety Officer would be unable to authorise system upgrades or patches due to lack of testing
- Business case (2022) – system support was reduced from recommended 0.6wte to 0.2wte, this was absorbed by the existing clinical systems team but there is no longer any capacity to continue the additional neonatal workload
- Risk Rating = 12
- Reviewed at SBU Safecare (6/3/2025) & added to risk register & alert in AAA report

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 23

Report Title:	**Nursing Staffing Exception Report**			
Name of Meeting:	Board of Directors- Part 1			
Date of Meeting:	26th March 2025			
Author:	Helen Larkin, Clinical Lead E-rostering			
Executive Sponsor:	Gillian Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Drew Rayner, Deputy Chief Nurse Helen Larkin, Clinical lead E-rostering			
Purpose of Report	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	This report is to provide assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis to provide adequate staffing levels.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by:	Safecare Steering Group			
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 2025. February has demonstrated some areas with staffing challenges relating to sickness absence and enhanced care requirements. During February, we continued to experience periods of increased patient activity with surge pressure resulting in escalation areas open in Ward 11. Additionally escalation beds continue to be open on wards 22, 24 and 25. This has affected staffing resource. There is continued focused work around the retention of staff and managing staff attendance. Wards where staffing fell below 75% of the funded establishment are shown within the paper. Detailed context and actions taken to mitigate risk are documented. A staffing escalation protocol is now in operation across all areas within the organisation and			

	assurance of this operating as expected, is provided by the number of staffing incident reports raised through the incident reporting system.				
Recommended actions for this meeting:	The Board is asked to: • receive the report for assurance • note the work being undertaken to address the shortfalls in staffing				
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)	There were 7 nurse-staffing incidents raised via InPhase during the month of February, of which one reported low physical harm, three incidents recorded low psychological harm.				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Gateshead Health NHS Foundation trust
Nursing and Midwifery Staffing Exception Report
February 2025

1. Introduction

This report details the staffing exceptions for Gateshead Health NHS Foundation Trust during the month of February 2025. 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 2025

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 (%)**
82.9%	**86.8%**	**96.3%**	**93.6%**

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

Exceptions:

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

Safer Nursing Care Tool (SNCT) data collection is usually completed bi-annually in January and July each year. Patient acuity and dependency data is triangulated with key performance indicators and professional judgement templates in line with the Developing Workforce Safeguards and Safe Staffing Recommendations (NHSi 2018). A revised SNCT tool has been introduced, which incorporates 1-1 enhanced care requirements along with considerations for single side room environments to support establishment reviews. Data collection is completed on a six-monthly basis, with the most recent collection haven taken place in January 2025.

Contextual information and actions taken

Critical Care reported a reduction in Registered nursing workforce for dayshift, at 65.3%. The reduction was reflective of the acuity, dependency and activity within the department. This demonstrated a reduced number of bank shifts requested. Critical care currently have three Registered Nurses on Maternity Leave.

Ward 14 demonstrated fill rates of 70.1%, during February attributable to 2 Registered Nurse vacancies, of which both are in the process of being filled with internal staff moves. Escalation process was followed by the ward to mitigate against any risk.

Ward 28 report a registered nurse fill rate of 72.4% for days. Whilst low, this is improved from January. The ward currently has two WTE on Maternity leave and one WTE on long term sick. The Ward Manager ensured safe staffing levels relative to the occupancy and acuity levels throughout the month.
Additionally Ward 28 demonstrate HCA fill rates days at 45.7% and 47.5% for nights. Healthcare assistants (HCA) were rostered relative to the peaks in activity. There is a noted 6.8 WTE vacancies within their non-registered workforce, however a review of their nursing establishment is planned following the January SNCT process.
CHPPD for Ward 28 is 15.4, which demonstrates higher than the Trust average and an increase from January 2025.

Ward 25 demonstrate a registered nurse fill rate of 71.9% for days. This is predominantly due to the ward being closed to admissions for approximately one week due to IPC reasons, therefore staff were able to support additional occupancy into ward 11.

Cragside Court report 68.8% fill rates for registered nurse nightshifts. Mitigations for safer staffing were with additional HCA staff rostered at night to support dependency and enhanced observations.

JASRU reported HCA fill rates of 67.8% for days. This is attributable to regular redeployments of staff to support shortfalls across the organisations.

Ward 23 showed a reduction of HCA on nights, mitigated at times with a ward Registered Nurse on duty. This was only possible due to a current over establishment position.

Ward 9 demonstrated HCA fill rates of 64.8% for days. This is a result of two HCA's on Maternity, and long term sickness.

The HCA fill rates for Ward 21 during dayshift was 66.7%, attributable to long term sickness and maternity leave. CHPPD remains consistent from January at 5.9. There were no staffing incidents or red flags raised.

Ward 24 demonstrated 73% for HCA days. They currently have two WTE Band 3 vacancies. One staffing incident was raised via Inphase and 2 red flags (one of which was in error). Overall the senior nursing team report the ward was safely staffed due to the over establishment of Band 5s. Ward 24 supported organisational staffing gaps with redeployed qualified nurses.

Ward 11 escalation area was utilised to support patients through peaks in activity, staffed from areas across the organisation deemed safely able to support. The Ward was not fully utilised for the full calendar month and was assessed daily for safe de-escalation.

Incidents related to nurse staffing raised via Inphase and as a Red Flag are still demonstrated within the paper to highlight any identified concerns related to safer staffing within the department.

The exceptions to report February are as below:

February 2025	
Registered Nurse Days	**%**
Critical Care	65.3%
Ward 14 Medicine	70.1%
Ward 28	72.4%
Ward 25	71.9%
Registered Nurse Nights	**%**
Cragside Court	68.8%
Healthcare Support Worker Days	**%**
JASRU	67.8%
Ward 9	64.8%
Ward 21	66.7%
Ward 28	45.7%
Ward 24	73.0%
Healthcare Support Worker Nights	**%**
Ward 28	47.5%
Ward 23	70.1%

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)

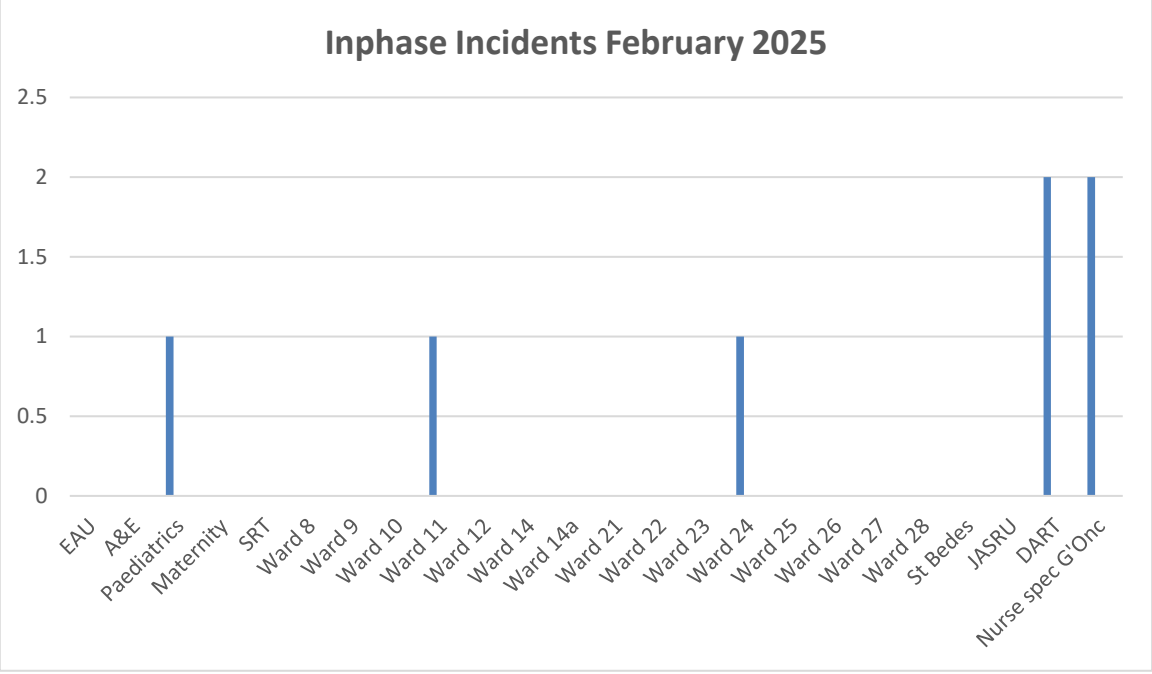
Following discussion with the National Safer Staffing faculty, it was recommended CHPPD is an unsuitable metric for Paediatric services, therefore has been removed from this report. This is due to the model of care including Emergency department care and outpatient services. The CHPPD metric accounts for patients occupying a bed at midnight, therefore providing an unwarranted depiction of their current care delivery.

Ward level CHPPD is outlined in Appendix 1. For the month of February, the Trust total CHPPD was 7.6. This compares slightly lower when benchmarked with other peer-reviewed hospitals.

4. Monitoring Nurse Staffing via Incident Reporting system

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

There were 7 reported Nurse staffing incidents raised via InPhase.

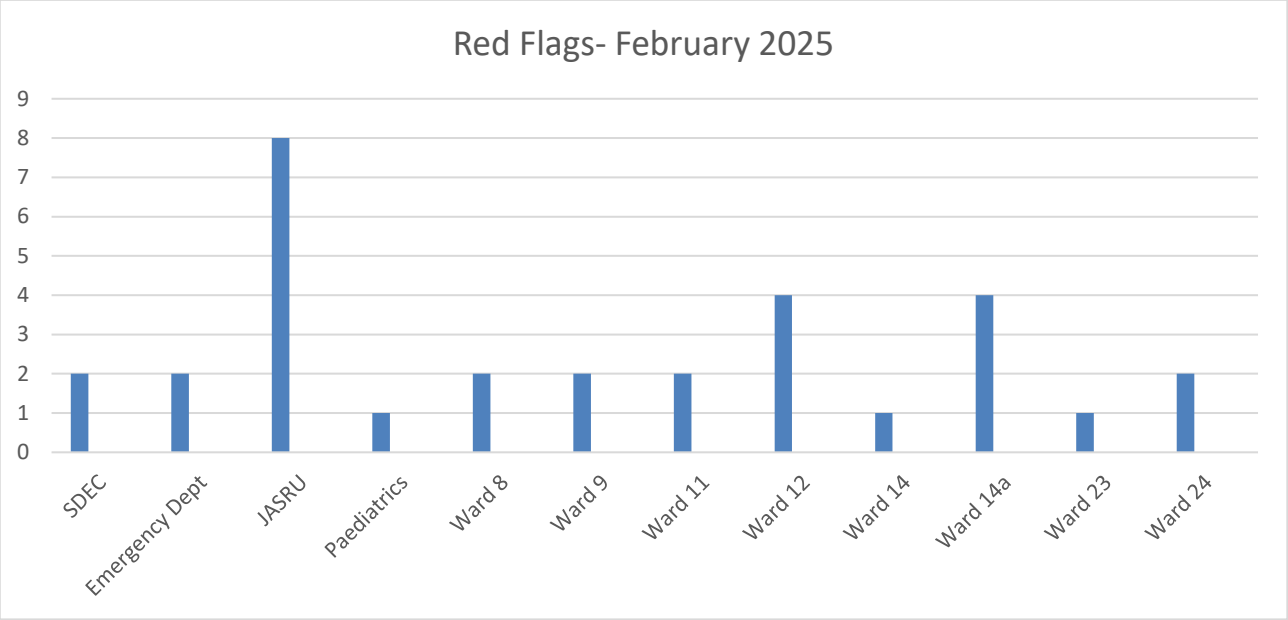


Nursing Red Flags

The National Institute for Health and Care Excellence (NICE) guideline for Safe Staffing for nursing in adult inpatient wards in acute hospitals (2014) recommend the use of nursing Red Flag reporting. A Nursing red flag can be raised directly because of rostering practice/shortfall in staffing or by the nurse in charge if they identify a shortfall in staffing requirements resulting in basic patient care not able to be delivered. Throughout the month of February there were 31 nursing red flags reported. This compares to 48 red flags reported in January. Additional to raising

a red flag on the system, the owner of the red flag escalates this timely to the Matron of senior nurse for mitigation.

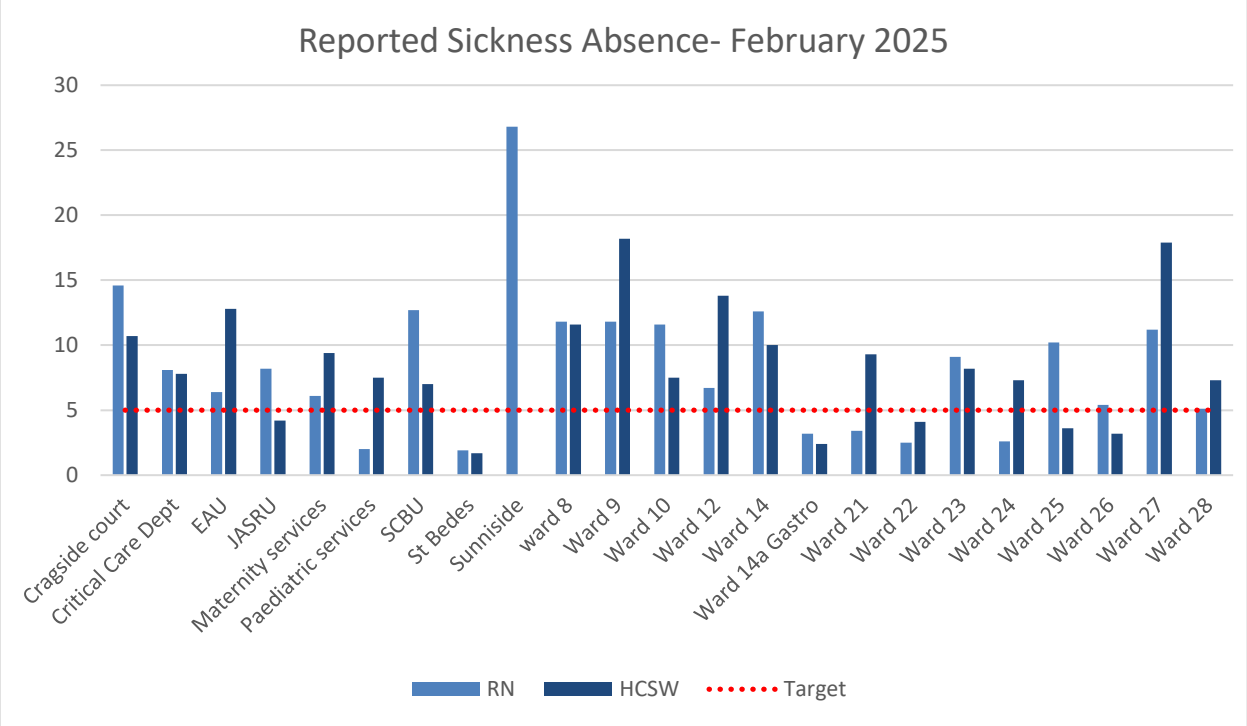
The graph below outlines the number of red flags raised per department through the month of February .



The Red Flags raised by areas that also report a fill rate below 75% were:- Ward 14 with shortfall in RN and HCSW time (escalation protocol followed). JASRU with missed 'intentional rounding' highlighted on each entry. Ward 9 with missed 'intentional rounding' and shortfall in HCSW. Ward 23 with shortfall in RN time, and Ward 24 with missed 'intentional rounding' due to levels of enhanced care.

5. Attendance of Nursing workforce

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



6. Governance

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

7. Conclusion

This paper provides an exception report for nursing and midwifery staffing for February 2025, outlining ongoing work to present triangulated workforce metrics. Collaborative work is underway to provide monthly dashboard metrics, triangulating vacancy, sickness absence, bank spend with ward quality measures and patient safety.

8. Recommendations

The Board are 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 2025

Decrease from previous month Increase form previous month

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Cragside Court	↓ 83.7%	↓ 83.7%	↓ 68.8%	↓ 151.6%	↓ 252	↓ 5.5	↓ 8.3	↓ 13.8
Critical Care Dept	↓ 65.3%	↑ 90.7%	↓ 87.0%	↓ 87.6%	↓ 165	↑ 38.2	↓ 5.5	↑ 43.7
Emergency Care Centre - EAU	↓ 82.8%	↓ 92.9%	↑ 101.6%	↓ 82.6%	↓ 1274	↑ 5.6	↓ 3.8	↓ 9.3
JASRU	↑ 96.4%	↑ 67.8%	↑ 113.4%	↑ 84.2%	↓ 553	↑ 3.8	↓ 3.2	↑ 7.0
Maternity Unit	↑ 77.6%	↓ 107.0%	↓ 99.0%	↓ 88.2%	↓ 598	↓ 12.0	↓ 3.9	↓ 15.8
Special Care Baby Unit	↓ 76.8%	↑ 137.0%	↓ 102.0%	↓ 85.9%	↓ 132	↑ 13.1	↑ 3.4	↑ 16.5
St. Bedes	↓ 87.6%	↓ 91.5%	↓ 101.4%	↓ 112.7%	↓ 262	↑ 5.3	↓ 3.9	9.2
Sunniside Unit	↑ 86.2%	↓ 108.6%	↑ 111.2%	↓ 90.6%	↓ 208	↑ 7.1	↓ 5.0	↓ 12.1
Ward 08	↓ 81.4%	↓ 97.5%	↓ 90.9%	↑ 111.1%	↓ 443	↑ 4.9	↑ 4.0	↑ 8.9
Ward 09	↓ 76.1%	↓ 64.8%	↓ 98.3%	↓ 85.3%	↓ 526	↑ 3.2	↑ 2.4	↑ 5.6
Ward 10	↑ 79.6%	↓ 88.2%	↓ 100.4%	↓ 101.3%	↓ 709	2.5	↓ 2.3	↓ 4.8

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Ward 12	90.6%	83.1%	104.1%	100.2%	736	2.6	2.1	4.7
Ward 14 Medicine	70.1%	78.6%	96.3%	99.8%	691	3.1	2.2	5.3
Ward 14a Gastro	104.2%	122.7%	91.0%	147.3%	710	2.9	3.2	6.1
Ward 21 T&O	113.4%	66.7%	103.7%	99.4%	784	3.4	2.5	5.9
Ward 22	96.3%	85.8%	91.7%	81.8%	845	2.5	2.4	4.9
Ward 23	88.7%	101.7%	116.3%	70.1%	663	2.8	2.7	5.4
Ward 24	110.8%	73.0%	88.6%	88.6%	854	2.7	2.2	4.9
Ward 25	71.9%	90.2%	85.1%	76.4%	518	3.4	4.0	7.3
Ward 26	99.8%	115.4%	94.2%	111.2%	763	3.0	3.2	6.1
Ward 27	91.0%	79.7%	98.0%	101.9%	787	2.8	2.3	5.1
Ward 28	72.4%	45.7%	101.0%	47.5%	141	10.2	5.2	15.4
QUEEN ELIZABETH HOSPITAL - RR7EN	**82.9%**	**86.8%**	**96.3%**	**93.6%**	**12614**	4.5	3.1	7.6

Meeting:	Trust Board
Chair:	Alison Marshall
Financial year:	2025/26

	Lead	Type of item	Public/Private	May-25	25 June 25 (year end only)	Jul-25	Sep-25	Nov-25	Jan-26	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 Partnerships	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	√		√	√	√	√	√
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	Group Director of People & OD	Item for Assurance	Part 1 & Part 2						√	√
Finance Report	Group Director of Finance	Item for Assurance	Part 1	√		√	√	√	√	√
Strategic Objectives and Constitutional Standards Report	Group Director of Finance	Item for Assurance	Part 1	√		√	√	√	√	√
Maternity Integrated Oversight Report	Chief Nurse	Item for Assurance	Part 1	√		√	√	√	√	√
Maternity Staffing Report	Chief Nurse	Item for Assurance	Part 1	√						
Nurse Staffing Exception Report	Chief Nurse	Item for Assurance	Part 1	√		√	√	√	√	√
Bi-annual Inpatient Safer Nursing Care Staffing Report	Chief Nurse	Item for Assurance	Part 1	√				√		
Learning from Deaths (quarterly report)	Group 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	Group Director of People & OD	Item for Assurance	Part 1				√		√	
WRES and WDES Report	Group Director of People & OD	Item for Assurance	Part 1				√			
Green Plan	QEF Managing Director	Item for Assurance	Part 1	√						
Board Walkabout Feedback	Chief Nurse	Item for Assurance	Part 1	√		√	√	√	√	√
Great North Healthcare Alliance Progress Report	Director of Strategy and Partnerships	Item for Assurance	Part 1 & Part 2	√		√	√	√	√	√
Items for Information			Part 1 & Part 2							
Register of Official Seal	Company Secretary	Item for Information	Part 1				√			
Ad Hoc Items (i.e. items emerging during the year)			Part 1 & Part 2							
Organisational Structure - Clinical Leadership GHLG Apr 2026	Group Medical Director	Item for Assurance	Part 1							
Cyber Assurance Framework report	Group Director of Finance	Item for Assurance	Part 1				√			

Charitable Fund Board										
Charitable Funds Audited Financial Performance	Group Director of Finance	Item for Board of Trustees	Part 1						√	