

Board of Directors (Part 1 – Public)

A meeting of the Board of Directors (Part 1 – Public) will be held at 09:30am on 25th September 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 30 July 2025	Decision	Chair	Paper
5.	09:37	Action log and matters arising	Assurance / decision	Chair	Paper
6.	09:40	Top Organisational Risks	Information	Chair	Paper
7.	09:45	Patient and Staff Story	Assurance	Patient	Presentation
ITEMS FOR DECISION					
8.	10:00	Calendar of Board Meetings 2026/27	Decision	Company Secretary	Paper
9.	10:05	Corporate Governance Manual – Standing Orders, Standing Financial Instructions, and Scheme of Reservation and Delegation of Powers	Decision	Company Secretary / Group Director of Finance	Paper
10.	10:15	Trust 5 Year Strategy	Decision	Director of Strategy and Partnerships	Paper
11.	10:25	Winter Plan	Decision	Group Chief Operating Officer	Paper
12.	10:35	Green Plan	Decision	Group Medical Director	Paper
13.	10:45	Premises Assurance Model	Decision	QE Facilities Managing Director	Paper
14.	10:55	Responsible Officer Assurance Report and NHSE submission	Decision	Group Medical Director	Paper
15.	11:05	National Agenda for Change Pay Award	Decision	Group Director of Finance	Paper
ITEMS FOR ASSURANCE					
16.	11:10	Chair's Report	Assurance	Chair	Paper
17.	11:15	Acting Chief Executive's Report	Assurance	Acting Chief Executive	Paper
18.	11:25	Governance Reports:			
		i) Board Assurance Framework	Assurance	Company Secretary	Paper
		ii) Organisational Risk Register	Assurance	Chief Nurse	Paper
19.	11:35	Assurance from Board Committees:			
		i) Finance and Performance Committee – August and September 2025	Assurance/ Decision	Chair of the Committee	Paper
		ii) Quality Governance Committee – August 2025	Assurance	Chair of the Committee	Paper

No	Start time	Item	Purpose	Lead	Paper / Verbal
		iii) Digital Committee – August 2025	Assurance	Chair of the Committee	Paper
		iv) Audit Committee – September 2025	Assurance	Chair of the Committee	Paper
		v) Remuneration Committee – July and September 2025	Assurance	Chair of the Committee	Paper
20.	11:55	Finance Report	Assurance	Group Director of Finance	Paper
21.	12:05	Strategic Objectives and Constitutional Standards Report	Assurance	Group Director of Finance	Paper
22.	12:15	EPRR Core Standards Self-Assessment Report	Assurance	Group Chief Operating Officer	Paper
23.	12:25	WRES and WDES report	Assurance	Group Director of People and Organisation Development	Paper
24.	12:35	Maternity Integrated Oversight Report	Assurance	Associate Director of Midwifery/SCBU	Paper
		i) Maternity Safety Champion Report	Assurance	Maternity Safety Champion	Paper
25.	12:40	Maternity Staffing Report	Assurance	Associate Director of Midwifery/SCBU	Paper
26.	12:45	Nurse Staff Exception Report	Assurance	Chief Nurse	Paper
ITEMS FOR INFORMATION / MEETING GOVERNANCE					
27.	12:50	Register of Official Seal	Information	Company Secretary	Paper
28.	12:55	Cycle of Business 2025/26	Information	Company Secretary	Paper
29.	13:00	Questions from Governors in Attendance	Discussion	Chair	Verbal
30.	13:05	Any Other Business	Discussion	Chair	Verbal
31.	13:10	Date and Time of Next Meeting – 9:30am on Friday 5 December 2025	Information	Chair	Verbal
Exclusion of the Press and Public To resolve to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed					

Board of Directors (Part 1 – Public)

Minutes of a meeting of the Board of Directors (Part 1) held at 9.30am on Wednesday 30th July 2025 in Room 3, Education Centre, Queen Elizabeth Hospital and via MS Teams.

Name	Position
Members present	
Mrs Alison Marshall	Chair
Mr Andrew Besford	Non-Executive Director
Mr Adam Crampsie	Non-Executive Director
Mrs Trudie Davies	Group Chief Executive
Mr Gavin Evans	Managing Director for QE Facilities
Dr Gill Findley	Deputy Chief Executive / Chief Nurse
Mr Neil Halford	Medical Director of Strategic Relations
Mrs Joanne Halliwell	Group Chief Operating Officer
Mrs Kris Mackenzie	Group Director of Finance
Dr Gerry Morrow	Non-Executive Director
Mrs Hilary Parker	Non-Executive Director
Mrs Maggie Pavlou	Deputy Chair / Non-Executive Director
Attendees present	
Mrs Jennifer Boyle	Company Secretary
Dr Andrew Bright	Consultant Paediatrician (25/07/07)
Ms Nicola Bruce	Director of Strategy and Partnerships (25/07/12)
Sir Paul Ennals	Shared Chair for Northumbria and Newcastle (observing)
Dr Sachin Mannikar	Consultant Paediatrician (25/07/07)
Max McCrea and Family	Patient and his family (25/07/07)
Ms Diane Waites	Corporate Services Assistant
Governors and Observers	
Mr Steve Connolly	Lead Governor
Mr Mark Learmouth	Public Governor – Central and Eastern Gateshead
Apologies	
Mr Martin Hedley	Non-Executive Director / Senior Independent Director
Dr Carmen Howey	Group Medical Director
Mr Robert Hughes	Non-Executive Director
Mrs Amanda Venner	Group Director of People & Organisational Development

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25/07/01	Chair's Business: The meeting being quorate, Mrs A Marshall, Chair, declared the meeting open at 9.30 am and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. She welcomed those present including the Trust Governors and observers. Mrs Marshall highlighted that this will be the first public Board meeting for Andrew Besford as Non-Executive Director and the last meeting for Trudie Davies whilst she undertakes a six-month secondment as Acting	

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	Chief Executive at North Cumbria Integrated Care NHS Foundation Trust (NCIC).	
25/07/02	Declarations of Interest: Mrs Marshall requested that Board members present report any revisions to their declared interests or any additional declaration of interest in any of the items on the agenda. The Board received the updated register following new declarations from Mr A Besford and amendments from Mr A Crampsie and Mrs J Halliwell.	
25/07/03	Apologies for Absence: Apologies were received from Mr M Hedley, Dr C Howey, Mr R Hughes and Mrs A Venner.	
25/07/04	Minutes of the Previous Meeting: The minutes of the meeting of the Board of Directors held on Wednesday 21st May 2025 were approved as a correct record.	
25/07/05	Action Log and Matters Arising from the Minutes: The Board reviewed the action tracker as below: • Action 24/09/08 and Action 24/09/09 relating to updating the Standing Orders and Scheme of Delegation to reflect changes to Terms of Reference and National Pay Award. It was noted at the last meeting that these are scheduled to be presented at the September Board meeting to allow review by the Audit Committee. • Action 25/05/10 relating to highlighting those risks with no movement which are classed “as low as reasonably practicable” (ALARP) and include further detail around the work that is being completed to provide further Board assurance. It was reported that all ALARP risks now include the word ALARP at the beginning of the risk descriptor and all ALARP risks have been reviewed via the Executive Risk Management Group therefore this action was agreed for closure. • Action 25/05/14 relating to providing the NHS England data analysis report in relation to urgent and emergency care. This has been included in the supplementary paper pack to accompany the Strategic Objectives and Constitutional Standards Report therefore this action was agreed for closure.	

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	• Action 25/05/15 relating to updating the wording of the risk description for Risk 4729 which relates to the workforce model in place to support services that are required to be delivered from the Women's Health Centre particularly around the "drift basis". It was confirmed that this had been completed therefore this action was agreed for closure. • Action 25/05/16 relating to providing further narrative and more meaningful intelligence to the Board via the cover sheet for the Nurse Staffing Exception Report. This has been completed and can be demonstrated via this month's report on today's agenda. Action therefore agreed for closure. The Board reviewed the actions closed at the last meeting which ensures actions have been closed in line with expectations and the agreements made at the previous Board meeting. • Action 25/03/17 relating to further discussion taking place at a Board Development Day in relation to system support around complex employment cases was closed at the last meeting as this had been added to the agenda on 25th June 2025 however this was deferred due to unavoidable circumstances. This action was therefore reopened until the session is rescheduled.	
25/07/06	Top Organisational Risks: The top organisational risks were noted as follows: • Risk 4694 (Finance). Risk that the Trust will not achieve its revenue plan for 2025-26 and a deterioration from the 2024-25 planned deficit, resulting in a deterioration to the Trust's NHS Oversight Framework rating. (Risk Score 20) • Risk 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. (Risk Score 15) • Risk 4734 (Medicine) Risk of patient harm due to the variability in meeting 4-hour Emergency Department Emergency Care standard. Resulting in potential regulatory action and poor patient experience. (Risk Score 16) Mrs J Halliwell, Group Chief Operating Officer, highlighted that Risk 4734 will be de-escalated due to improved performance and a new risk will be added relating to the challenges of managing multiple sources of clinical information.	

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	The Board were reminded to consider the top risks whilst the reports from today's agenda were presented and discussed at the meeting.	
25/07/07	Staff Story – Paediatrics: The Board welcomed Dr Andrew Bright, Consultant Paediatrician, and Dr Sachin Mannikar, Consultant Paediatrician, to the meeting. Mrs T Davies, Group Chief Executive, explained that the team had been invited to the Board to highlight the inspiring work provided by the Paediatric Allergy and Eczema Service within the organisation which supports current drives around health prevention and care in the community. Dr Bright and Dr Mannikar provided a background on the services relating to allergic diseases including anaphylaxis for younger people and shared a moving video about a family affected by the death of their daughter due to an allergic reaction. Max McCrea and his family also joined the meeting via Teams to share the story of Max who has been under the care of Dr Mannikar for a peanut allergy since he was 18 months old. Max is now 10 years old and has built up a tolerance to peanuts via intervention from the service which has greatly improved his standard of life. Max and his parents, Bruce and Lindsay, thanked Dr Mannikar for the care provided and highlighted the importance of the service which has been life changing for the family. Mrs Marshall thanked Bruce, Lindsay and Max for sharing their story and following a query from Dr G Findley, Chief Nurse and Deputy Chief Executive, relating to support from Max's school, Mrs McCrea highlighted that the school has been very supportive as well as Gateshead Council who have provided awareness and information relating to school meals. Dr Mannikar highlighted that longer-term goals for the service include reducing waiting times however further resources would be required to maximise capacity and enhance the service. Current financial challenges were acknowledged however Mrs Davies felt that it was important to recognise and support innovative services and Mrs K Mackenzie, Group Director of Finance, will be working with the team to develop a mechanism to support plans around treatment and prevention despite financial challenges to provide the best services for patients. Mrs Marshall thanked Dr Bright and Dr Mannikar for attending and highlighting the good work being undertaken and discussion will continue to take place. Dr Bright and Dr Mannikar left the meeting.	
25/07/08	QE Facilities Pay Award: Mr G Evans, QE Facilities Managing Director, presented the report in relation to the QE Facilities Pay Award proposal for 2025/26 which has been considered and approved by the QE Facilities Board.	

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	Mr Evans reminded the Board that the 2025/26 Agenda for Change (AfC) pay bands will receive a 3.6% consolidated uplift however QE Facilities has employees subject to both AfC and its own QE Facilities terms and conditions. To maintain parity, National Pay Awards have previously been mirrored although some employees subject to QE Facilities terms and conditions received a 1.75% uplift due to the National Living Wage increase in April 2025. Mr Evans explained that discussions took place at the QE Facilities Board and the implementation of a revised Pay Award in line with national NHS Agenda for Change (AfC) guidance was approved which includes applying the 3.6% pay award uniformly to all QE Facilities and Agenda for Change staff with an additional uplift to 4.25% for QEF Band A staff was approved to bridge the gap to ensure an equivalent £12.51 per hour salary to AFC Band 2 however this will result in the loss of the Real Living Wage accreditation (equivalent to £12.60 per hour). The Board expressed its disappointment in being unable to maintain the accreditation at the present time however it was recognised that this misalignment required national level discussion. Sir P Ennals, Shared Chair for Northumbria and Newcastle, noted that there was continued commitment to the principles of the accreditation therefore should be recognised as a pause pending further discussion. The Board felt that it would be important to emphasise this within communications to staff and Mr Evans confirmed that staff members will receive letters to confirm the changes as well as planned briefings and roadshows. After further consideration, it was: RESOLVED: to approve the 2025/26 QEF Pay Award as recommended by the QE Facilities Board, for implementation in August 2025, ensuring alignment across staff groups and compliance with national and statutory pay obligations.	
25/07/09	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 reminded the Board that Mrs T Davies, will be taking on a secondment as Acting Chief Executive of North Cumbria Integrated Care NHS Foundation Trust (NCIC) and interviews for the Acting Chief Executive role at Gateshead Health are scheduled to be held on 31 July 2025. Internal recruitment is also underway in relation to the appointment of a Vice Chair to support Sir Ennals when he commences in post as the new Chair on 1 October 2025. The Vice Chair role has been fully	

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	refreshed to provide the Chair with more routine support in line with the plans for Vice Chair appointments in Newcastle and Northumbria and interviews for this position will also be held on 31 July 2025. As this is a Governor appointment our Lead Governor and one of our Staff Governors form the decision-making element of the interview panel. Sir Ennals has been spending time getting to know the Trust prior to his formal start date of 1 October 2025 and Mrs Marshall has been working closely with him during this period to support a smooth handover at the end of September 2025. Mrs Marshall drew attention to the Star of the Month nominations and congratulated Will Warrington who was recognised for his work as a receptionist at Blaydon Urgent Treatment Centre. After consideration, it was: RESOLVED: to receive the report for assurance.	
25/07/10	Chief Executive's Report: Mrs T Davies, Group Chief Executive, gave an update to the Board on current issues which have been aligned to the Trust's new Strategic Aims. She drew attention to the key areas in relation to national policy, context and operating models and highlighted the Trust's position from the table of trusts' performance, which NHS England has published on key activities including planned treatment, A&E and cancer care. This is demonstrative of the impact on cancer and diagnostic performance as a result of the recent Picture Archiving and Communication Service (PACS) disruption. Mrs Davies drew attention to the Trust's Strategic Aim for Excellent Patient Care and highlighted that the Trust has had 8 confirmed Surgical Site Infections (SSIs) in relation to patients who have received trauma and orthopaedic surgery at Gateshead. There have been no obvious trends identified, but investigations are ongoing. In relation to Great Place to Work, Mrs Davies highlighted that Dr Simon Lowes, Consultant Breast Radiologist at the Gateshead Breast Unit, has been named the Royal College of Radiologists (RCR) Roentgen Professor for 2026 and Dr Lowes recently attended a Board meeting to provide an update on the Northern Centre for Breast Research. There has also been a sustained reduction in the number of people absent from work which shows that the sickness / absence reduction work is having an impact and colleagues are being supported back into the workplace. In relation to Working Together for Healthier Communities, Mrs Davies highlighted that the HIVE team were finalists for the Royal College of	

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	Physicians' Excellence Awards which recognised that the HIVE Programme brings together local clinical knowledge with insight from people with lived experience and the expertise of local authority and community services. In relation to Fit for the Future, Mrs Davies highlighted that the Trust is continuing to maintain a strong focus on securing a sustainable future for Gateshead Health which includes protecting the services our patients and communities rely on and an update is included in the supplementary information pack alongside the Board papers for this meeting. Mrs Davies also welcomed Mr Daryl Perry to the management team and will be leading on the sustainable future work, using productivity and Model Hospital data to support us to treat as many patients as possible efficiently and effectively. After further discussion, it was: RESOLVED: to receive the report for assurance.	
25/07/11	Fit and Proper Person Independent Review: Mrs T Davies, Group Chief Executive, presented the finding from the independent review of the Trust's Fit and Proper Person Test (FPPT) which was undertaken to provide assurance that current and previous FPPT policies since 2019 and related actions were in line with statutory requirements. Mrs Davies highlighted that the findings concluded that the policy has been continuously upgraded over the past five years and each version met the requirements at the time of publication and the policy has been correctly applied to all persons subject to the FPPT since 2019. The recommendations within the report will be reviewed in advance of the national work around the regulation of managers and the policy will be updated accordingly. Following consideration, it was: RESOLVED: to receive the report for assurance and note the recommendations for upgrades to the policy.	
25/07/12	Strategy Update: Mrs N Bruce, Director of Strategy and Partnerships, provided a summary of the recently published NHS 10 Year Health Plan for England 'Fit for the Future' and an update on the draft Trust strategy following its publication.	

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	Ms Bruce highlighted the NHS 10 Year Plan 'Fit for the Future' was published by the Government on 3rd July 2025 and sets out a transformative vision for healthcare in England building on the findings of the independent investigation of the NHS in England completed by Lord Darzi in 2024. She drew attention to the three 'shifts': • moving care from hospitals to communities; • moving from analogue to digital; and • moving from sickness to prevention. There are also five key enablers to support delivery of the 10 Year Plan: • the development of a new operating model; • introducing additional levels of transparency; • creating a new workforce model; • development of a new innovation strategy; and • reforming NHS finances. The report focuses on the implications of the 10 Year Plan for hospitals, including Gateshead Health and the changes needed to deliver the national ambitions however Ms Bruce highlighted that the Trust is in a good starting position in terms of strong relationships with current partners and working as part of the Great North Healthcare Alliance however challenges remain across all providers in relation to how care will be delivered in the future and the funding flows that will support this. Therefore further discussions will need to take place as part of future Board Development sessions. Ms Bruce reminded the Board that a draft of the Trust's 5 Year Strategy was agreed in principle at the June meeting pending the publication of the NHS 10 Year Plan. Following its publication, a read across has demonstrated good alignment with the national priorities and ambitions therefore no changes are proposed for the draft Trust strategy in light of this. Work will continue on the supporting chapters within the strategy with launch and publication scheduled for the Autumn when the entire document is complete. The Board were reassured that the Trust's Strategy aligns to the NHS 10 year plan and following a query from Mr A Crampsie, Non-Executive Director, in relation to how commissioning of future services particularly around neighbourhood health will be developed, Mr N Halford, Medical Director for Strategic Relations, explained that further discussions will need to take place around future opportunities however some models are already in place which could be explored further. Dr G Morrow, Non-Executive Director, queried whether Primary Care were involved in developments and Mrs T Davies, Group Chief Executive, highlighted that discussions are already taking place with Integrated Care Board colleagues and Mrs J Halliwell, Group Chief Operating Officer, explained that the Trust has strong local Place relationships which is reflective of working together and engagement with Primary Care.	Cycle of business

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	Mrs Davies informed the Board that Mr Martin Wilson, Great North Healthcare Alliance and Strategy Director, will be working with the Executive Management Team on strategic opportunities and will be attending the next Board Development Day to enable a unitary Board view for the future. After further discussion, it was: RESOLVED: i) to note the alignment of the Trust's goals and objectives with the national 10 Year Plan ii) to support the recommendation that no changes are made to the draft Trust strategy iii) to note that work is continuing on the supporting chapters ahead of launch and publication in the Autumn	
25/05/13	Governance Reports: Board Assurance Framework (BAF): Mrs J Boyle, Company Secretary, presented the current BAF position which shows the latest updates agreed at each Committee meeting. Mrs Boyle reminded the Board that it was agreed for the 2024/25 BAF to continue into 2025/26 until the new strategic objectives were agreed. As the new strategy has now been approved, the new BAF will be developed to align to the new strategic objectives and a session with Board members will take place via the Board Development Day in August 2025 to set the target scores for the risks. Mrs Boyle highlighted that 7 summary risk scores have met their target levels which provides good assurance that these are being reviewed and monitored by the Board Committees. She drew attention to the summary risk relating to achieving the sickness and absence and turnover standards and highlighted that this has been reduced following discussion at the People and Organisation Development Committee which took place following the completion of the report. Mrs Boyle also reminded the Board that the Alliance BAF extract is monitored directly by the Board and highlighted that the risk score was reduced at the last meeting down to 6 which meets the target score. After consideration, it was: RESOLVED: to receive the report for assurance. Organisational Risk Register (ORR): Dr G Findley, Chief Nurse and Deputy Chief Executive, presented the updated ORR to the Board which shows the risk profile of the ORR, top ORR risks and provides details of reviewed compliance and risk	

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	movements, including movement over the previous 12 months. This report covers the period 19th May 2025 to 19th July 2025. Dr Findley reported that there are currently 15 risks on the ORR. No risks have been added within the period however one risk has been escalated in relation to the risk of harm to staff due to exposure to violence and aggression from patients and visitors who exhibit challenging behaviours. The score has increased from 12 to 16 due to a significant increase in the number of reported incidents and a Violence Reduction Group has been re-established. One risk has been reduced relating to the Picture Archiving and Communication Service (PACS) system failure and no risks have been closed during the period. Dr Findley highlighted that there has been a decline in the risks and actions review compliance however support with reviews continues to be offered by the Corporate and Clinical Risk Lead. After consideration, it was: RESOLVED: to receive the report for assurance.	
25/07/14	Assurance from Board Committees: The Board reviewed the Committee escalation and assurance reports which identify areas of concern and ongoing monitoring of assurances. Finance and Performance Committee: Mrs H Parker, Non-Executive Director and on behalf of the Committee Chair, provided a brief verbal overview to accompany the narrative reports from the June 2025 meeting and drew attention to the most recent meeting which took place on 29th July 2025. She reported that there was one issue requiring escalation to the Board to highlight that the cash position continues to deteriorate in line with the plan however further emerging risks have been identified which will continue to be monitored via the Committee. The Committee also reviewed some business cases and contract awards which were recommended for approval and will be presented later in the meeting. The Committee received positive assurance in relation to cost reduction plans which have been delivered within Quarter 1 and urgent and emergency care performance targets including 4-hour, 12-hour, and ambulance handovers. Mrs Parker reported that the terms of reference have been reviewed to ensure that they accurately reflect the role and responsibility of the Committee and some minor changes have been made including job titles and updates to attendees.	

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	The revised Terms of Reference were therefore ratified on the recommendation of the Finance and Performance Committee. Quality Governance Committee: Mr A Crampsie, Committee Chair, provided a brief verbal overview to accompany the narrative report following the July 2025 meeting. He reported that there were four issues requiring escalation to the Board, one relates to Surgical Site Infections (SSIs) discussed earlier in the meeting and investigations are ongoing to provide further assurance to the Committee. Mr Crampsie also attended a visit to Theatres and the team are confident that the issues are being investigated. Another alert relates to the time taken to address the backlog in mortality reviews and further assurances have been requested however Dr G Findley, Chief Nurse and Deputy Chief Executive, assured the Board that this has not resulted in any delays in terms of families. As reported earlier, there has been an increase in incidents of violence and aggression against staff therefore the Committee has asked for further assurances on the action being taken to address this and is also being picked up with the Health and Safety team within QE Facilities. Dr Findley explained that the Violence Reduction Group is reviewing the threshold for yellow and red cards and undertaking some benchmarking work across other Trusts. There are some areas subject to ongoing monitoring in relation to the Trust being identified as an outlier within the National Maternity and Perinatal Audit in relation to post-partum haemorrhage and poor APGAR (Appearance, Pulse, Grimace, Activity, Respiration) scores. It has been noted however that the data used is from 2023 and this has been raised as an issue at national level. Dr Findley advised that the publication of the audit has been delayed and it is hoped that this will incorporate a revised version. Mr Crampsie explained that discussions have been held with the Associate Director of Midwifery/Special Care Baby Unit and draft communications are in place People and Organisational Development Committee: Mrs M Pavlou, Committee Chair, provided a brief verbal overview to accompany the narrative report following the July 2025 meeting. She reported that there were two issues requiring escalation to the Board. One relates to Tier 2 meetings being stood down but the Committee acknowledged that a review is being undertaken. The other relates to proposed changes to the Freedom to Speak Up report however it was noted that the Freedom To Speak Up Guardian is currently absent and Dr Findley highlighted that due to changes in national guidance and structures, expressions of interest will be sought to fill the role however she assured the Board that there will be no change to the Trust's approach.	

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	There are some areas subject to ongoing monitoring in relation to the Voluntary Severance Scheme and a report will come back to the Committee once the exercise has been completed to understand the impact. The Committee was assured of the positive change in sickness rates which has resulted in a reduction in the risk rating on the Board Assurance Framework. It has also been confirmed that the Star Awards will take place again this year however will be in a different format. Digital Committee: The Board received the assurance report for information, and it was noted that there were two items for escalation, one relating to the proposed route for Digital Records Programme and the Committee recommended that this continues to progress to ensure that resource allocation and prioritisation is confirmed. The other relates to the need to review the onward reporting of Freedom of Information compliance. Group Remuneration Committee: The Board received the assurance report for information. There were no matters of concern to alert to the Board however it was noted that the new NHS Very Senior Managers (VSM) Framework has been launched and this will be reviewed further in September 2025 following the confirmation of the NHS Oversight Framework (NOF) implications. Mrs Marshall thanked the Committee Chairs for their reports. After consideration, it was: RESOLVED: to receive the reports for assurance	
25/07/15	Finance Report: Mrs K Mackenzie, Group Director of Finance, provided the Board with assurance against delivery of the approved 2025/26 revenue, capital and cash plan as at 30th June 2025. Mrs Mackenze reported that the Trust has reported an actual deficit of £4.2m which is an adverse variance from plan of £300k mainly associated with recovery from the Picture Archiving and Communication Service (PACS) outage issues. The Trust has achieved its current cost reduction programme target of £6.6m and £15.9m of its £32.8m full year target which includes £8m recurrent savings. Dr G Morrow, Non-Executive Director, felt that it was important to recognise the hard work that has been undertaken by teams to achieve the expected targets. As reported earlier, the Trust's cash position continues to deteriorate in line with the plan and an emerging risk has been identified in relation to implications around the pay award and potential gaps in funding. Following a query from Mr A Crampsie, Non-Executive Director in	

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	relation to cash support, Mrs Mackenzie reported that there is an expectation that this should be managed within local systems. After consideration, it was: RESOLVED: to receive the Month 3 financial position and note partial assurance for the achievement of the 2025/26 planned financial targets.	
25/07/16	Strategic Objectives and Constitutional Standards Report: Mrs K Mackenzie, Group Director of Finance, presented the progress, risks and assurance in relation to the Trust's strategic objectives and constitutional standards for Month 3 2025/26. Mrs Mackenzie reported that the main headlines have already been raised for example, reduction in sickness absence, recovery from the Picture Archiving and Communication Service (PACS) outage and improving performance within urgent and emergency care. Mrs J Halliwell, Group Chief Operating Officer, highlighted that NHS England Accident and Emergency Provider Flow Pack has been included within the Board Supplementary Information pack and provides bespoke metrics for Gateshead which includes national and regional benchmarking. Following a query from Mr A Crampsie, Non-Executive Director, in relation to whether any impact from the industrial action is expected, Mrs Halliwell reported that minimal impact is expected however the aim is to deliver services as usually and prioritise urgent and emergency care activity. Discussion took place in relation to recovery from the PACS outage and Mrs Halliwell reported that a final report was presented to the Finance and Performance Committee which provided details around the financial and performance impact. Following consideration, it was: RESOLVED: to receive the report for assurance and note the key areas of improvement and challenge.	
25/07/17	Winter Plan: Mrs J Halliwell, Group Chief Operating Officer, provided the strategic overview for winter planning for 2025/26. Mrs Halliwell reported that internal planning sessions have taken place during June and July 2025 as well as a system planning workshop which	

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	took place on 11th July 2025. The outputs from the workshop will form the basis of the system winter plan and will be stress-tested in September 2025 prior to presentation of the final winter plan to the Board on 25th September 2025. This will include a Board Assurance Statement which will need to be submitted to NHS England and signed by the Chair and Chief Executive and a copy of this has been included within the Board Supplementary Information Pack. The Board noted that staff vaccination programmes and preparatory actions are underway and Mrs Halliwell confirmed that this is being picked up by the Deputy Chief Nurse and plans are in place to provide greater accessibility to peer vaccinators. Following a query from Mrs Marshall in relation to when the vaccines will be available, Dr G Findley, Chief Nurse and Deputy Chief Executive, reported that plans are being developed with the NHS England Regional Director however the Trust has been contacted to share best practice plans to support national standardisation work and has been invited to attend the National Patient Flow Conference in November 2025 to showcase our services. Dr G Morrow, Non-Executive Director, raised a query in relation to vaccination programmes within the community particularly supporting the Jewish community and Mrs Halliwell advised that this would be provided via Public Health and Primary Care services however will raise this as part of the system discussions. Following discussion, it was: RESOLVED: to receive the draft plan for assurance and note the final plan will be presented to the Board in September 2025.	Cycle of business
25/07/18	Learning from Deaths Quarterly Report: Mr N Halford, Medical Director for Strategic Relations, presented the report which provides an overview of the organisational learning from deaths for Quarter 4. The report is supported by the Mortality Data report and the Medical Examiner report for Quarter 4 to ensure an understanding of the context and an overview of the mortality related activity within the Trust. The backlog in mortality reviews was raised as a concern at the Quality Governance Committee and Mr Halford drew attention to the addendum to the report which was completed following the meeting. This provides further assurance around the process being undertaken to address the backlog which includes additional Mortality and Morbidity Steering Group meetings taking place to focus on the backlog. It has also been proposed that the timescales within the Trust policy will be amended against the National Quality Board categories. After consideration, it was:	

Agenda Item No		Action Owner
	RESOLVED: to receive the report for assurance noting that partial assurance is provided regarding internal processes at present.	
25/07/19	Maternity Integrated Oversight Report: Dr G Findley, Chief Nurse and Deputy Chief Executive, presented a summary of the maternity indicators for the Trust for June 2025. She drew attention to the key performance indicators within the Maternity Dashboard and highlighted that there were 153 deliveries in June 2025 which is just under the cap of 160 and no issues have been reported. The Trust remains a positive outlier for smoking at the time of delivery which has reduced further since the last report and is now the lowest rating across all areas of the North East and North Cumbria Integrated Care Board. Two incidents have been reported in relation to missing instruments in theatres however Dr Findley assured the Board that these did not result in any patient harm and a detailed report has been shared with the Quality Governance Committee. Mrs T Davies, Group Chief Executive, provided an update on the National Maternity Investigation which was announced by the Secretary of State in June 2025 and letters have been sent to all Provider Trusts and Integrated Care Boards to outline clear recommendations and a Taskforce Group has been set up to manage the national review. Mrs Davies felt that it was important for the Board to receive assurances from the maternity team to provide visibility and share key messages. The importance of the Maternity Champion which is a Non-Executive Director role has also been raised and it has been suggested that a report is provided to the Board for greater assurance. Following discussion, it was: RESOLVED: to receive the report for assurance.	
25/07/20	Bi-annual Inpatient Safer Nursing Care Staffing Report: Dr G Findley, Chief Nurse and Deputy Chief Executive, presented the report which provides an overview of the Safe Staffing nursing reviews undertaken by the Trust in August 2024 and January 2025. She reported that there is currently a variance between the Safer Nursing Care Tool (SNCT) recommended uplift and professional judgement which is explained by the ongoing bed base reductions and enhanced rostering work. Work around Enhanced Care and Mental Health staffing has been completed and it is felt that this does not currently require separate establishment change however will continue to be monitored	

Agenda Item No		Action Owner
	through national programmes and the Trust is working closely with Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust. Dr Findley confirmed that no changes will be made at this time however acuity will continue to be monitored through professional judgement with a review taking place once the new model is in place. Following a query from Mrs Marshall around the variance between the SNCT recommendations and professional judgement, Dr Findley explained that some difference is expected however the tool relates to staff in budget therefore reviews will continue to take place through bed base changes and the Enhanced Rostering programme which will be reported via the People and Organisational Development Committee. After further consideration, it was: RESOLVED: to receive the report for assurance.	
25/07/21	Nurse Staffing Exception Report: Dr G Findley, Chief Nurse and Deputy Chief Executive, presented the report for June 2025 which provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls. Dr Findley highlighted that the cover sheet provides a more detailed analysis of the report following discussions at the last Board meeting. She reported that increased patient activity continues to be reported which is affecting staffing resource. Craggside have reported high levels of sickness which may be related to an increase in violence and aggression incidents and different approaches to care provision are being explored. Dr Findley explained that there has been an increase in health care assistant roles however some vacancies are being held to ensure positions are available to support cost reduction plans however some posts may need to be filled by bank staff to maintain safety until new staffing models are rolled out. Following discussion, it was: RESOLVED: to receive the report for information and assurance.	
25/07/22	Cycle of Business 2025/26: Mrs J Boyle presented the cycle of business for 2025/26 which outlines forthcoming items for consideration by the Board. This provides advanced notice and greater visibility in relation to forward planning	

Agenda Item No		Action Owner
	however requested Board members to provide any feedback to ensure this is reflective of the required Board business. After consideration, it was: RESOLVED: to review the cycle of business for the financial year 2025/26.	
25/07/23	Questions from Governors in Attendance: There were no questions received from Governors.	
25/07/24	Any Other Business: There was no other business discussed.	
25/07/25	Date and Time of Next Meeting: The next meeting of the Board of Directors will be held at 9.30am on Thursday 25th September 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

	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
24/09/08	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 30/07/2025 25/09/2025	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 – expected at July Board meeting to allow review by the Audit Committee. May 25 – recommended that they will now presented at the September Board meeting due to other organisational priorities September 25 – updates made and the Corporate Governance Manual is included on the agenda with a recommendation from the Audit Committee to approve the changes. Action recommended for closure.	
24/09/09	24/09/2024	National Pay Award	To review and update the wording in the SFIs and Scheme of	27/11/2024 30/07/2025 25/09/2025	Kmac	Nov 24 - links to action 24/09/08 therefore action agreed for closure as above Jan 25 – as above	

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
			Delegation relating to Board approval of national pay awards.			Feb 25 – recommendation to reopen the action until updates are made – expected at July Board meeting to allow review by the Audit Committee May 25 – recommended that they will now presented at the September Board meeting due to other organisational priorities September 25 – updates made and the Corporate Governance Manual is included on the agenda with a recommendation from the Audit Committee to approve the changes. Action recommended for closure.	
25/03/17	26/03/2025	Freedom to Speak Up Guardian Report	To consider whether further discussion to take place at Board Development Day in relation to system support around complex employment cases	21/05/2025	JB	May 25 – added to the agenda for the next Board development day on 25 June. July 25 – note that this item was deferred due to unavoidable circumstances. Recommendation to reopen action until the session can be rescheduled.	

Closed Actions from last meeting

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
25/05/10	21/05/2025	Organisational Risk Register	To highlight those risks with no movement which are classed “as low as reasonably practicable” (ALARP) and include further detail around the work that is being completed to provide further Board assurance.	30/07/2025	GF	All ALARP risks now include the word ALARP at the beginning of the risk descriptor. All ALARP risks have been reviewed via ERMG. Action recommended for closure.	
25/05/14	21/05/2025	Strategic Objectives and Constitutional Standards Report	To include the NHSE data analysis report in relation to urgent and emergency care within the Finance and Performance Board Assurance Report	30/07/2025	JH/Kmac	July 25 – included in supplementary paper pack to accompany the Strategic Objectives and Constitutional Standards Report. Action recommended for closure	
25/05/15	21/05/2025	Maternity Integrated Oversight Report	To review and update the wording of risk description for Risk 4726 which relates to the workforce model in place to support services that are required to be delivered from the Women’s Health Centre particularly around the “drift basis”.	30/07/2025	GF	Relates to risk 4729 not 4726 however wording of risk has been reviewed. Action recommended for closure.	
25/05/16	21/05/2025	Nurse Staff Exception Report	To consider whether further narrative and more meaningful intelligence can be provided to the Board via the cover sheet	30/07/2025	EMT	Further information provided within the cover sheet this month. Action recommended for closure.	

Top Organisational Risks – September 2025

The top 3 organisational risks as agreed by the Executive Risk Management Group on 1 September 2025 are as follows:

Top 3 Organisational Risks:

Risk Id	Division	Description	Initial Risk Grade	Grade▼	Target Grade
4694	Finance	Risk that the Trust will not achieve its 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
4704	Digital	Risk of failure to review appropriate clinical information due to multiple sources and lack of interoperability of data stored across a variety of digital systems and in paper format. This could result in patient harm or sub optimal care.	20	16	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



Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 8

Report Title:	Calendar of Board Meetings 2026/27			
Name of Meeting:	Board of Directors – Part 1			
Date of Meeting:	25 September 2025			
Author:	Diane Waites, Corporate Services Assistant			
Executive Sponsor:	Alison Marshall, Chair			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report <i>Briefly describe why this report is being presented at this meeting</i>	Decision: ☒	Discussion: ☐	Assurance: ☐	Information: ☒
	To inform the Board of the planned Board meeting dates for 2026/27.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	Fully assured ☐ <i>No gaps in assurance</i>	Partially assured ☐ <i>Some gaps identified</i>	Not assured ☐ <i>Significant assurance gaps</i>	Not applicable ☒
Paper previously considered by: <i>State where this paper (or a version of it) has been considered prior to this point if applicable</i>	-			
Key issues: <i>Briefly outline what the top 3-5 key points are from the paper in bullet point format</i> <i>Consider key implications e.g.</i> • Finance • Patient outcomes / experience • Quality and safety • People and organisational development • Governance and legal • Equality, diversity and inclusion	• Proposed dates follow a similar pattern to previous years and are scheduled to enable timely review of the previous month's finance and performance data.			
Recommended actions for this meeting:	The Board is asked to approve and receive the dates of the Board of Directors' meetings to be held in 2026/27.			

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 ☒		

Board of Directors' Meetings 2026/27

During 2026/27 the Board of Directors will hold 7 public meetings including the Annual General Meeting. The Board are also asked to note the Board Development dates.

Date	Time	Venue
22 April 2026 Board Development Day	9.00am	Room 3, Education Centre
27 May 2026	9.30am	Room 3, Education Centre
24 June 2026 Board Development Day	9.00am	Room 3, Education Centre
29 July 2026	9.30am	Room 3, Education Centre
19 August 2026 Board Development Day	9.00am	Room 3, Education Centre
29 September 2026 (Tuesday)	9.30am	Room 3, Education Centre
30 September 2026 Annual General Meeting	9.30am	Lecture Theatre, Education Centre
21 October 2026 Board Development Day	9.00am	Room 3, Education Centre
25 November 2026	9.30am	Room 3, Education Centre
16 December 2026 Board Development Day	9.00am	Room 3, Education Centre
27 January 2027	9.30am	Room 3, Education Centre
3 March 2027 Board Development Day	9.00am	Room 3, Education Centre
31 March 2027	9.30am	Room 3, Education Centre

Report Cover Sheet

Agenda Item: 9

Report Title:	Corporate Governance Manual – Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation of Powers			
Name of Meeting:	Board of Directors			
Date of Meeting:	25 September 2025			
Author:	Jane Fay, Deputy Director of Finance Jennifer Boyle, Company Secretary			
Executive Sponsor:	Kris Mackenzie, Group Director of Finance			
Report presented by:	Kris Mackenzie, Group Director of Finance Jennifer Boyle, Company Secretary			
Purpose of Report <i>Briefly describe why this report is being presented at this meeting</i>	Decision: ☒	Discussion: ☒	Assurance: ☒	Information: ☐
	The purpose of this report is to provide the Board of Directors with a summary of proposed changes to the Corporate Governance Manual and request ratification of the changes (as recommended by the Group Audit Committee)			
Proposed level of assurance – to be completed by paper sponsor:	Fully assured ☒ <i>No gaps in assurance</i>	Partially assured ☐ <i>Some gaps identified</i>	Not assured ☐ <i>Significant assurance gaps</i>	Not applicable ☐
Paper previously considered by: <i>State where this paper (or a version of it) has been considered prior to this point if applicable</i>	Group Audit Committee – 2 September 2025			
Key issues: <i>Briefly outline what the top 3-5 key points are from the paper in bullet point format</i> <i>Consider key implications e.g.</i> • Finance • Patient outcomes / experience • Quality and safety • People and organisational development • Governance and legal • Equality, diversity and inclusion	The Trust Board approved an updated set of Standing Orders, Standing Financial Instructions and Delegated Limits in March 2024, all of which form the Trust's Corporate Governance Manual. In accordance with best practice and in recognition of changes to the Trust governance a number of minor changes to the current version is proposed. This paper provides a summary of proposed changes. Changes have been approved by the Group Audit Committee, which recommends that the Board ratifies the revisions. The full Corporate Governance Manual (with tracked changes enabled to illustrate the amendments) accompanies this covering paper.			

Recommended actions for this meeting: <i>Outline what the meeting is expected to do with this paper</i>	The Group Audit Committee recommends that the Board of Directors ratifies the changes to the Corporate Governance Manual.				
Trust Strategic Aims that the report relates to:	☐	Excellent patient care			
	☒	Great place to work			
	☐	Working together for healthier communities			
	☒	Fit for the future			
Trust strategic objectives that the report relates to:	10) We will ensure effective and efficient use of our resources identifying opportunities to improve productivity and ensure best use of public money 12) We will focus on productive utilisation of our estate to facilitate care in the right setting and providing our services in an environmentally sustainable way				
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 directly from this paper				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	Yes ☐		No ☒		Not applicable ☐

Corporate Governance Manual Review

1.0 Introduction

- 1.1 The purpose of this report is to provide a summary of proposed changes to the Trust Corporate Governance Manual and recommend ratification by Trust Board. The changes have been reviewed and approved by the Group Audit Committee – the Committee recommends the ratification of the Corporate Governance Manual.

2.0 Summary of Proposed Changes

Standing Orders

- Updates to job titles and terminology, such as changing Deputy Chair to Vice Chair, replacing Business Units with Divisions and changing Chief Information Officer to Chief Digital Officer.
- 6.4 / 6.5 – update to the appointment process for and the role of the Vice Chair
- 22.8 – addition of the Committee in Common and Great North Healthcare Alliance Joint Committee to the list of committees established by the Board
- 23.11 – updated reference to the NHS England fit and proper person requirements

Standing Financial Instructions

- Where necessary job titles updated
- 32.1 inclusion of financial gap and cost reduction target
- 32.2 inclusion of wte funded establishment
- 32.3 inclusion of information on underlying deficit
- 32.3 inclusion of process for changes to budget arising from cost reduction programme
- 32.4 update on reporting and monitoring of capital spend
- 34.5 updated to include reference to BACS bank payments
- 35.3.2 updated to reference Trust's overpayment policy
- 38.1 updated to include the role of the Group Remuneration Committee in relation to advising the Board on severance packages
- 38.2 updated to reference Trust's budget virement process
- 38.3 updated to clarify that the application of national pay awards under Agenda for Change still require formal approval by the Board of Directors
- 38.4 updated to strengthen controls on staff over/under payments
- 41.1.2 change to require a business case for capital schemes over £1m only, current version requires a business case for all capital schemes
- 43.2.9 updated to confirm all losses must be approved by the Group Director of Finance prior to being reported to the Audit Committee

Scheme of Delegation

- Clarification that approval of severance / redundancy schemes is a matter reserved for the Board of Directors
- Clarification that approval of national pay awards for Agenda for Change staff is a matter reserved for the Board of Directors
- Change of approval threshold for capital scheme business cases from nil to £1m by Trust Board
- Increase of threshold for the waiving of competitive tendering which requires Executive Director approval from £100,000 to £200,000

- Inclusion of approval of all redundancy payments regardless of value by Chief Executive
- Updated budget virement process thresholds to align with budget virement process

3.0 Recommendation

- 3.1. The Group Audit Committee recommends that the Board of Directors ratifies the changes to the Corporate Governance Manual.

Corporate Governance Manual

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

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Introduction

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

It is composed of:

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

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

Change control

Version	Date	Main changes
1.0	September 2019	• Full review of all three component elements of the Corporate Governance Manual. • Note that version numbers were not previously tracked and therefore this is considered to be version 1.0, but recognising that the documents were in existence prior to this time.
2.0.	March 2024	• Full review of all three component elements, including a significant number of changes to modernise the documents and ensure they are fit for purpose.
3.0	August 2025	• Updates made to reflect some identified gaps / clarification points which have arisen since the last full review, as well as changes to the governance structure

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

1. Statutory Framework

- 1.1. Gateshead Health NHS Foundation Trust is a statutory body which became a public benefit corporation on 5 January 2005 following its approval as an NHS Foundation Trust by the independent regulator at the time (Monitor) pursuant to the Health and Social Care (Community Health and Standards) Act 2003 (the 2003 Act).
- 1.2. The Trust operates from a number of locations, but its principle place of business is at Queen Elizabeth Hospital, Sheriff Hill, Gateshead, NE9 6SX.
- 1.3. NHS Foundation Trusts are governed by Acts of Parliament, mainly the National Health Service Act 2003, the National Health Service Act 2006, the Health and Social Care Act 2012, the Health and Care Act 2022, by their constitutions and by the provider licence to operate granted by the regulator. The functions of the Trust are conferred by this legislation and authorisation.
- 1.4. As a public benefit corporation, the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role, it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State for Health and Social Care. The Trust also has a common law duty as a bailee (custodian) for property held by the Trust on behalf of patients.
- 1.5. Documents including the Standing Financial Instructions and the Scheme of Delegation and Reservation of Powers shall have effect as if incorporated into Standing Orders.

2. Interpretation

- 2.1. Save as otherwise permitted by law and subject to the Constitution, at any meeting the Chair of the Trust shall be the final authority on the interpretation of standing orders (on which they should be advised by the Company Secretary).
- 2.2. Any expression to which a meaning is given under the Health Service Acts, or in the regulations or orders made under the Acts shall have the same meaning in this interpretation.
- 2.3. Key definitions relevant to these Standing Orders are outlined below:

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

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

3. Board of Directors

- 3.1. All business shall be conducted in the name of the Trust. All decisions must be taken objectively and in the interests of the Trust.
- 3.2. All funds received in trust (Charitable funds) shall be held in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised

by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

- 3.3. Directors acting on behalf of the Trust as a corporate trustee are responsible for ensuring that the trustee duties of the Trust are complied with. Accountability for charitable funds held on trust is to the Charity Commission.
- 3.4. The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in Reservation of Powers to the Board and have effect as if incorporated into the Standing Orders.

4. The Role of the Board of Directors

- 4.1. The role of the Board of Directors is to provide active leadership of the NHS Foundation Trust within a framework of prudent and effective controls which enables risk to be assessed and managed. The Board of Directors and each Director individually, has a duty to promote the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.
- 4.2. The Board as a whole is responsible for ensuring the quality and safety of services, setting the Trust's strategic aims, taking into consideration the views of the Council of Governors, ensuring that the necessary financial and human resources are in place and agreeing the Trust's values and standards of conduct and behaviour.
- 4.3. The Board of Directors is responsible for ensuring that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance. Where appropriate the Board will commission independent advice to provide an adequate and reliable level of assurance.

5. Composition of the Board

- 5.1. The composition of the Board will be in accordance with the Constitution of the Trust.
- 5.2. **Executive Directors** will exercise their authority within the terms of these Standing Orders and the Trust's Standing Financial Instructions and the Scheme of Delegation.
- 5.3. The **Chief Executive** is responsible for the overall performance of the executive functions of the Trust and is the Accounting Officer who shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with

the requirements of the NHS Foundation Trust Accounting Officer Memorandum.

- 5.4. The **Group Director of Finance & Digital** shall be responsible for the provision of financial advice to the Trust for the supervision of financial control and accounting systems and will be responsible, along with the Chief Executive, for ensuring the discharge of obligations under relevant Financial Directions.
- 5.5. The **Non-Executive Directors** will not be granted nor will they seek to exercise any individual executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of, or when chairing, a committee of the Trust which has delegated powers.
- 5.6. Non-Executive Directors should receive the necessary information and feel able to raise appropriate challenge of recommendations or decisions of the Board, in particular making full use of their skills and experience gained both as a Director of the Foundation Trust and also in other leadership roles.
- 5.7. The **Chair** is responsible for the operation of the Board and will chair all Board meetings when present. The Chair has certain delegated executive powers. The Chair must comply with their terms of appointment and with these Standing Orders.
- 5.8. The Chair will take responsibility either directly or indirectly for the induction of the Non-Executive Directors, their portfolios of interests and assignments, and their performance.
- 5.9. The Chair will work in close harmony with the Chief Executive and will ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate and ultimate resolutions.

6. Appointment of Board Members

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

- 6.4. The ~~Board~~ Council of Governors can appoint one of the Non-Executive Directors to be ~~Deputy-Vice~~ Chair for a period of time not exceeding the remainder of their term. The ~~Deputy-Vice~~ Chair cannot be the Audit Committee Chair.
- 6.5. Where the Chair of the Trust has ceased to hold office or are unable to perform their duties due to illness or any other cause, the ~~Deputy-Vice~~ Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties. References to the Chair in these Standing Orders shall ~~so long as there is no Chair able to perform their duties,~~ be taken to include references to the ~~Deputy Vice~~ Chair.
- 6.6. The Board can appoint one of the Non-Executive Directors to be the Senior Independent Director for a period of time not exceeding the remainder of their term. The appointment must be made in consultation with the Council of Governors. The Senior Independent Director cannot be the Audit Committee Chair.

7. Terms of Office of Board Members

- 7.1. In accordance with the Code of Governance for NHS Provider Trusts, Non-Executive Directors, including the Chair, should be appointed by the Council of Governors for specified terms subject to re-appointment thereafter at intervals of no more than three years.
- 7.2. Any decision to extend a term beyond six years from the date of the first appointment to the Board is subject to rigorous review. The Chair and Non-Executive Directors should not remain in post beyond nine years. A Non-Executive Director becoming Chair after a three-year term as a Non-Executive Director would not trigger a review after three years in post as Chair.
- 7.3. All extensions and re-appointments must be considered in the context of the latest requirements of the Code of Governance.

8. Meetings of the Board of Directors – Calling Meetings

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

- 8.3. Agendas will be sent to Members of the Board six days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than three clear days before the meeting, save in emergency. Failure to serve such a notice on more than three Members of the Board will invalidate the meeting. A notice shall be presumed to have been served once issued electronically.
- 8.4. Before each meeting of the Board of Directors a public notice of the time and place of the meeting shall be displayed on the Trust's website at least three clear days before the meeting.
- 8.5. At the discretion of the Chair meetings may be held in person, using virtual technology or in a hybrid format (a combination of the two). A Board meeting held in any of these formats constitutes a properly governed meeting to which these Standing Orders apply. This extends to all groups within the Board's governance structure. The same principles regarding voting rights and quorum will apply to virtual / hybrid meetings.
- 8.6. At the discretion of the Chair an extraordinary Board meeting may be called provided Board Members are given at least twenty-four hours notice, with best endeavours to provide as much notice as possible. No business shall be transacted at an exceptional meeting of the Board of Directors unless at least one-third of the whole number of the Directors appointed (including at least two Non-Executive Directors and two Executive Directors) are present.
- 8.7. The Board of Directors is divided into a public and private session. The Board of Directors recognises the need to be as open and transparent as possible and therefore the majority of its business will be conducted in public session. Provision is made for parts of the meeting to be held in closed session where items of a confidential nature are discussed. Such items may relate to personal data, commercial interests or issues which would prejudice the effective conduct of public affairs.

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

- 9.1. The Board may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted.
- 9.2. A Member of the Board desiring a matter to be included on an agenda shall make his request in writing to the Chair at least 10 clear days before the meeting. The request should include appropriate supporting information. Requests made less than 10 clear days before a meeting may be included on the agenda at the discretion of the Chair.
- 9.3. Requests for agenda items should state whether the item of business is proposed to be transacted in the presence of the public or reserved for

discussion in private session and should include appropriate supporting information.

10. Meetings of the Board of Directors – Petitions

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

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

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

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

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

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

- 13.1. A Member of the Board desiring to move or amend a motion shall send a written notice (including by email) thereof at least 10 clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice, on any business mentioned on the agenda.
- 13.2. A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chair.
- 13.3. Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Member of the Board who gives it and also the signature of four other Board Members. When any such motion has been disposed of by the Board, it shall not be competent for any Member other than the

Chair to propose a motion to the same effect within six months, however the Chair may do so if they consider it appropriate.

- 13.4. The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.
- 13.5. When a motion is under discussion or immediately prior to discussion it shall be open to a Member of the Board to move:
 - an amendment to the motion.
 - the adjournment of the discussion or the meeting.
 - that the meeting proceed to the next business (*)
 - the appointment of an ad hoc committee to deal with a specific item of business.
 - that the motion be now put (*)

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

- 13.6. No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the motion.
- 13.7. Subject to the agreement of the Chair, a Director may give notice of an emergency motion after the issue of the notice of the meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared at the commencement of the business of the meeting as an additional agenda item included in the agenda. The Chair's decision to include the item is final.

14. Meetings of the Board of Directors - Voting

- 14.1. A question at a meeting shall be determined by a majority of the votes of the Chair of the meeting and Members of the Board present and voting on the question and, in the case of the number of votes for and against a motion being equal, the Chair of the meeting shall have a second or casting vote.
- 14.2. All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Members of the Board present so request.
- 14.3. If at least one-third of the Members of the Board present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Member of the Board present voted or abstained.
- 14.4. If a Member of the Board so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).

- 14.5. In no circumstances may an absent Member of the Board vote by proxy. Absence is defined as being absent at the time of the vote.
- 14.6. An officer who has been appointed formally by the Board of Directors to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director. An officer attending the Board of Directors to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

15. Meetings of the Board of Directors – Minutes

- 15.1. The Minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting.
- 15.2. The names of the Chair and Members of the Board present at the meeting shall be recorded in the minutes.
- 15.3. No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.
- 15.4. Minutes shall be circulated to all Board Members. Where providing a record of a public meeting, the minutes shall be made available to the public.

16. Meetings of the Board of Directors - Quorum

- 16.1. No business shall be transacted at a meeting of the Board of Directors unless at least one-third of the whole number of the Directors appointed, (including at least two Non-Executive Directors and two Executive Directors) are present.
- 16.2. An officer in attendance for an Executive Director but without formal acting- up status may not count towards the quorum.
- 16.3. If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest, he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.
- 16.4. The above requirement for at least two Executive Director to form part of the quorum shall not apply where the Executive Directors are excluded from a

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

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

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

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

- 18.1. The Board of Directors may, by resolution, adjourn any meeting to some other specified date, place and time and such adjourned meeting shall be deemed a continuation of the original meeting. No business shall be transacted at any adjourned meeting which was not included in the agenda of the meeting of which it is an adjournment.
- 18.2. When any meeting is adjourned to another day, other than the following day, notice of the adjourned meeting shall be sent to each Director specifying the business to be transacted.

19. Arrangements for the Exercise of Functions by Delegation

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

20. Exercise of Functions by Delegation – Emergency Powers

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

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

- 21.1. The Board shall agree from time to time to the delegation of executive powers to be exercised by committees, or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board.
- 21.2. Those routine functions of the Trust which have not been retained as reserved to the Board of Directors or delegated to a committee, sub-committee or joint committee shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate officers to undertake the remaining functions for which they will still retain accountability to the Board.
- 21.3. The Chief Executive shall prepare a Reservation and Delegation of Powers identifying proposals which shall be considered and approved by the Board, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendments to the Reservation and Delegation of Powers that shall be considered and approved by the Board as indicated above.
- 21.4. Nothing in the Scheme of Delegation by the Board shall impair the discharge of the direct accountability of the Executive Directors to the Board of the Directors to provide information and advise the Board in accordance with the Constitution, Authorisation, statutory provisions.
- 21.5. The arrangements made by the Board as set out in the Reservation and Delegation of Powers to the Board and Delegation of Powers document shall have effect as if incorporated in these Standing Orders.

22. Committees

- 22.1. Subject to the Constitution and any statutory provisions, the Board of Directors may and, if directed, shall appoint committees of the Trust, consisting wholly or partly of the Chair and Directors of the Board.
- 22.2. These committees may appoint sub-committees consisting wholly or partly of members of the committee, or wholly of persons who are not members of the committee.
- 22.3. The Standing Orders of the Board, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Board. In which case the term “Chair” is to be read as a reference to the Chair of the committee as the context permits, and the term “Member of the Board” is to be read as a reference to a member of the committee also as the context permits.

- 22.4. Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with the Regulatory Framework and any direction or guidance issued by NHS England. Such terms of reference shall have effect as if incorporated into the Standing Orders.
- 22.5. Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board.
- 22.6. The Board shall approve the appointments to each of the committees which it has formally constituted.
- 22.7. Where the Trust is required to appoint persons to a committee and/or to undertake statutory functions as required by the Independent Regulator, and where such appointments are to operate independently of the Board of Directors, such appointments shall be made in accordance with the regulations and directions laid down by the Board of Directors.
- 22.8. The committees established by the Board of Directors are:
- Group Audit Committee
 - Finance and Performance Committee
 - Quality Governance Committee
 - People and Organisational Development Committee
 - Digital Committee
 - Group Remuneration Committee
 - Committee in Common (for Great North Healthcare Alliance-related business)
 - Great North Healthcare Alliance Joint Committee (a collective committee with The Newcastle-upon-Tyne Hospitals NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust).
- 22.9. The Board of Directors may establish other committees, sub-committees and joint committees, including ad hoc committees, sub-committees and joint committees at its discretion without requirement to amend these standing orders.
- 22.10. A member of the Board of Directors or a member of a committee shall not disclose any matter reported to the Board or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or committee shall resolve that it is confidential or embargoed.
- 22.11. Non-Executive Directors may attend any meeting of any committee by submitting prior notice to the Committee Chair. The Chair of the Group Audit

Committee reserves the right to restrict attendance to all or part of any Group Audit Committee meeting according to the nature of the agenda.

23. Declaration of Interests and Register of Interests

- 23.1. In accordance with the Constitution, provider licence and regulatory framework all Board Members are required to declare interests which are relevant and material to the Board of which they are a Member. All existing Board members should declare such interests. Any Board members appointed subsequently should do so on appointment.
- 23.2. This section of the Standing Orders should be read in conjunction with the Constitution and the Trust's policy on conflicts of interest.
- 23.3. Interests which are 'relevant and material' are to be interpreted in accordance with guidance issued by NHS England. This includes, but is not limited to:
 - (a) Directorships, including Non-Executive directorships held in private companies or public limited companies (with the exception of those of dormant companies).
 - (b) Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
 - (c) Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.
 - (d) A position of trust in a charity or voluntary organisation in the field of health and social care.
 - (e) Any connection with a voluntary or other organisation contracting for NHS services.
 - (f) To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.
 - (g) Any other commercial interest in the decision before the meeting.
- 23.4. If Board Members are in any doubt about the relevance of an interest, this should be discussed with the Chair or the Company Secretary.
- 23.5. At the time Board members' interests are declared; they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring.
- 23.6. Declared interests are maintained on a register by the Company Secretary, which is available for public inspection.
- 23.7. During the course of a Board meeting, if a conflict of interest is established, the Member of the Board concerned should play no part in the relevant discussion or decision and may be asked to withdraw from the meeting at the Chair's discretion.

- 23.8. The interests of Board members' spouses or cohabiting partners should be regarded as relevant and should be disclosed.
- 23.9. Influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.
- 23.10. If the Chair or another Member of the Board has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.
- 23.11. As well as declaring interests, all Board Members must also comply with the requirements of Regulation 5 (Fit and Proper Persons: Directors) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and associated [fit and proper person](#) regulatory requirements as set by NHS England. Board Members must demonstrate compliance upon appointment and annually.

24. Declarations of Interest – Appointments and Relations

- 24.1. A Member of the Board shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a Member of the Board from giving written or verbal testimonial of a candidate's ability, experience or character for submission to the Trust.
- 24.2. Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee by the Member of the Board who conducted the discussion.
- 24.3. Candidates for any Trust appointment shall be advised that, when making their application, they must disclose in writing to the Trust whether to their knowledge they are related to any Member of the Board or Director of the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.
- 24.4. The Chair and every Member of the Board and officer of the Trust shall disclose to the Chief Executive any relationship between themselves and a candidate of whose candidature that Member of the Board or officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.
- 24.5. On appointment, members of the Board (and prior to acceptance of an appointment in the case of officer members) should disclose to the Board

whether they are related to any other Member of the Board of Directors or holder of any office within the Trust.

25. Custody of the Seal and the Sealing of Documents

- 25.1. The Common Seal of the Trust shall be kept by the Chair or an officer authorised by them in a secure place.
- 25.2. In accordance with common law, all deeds should be executed under seal. A deed is a written document which is executed with the necessary formality (that is, more than a simple signature), and by which an interest, right or property passes or is confirmed.
- 25.3. The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board or of a committee, thereof or where the Board has delegated its powers.
- 25.4. The seal shall be affixed in the presence of the Chair and Chief Executive or another Executive Director.
- 25.5. An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all these transactions shall be made to the Board annually. (The report shall contain details of the seal number, the description of the document and date of sealing).

26. Signature of Documents

- 26.1. Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, or in their absence, an Executive Director (to whom the Board and Chief Executive has granted the necessary authority), unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.
- 26.2. The Chief Executive (or nominated officer) shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board of Directors or any committee, sub-committee or standing committee with delegated authority.

27. Waiver of Standing Orders

- 27.1. Except where this would contravene any statutory provision or any guidance issued by NHS England, any one or more of the Standing Orders may be waived at any meeting, provided that at least two-thirds of the Board are present, including two Executive Directors and two Non-Executive Directors, and that a majority of those present vote in favour of suspension.
- 27.2. A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.
- 27.3. The Group Audit Committee shall review every decision to suspend Standing Orders. The Company Secretary shall notify the Committee of such decisions.
- 27.4. All Directors and officers have a duty to disclosure any non-compliance with these Standing Orders to the Chair and Chief Executive as soon as possible.

28. Variation and Amendment of the Standing Orders

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

Standing Financial Instructions

29. General

- 29.1. These Standing Financial Instructions (SFIs) detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Reservation and Delegation of Powers adopted by the Trust.
- 29.2. These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Group Director of Finance ~~& Digital~~.
- 29.3. Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Group Director of Finance ~~& Digital~~ or Deputy Director of Finance must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.
- 29.4. The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.
- 29.5. **Overriding Standing Financial Instructions** – if for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Group Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Group Director of Finance ~~& Digital~~ as soon as possible.
- 29.6. Officers of the Trust should note that the Standing Orders, SFIs and the Reservation and Delegation of Powers, do not contain every legal obligation applicable to the Trust. The Trust and each officer of the Trust must comply with all requirements of legislation such as those contained in Health Service Acts and all guidance and directions binding on the Trust. Legislation, guidance and directions will impose requirements additional to standing orders, SFIs and the Reservation and Delegation of Powers. All such legislation and binding guidance and directions shall take precedence over standing orders, SFIs and the Reservation and Delegation of Powers, which shall be interpreted accordingly.

30. Responsibilities and delegation

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

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

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

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

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

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

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

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

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

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

30.7. All Board Members and employees are responsible for:

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

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

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

31. Audit

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

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

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

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

- 31.3. The Group Director of Finance ~~& Digital~~ or designated auditors are entitled without necessarily giving prior notice to require and receive:
- (a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
 - (b) access at all reasonable times to any land, premises, member of the Board or employee of the Trust;
 - (c) the production of any cash, stores or other property of the Trust under a member of the Board or an employee's control; and
 - (d) explanations concerning any matter under investigation.
- 31.4. **Internal Audit** will review, appraise and report upon:
- (a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;
 - (b) the adequacy and application of financial and other related management controls;
 - (c) the suitability of financial and other related management data;
 - (d) the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:
 - (i) fraud and other offences;
 - (ii) waste, extravagance, inefficient administration;
 - (iii) poor value for money or other causes.
- 31.5. Whenever any matters arise which involve, or are thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Group Director of Finance ~~& Digital~~ must be notified immediately. The Group Director of Finance in conjunction with the Group Internal Audit Manager will determine if the Chief Executive is to be notified. The Chief Executive in discussion with the Group Director of Finance will determine if the Trust Chair is to be notified.
- 31.6. The Group Internal Audit Manager will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.
- 31.7. The NHS Foundation Trust Accounting Officer Memorandum provides that Internal Audit should accord with the objectives standards and practices set out in the Public Sector Internal Audit Standards, which states that Internal Audit is an independent and objective appraisal service within an organisation.

- 31.8. Accordingly the Group Internal Audit Manager shall be accountable to the Group Director of Finance ~~& Digital~~, and the Audit Committee. The reporting system for Internal Audit shall be agreed between, Internal Audit, the Group Director of Finance ~~& Digital~~ and the Audit Committee. The annual plan and contractual agreement will be approved by the Audit Committee and shall comply with the guidance on reporting and relationships contained in the Government Internal Audit Standards.
- 31.9. Managers in receipt of audit reports referred to them have a duty to take appropriate remedial actions within the agreed time-scales within the report. The Group Director of Finance shall identify a formal review process to monitor the extent of compliance with audit recommendations. Where appropriate remedial action has failed to take place within a reasonable period, the matter shall be reported by the Group Director of Finance and Group Internal Audit Manager to the Group Audit Committee.
- 31.10. The **External Auditor** is appointed by the Council of Governors on the recommendation of the Audit Committee. The Audit Committee should assess the annual effectiveness of the External Auditor and provide assurance to the Council of Governors. If there are any performance issues relating to the service provided by the External Auditor, then this will be addressed using the contractual mechanisms.
- 31.11. In auditing the accounts, the Auditor must comply with any directions given by NHS England and to the standards, procedures and techniques to be adopted, in particular the Audit Code for NHS Foundation Trusts.
- 31.12. **Fraud and Corruption** - in line with their responsibilities, the Chief Executive and Group Director of Finance ~~& Digital~~ shall monitor and ensure compliance with the requirements of the conditions included in the NHS Standard Contract for Providers in relation to counter fraud requirements.
- 31.13. The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Counter Fraud Authority and NHS Anti-Fraud Manual.
- 31.14. The Local Counter Fraud Specialist shall report to the Group Director of Finance ~~& Digital~~ and shall work with staff in NHS Counter Fraud Authority in accordance with the NHS Anti-Fraud Manual.
- 31.15. On becoming aware of any suspected or actual bribery, corruption or fraud involving NHS-funded services, the Group Director of Finance ~~& Digital~~ must promptly report the matter to its nominated Local Counter Fraud Specialist and to NHS Counter Fraud Authority.

- 31.16. The Local Counter Fraud Specialist will provide a written report, at least annually, on counter fraud work within the Trust and submit this to the Audit Committee.
- 31.17. **Security management** - in line with their responsibilities, the Chief Executive will monitor and ensure compliance with Directions issued by the NHS Counter Fraud Authority on NHS security management.
- 31.18. The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.
- 31.19. The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

32. Business Planning, Budgets, Budgetary Control and Monitoring

32.1. Preparation and Approval of Plans and Budgets

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

- (a) a statement of the significant assumptions on which the plan is based;
- ~~(a)~~(b) an estimation of any financial gap between planned income and expenditure; and
- ~~(b)~~(c) details of major changes in workload, delivery of services or resources required to achieve the plan.

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

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

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

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

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

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

32.2. Budgetary Delegation

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

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

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

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

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

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

32.3. Budgetary Control and Reporting

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

- (a) monthly financial reports to the Finance & Performance Committee ~~(and bi monthly reported to the Trust Board)~~ in a form approved by the Board containing:
 - i. income and expenditure to date showing trends and forecast year-end position;
 - ~~ii.~~ underlying income and expenditure (deficit / surplus);
 - ~~iii.~~ movements in working capital;
 - ~~iv.~~ movements in cash and capital;
 - ~~v.~~ capital project spend and projected outturn against plan;
 - ~~vi.~~ explanations of any material variances from plan;
 - ~~vii.~~ achievement of waste reduction and financial sustainability programme
 - ~~viii.~~ details of any corrective action where necessary and the Chief Executive and/or Group Director of Finance & Digital view of whether such actions are sufficient to correct the situation;
- (b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;
- (c) investigation and reporting of variances from financial, workload and workforce budgets;
- (d) monitoring of management action to correct variances; and
- (e) arrangements for the authorisation of budget transfers via an approved budget virement process aligned to the scheme of delegation
- ~~(f)~~ arrangements for the authorisation of skill mix changes to approved budgets via an approved budget virement process aligned to the scheme of delegation
- ~~(g)~~ arrangements for the reduction to delegated budgets to support financial sustainability via an approved cost reduction governance process and budget virement process

32.3.2. Each Budget Holder is responsible for ensuring that:

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

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

32.4. Capital Expenditure

- 32.4.1. The Group Director of Finance ~~& Digital~~ will, on behalf of the Chief Executive, prepare and submit for approval by the Board of Directors, a capital spending plan.
- 32.4.2. The Group Director of Finance ~~ee & Digital~~ will, on behalf of the Chief Executive prepare and submit to the Capital Oversight Group (and onwards to Executive Management Team Gateshead Health Leadership Group) in-year changes to the approved capital plan.
- 32.4.3. The Group Director of Finance ~~& Digital~~ will, on behalf of the Chief Executive prepare and submit to the Finance and Performance Committee Executive Management Team in year monitoring of spend against the approved capital plan, including the risk of scheme over and under spends.
- 32.4.4. The general rules applying to delegation and reporting shall also apply to capital expenditure. The particular applications relating to capital are contained in SFI 41.

32.5. Financial Reporting to NHS England

- 32.5.1. The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to the Integrated Care Board and NHS England.
- 32.5.2. The Group Director of Finance ~~& Digital~~ will, on behalf of the Chief Executive prepare and submit the appropriate monitoring forms to the Integrated Care Board and NHS England.

33. Annual Accounts and Reports

- 33.1. The Group Director of Finance ~~& Digital~~, on behalf of the Trust, will:
 - (a) prepare financial returns in accordance with the accounting policies and guidance given by NHS England, the treasury, the Trust's accounting policies, and generally accepted accounting practice/International Financial Reporting Standards;
 - (b) prepare and submit annual financial reports to NHS England in accordance with current guidelines which are presented before Parliament for each financial year in accordance with the prescribed timetable; and
 - (c) submit financial returns to NHS England and the Department of Health and Social Care which are presented before Parliament for each financial year in accordance with the prescribed timetable.
- 33.2. The Trust's annual accounts must be audited by an auditor appointed by the Council of Governors.

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

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

34. Bank and Government Banking Services (GBS) Accounts

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

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

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

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

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

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

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

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

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

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

35.1. Income Systems

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

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

35.2. Fees and Charges

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

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

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

35.3. Debt Recovery

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

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

35.3.3. Overpayments should be detected (or preferably prevented) and recovery initiated in accordance with the overpayment policy.

35.4. Security of Cash, Cheques and Other Negotiable Instruments

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

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

(d)prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

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

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

35.4.4. The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

36. Tendering and Contracting Procedure

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

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

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

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

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

36.6. Formal Competitive Tendering: General Applicability

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

- the supply of goods, materials and manufactured articles;

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

36.7. Formal Competitive Tendering: Health Care Services

- 36.7.1. Where the Trust has a requirement to procure healthcare services (and/or other services classed as the “light touch” regime as part of Regulation 74 onwards of the Public Contracts Regulations 2015) (whether by way of sub-contract or otherwise), the Trust shall consider its duties under the EU Treaty and whether such service requirement should be advertised. A service contract will fall within the scope of the Light Touch regime if it is for the type of health, social and other services listed at Schedule 3 of the PCR2015. For these Light Touch regime contracts, a higher threshold than that for ordinary service contracts will apply, before the Light Touch regime is applicable. This threshold is set out at Article 4(d) of the Directive.
- 36.7.2. Where the Trust considers that the circumstances require it to advertise for the supply of healthcare services, Standing Orders and these SFIs shall apply, as far as they are applicable to the tendering procedure, although at all times the Trust should consider its duties under SFI 37.

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

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

- (a) the estimated expenditure or income does not, or is not reasonably expected to, exceed the tender limit as specified in the Reservation and Delegation of Powers.
- (b) where the supply is proposed under special arrangements negotiated by the DHSC in which event the said special arrangements must be complied with;
- (c) regarding disposals as set out in SFI 28.

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

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

- (e) where the requirement is covered by an existing contract;
- (f) where nationally negotiated agreements applicable to Foundation Trusts are in place;
- (g) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;
- (h) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;
- (i) where specialist expertise is required and is available from only one source;
- (j) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;
- (k) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;
- (l) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

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

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

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

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported

to the Board via the Finance and Performance Committee or as delegated to the Supply Procurement Committee.

36.9. Fair and Transparent Competition

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

36.10. Items Which Subsequently Breach Thresholds After Original Approval

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

36.11. Contracting / Tendering Procedure

36.11.1. Electronic tendering procedure:

(a) Invitation to tender:

- (i) All invitations to tender on a formal competitive basis shall state the date and time as being the latest time for the receipt of tenders and that no tender will be considered for acceptance unless submitted through the appropriate process, as instructed within the tender documentation electronically.
- (ii) Every tender for goods and services shall embody the adopted contract terms and conditions as appropriate with the contract form required for the specific goods and services.

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

- (i) An auditable date/time stamp of all actions must be automatically created through the eTendering service. This audit trail will be available for review in real-time
- (ii) Tenders may not be 'opened' or supplier information viewed until the pre-defined time and date for opening has passed.

(c) Opening formal tenders:

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

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

Procurement actions:

- Time/date stamp of 'publication' of tender by buyer
 - Time/date stamp of any amendments to a 'published' tender (eg if any buyer tender document attachments are added/amended during the process).
- (d) Every tender for goods, materials, services or disposals for the Group shall contain and comprise appropriate terms and conditions regulating the conduct of the tender, shall contain appropriate terms and conditions on which the contract is to be awarded and shall be substantively based to regulate the provision of the goods, materials, services to be provided or in relation to the disposal.
- (e) Every tender for building or engineering works (except for maintenance work, when *Estatecode* guidance shall be followed) for the Group shall contain terms and conditions on which the contract is to be awarded and shall be substantively based that shall embody or be in the terms of the current edition of a suitable and recognised industry form of contract, including but not limited to, one of the Joint Contracts Tribunal Standard Forms of Building Contract or the NEC standard forms of contract or Department of the Environment (GC/Wks) standard forms of contract; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A) or (in the case of civil engineering work) the General Conditions of Contract recommended by the institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents may be modified (in minor respects only), to cover special features of individual projects.

36.11.2. Invitation to tender – manual process:

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

- (a) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.
- (b) All invitations to tender shall state that no tender will be accepted unless:
- (i) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such

tender addressed to the Chief Executive or nominated Manager;

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

(c) Receipt and safe custody of tenders

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

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

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

- (de) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by one Executive Director and one Senior Manager, designated by the Chief Executive. These managers must not have been involved in the tender process or be from the originating department. The Trust Secretary on behalf of the Chief Executive shall maintain a list of designated officers to open tenders. A copy of this list will be held with the Register of Tenders.
- (e) A member of the Trust Board will be required to be one of the two approved persons present for the opening of tenders estimated above the tender limit. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Reservation and Delegation of Powers. This applies to both paper and electronic tenders.
- (f) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender. The tender process will include the preparation, specification and evaluation of the tender.
- (g) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Group Director of Finance or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders.
- (h) All Executive Directors/members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.
- (i) Every tender received shall be marked with the date of opening and initialled by those present at the opening.

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

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

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

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

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

36.11.3. Admissibility of tenders:

- (a) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Trust Board or under delegated limits as set out in the Standard Operating Procedures for the Supply Procurement Group.
- (b) Where only one tender is received, the Chief Executive and Director of Finance shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

36.11.4. Late tenders:

- (a) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.
- (b) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders, that, in the case of the manual procedure have been duly opened, have not

left the custody of the Chief Executive or their nominated officer. In the case of both the manual and electronic procedure, the process of evaluation and adjudication must not have been started.

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

36.11.5. Acceptance of formal tenders:

- (a) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of their tender before the award of a contract will not disqualify the tender.
- (b) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

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

- (i) experience and qualifications of team members;
- (ii) understanding of client's needs;
- (iii) feasibility and credibility of proposed approach;
- (iv) ability to complete the project on time.

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

- (c) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
- (d) The use of these procedures must demonstrate that the award of the contract was:
 - (i) not ~~in excess of more than~~ the going market rate/price current at the time the contract was awarded;

(ii) that best value for money was achieved.

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

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

36.11.7. List of approved firms:

(a) Responsibility for maintaining list

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

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

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

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

(b) Building and Engineering Construction Works

Invitations to tender shall normally be made to firms included on the approved list of tenderers. This will include firms selected on the Department of Health

& Social Care Procure 21 or the Construction Line Contractors list of primary supply chain partners.

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

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

36.11.8. Exceptions to using approved contractors:

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

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

36.12. Quotations: Competitive and Non-Competitive

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

36.12.2. Competitive quotations:

- (a) Quotations should be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.
- (b) Quotations should be obtained using the electronic tendering portal or in writing to the Chief Executive or his nominated officer unless it is determined that it is impractical to do so in which case quotations may be obtained verbally. Confirmation of verbal quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

- (c) All quotations should be treated as confidential and should be retained for inspection. The Chief executive or their nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation, if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record, or in the electronic system.

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

- (a) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;
- (b) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;
- (c) miscellaneous services, supplies and disposals;
- (d) single quotations may be obtained where the value of the goods or service is less than the quotation limit as stated in the Delegation of Powers.
- (e) where goods or services are for building and engineering works the Director of Estates or nominated officer may approve single quotations where the value is between the quotation and tender limit as stated in the Standard Operating Procedures providing they certify that the first two conditions of this SFI (i.e. SFI 36.12.3 (a) and (b) apply).

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

36.13. Authorisation of tenders and competitive quotations:

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

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

36.14. Private finance for capital procurement:

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

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

36.15. Compliance requirements for all contracts

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

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

36.16. Personnel and agency or temporary staff contracts

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

36.17. Disposals

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

- (a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer;
- (b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

- (c) items to be disposed of with an estimated sale value of less than £500 this figure to be reviewed on a periodic basis;
- (d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
- (e) assets required for the provision of mandatory goods and services are protected. They may not be disposed of without the agreement of NHS England.

36.18. In-House Services

- 36.18.1. The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.
- 36.18.2. In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:
 - (a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.
 - (b) In-house tender group, comprising a nominee of the Chief Executive and technical support.
 - (c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Group Director of Finance ~~& Digital~~ representative. A non-officer member should be a member of the evaluation team.
- 36.18.3. All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.
- 36.18.4. The evaluation team shall make recommendations to the Board of Directors following any benchmarking process or a market testing exercise carried out pursuant to SFI 36.2.

37. Contract for the Provision of Healthcare Services

- 37.1. The Board shall regularly review, and shall ~~at all times~~always maintain and ensure, the capacity and capability of the Trust to provide the mandatory goods and services referred to in the Trust's Licence, Terms of Authorisation and compliance with annual declarations as detailed in the NHS Foundation Trust Annual Reporting Manual.
- 37.2. The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the Annual Operational Plan. In carrying out these functions, the Chief Executive should take into account the advice of the Group Director of Finance ~~& Digital~~ regarding costing and pricing of services, payment terms and conditions and amendments to service agreements.

- 37.3. Contracts should be so devised as to achieve activity and performance targets, minimise risk, and maximise the Trust's opportunity to generate income. The Trust will produce a cost tariff in accordance with NHS guidelines.
- 37.4. The Group Director of Finance ~~& Digital~~ shall ensure that a summary of the Trust's new contracts is reported annually to the Board, in line with the Scheme of Delegation. The Group Director of Finance ~~& Digital~~ shall also produce regular reports to the Board detailing actual and forecast contract income with a detailed assessment of the variable elements of income.
- 37.5. Where the Trust enters into a relationship with another organisation for the supply or receipt of other services, whether clinical or non-clinical, the responsible officer should ensure that an appropriate contract is present and signed by both parties.
- 37.6. All contracts shall be legally binding, shall comply with best costing practice and shall be so devised as to manage contractual risk, in so far as is reasonably achievable in the circumstances of each contract, whilst optimising the Trust's opportunity to generate income.
- 37.7. The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable contracts with Commissioners for the provision of NHS services. [See the Reservation and Delegation of Powers section for additional information.](#)

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

38.1. Remuneration and Terms of Service

- 38.1.1. In accordance with Standing Orders SO 6 the Board shall establish a **Group Remuneration Committee**: The committee shall have clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.
- 38.1.2. The Group Remuneration Committee will:
 - (a) ensure an annual review of remuneration, allowances and terms of service is conducted to determine whether an uplift should be awarded and if so, the level of uplift for all employees which fall within its scope.
 - (b) monitor and evaluate the performance of such designated senior staff
 - (c) oversee and advise on any severance packages [on behalf of the Board \(including those with wider applicability – i.e. not just for Very Senior Manager posts\)](#).
 - (d) review regularly the structure, size and composition (including the skills, knowledge and experience) required of the Board of Directors and agree any changes

- (e) give full consideration to succession planning for senior Trust staff, taking into account the challenges and opportunities facing the Trust and what skills and expertise are therefore needed on the Board in the future.
- (f) be responsible for identifying and nominating on behalf of the Board Directors candidates to fill Executive Director and Trust subsidiary Directors as and when they arise.

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

38.1.4. The Council of Governors' Remuneration Committee will:

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

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

38.2. Funded Establishment

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

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

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

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

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

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

38.3. Staff Appointments and Regrading

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

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

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

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

~~(a)~~ 38.3.3. Where national pay awards are recommended to be applied to Agenda for Change staff the formal approval of the pay award will be considered by the Board of Directors.

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38.4. Processing Payroll

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

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment; and

~~(d)~~(e) appropriate controls to minimise the number and value of staff over / under payments.

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

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for pensions, income tax, social security and other authorised deductions from pay;

- (d) security and confidentiality of payroll information;
- (e) checks to be applied to completed payroll before and after payment;
- (f) authority to release payroll data under the provisions of the GDPR;
- (g) methods of payment available to various categories of employee and officers;
- (h) procedures for payment by cheques or bank credit, to employees and officers;
- (i) procedures for the recall of cheques and bank credits;
- (j) pay advances and their recovery;
- (k) maintenance of regular and independent reconciliation of pay control accounts;
- (l) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

38.4.3. Appropriately nominated managers have delegated responsibility for:

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

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

38.5. Contracts of Employment

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

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

39. Non-Pay Expenditure

39.1. Delegation of Authority

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

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

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

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

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

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

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

39.2.3. The Group Director of Finance ~~and Digital~~ will:

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

- (i) A list of Trust employees (including specimens of their signatures) authorised to certify invoices.
- (ii) Certification that:
 - goods have been duly received, examined and are in accordance with specification and the prices are correct;
 - work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
 - in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the authorised time records, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
 - where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
 - the account is arithmetically correct;
 - the account is in order for payment.
- (iii) A timetable and system for submission to the Group Director of Finance ~~& Digital~~ of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.
- (iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.
- (e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI 39.2.4 below.

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

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

39.2.5. Official orders must:

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

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

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

39.2.7. The Chief Executive and Group Director of Finance ~~& Digital~~ shall ensure that the arrangements for financial control and financial audit of building and

engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.

40. External Borrowing

- 40.1. The Group Director of Finance ~~& Digital~~ will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed commercial borrowing with the Foundation Trust Financing Facility or any commercial lender, within the limits set in the Foundation Trust's authorisation and reviewed annually by NHS England.
- 40.2. The Group Director of Finance ~~& Digital~~ is also responsible for reporting periodically to the Board concerning the PDC and all loans and overdrafts. These reports should include key balance sheet information showing changes to long term debt, PDC and other borrowings (i.e. prudential borrowing). Taken together with the Income & Expenditure report it will show the planned and projected position on interest and capital.
- 40.3. The Group Director of Finance ~~& Digital~~ will ensure that all loans negotiated with the Foundation Trust Financing Facility (FTFF) or any commercial lender are clearly documented and a nominated responsible officer will ensure that the terms of repayment are adhered to. All changes to the structure of any loan or a change in repayment terms will be reported by the Group Director of Finance ~~& Digital~~ to the Board.
- 40.4. Any application for a loan or overdraft will only be made by the Group Director of Finance ~~& Digital~~ or by an employee acting on his/her behalf, and in accordance with the Reservation and Delegation of Powers.
- 40.5. The Group Director of Finance ~~& Digital~~ must prepare detailed procedural instructions concerning applications for loans and overdrafts.
- 40.6. All short-term borrowings should be kept to the minimum period ~~of time~~ possible, consistent with the overall cash flow position. Any short term borrowing requirement ~~in excess of~~ more than one month must be authorised by the Group Director of Finance ~~& Digital~~.
- 40.7. All long-term borrowing must be consistent with the Plan and be subject to the limits authorised by NHS England and approved by the Trust Board.

40.8. Investments

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

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

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

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

41.1. Capital Investment

41.1.1. The Chief Executive:

- (a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;
- (b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;
- (c) shall ensure that capital investment is not undertaken without confirmation on the availability of resources to finance all revenue consequences of the capital scheme;
- (d) shall ensure that where applicable support for the scheme is confirmed from commissioners and or NHS England.

41.1.2. For capital expenditure proposals greater than £1m the Chief Executive shall ensure:

- (a) that an appropriate business case is produced setting out:
 - (i) where possible an appropriate option appraisal has been undertaken comparing costs and benefits
 - (ii) the involvement of appropriate Trust personnel and external agencies, if appropriate
 - (ii) appropriate project management and control arrangements are in place
- (b) that a Director or nominated officer has certified professionally to the costs and revenue consequences detailed in the business case.

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

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

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

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

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

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

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

41.2. Asset Registers

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

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

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

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

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

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

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

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

~~41.2.7.~~

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

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41.3. Security of Assets

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

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

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

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

41.3.4. Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to

NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedure.

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

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

42. Stores and Receipt of Goods

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

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

42.2. Control of Stores, Stocktaking, Condemnations and Disposal

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

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

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

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

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

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

42.3. Goods Supplied by NHS Supply Chain

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

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

43.1. Disposals and Condemnations

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

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

43.1.3. All unserviceable articles shall be:

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

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

43.2. Losses and Special Payments

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

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

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

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

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

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

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

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

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

43.2.9. All losses and special payments must be approved by the Group Director of Finance and reported to the Audit Committee.

44. Information Technology

44.1. Responsibilities and Duties of the Chief ~~Information-Digital~~ Officer

- 44.1.1. The Chief ~~Information-Digital~~ Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:
- (a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018
 - (b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;
 - (c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;
 - (d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.
- 44.1.2. The Chief ~~Information-Digital~~ Officer shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.
- 44.1.3. The Chief ~~Information-Digital~~ Officer with responsibility for Information Technology shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.
- 44.2. Responsibilities and Duties of Other Directors and Officers in Relation to Computer Systems of a General Application**
- 44.2.1. In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the ~~Group Director of Finance~~Chief Digital Officer & Digital:

- (a) details of the outline design of the system;

- (b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

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

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

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

44.4. Risk Assessment

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

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

44.5.1. Where computer systems have an impact on corporate financial systems the Chief ~~Information-Digital~~ Officer and Group Director of Finance shall need to be satisfied that:

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

45. Patients' Property

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

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

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

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

- 45.3. The Group Director of Finance ~~& Digital~~ must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.
- 45.4. Separate accounts for patients' moneys, shall be opened and operated under arrangements agreed by the Group Director of Finance ~~& Digital~~.
- 45.5. In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.
- 45.6. Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.
- 45.7. Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

46. Charitable Funds

46.1. Corporate Trustee

- 46.1.1. SO 1.4 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust.
- 46.1.2. The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety.

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

46.2. Accountability to Charity Commission

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

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

46.3. Applicability of Standing Financial Instructions to Charitable Funds

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

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

46.4. Charitable Funds Committee

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

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

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

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

46.5. Administration of the Charitable Fund

46.5.1. The Charitable Funds Committee will arrange for the proper administration of charitable funds in accordance with their respective terms of trust, and ensure that accounting records are kept in a way that identifies separately the different

categories of fund between unrestricted funds, restricted funds and endowment funds, and complies with charities legislation.

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

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

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

46.6. Income

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

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

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

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

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

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

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

46.7. Fundraising

46.7.1. The Charitable Funds Committee shall:

- (a) in respect of legacies and bequests, provide guidelines to officers of the Trust covering any approach regarding the wording of Wills;
- (b) after taking appropriate legal and tax advice, deal with all arrangements for fund raising by and/or on behalf of this body, and ensure compliance with all statutes and regulations;
- (c) be empowered to liaise with other organisations/persons raising funds for this body, and provide them with an adequate discharge. The Chief Executive (acting under the instructions of the Charitable Funds Committee) shall be the only officer empowered to give approval for such fund raising subject to the over-riding direction of the Charitable Trust;
- (d) be responsible for alerting the Charitable Trust to any irregularities regarding the use of the Trust's name or its registration numbers; and
- (e) be required to advise the Charitable Trust on the financial implications of any proposal for fund raising activities which the Trust as corporate trustee may initiate, sponsor or approve.

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

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

46.8. Investment Management

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

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

46.9. Use of Funds

- 46.9.1. Authorisation of expenditure from charitable funds will be laid down in the Reservation and Delegation of Powers.
- 46.9.2. The exercise of the Trust's discretion in the application of charitable funds shall be managed by the Charitable Funds Committee. In doing so, it shall be aware of the following:
 - (a) the objects of the charitable funds;
 - (b) the availability of liquid funds;
 - (c) the powers of delegation available to commit resources as detailed in the Reservation and Delegation of Powers;
 - (d) the avoidance of use of Exchequer funds to discharge charitable fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Trustee Exchequer funds shall be discharged by charitable funds at the earliest possible time;
 - (e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the body and any reserved policy;
 - (f) the definitions of "charitable purposes" as determined by the charity commission and relevant legislation and case law; and
 - (g) any restrictions on spending capital.

46.10. Banking Services

- 46.10.1. The Charitable Funds Committee shall advise the Charitable Trust and, with its approval, shall ensure that appropriate banking services are available to this body as corporate trustee.
- 46.10.2. The Trust as corporate trustee shall approve the bank accounts to be used for charitable funds.

46.11. Reporting

- 46.11.1. The Charitable Funds Committee shall ensure that regular reports are made to the Charitable Trust with regard to, inter alia, the receipt of funds, investments and the disposition of resources.
- 46.11.2. The Charitable Funds Committee shall prepare annual accounts in the required manner that shall be submitted to the Charitable Trust within agreed timescales.
- 46.11.3. The Charitable Funds Committee shall prepare an annual trustee's report and the required returns and to the Charity Commission for adoption by the Charitable Trust.

46.12. Accounting and Audit

- 46.12.1. The Charitable Funds Committee shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit;
- 46.12.2. The Charitable Funds Committee shall liaise with external audit and provide them with all necessary information.

46.13. Administration Costs

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

46.14. Custody of Investment Certificates and the Deeds of Properties

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

46.15. Legacies

- 46.15.1. The Group Director of Finance ~~& Digital~~ shall be authorised to give executors good discharge from their duties.
- 46.15.2. The Group Director of Finance ~~& Digital~~, shall be authorised to obtain a grant of probate or make application for letters of administration where the Trust is the beneficiary.

47. Managing Conflicts of Interest

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

48. Retention of Records

- 48.1. The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health & Social Security guidelines.
- 48.2. The records held in archives shall be capable of retrieval by authorised persons.
- 48.3. Records held in accordance with latest NHS England guidance ie "Records Management Code of Practice" Practice" shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed. Records Management Policy IG05 provides further information.

49. Risk Management and Insurance

49.1. Programme of Risk Management

- 49.1.1. The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with the Governance framework requirements, which must be approved and monitored by the Board.
- 49.1.2. The programme of risk management shall include:
 - (a) a process for identifying and quantifying risks and potential liabilities;
 - (b) engendering among all levels of staff a positive attitude towards the control of risk;
 - (c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
 - (d) contingency plans to offset the impact of adverse events;
 - (e) audit arrangements including; Internal Audit, clinical audit, health and safety review;
 - (f) a clear indication of which risks shall be insured;
 - (g) arrangements to review the Risk Management programme.
- 49.1.3. The existence, integration and evaluation of the above elements will assist in providing a basis to make an Annual Governance Statement within the Annual Report and Accounts as required by NHS England.

49.2. Insurance: Risk Pooling Schemes administered by NHS Resolution

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

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

- 49.3.1. Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Managing Director QEF shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Managing Director QEF shall ensure that documented procedures cover these arrangements.
- 49.3.2. Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for one or other of the risks covered by the schemes, the Managing Director QEF shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Managing Director will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.
- 49.3.3. All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Managing Director QEF should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

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

Reservation of Powers to the Board of Directors

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

Finance General		
SFI	30.1.b	Approval of revenue and capital plan
Audit		
SFI	31.1.	Establishment of an Audit Committee
Allocations, Planning, Budgets, Budgetary Control and Monitoring		
SFI	32.1.1.	Production of revenue plan
SFI	32.1.2.	Production of revenue budgets
SFI	32.3.1.	Maintain systems of budgetary control & reporting
SFI	32.3.2.	Budget holder responsibilities
SFI	32.4.1.	Production of capital plan
Financial Control and Reporting		
SFI	32.2.3.	Authorisation of budget overspend
SFI	32.1.3	Review financial performance against approved financial plans
Bank and GBS Accounts		
SFI	34	Approval of Banking arrangements
Remuneration		
SFI	38.1	Establishment of Remuneration Committee
SFI	38.1.2	Approval of severance / redundancy schemes
Staff Appointments		
SFI	38.3	Approval of funded establishment
SFI	38.3.3.	Approval of national pay awards for Agenda for Change staff
Non Pay Expenditure		
SFI	39.1.1.	Approval of level of annual non-pay spend
External Borrowing		
SFI	40	Approval of long term borrowing
Capital Investment		
SFI	41.1.	Approval of long term borrowing
Risk Management and Insurance		

SFI	49	Approval of Trust insurance Arrangements

Scheme of Delegation

		Delegation of Powers	Delegated to	Operational Responsibility
Standing Orders				
SO	2.1	Interpretation of standing orders	Chair	Company Secretary
SO	5.8	Induction of the Non-Executive Directors	Chair	Company Secretary
SO	6.1 / 7.1	Appointment and removal of the Chair and Non-Executive Directors	Council of Governors	-
SO	6.2	Appointment of the Chief Executive	Group Remuneration Committee	-
SO	6.3	Appointment of Executive Directors	Group Remuneration Committee	-
SO	6.5	Performance of Chair duties in the absence of the Chair	~~Deputy Vice~~ Chair	-
SO	8.1	Calling a Board Meeting	Chair	-
SO	9.2	Approval of Board Meeting agendas	Chair	
SO	12.1	Final decision on questions of order, relevancy and regularity	Chair	
SO	20.1	Exercise of emergency powers	Chief Executive and Chair (following consultation with at least two Non-Executive	

		Delegation of Powers	Delegated to	Operational Responsibility
			Directors)	
SO	21.2	Exercise of functions not reserved for the Board or delegated to a committee	Chief Executive	Executive Directors
SO	25.1	Secure storage of the seal	Chair	
SO	25.4	Oversight of the affixing of the seal	Chair and Chief Executive / Executive Directors	
SO	26.1/2	Signing of legal documents as approved by the Board	Chief Executive	Executive Directors
SO	3.28	Review suspension of standing orders	Group Audit Committee	Company Secretary
Interests				
SO	23.6	Establish register of interests	Company Secretary	
Strategy				
Digital Committee Terms of Reference		Ensure Trust-wide IT Strategy in place and monitor	Chief Executive	<u>Chief Digital Officer</u>
		Delivery of Trust Strategy	Chief Executive	All Executive Directors
		Signing of leases	Group Director of Finance & Digital	
		Signing of documents in legal proceedings	Chief Executive/Deputy Chief Executive	
Finance and Performance Committee		Seek assurance of effective arrangements for management of contracts and SLA's with Commissioners	Finance and Performance Committee	Group Director of Finance & Digital

		Delegation of Powers	Delegated to	Operational Responsibility
Terms of Reference				
SFI	37.2	Negotiation & approval of contracts for provision of healthcare services	Chief Executive	Group Director of Finance & Digital
SFI	37.3	Production of cost tariff in accordance with NHS guidelines	Chief Executive	Group Director of Finance & Digital
SFI	37.4	Reporting of contracts for goods to Board	Chief Executive	Group Director of Finance & Digital
SFI	37.4	Reporting of contracts for services to the Board	Chief Executive	Group Director of Finance & Digital
Finance General				
SFI	30.1.a	Formulating financial strategy	Group Director of Finance & Digital	Deputy Director of Finance & Digital
SFI	30.1.c	Defining essential features of procedures and systems	Group Director of Finance & Digital	Deputy Director of Finance
SFI	30.1.c.	Responsibility for ensuring the organisation delivers value for money	Chief Executive & Executive Directors	
SFI	30.1.c	Seek assurance of ensuring the organisation delivers value for money	Finance & Performance Committee	Chief Executive & Executive Directors
SFI	30.3	Responsibility for Financial Control	Chief Executive & Group Director of Finance & Digital	
SFI	30.6.a	Implementation of financial policies	Group Director of Finance & Digital	Deputy Director of Finance
SFI	30.6.b	Maintaining an effective system of financial control	Group Director of Finance & Digital	Deputy Director of Finance

		Delegation of Powers	Delegated to	Operational Responsibility
SFI	30.6.c	Maintenance of financial records	Group Director of Finance & Digital	Deputy Director of Finance
SFI	30.6.d	Provision of financial advice to the Board and employees	Group Director of Finance & Digital	Deputy Director of Finance
SFI	30.6.e	Design, implementation and supervision of systems of internal control	Group Director of Finance & Digital	Deputy Director of Finance
SFI	30.6.f	Preparation and maintenance of accounts etc	Group Director of Finance & Digital	Deputy Director of Finance
SFI	30.7.a	Security of the property of the Trust	All Staff	
SFI	30.7.b	Avoiding loss	All Staff	
SFI	30.7.c	Exercising economy and efficiency in the use of resources	All Staff	
SFI	30.7.d	Conforming with standing orders, standing financial instructions, financial procedures, and the scheme of delegation	All Staff	
Audit				
SFI	31.2.a	Ensuring adequate arrangements in place for the review of effectiveness of internal audit	Group Director of Finance & Digital	Deputy Director of Finance
SFI	31.2.b	Ensuring adequacy and effectiveness of internal audit	Group Director of Finance & Digital	Deputy Director of Finance
SFI	31.2.c	Decide stage to involve police in cases of misappropriation and other irregularities	Group Director of Finance & Digital	Deputy Director of Finance

		Delegation of Powers	Delegated to	Operational Responsibility
SFI	31.2.d	Ensuring the preparation of an annual audit report by Internal Audit, External Audit & Counter Fraud as required.	Group Director of Finance ~~& Digital~~	Deputy Director of Finance
SFI	31.8	Determining the audit system for Internal Audit	Group Audit Committee, Group Director of Finance ~~& Digital~~ & Internal Audit	Deputy Director of Finance
SFI	31.10	Appointment of External Auditor	Council of Governors	
SFI	31.12	Ensure compliance with the NHS standard contract in respect of fraud, bribery and corruption	Chief Executive & Group Director of Finance ~~& Digital~~	
Group Audit Committee Terms of Reference		Obtaining outside legal or independent advice on audit matters	Group Audit Committee	Group Director of Finance ~~& Digital~~
Group Audit Committee Terms of Reference		Review work and findings of External & Internal Audit, Internal including agreeing nature and scope of audit	Group Audit Committee	Group Director of Finance ~~& Digital~~
Group Audit Committee Terms of Reference		Responsible for seeking assurance for all audit and counter fraud functions.	Group Audit Committee	Group Director of Finance ~~& Digital~~
Group Audit Committee Terms of Reference		Agreement and implementation of action plans arising from audit reports	All Staff	

		Delegation of Powers	Delegated to	Operational Responsibility
Security Management				
SFI	31.17	Monitoring compliance with SoS Directions	Chief Executive	Group Director of Finance & Digital
SFI	31.19	Controlling & Co-ordinating security	Chief Executive	Security Management Director & Local Security Management Specialist
Business Planning, Budgets, Budgetary Control and Monitoring				
SFI	32.1.1.	Preparation of Annual Plan	Chief Executive	Executive Directors
SFI	32.1.2	Preparation of annual budgets	Chief Executive	Group Director of Finance & Digital
SFI	32.1.2.	Approval of annual Income & expenditure spending plan	Board of Directors	
SFI	32.1.3.	Monitoring of financial performance against budget	Group Director of Finance & Digital	Deputy Director of Finance
SFI	32.1.4.	Provision of information to inform budget setting	Deputy Director of Finance	Assistant Finance Directors & All Budget Holders
SFI	32.1.5	Agree ~~Business Unit~~ divisional revenue budgets for the year	Deputy Director of Finance	All Budget Holders
SFI	32.1.6	Provision of adequate training in budgetary control	Group Director of Finance & Digital	Deputy Director of Finance
Budget Delegation				
SFI	32.2.1.	Delegation of budgetary control	Chief Executive	Budget Holders
SFI	32.2.5.	Authorisation of use of non-recurrent funds for recurrent purposes	Chief Executive	Group Director of Finance & Digital
Financial Control and Reporting				

		Delegation of Powers	Delegated to	Operational Responsibility
SFI	32.3.1.	Devise & maintain systems of budgetary control	Group Director of Finance ~~& Digital~~	Deputy Director of Finance
SFI	32.3.1.a	Provision of monthly budget reports to the Finance & Performance Committee & bi monthly reports to Board	Group Director of Finance ~~& Digital~~	Deputy Director of Finance
SFI	32.3.1.b	Provision of monthly budget information to budget holders	Group Director of Finance ~~& Digital~~	Deputy Director of Finance
SFI	32.3.1.c	Investigation and reporting of variances from budgets	Group Director of Finance ~~& Digital~~	Deputy Director of Finance
SFI	32.3.1.d	Monitoring of action to correct variances	Group Director of Finance ~~& Digital~~	Deputy Director of Finance
SFI	32.3.1.e	Authorisation of budget transfers, outside of Trust virement process	Group Director of Finance ~~& Digital~~	Deputy Director of Finance
SFI	32.3.2.a	Management of budget within allocation	Group Director of Finance ~~& Digital~~	Budget Holders
SFI	32.3.2.b	Ensuring allocated funds are used for the purpose intended	Group Director of Finance ~~& Digital~~	Budget Holders
SFI	32.3.2.c	Appointment of permanent employees within available resources	Operational Directors, Heads of Corporate Business Units	Budget Holders
SFI	32.3.2.c	Appointment of permanent employees outside of available resources	Chief Executive	
SFI	32.3.3.	Identification of cost improvements and income generation initiatives	Chief Executive	Group Director of Finance ~~& Digital~~
SFI	32.5.1.	Submission of financial monitoring returns as required by appropriate bodies	Chief Executive	Group Director of Finance ~~& Digital~~

		Delegation of Powers	Delegated to	Operational Responsibility
SFI	33.1.	Preparation & submission of annual accounts and reports	Group Director of Finance ~~& Digital~~	Deputy Director of Finance
Capital Expenditure				
SFI	32.4.1.	Preparation of capital spending plan	Chief Executive	Group Director of Finance ~~& Digital~~
SFI	32.4.1.	Approval of capital spending plan	Board of Directors	
SFI	32.4.2.	Approval of in-year changes to the capital spending plan	~~Executive Management Team~~ Gateshead Health Leadership Group	
SFI	32.4.3	Notification of in-year spending against the approved capital spending plan	Group Director of Finance ~~& Digital~~	Deputy Director of Finance
Bank and GBS Accounts				
SFI	34.1	Management of banking arrangements	Group Director of Finance ~~& Digital~~	Deputy Director of Finance
SFI	34.2	Approval of all banking arrangements	Board of Directors	
SFI	34.5	Preparation of detailed instructions on the operation of bank and GBS accounts	Group Director of Finance ~~& Digital~~	Deputy Director of Finance
SFI	34.7	Review of commercial banking arrangements	Group Director of Finance ~~& Digital~~	Deputy Director of Finance
Income, Fees and Charges and Security of Cash, Cheques and other Negotiable Instruments				
SFI	35.1.1.	Designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due	Group Director of Finance ~~& Digital~~	Deputy Director of Finance
SFI	35.1.2	Prompt banking of cash	Group Director of Finance ~~& Digital~~	Deputy Director of Finance

		Delegation of Powers	Delegated to	Operational Responsibility
SFI	35.2.1.	Approval and review of all local fees and charges	Group Director of Finance & Digital	Deputy Director of Finance
SFI	35.3.1.	Recovery of all outstanding debts	Group Director of Finance & Digital	Deputy Director of Finance
SFI	35.4.1	Security of cash, cheques and other negotiable instruments	Group Director of Finance & Digital	Deputy Director of Finance
Tendering and Contracting Procedures				
SFI	36.8.1	Waiving of formal tendering procedures	See Financial Delegation Limits	
SFI	36.8.1.m	Preparing a report on tender waivers for Board via Finance and Performance Committee and the Supply Procurement Committee	Group Director of Finance & Digital	Deputy Director of Finance
SFI	36.11.7.a	Maintenance of list of approved suppliers	Group Director of Finance & Digital	Director of Finance QEF Trust subsidiary
SFI	36.11.1	Receipt and safe custody of tenders	Electronic portal or Chief Executive	
SFI	36.11.1	Opening of tenders >£25K	Electronic portal or Chief Executive, Executive Director	Electronic portal or designated senior manager
SFI	36.11.4	Considering of late tenders	Chief Executive	
	36.11.5.c	Acceptance of tenders that commit to expenditure in excess of allocated budget	Chief Executive	
SFI	36.11.8	Use of contractors not on approved list	Chief Executive, Group Director of Finance & Digital	

		Delegation of Powers	Delegated to	Operational Responsibility
SFI	36.12.2.	Competitive quotations	Group Director of Finance ~~& Digital~~ , Head of Procurement using the electronic portal	
SFI	36.12.4	Approval of quotations above budgetary limit	Chief Executive	Group Director of Finance ~~& Digital~~
SFI	36.13	Authorisation of Tenders and Competitive Quotations	See Financial Delegation Limits – Orders	
SFI	36.14	Approval of proposals to utilise private finance for capital procurement	Board of Directors	
SFI	39.2.6.f	Issuing of verbal orders	Chief Executive	
In-House Services				
SFI	36.18.1	Ensuring value for money	Chief Executive Officer	Executive Director, Associate Director
Human Resources				
People and Organisational Development Committee Terms of Reference		Provide people-related advice to the Board	Director of People & OD	
People and Organisational Development Committee		Seek assurance over the delivery of People and OD strategies, plans and initiatives covering culture, workforce development, workforce management,	POD Committee	Director of People & OD

		Delegation of Powers	Delegated to	Operational Responsibility
Terms of Reference		equality and diversity, health and wellbeing		
SFI	32.1.2.	Approve spending plans for training & OD requirements	Board of Directors (via approval of annual spending plan)	
Terms of Service				
SFI	38.1.2.a	Review remuneration, allowances and terms of service annually for senior employees in its remit	<u>Group</u> Remuneration Committee	Chief Executive and Chair
SFI	38.1.2.b	Monitor and evaluate the performance of designated senior staff within its area of responsibility, its composition and its arrangements for reporting	<u>Group</u> Remuneration Committee	Chief Executive and Chair
SFI	38.1.2.d	Review the structure, size and composition of the Board	<u>Group</u> Remuneration Committee	Chief Executive and Chair
SFI	38.1.2.e	Review succession planning and assess the skills and expertise required for the Board	<u>Group</u> Remuneration Committee	Chief Executive and Chair
SFI	38.1.2.f	Identify and nominate candidates to fill Board vacancies within its remit	<u>Group</u> Remuneration Committee	Chief Executive and Chair
SFI	38.1.4.a	Review remuneration, allowances and terms of service annually for the Chair and Non-Executive Directors	Council of Governors	Council of Governors' Remuneration Committee
SFI	38.1.4.b	Seek assurance that the performance of the Chair and Non-Executive Directors is evaluated in line with agreed performance frameworks	Council of Governors	Council of Governors' Remuneration Committee

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

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

		Delegation of Powers	Delegated to	Operational Responsibility
Finance and Performance Committee Terms of Reference		Seeking assurance over commercial opportunities and contract delivery within its remit	Finance & Performance Committee	Director of Strategy, Planning & Partnerships
Finance and Performance Committee Terms of Reference		Seeking assurance of performance against National and Local targets	Finance & Performance Committee	Group Director of Finance & Digital
Finance and Performance Committee Terms of Reference		Seeking assurance of performance against cost reduction programme, transformation and productivity targets	Finance & Performance Committee	
		Approval of budget virement	See financial delegation Limits	
		Approval of capital expenditure	See financial delegation Limits	
		Oversee the delivery of the capital financial plan	Group Director of Finance & Digital	Deputy Director of Finance
		Oversee the delivery of the revenue financial plan	Group Director of Finance & Digital	Deputy Director of Finance
Contracts of Employment				
SFI	38.5.1.a	Ensuring that all employees are issued with a contract of employment	Group Executive Director of People and OD	Deputy Director of People and OD

		Delegation of Powers	Delegated to	Operational Responsibility
Non-Pay Expenditure				
SFI	39.1.1.	Approval of non-payment expenditure levels annually	Board of Directors	
SFI	39.1.1	Determine level of non-pay delegation to budget managers	Chief Executive	Group Director of Finance & Digital
SFI	39.2.4.	Authorisation of prepayments	Group Director of Finance & Digital	Deputy Director of Finance
SFI	39.2.5.	Authorisation of those who official orders can be issued to	Chief Executive	Group Director of Finance & Digital
SFI	39.2.6.j	Approval of petty cash limit	Group Director of Finance & Digital	Deputy Director of Finance
SFI	39.2.7	Ensuring that arrangements for the financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE	Group Director of Finance & Digital	Managing Director of QEF Subsidiary
External Borrowing				
SFI	40.1	Advise the Board on borrowing and payment of PDC	Group Director of Finance & Digital	Deputy Director of Finance
SFI	40.3	Ensure that all loans are clearly documented	Group Director of Finance & Digital	Deputy Director of Finance
SFI	40.2	Report to Board periodically on PDC, loans and overdrafts	Group Director of Finance & Digital	Deputy Director of Finance
SFI	40.4	Application for an external loan or overdraft	Group Director of Finance & Digital	Deputy Director of Finance

		Delegation of Powers	Delegated to	Operational Responsibility
SFI	40.5	Preparation of procedural instructions on the application of loans and overdrafts	Group Director of Finance & Digital	Deputy Director of Finance
SFI	40.6	Approval of short term borrowing	Group Director of Finance & Digital	Deputy Director of Finance
Investments				
SFI	40.8.2	Advising the Board on investment strategy	Group Director of Finance & Digital	Deputy Director of Finance
SFI	40.8.3	Preparation of procedural instructions on the operation of investment accounts	Group Director of Finance & Digital	Deputy Director of Finance
Capital Investment				
SFI	41.1.1.a	Ensuring adequate approval process and investment appraisal systems for all capital projects	Chief Executive	Managing Director of QEF Subsidiary
SFI	41.1.1.b	Authority for the management of all capital schemes to be delivered on time and to cost	Chief Executive	Managing Director of QEF Subsidiary
SFI	41.1.1.d	Seeking support for schemes where required from commissioners or NHS England	Chief Executive	
SFI	41.1.5.	Issue procedures for the regular reporting of capital expenditure	Group Director of Finance & Digital	Deputy Director of Finance

		Delegation of Powers	Delegated to	Operational Responsibility
SFI	41.1.6.c	Authority to commit capital expenditure in year (post approval of capital programme)	See Financial Delegation limits	
SFI	36.11.5	Approval to accept a successful tender	Chief Executive – see Financial Delegation limits	
Asset Registers				
SFI	41.2.1.	Responsible for maintenance of register of assets	Chief Executive	Group Director of Finance & Digital
SFI	41.2.5.	Approve procedures for reconciliation of fixed asset balances	Group Director of Finance & Digital	Deputy Director of Finance
SFI	41.2.8.	Calculation of capital charges	Group Director of Finance & Digital	Deputy Director of Finance
Security of Assets				
SFI	41.3.1.	Overall control of fixed assets	Chief Executive	Executive Directors
SFI	41.3.2.	Approval of asset control procedures	Group Director of Finance & Digital	Deputy Director of Finance
Stores and Receipt of Goods				
SFI	42.2.1	Systems of control	Chief Executive	Group Director of Finance & Digital
SFI	42.2.1.	Day to day responsibility for stores	Supplies Manager, Pharmacy Manager, Catering Manager, Pathology Manager.	
SFI	42.2.3.	Procedures and systems for regulation of stores	Group Director of Finance & Digital	Deputy Director of Finance

		Delegation of Powers	Delegated to	Operational Responsibility
SFI	42.2.4	Stocktaking arrangements	Group Director of Finance & Digital	Deputy Director of Finance
SFI	42.2.5	Approval of alternative arrangements where a complete system of stores control is not justified	Group Director of Finance & Digital	Deputy Director of Finance
SFI	42.3.6	System of review of slow moving and obsolete items and their subsequent disposal / replacement	Delegated Manager	Group Director of Finance & Digital
SFI	42.3.1.	Identification of staff authorised to requisition and accept goods supplied via the NHS Supply Chain central warehouses	Chief Executive	Group Director of Finance & Digital
Disposals and Condemnations, Losses and Special Payments				
SFI	43.1.1.	Preparation of detailed procedures	Group Director of Finance & Digital	Deputy Director of Finance
SFI	43.1.3.a	Approval of condemnations/disposals	Group Director of Finance & Digital	Authorised condemning officer
SFI	43.2.1.	Preparation of procedural instructions on the recording and accounting for condemnations, losses and special payments.	Group Director of Finance & Digital	Deputy Director of Finance
SFI	43.2.2.	Duty to report actual and suspected losses to the head of department who will then inform the Chief Executive, Group Director of Finance or officer charged with responsibility for responding to concerns involving losses	All Staff	

		Delegation of Powers	Delegated to	Operational Responsibility
SFI	43.2.2.	Notification to External Audit of frauds and the NHS Counter Fraud Authority	Group Director of Finance ~~& Digital~~	Deputy Director of Finance
SFI	43.2.4.	Notification to the Board and External Audit of losses caused by theft, arson, neglect of duty or gross carelessness	Group Director of Finance ~~& Digital~~	Deputy Director of Finance
SFI	43.2.5	Approval of losses	Group Audit Committee	
SFI	43.2.6.	Safeguarding of Trust assets in bankruptcies and liquidations	Group Director of Finance ~~& Digital~~	Deputy Director of Finance
SFI	43.2.8.	Maintenance of losses register	Group Director of Finance ~~& Digital~~	Deputy Director of Finance
SFI	43.2.9.	Receive reports on all losses and special payments	Group Audit Committee	
Information Technology				
SFI	44.1.1.	Responsibility for the accuracy and security of computerised data	~~Group Director of Finance~~ Chief Digital Officer ~~& Digital~~	Chief Digital Information Officer
SFI	44.1.3.	Publication of Freedom of Information Publication Scheme	~~Group Director of Finance~~ Chief Digital Officer ~~& Digital~~	Chief Digital Information Officer
SFI	44.3.	Responsibility for contracts for computer services with other health bodies or outside agencies	~~Group Director of Finance~~ Chief Digital Officer ~~& Digital~~	Chief Digital Information Officer
SFI	44.4.1.	Identification of organisational risks arising from the use of IT	~~Group Director of Finance & Digital~~ Chief Digital Officer	Chief Digital Information Officer
Patients' Property				

		Delegation of Powers	Delegated to	Operational Responsibility
SFI	45.2	Notification to patients/guardians prior to admission of Trust responsibilities and liabilities around patient's property	Chief Executive	Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals
SFI	45.3	Provision of detailed written instructions on the collection, custody, investment, recording, safekeeping and disposal of patients' property	Group Director of Finance & Digital	Deputy Director of Finance
SFI	45.4	Agreements for the provision of separate accounts for patients' monies	Group Director of Finance & Digital	Deputy Director of Finance
Charitable Funds				
SFI	46.1.3	Ensuring that each trust fund is appropriately managed	Group Director of Finance & Digital	Deputy Director of Finance
SFI	46.1 – 46.7	Ensuring charitable funds are managed and administered appropriately and in line with the SFIs	Charitable Funds Committee	Group Director of Finance & Digital
SFI	46.8	Responsible for all aspects of the management of the investment of charitable funds	Charitable Funds Committee	Group Director of Finance & Digital
SFI	46.9	Authorisation of expenditure from charitable funds	Charitable Funds Committee and as per delegated limits	
SFI	46.10	Approval of bank accounts for charitable funds	The Trust as corporate trustee (via the Board of Trustees)	

		Delegation of Powers	Delegated to	Operational Responsibility
SFI	46.11	Preparation of annual accounts, returns and reports as required by the Charity Commission and Charitable Trust	Charitable Funds Committee	Group Director of Finance & ~~Digital~~
SFI	46.14	Ensure that investment certificate and deeds of properties are held in a safe and secure location	Group Director of Finance & ~~Digital~~	Deputy Director of Finance
SFI	46.15.1	Giving executors good discharge from their duties	Group Director of Finance & ~~Digital~~	Deputy Director of Finance
SFI	46.15.2	Application to obtain grant of probate	Group Director of Finance & ~~Digital~~	Deputy Director of Finance
Retention of Records				
SFI	48.1	Maintaining archives for all records required to be retained	Chief Executive	Group Director of Finance & ~~Digital~~
SFI	48.3	Authorisation to destroy records	Chief Executive	Group Director of Finance & ~~Digital~~
Risk Management and Insurance				
SFI	49.1.1.	Ensuring that the Trust has a programme of risk management	Chief Executive	Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals
SFI	49.1.1.	Programme of risk management approved and monitored	Board of Directors	Group Audit Committee
SFI	49.2.1.	Determine whether the Trust will insure through the risk pooling schemes administered by NHS Resolution	Board of Directors	
SFI	49.3	Ensuring insurance arrangements entered into are appropriate and	Managing Director of QEF Subsidiary	

		Delegation of Powers	Delegated to	Operational Responsibility
		complementary to the risk management programme and that the Board is informed of the nature and extent of the risks. Ensuring there are documented procedures to cover the management of claims and payments		

Financial delegation levels

Delegated area	Specifics / values	Authority delegated to:	Notes
1. Financial Plan			
1.1 Approval of Trust annual income & expenditure plan	At Trust Level	Trust Board	
1.2 Approval of Trust annual capital plan	At Trust Level	Trust Board	
2. Management of Budgets			
2.1 Annual Revenue Budgets			

Delegated area	Specifics / values	Authority delegated to:	Notes
2.2 Annual Capital Budget	At Trust Level	Chief Executive	
	At Operational Division Level	Operational Director	
	At Corporate Division Level	Corporate Division Director	
	At Department Level	Nominated Budget Manager	
2.3 Business Cases –Revenue	At Trust Level	Chief Executive	
	At Capital Scheme Level – Excluding IT Schemes	Managing Director QEF	
	At Capital Scheme Level – IT Schemes	Chief Digital Officer	
	Over £1,000,000	Trust Board	
	Less than £1,000,000	Chief Executive via Gateshead Health Leadership Group	
2.4 Business Cases – Capital			

Delegated area	Specifics / values	Authority delegated to:	Notes
2.5 Contract Awards – Provision of Services Patient & Non-Patient Care Services	Over £1,000,000	Trust Board	
	Over £1,000,000 (total value of contract)	Chief Executive	
	Less than £1,000,000 up to £250,000	Executive Director of relevant service/function	
	Up to £250,000	Operational Director/Head of Service of relevant function	
3. Non-Pay Expenditure 3.1 Revenue Expenditure Approval of orders for goods or services within delegated budgets	Up to £2,500 Up to £10,000 Up to £50,000 Up to £100,000 Over £100,000	Band 6 or above Band 8 or above Operational Director, Head of Corporate Division Executive Director Chief Executive, Group Director of Finance	In the absence of the Chief Executive and Group Director of Finance delegated to Deputy Chief Executive and Deputy Director of Finance

Delegated area	Specifics / values	Authority delegated to:	Notes
Invoice Verification	All - Where the charge forms part of a previously authorised contract e.g. Pharmacy/ Roche et	Band 6 or above	The placing of the order is the point at which expenditure is approved. All invoices should be supported by a purchase order except for those excluded in the purchase to pay policy including LET doctors and NHS Supply Chain invoices.
3.2 Capital Expenditure			
Individual Capital Project – Estates & Equipment	Up to £50,000	QEF Head of Estates	
Approval of orders for goods/services within the approved capital programme	Up to £100,000	QEF Director of Finance	
	Over £100,000	QEF Managing Director	
Individual Capital Project- Digital	Up to £50,000	Chief Digital Officer	
Approval of orders for goods and services with the approved capital programme	Up to £100,000	Executive Director	
	Over £100,000	Chief Executive, Group Director of Finance	In the absence of the Chief Executive and Group Director of Finance delegated to Deputy Director of Finance
In year changes to approved capital projects	Up to £1,000,000	Chief Executive, via Gateshead Health Leadership Group	

Delegated area	Specifics / values	Authority delegated to:	Notes
Land transactions	Over £1,000,000 All	Trust Board, via business case process Trust Board	
4. Quotation and Tendering Recorded on the Tender registered held in the Procurement Department 4.1 Expenditure	From £1,000 to £9,999 From £10,000 up to £49,999 From £50,000 up to Sterling thresholds (UK procurement thresholds) (for the application of the Public Contract Regulations) Public Procurement thresholds from 1 st January 2024 inclusive of Value Added Tax: Supplies and services Central Government - £139,688 Supplies & services all other contracting	2 verbal quotes 3 quotations (electronic) Formal tender process (electronic) advertised on Contract finder Above thresholds are subject to Public Contract Regulations & relevant procurement process	All elements of expenditure refer to the cumulative cost over the whole life of the contract, and all limits are exclusive of VAT.

Delegated area	Specifics / values	Authority delegated to:	Notes
	authorities £214,904 Works - £5,372,609 Light Touch Regime - £663,540 Concession Contracts - £5,372,609		
4.2 Contract Awards The award of new contracts for the purchase of goods and services	Up to £50,000 Up to £200,000 Over £200,000 Over £1,000,000	Operational Director, Head of Corporate Division Executive Director Chief Executive, Group Director of Finance Trust Board	
3.3 Specific Circumstances In certain very specific circumstances (as stated in the Standing Financial Instructions) the Chief Executive, Director of Finance or nominated deputy may waive the quotation process and the CEO or DoF may waive the tender process.	Waiving of Standing Orders up to £200,000 per annum exclusive of VAT Waiving of Standing Orders Over £200,000 exclusive of VAT	Supply and Procurement Committee Chief Executive via a sub-set of Executive Management Team including Deputy Chief Executive and Group Director of Finance	Chair's action can be sought in exceptional circumstances between the meeting of the Supply and Procurement Committee To meet on a timely basis as a triumvirate.

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

Delegated area	Specifics / values	Authority delegated to:	Notes
5.3 Lease Cars	Removal Packages up to £8,000	Deputy Director of POD and Deputy Director of Finance	All agency requests only allowable in exceptional circumstances only necessitated by clinical risk.
	Lease Car Application	Operational Director or Head of Service	
5.4 Agency Staff	Registered Nursing/AHP/Scientific & Professional Agency On Framework in hours 8am to 5pm	Chief Matron or Operational Director via agency booking process	
	Registered Nursing/AHP/Scientific & Professional Agency On Framework out of	Strategic on Call via agency booking process	

Delegated area	Specifics / values	Authority delegated to:	Notes
	hours		
	Registered Nursing/AHP/Scientific & Professional Agency Off Framework in hours 8am to 5pm	Executive Director, via agency booking process	
	Registered Nursing/AHP/Scientific & Professional Agency Off Framework out of hours	Strategic on Call via agency booking process	In absence of Chief Executive delegated to Deputy Chief Executive
	Healthcare Assistant On Framework in hours 8am to 5pm	Chief Nurse, Operational Director via agency booking process	
	Healthcare Assistant On Framework out of hours	Strategic on Call via agency booking process	Agency-rules-changes-for-2023-to-2024.pdf (england.nhs.uk)
	Healthcare Assistant	Executive Director via agency	

Delegated area	Specifics / values	Authority delegated to:	Notes
	Off Framework in hours 8am to 5pm	booking process	
	Healthcare Assistant Off Framework out of hours	Strategic on Call via agency booking process	
	Medical Staff On-Framework below £100 or published price cap in hours 8am to 5pm	Executive Director via agency booking process	
	Medical Staff On-Framework within price cap out of hours	Strategic on Call via agency booking process	
	Medical Staff Off Framework above £100 or published price cap	Chief Executive Executive via agency booking process	
	Any shift by individuals costing more than £100 per hour or	Strategic on Call via agency booking process with retrospective approval by Chief Executive or Deputy Chief	https://www.england.nhs.uk/wp-content/uploads/2023/04/Agency-

Delegated area	Specifics / values	Authority delegated to:	Notes
5.5 Bank Staff	above published price cap –see link in notes section	Executive	<u>rules-changes-for-2023-to-2024.pdf</u>
	Non-Clinical Agency Staff including domestics and porters – see link in notes section	Band 8 or above, example Service Line Manager	
	Medical Staff Bank - payment to cover vacant shift in funded establishment	Band 8 or above, example Service Line Manager	
	Nurse/AHP/Scientific & Therapeutic	Operational Director via waiting list approval process	
5.6 Waiting List Initiatives	Waiting list initiative – payment		
6. Losses and Special Payments Losses and Special Payments other than those settlements made on behalf of the Trust by the NHS Resolution under the Clinical	All	Chief Executive, Group Director of Finance	
	Losses and gifts over £300,000	Approval by NHSE and HMT	

Delegated area	Specifics / values	Authority delegated to:	Notes
Negligence Scheme for Trusts (CNST) and the Risk Sharing Pooling Scheme for Trust (PSPT):	Special payments of any kind over £95,000	Approval by NHSE and HMT	
67Fee Setting	Agreeing Contract Prices with Commissioners Income Generation Scheme Prices Private Patient Fees Overseas Visitor Fees Trading Agencies Charges	Group Director Finance, Deputy Director of Finance	
8. Tenders for Services to be Provided Where tenders are prepared to bid for services these shall be approved prior to submission.	All	Group Director of Finance via, Gateshead Health Leadership Group	
9. Charitable Funds 9.1 Fund Expenditure 9.2 Charitable Fund 9.3 Investment	Up to £2,500 From £2,501 to £10,000 Over £10,000 Responsibility for the Investment Policy for Charitable Funds	Funds Managers Charitable Funds Operational Group Charitable Fund Committee acting on behalf of the Corporate Trustee Charitable Fund Committee acting on behalf of the Corporate Trustee	Per item
10. Hospitality			

Delegated area	Specifics / values	Authority delegated to:	Notes
10.1 Gift and Hospitality Register	Keeping the register	Trust Board Secretary	
10.2 Declarations			
10.3 Authorisations	Declaring hospitality received over £25 Authorisation over £25	All staff Chief Executive, Group Director of Finance	
11. Condemning Disposal All capital items that are obsolete, redundant, or beyond economic repair must be disposed of in accordance with the agreed procedure and reported to Associate Director of Financial Services for inclusion in the losses report. Disposal of assets with a net book value:	All	Delegated to QEF	
12. Banking Arrangements Signing of payable orders and cheques or other orders drawn on the Trust's commercial bank accounts and the Government Banking Service Accounts:	Up to £25,000 Over £25,000	1 x signatory nominated in writing by the Group Director of Finance 2 x signatories nominated in writing by the Group Director of Finance	
13. Virements All virements between same account lines, ie, pay, non-pay and income	Up to £150,000 Over £150,000	Operational Director, Head of Corporate Service Above plus Executive Director	

Delegated area	Specifics / values	Authority delegated to:	Notes
All virements for pass through commissioning changes	All	Operational Director, Head of Corporate Service plus Deputy Director of Finance or Assistant Director of Finance	Can only happen in exceptional circumstances
All virements relating to disestablishment or establishment of service changes via a commissioning change	All	Operational Director, Head of Corporate Service plus Executive Director and Deputy Director of Finance or Assistant Director of Finance	
All virements across account lines, for example non-pay to pay lines	All	Operational Director, Head of Service plus Chief Executive or Group Director of Finance	
All virements relating to a cost reduction scheme	Up to £150,000	Operational Director, Head of Service	
	Above £150,000	As above plus Executive Director	
Virement to fund Category D requests	Up to £5,000	Operational Director, Head of Service	

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Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 10

Report Title:	Trust Strategy 2025 – 2030			
Name of Meeting:	Trust Board (Part 1)			
Date of Meeting:	25 th September 2025			
Author:	Nicola Bruce, Director of Strategy and Partnerships Jane Taylor, Strategy Development, QEF Mr Neil Halford, Medical Director for Strategic Relations (and SRO)			
Executive Sponsor:	Sean Fenwick, Chief Executive Officer			
Report presented by:	Nicola Bruce, Director of Strategy and Partnerships			
Purpose of Report <i>Briefly describe why this report is being presented at this meeting</i>	Decision: ☒	Discussion: ☐	Assurance: ☒	Information: ☒
	To provide Trust Board with a copy of the Trust Corporate Strategy 2025 – 2030 for sign off.			
Proposed level of assurance <i>– to be completed by paper sponsor:</i>	Fully assured ☒ <i>No gaps in assurance</i>	Partially assured ☐ <i>Some gaps identified</i>	Not assured ☐ <i>Significant assurance gaps</i>	Not applicable ☐
Paper previously considered by: <i>State where this paper (or a version of it) has been considered prior to this point if applicable</i>	Draft Trust corporate strategy shared with Trust Board 30 th July 2025 (Part 1) following the publication of the NHS 10 Year Plan – Fit for the Future.			
Key issues: <i>Briefly outline what the top 3-5 key points are from the paper in bullet point format</i> <i>Consider key implications e.g.</i> • Finance • Patient outcomes / experience • Quality and safety • People and organisational development • Governance and legal • Equality, diversity and inclusion	Work to update the Trust corporate strategy commenced earlier this year with significant internal and external engagement with stakeholders. This has been an iterative process with feedback informing the goals and objectives. A draft of the strategy was agreed in principle at the Trust Board in June pending the publication of the NHS 10 Year Plan with a further update shared at the July meeting. With the 10 Year Plan published on 3rd July, a read across demonstrated good alignment with the national priorities and ambitions. The Board agreed that no changes should be made to the Trust strategy.			

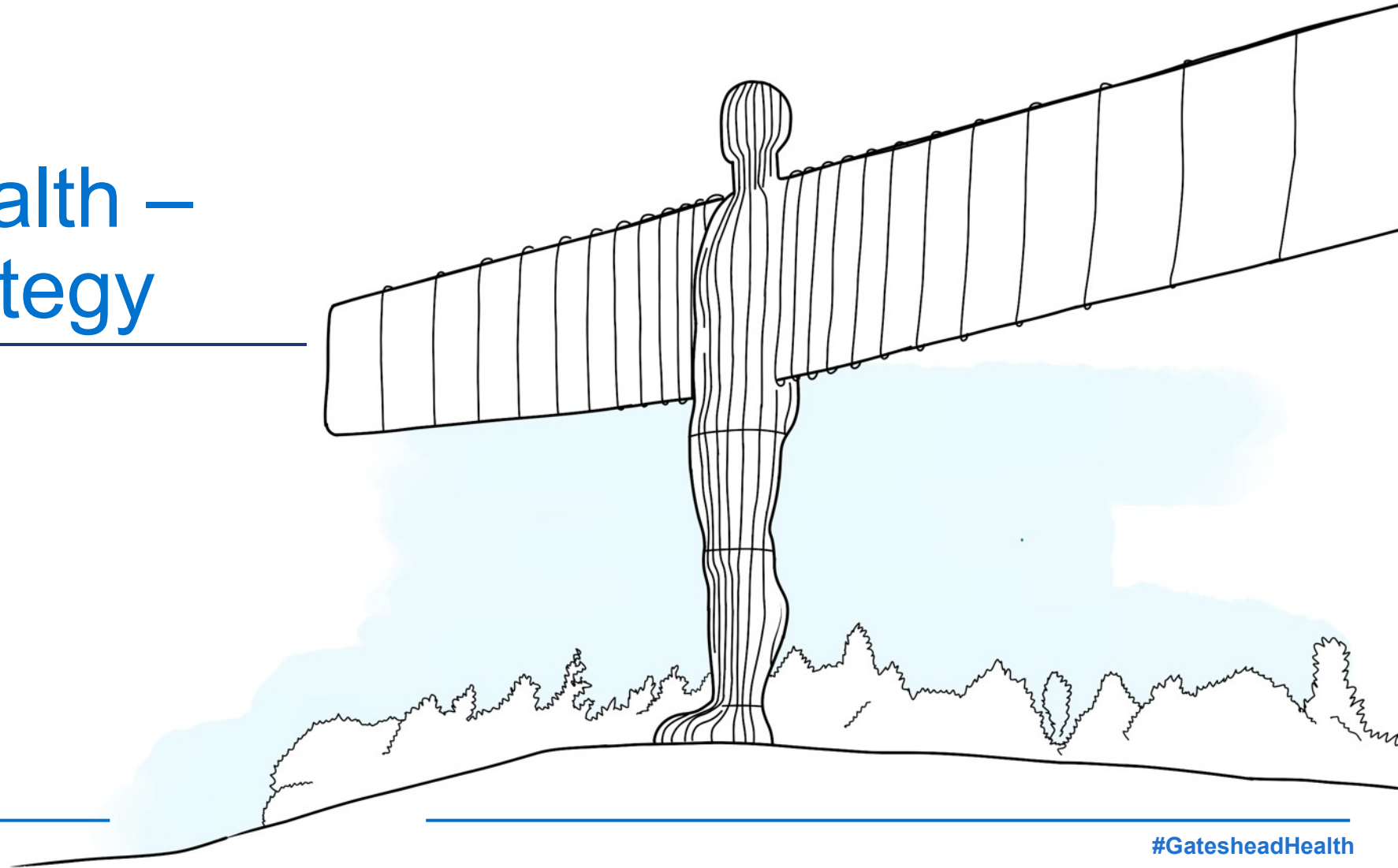
	Attention since the last meeting has been on populating the supporting chapters within the corporate strategy ahead of the launch and publication. This paper provides the Trust Board with the complete document for sign off.				
Recommended actions for this meeting: <i>Outline what the meeting is expected to do with this paper</i>	Trust Board are asked to: • Review and sign off the proposed Corporate Strategy 2025 – 2030 • Support the launch and publication of the strategy				
Trust strategic priorities that the report relates to:	☒	Excellent patient care			
	☒	Great place to work			
	☒	Working together for healthier communities			
	☒	Fit for the future			
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	All 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):	To be determined				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	Yes ☐	No ☐		Not applicable ☒	

Gateshead Health – Corporate Strategy

2025 – 2030

DRAFT FOR SIGN OFF

September 2025



Foreword and content

An overview of our strategy

Our Corporate Strategy 2025-30 outlines our vision for the future of healthcare within Gateshead. It has been developed during a period of significant change both locally and nationally, and we are confident that it sets out the steps we will need to take to secure a sustainable future for our organisation and for the communities we serve.

We know that health outcomes for the residents of Gateshead differ greatly depending on where they live. A key focus for us over the next five years will be to close the gap in the most profound health variances across our communities, working collaboratively to support health prevention, improve access and reduce the time patients need to spend within the hospital environment.

We will focus on addressing the three shifts outlined within the Government's Ten Year Health Plan, namely:

- Shifting care from hospitals to the community, with an emphasis on providing care closer to people's homes including through neighbourhood health services;
- Preventing ill health, moving from a system which primarily treats sickness to one that focuses on prevention and shortening the amount of time people spend in ill-health; and

- Moving from analogue to digital, embracing new technologies and digital approaches to modernise the way we interact and provide services.

However, we cannot ignore the wider context in which we operate. Public satisfaction in the NHS is at an all time low and the NHS continues to face immense financial pressures. Our Trust, like many, will need to carefully balance ongoing cost constraints with rising demand for services, alongside the need to reform our services.

Throughout this, our priority will remain on the delivery of safe, high-quality care. We will build on our strengths in Women's Health and Diagnostic services as well as collaborating with partners to ensure that collectively we are utilising our skills and resources in the right way to transform the way we design and deliver services across the region.

Delivering the level of change needed is going to require strong leadership along with time, energy and commitment from across the entire organisation. We are confident that our people can rise to the challenge to make our strategy a reality and secure a sustainable Gateshead's future.

Alison Marshall &
 Sir Paul Ennals[^]
 Chair

Trudie Davies &
 Sean Fenwick*
 Chief Executive Officer

This document sets out our vision for the next five years which can be navigated using the sections below:

Content	Page
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Our strategic response	6
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Our strategy on a page	12
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[^]From 1st October 2025

*Acting CEO from August 2025

About us

Our Trust

Established in 2005, Gateshead Health was among the first Foundation Trusts in the country. We have consistently delivered the highest standards of care for our patients over the past 20 years.

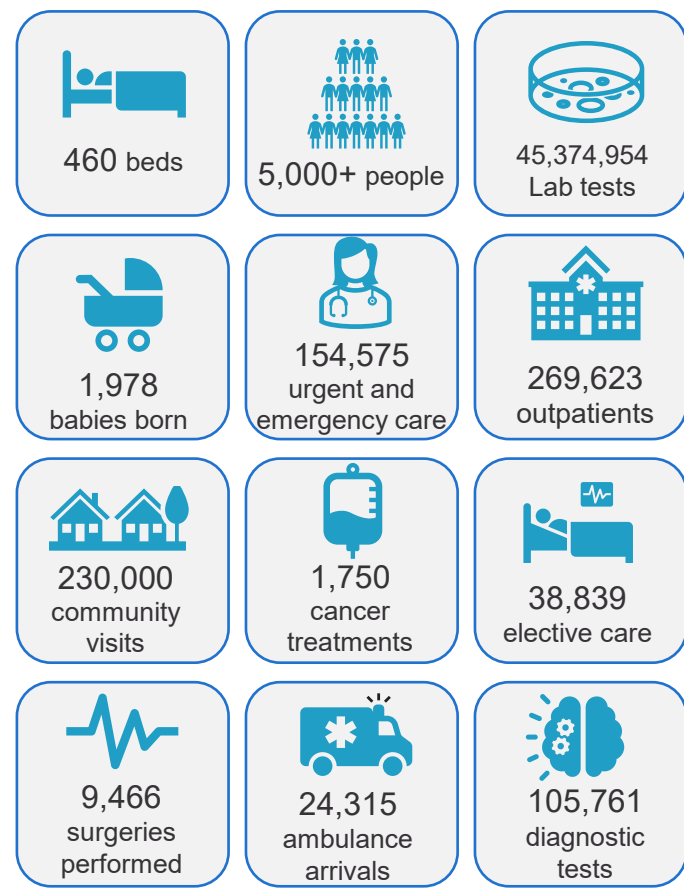
An integrated community provider, we provide a range of acute and community services to the population of Gateshead along with a number of specialist services to a wider population.

We deliver a wide range of screening services supported by our regional laboratory services.

Our main sites include Queen Elizabeth Hospital, Bensham Hospital, Metrocentre Community Diagnostic Centre (CDC) and Blaydon Primary Care Centre, alongside a number of smaller community sites across Gateshead.

The Trust owns its subsidiary QE Facilities Limited. Established in 2014. QE Facilities provides a diverse offering including estates and facilities services, financial advisory, pharmacy, and logistics services across the region and beyond.

A year in numbers (2024/25)



Our Achievements

Since our last strategy we have achieved some amazing things. These include:

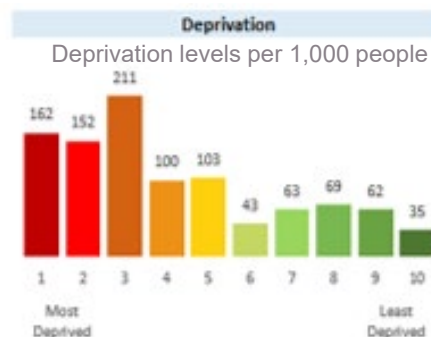
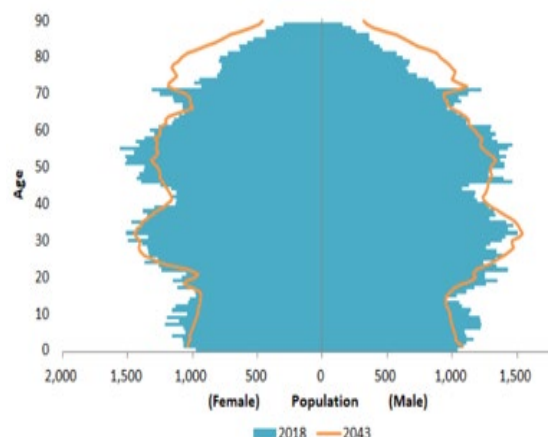
- Our **Maternity Services** were one of the first in the country to be rated 'good' by the Care Quality Commission (CQC) with a number of areas of outstanding practice highlighted. We were also rated as the #1 Trust in the UK for maternity services in the CQC's national patient survey
- We opened our **Community Diagnostic Centre** at the Metrocentre, one of the UKs largest shopping centres services providing the community with advanced imaging, respiratory, and cardiac diagnostic services
- We were a **finalist for the HSJ Trust of the Year Award**, highlighting excellence in innovation, collaboration, and patient outcomes
- We were recognised at the **Northern Cancer Alliance Awards** for exceptional work by the Breast Care Nursing and Gynae-Oncology teams
- We ranked among **the top 10 performing units** for professional development in obstetrics and gynaecology by the Royal College of Obstetricians and Gynaecologists
- We won the **HSJ Digital Equality, Diversity, and Inclusion Award** for diabetes care, improving access through donated technology

The communities we serve

Gateshead has a population of around 199,100 living in 89,000 households, which is expected to increase by 2043 to 216,750.

The population is ageing: it is projected that by 2043 there will be an additional 12,316 people aged 65 or older, an increase of 29%. Alongside this, a decrease in the number of children and young people aged 0-15 is expected of around 3,529 or 10%.

Gateshead Population Projections between 2018 – 2043 (ONS)



Gateshead is the 47th most deprived local authority in England, out of 317 local authorities. Around 32,700 (16%) people in Gateshead live in one of the 10% most deprived areas of England. Extending that range further, nearly 62,600 (31%) live in the 20% most deprived areas. 2 in 5 children in Gateshead live in poverty.

47.6% of those in the most deprived areas have at least 1 long-term condition.

Healthy life expectancy is significantly lower than the England average with a significant gap in life expectancy between those living in the most and least deprived postcodes in Gateshead.

Lifestyle factors:

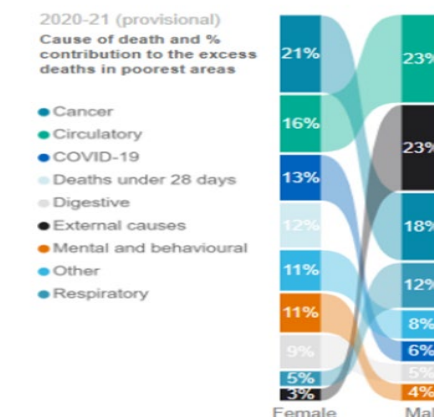
- 70% of adults in Gateshead have excess weight (England average 64%)
- There is an increasing rate of Type 2 diabetes in the adult population.
- Approx. 1 in 4 children in Reception are overweight or obese, rising to 2 in 5 in Year 6. This is worse than the national average
- The prevalence of smoking in adults is in line with the England average (9%), but varies significantly by deprivation and socioeconomic status
- The 2021 Balance North East report found that only 1 in 3 people were aware of the link between alcohol and cancer
- Admissions to the Trust for alcohol related conditions are among the highest in England
- Gateshead had the highest rate of hospital admissions due to stroke in the country (2022/23)

Impact on our services

In the North East and North Cumbria, people from the 1st deprivation centile have nearly twice the number of hospital admissions compared to people from the 10th centile

There is a clear link between levels of deprivation and the likelihood of poor health and preventable mortality.

Diseases that contribute most to the gap in life expectancy between the least and most deprived areas, by sex



In response, we know that we need to adapt and change the way we deliver services to better meet the needs of the population we serve.

The national context – NHS 10 Year Plan



The NHS 10 Year Plan 'Fit for the Future' was published by the Government on 3rd July 2025. The Plan sets out a transformative vision for healthcare in England.

The Plan builds on the findings of the independent investigation of the NHS in England completed by Lord Darzi in 2024.

The reforms set out in the 10 Year Plan focus on three 'shifts':

- **moving care from hospitals to communities:** focusing on providing more care outside of hospitals, with an emphasis on the development of 'neighbourhood health centres' and closing the gap on health inequalities – focusing on access and outcomes

- **moving from analogue to digital:** focusing on major expansion of the NHS App and greater use of AI and other technology
- **moving from sickness to prevention:** focusing more on preventing ill health than on treatment, including the wider determinants of health and factors that influence a person's need for care.



Five key enablers support delivery of the 10 Year Plan:

- The development of a new operating model - simplifying how the NHS operates; transforming how care is delivered; and, making the NHS more responsive to patients
- Introducing additional levels of transparency especially in relation to performance and quality of care
- Creating a new workforce model
- Development of a new innovation strategy
- Reforming NHS finances

What this means for us

For Gateshead Health as an integrated provider of acute and community services, working coterminously with local authority boundaries and primary care networks, the starting position for a move to integrated neighbourhood health is strong.

Our flagship Community Diagnostic Centre (CDC) at the Metrocentre is an excellent example of where we have shifted services from hospital into the community.

We are actively working as part of the Great North Healthcare Alliance, the objectives of which include improving patient access and outcomes; reducing inequalities; maximising the workforce opportunities; pioneering digital and innovation – all of which align to the national ambitions. In addition, as clinical pathway work progresses across the Trusts this will ultimately support the 10 Year Plan ambition to enable hospitals to focus on providing world class specialist care to those who need it.

Perhaps the biggest challenge and transformation for the Trust, and indeed all healthcare providers, is the radical review of how care is delivered in the future and the funding flows that support this. Delivery of our 5 year strategy is key to how we achieve this.

Our strategic response

Our clinical and diagnostics services strategy

We want to provide the highest standards of care to our patients and communities. Continually striving for clinical excellence. This includes ensuring timely access to services and meeting operational performance standards.

Through our clinically led approach to leadership and decision making, we will look to improve access to services through transformation. Starting at the front door, we will streamline emergency care pathways to ensure our most unwell patients receive the care they need in a timely manner. Working with partners we will look at alternatives to admission for those not needing acute medical care. Where patients do need a hospital admission we will look to keep their stay with us as short as possible.

We will reduce our waiting times and improve equity of access. Increasing the use of digital technology, scheduling and robotics to enhance services for our patients.

We will make the best use of the resources we have available – focusing on productivity, reducing unwarranted variation and striving for the best clinical outcomes for our patients.

Planned actions in response to the national three shifts include:

Hospital to community

- Transforming services including reforming outpatients
- Building seamless and coordinated services
- Focus on integrated neighbourhood health
- Home First principles
- Maximising virtual wards / care

Sickness to prevention

- Screening and early diagnostics
- Focusing on health inequalities
- Ensuring equitable access
- Making every contact count
- Promoting positive health choices
- Working with partners

Analogue to digital

- Digital by default
- Using data, insights and intelligence inc. for population health management
- Maximising technology and systems inc. the use of robotics and artificial intelligence
- Focus on digital optimisation and interoperability including via our digital records programme

Quality

The provision of safe, high quality, compassionate care will always be our top priority. We want patients to feel valued, respected and heard, and their families and carers to feel supported. Implementing and learning from best practice will be key to this.

We have engaged with our partners and stakeholders to understand our future priorities which we will group under the headings of:

- Clinical effectiveness
- Patient safety
- Patient experience
- Staff experience

Innovation and research

In support of our priorities in this area, research improvement and learning will flow through every part of our organisation, informing practice and enhancing outcomes.

We know that research active organisations improve the quality of services and improve patient satisfaction. We want to grow our research and innovation capacity and capability to inform our models of care. This includes, for example, opening the Northern Centre for Breast Research in 2025.

Women's health

Building on the National Women's Health Strategy for England (2022) and Gateshead's Director of Public Health Report, Mind the Gap, partners across Gateshead have a collective ambition to improve access and outcomes for women and girls.

Our ambition is to lead the Northern Centre of Excellence for Women's Health. This builds on our reputation for delivering excellent Maternity and regional Gynaecology services and reflects our commitment to addressing long-standing inequalities in women's health outcomes.

Diagnostics

Accurate and timely diagnostics play a vital role in preventative health by improving early detection of illness. Our flagship Community Diagnostic Centre and regional pathology laboratory play a significant role in our ambition in this area.

Specialist services

We want to be a good partner and play our part in ensuring the people of Gateshead and beyond have access to specialist services when they need them. This means building connections across teams and supporting resilience across organisations.

Our strategic response

Our clinical and diagnostics services strategy - improving population health and narrowing the gap in health inequality

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. They are rooted deep within our society, and are widening, leading to disparate outcomes amongst our population.

This results in earlier deaths, lost years of healthy life, increased likelihood of multiple long-term conditions and intergenerational effects from traumatic experiences. All of these create significant demand for our services as well as broader implications and economic cost for society.

For example, within Gateshead we know:

- Premature mortality from cardiovascular disease is significantly worse in Gateshead than in England
- Prevalence of cancer diagnoses are increasing
- The (age-standardised) rate of alcohol-related hospital admissions in Gateshead is 841 per 100,000 population, significantly above the regional and England average.

Our aim is that the population we serve will live more years in good health, closing the gap in healthy life expectancy between people living in the most and least disadvantaged communities in Gateshead. We will do this through the provision of high-quality care as well as by playing our part in prevention.

To achieve this, we recognise the importance of developing strong links with the communities we serve and working collaboratively with our partners to ensure that we are not only responsive, but proactive in our approach to meeting current healthcare and community needs.

We will work to:

- Improve our understanding of the needs of people who use our services
- Support early diagnosis and treatment
- Focus on high risk groups - people with complex health and care needs who require support from multiple organisations; and
- Design services to meet the needs of populations.

Our focus

As part of our work to date on health inequalities, we have identified a number of priority areas in response to the needs of our population which include:

- **Making every contact count** – focusing on using interactions with people to support them in making positive changes to their physical and mental health and wellbeing
- **Health literacy** – supporting people to understand and use information in ways which promote and maintain good health” for themselves, their families and their communities
- **Reasonable adjustments** - making changes in our approach and provision to ensure that services are accessible to all
- **Equitable elective recovery** – with an emphasis on reducing time to treatment for patients and by preventing worsening health while awaiting treatment.

Neighbourhood Health

As an integrated provider of health services, we see ourselves playing a pivotal role in the future of neighbourhood health services. Tailoring our service offer to those who need it most.

We want to ensure patients are treated in the best place for them. Be that at home, in the community, at the hospital or in another organisation. This includes working alongside colleagues in social care to adopt a **home first** approach to care.

Working with partners our ambition is to play a leading role in the development of integrated neighbourhood health centres with a focus on the best outcomes for the population of Gateshead, starting with the places where health expectancy is lowest and repurposing existing estate.

We want to connect mental and physical health services, social care and organisations across the voluntary, community and social enterprise to ensure the people of Gateshead who need our services the most have access to them.

Our strategic response

A collaborative partner

We know that system partnerships and collaborative working are crucial to support the delivery of services to the communities that we serve along with delivery of our strategy and the national priorities. Front and centre to this work will be integrated neighbourhood health.

We have a strong history of joint working and have excellent relationships across the region and beyond.

Working as part of the North East and North Cumbria (NENC) Integrated Care System, the regional ten-year plan 'Better health and wellbeing for all' sets out how we will work together to reduce inequalities, improve experiences of our health and care services and improve the health and wellbeing of people living and working in the North East and North Cumbria by 2030 and beyond.

Our four key goals...



Longer & healthier lives

Reducing the gap between how long people live in the North East and North Cumbria compared to the rest of England



Fairer outcomes for all

As not everyone has the same opportunities to be healthy because of where they live, their income, education and employment



Better health & care services

Not just high-quality services but the same quality no matter where you live and who you are



Giving children and young people the best start in life

Enabling them to thrive, have great futures and improve lives for generations to come

Key elements of this work feed into our own strategy.

At Gateshead **PLACE**, we are committed to working with partners in the local authority, primary care, the North East Ambulance Service (NEAS) and the voluntary, community & social enterprise (VCSE) organisations in an integrated way to achieve the ambitions set out in the Health and Wellbeing Strategy along with achieving our own ambitions and goals.

We will build on the work we led at Gateshead Place to co-design and co-produce a model of care for women's health hubs. Listening to service users about what matters to them and using the learning to scale up system wide transformation to improve access to services for the population we serve.

We want to work with Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) as our local mental health trust to improve access to services for the people of Gateshead.

We recognise that we play a significant role as an anchor institution at Place, with the ability to go beyond our role as a healthcare provider and large employer of the local population. This includes our broader responsibility for creating wider societal benefits, promoting health careers, creating jobs, tackling the climate emergency and reducing inequalities.

Under a single '**Community Promise**' framework we want to focus on improving people's lives, pushing the boundaries of what we can do as an NHS Trust by looking at how we can have an even larger impact for everyone who lives and works in the area and wider region.



With a focus on improving access to services through transformation we will look to be efficient, effective and responsive to the needs of our population.

We will enhance productivity by maximising the use of resources, optimising service delivery and utilising technology. We will empower our workforce to think innovatively and create an environment where working collaboratively is the norm.

Our strategic response

Great North Healthcare Alliance

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

The Alliance has changed ways of working across the four trusts, strengthening partnership between neighbouring organisations to drive better decision making for the benefit of patients, our people and external partners.

Our focus is to work together to deliver high quality, safe and reliable care to our population, with fairer outcomes for all and equal access regardless of geography.

Our aim is to leverage the best of each organisation for the benefit of all, building on the distinct strengths of each organisation.

We will work together to define our collective clinical strategy including outlining how services are located to make the best of our collective resources. This includes focusing on enabling rapid access to care, delivering positive experiences, providing the best possible outcomes, and preventing illness in the first place.

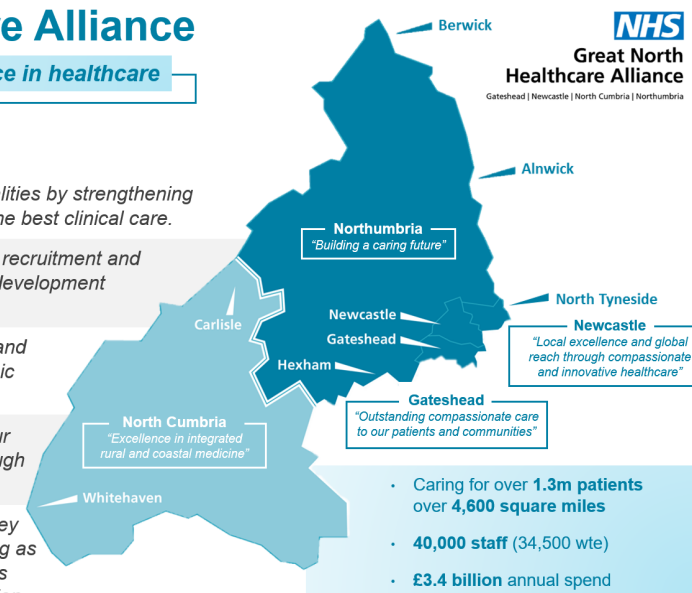
To support our strategic approach to the delivery of sustainable services and alliance working we have appointed a shared Chair across the three North East Trusts namely Gateshead, Newcastle and Northumbria. The shared Chair will support the development of a single, unified voice for the organisations making decision making more streamlined and increasing the strategic influence of the Alliance both regionally and nationally.

Great North Healthcare Alliance

Working together to deliver excellence in healthcare

By working together we will:

- *Improve patient outcomes and reduce inequalities by strengthening our services and making it easier to access the best clinical care.*
- *Create great places to work by joining up our recruitment and staff experience offer and by sharing career development opportunities.*
- *Pioneer innovation, transformation, research and development, making the most of our academic and commercial opportunities.*
- *Reduce health inequalities and do more for our economy, environment and communities through local and national partnerships.*
- *Create a financially sustainable value for money health economy that raises revenue by treating as many patients as possible within the resources available, commercial activity and cost reduction.*



The four Trusts within the Alliance are united in their commitment to deliver safe, high quality, personalised and integrated care. Prioritising population health and reducing health inequalities.

Working together we can deliver significant benefits to patients and our people ensuring resilient and sustainable services for our populations now and in the future.

Our strategic response

Aligning with system partners

In developing our corporate strategy we have worked closely with system partners including colleagues in primary care, the Great North Healthcare Alliance, Gateshead Council, North East and North Cumbria ICB as well as representatives from across the Voluntary, Community and Social Enterprise (VCSE) sector. Together we share a number of aligned priorities which are outlined below. These are based around a shared intent of leveraging our joint expertise, experience, and making use of our collective resources for the benefit of the populations we serve.

01. Health inequalities

➡ Focus on tackling inequalities in service access, health outcomes, and social determinants. Supporting our communities to support themselves and each other.

02. Prevention

➡ Improving health literacy, managing long-term conditions, and making Gateshead a place where everyone thrives.

03. Care closer to home

➡ Avoiding unnecessary hospital use and supporting the provision of care at home or in the community.

04. Reforming models of care

➡ Working together across primary, community, secondary, tertiary care, voluntary sector and social services to transform the way we design and deliver sustainable services across the region.

05. Patient safety and experience

➡ Listening to the patient voice. Greater involvement in decisions about their care and in shaping the future of service provision.

06. Digital enablement

➡ Using data to anticipate need, identify future trends as well as transforming the way we work and interact.

07. People transformation

➡ Supporting resilience, retention, and flexible working alongside transforming roles to support future models of care.



An introduction to our strategy

How it was developed

Our strategy has been informed by extensive engagement with a broad range of stakeholders. Various activities were undertaken to seek the views of our people, patients, partners and governors. We also drew from a wide array of surveys, feedback and research data.

Throughout these activities we heard:



We need to focus on consistently getting the basics right, including securing our sustainable future. This foundation should drive a renewed focus on innovation and productivity, ensuring we utilise our resources in the most efficient and effective way.



The quality and safety of patient care remains our top priority and will guide our decision making.



We need to focus on utilising our resources to provide the best care possible for the population of Gateshead. This will include reforming models of care with an emphasis on prevention and providing care closer to home, optimising the use of digital where possible and appropriate.



We need to play our part in improving the health of the population and reducing health inequalities. As part of this there needs to be increased collaboration across all health and care providers including greater understanding of the breath of health and care provision available.

An overview

Our purpose is to deliver excellent healthcare and play our part in improving population health by being a good partner and a great employer

Our vision is to be recognised as a provider of safe, high-quality integrated health services, diagnostics, and a centre of excellence for women's health

We will achieve this by focusing on four strategic priorities

Excellent patient care

Great place to work

Working together for healthier communities

Fit for the future



Innovation



Caring



Openness



Respect



Engagement

Our ICORE Values

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

Our strategy on a page

Purpose: To deliver excellent healthcare and play our part in improving population health by being a good partner and a great employer

Vision: To be recognised as a provider of safe, high quality integrated health services, diagnostics, and a centre of excellence for women's health

Excellent patient care

We will be a clinically-led organisation focused on delivering safe, high-quality care and improving health outcomes for our patients

We will ensure our patients experience the best possible compassionate care and make every contact count

We will continually improve our services creating a restorative culture where learning, innovation and research can flourish

Great place to work

We will care for our people, creating a fair, inclusive and respectful environment where everyone can thrive in their role

We will grow and develop our people with a focus on celebrating achievements and creating a culture of high performance and innovation

We will be an employer and training provider of choice within the local workforce recognising our role as an anchor institution

Working together for healthier communities

We will work in collaboration with our partners to improve the health of our population and reduce health inequalities

We will develop our neighbourhoods in line with the NHS 10 year plan

We will collaborate with system partners with an emphasis on maximising efficient use of collective resources across health and care services

Fit for the future

We will ensure effective and efficient use of our resources identifying opportunities to improve productivity and ensure best use of public money

We will be a data informed, digitally enabled organisation using technology to transform the way we plan and deliver care

We will focus on productive utilisation of our estate to facilitate care in the right setting and providing our services in an environmentally sustainable way



Innovation – Care – Openness – Respect – Engagement

Strategic goal 1 – Excellent patient care

Our aim:

We will provide safe, high-quality compassionate care for every patient, every time.

By improving access, redesigning care models, and embedding patient voice in all that we do, we will reduce unwarranted variation and ensure that people receive the right care, in the right place, at the right time.

Through innovation, research, and partnership, we will continuously raise standards and deliver outcomes that meet and exceed national expectations.

Our ambitions:



We will be a clinically-led organisation focused on delivering safe, high-quality care and improving health outcomes for our patients



We will ensure our patients experience the best possible compassionate care and make every contact count



We will continually improve our services creating a restorative culture where learning, innovation and research can flourish

Strategic goal 1 – Excellent patient care

Ambition 1:



We will be a clinically-led organisation focused on delivering safe, high-quality care and improving health outcomes for our patients

We will ensure safety will always come first. We know the impact when care goes wrong, so we will keep strengthening our culture of openness and learning. That means acting early on risks, supporting staff to speak up, and making sure feedback leads to visible change.

We will focus on reducing waiting times, with particular attention to those patients and communities who face the greatest inequalities. We will reform pathways of care to support smoother patient flow, making the best use of our beds and resources so that people are cared for in the most appropriate setting. Digital solutions including the NHS App and expanding virtual wards, using patient portals, and remote monitoring will help patients stay connected to their care while easing hospital pressure. For staff, better use of digital tools will free up time for direct care and improve decision-making.

Patients will wait less and will be cared for in the right place at the right time. Safety outcomes will improve, with fewer avoidable harms and stronger evidence of learning when things do go wrong. People who have struggled to access our services will see real improvements in equity of care. Digital tools will become part of everyday practice, making care more efficient and convenient for both patients and staff.

Executive owner
Gill Findley / Carmen Howey

Trust Committee

Quality Governance

To achieve this goal we will:

- Put safety first in all that we do
- Improve equitable access to our services with an emphasis on reducing time to treatment and preventing worsening health while awaiting care
- Reform models of care to maximise resources, enhance patient flow and emphasise providing care in the right setting
- Maximise the use of digital to transform the way we work and how our patients access our services
- Prioritise investment to enhance quality, safety and improve patient experience

What will be different

- ✓ Recognised as a safe, learning organisation
- ✓ Maintain or better our CQC ratings and safety standards
- ✓ Achievement of constitutional standards, with access and waiting times in the top quartile for our region
- ✓ Reduction in avoidable harms across all services
- ✓ Reduce Length of Stay to the minimum clinically required
- ✓ Digital first for both our patients and our services

Strategic goal 1 – Excellent patient care

Ambition 2:



We will ensure our patients experience the best possible compassionate care and make every contact count

Good care is not just about treatment it is about how people feel when they use our services including how, when and where they access them. We will prioritise dignity, respect, and compassion in every interaction. Our approach will be more personalised, shaped around what matters most to each individual patient.

We will strengthen co-production of care by involving patients, carers, and the public in the design and review of services. That means not just gathering feedback but acting on it and showing people how their input has helped shape change. We will work more closely with partners in primary care, mental health, social care, and the voluntary sector so that patients experience joined-up care that addresses their wider needs, not just their medical treatment. This includes shifting care out of hospital where it makes sense to do so.

Patients will feel listened to and involved in their care. Feedback scores, surveys, and conversations will show a more positive experience, with real improvements in how responsive and compassionate our services feel. Services will increasingly be designed with patients, not just for them. Pathways will be smoother across health and social care, reducing duplication and hand-offs. Patients will notice care that feels joined-up, personal, and respectful.

Executive owner
Gill Findley / Carmen Howey / Jo Halliwell

Trust Committee

Quality Governance

To achieve this goal we will:

- Focus on getting the basics right every time
- Ensure our patients have the best possible experience
- Develop our approach to co-production, increasing patient, service user, carer and public engagement
- Ensure patients and carers are listened to and feel valued for their contribution
- Work alongside our mental health trust to improve access to services
- Establish new models of care that better meet the needs of our population and reduce pressure on our hospital services

What will be different

- ✓ More of our people and patients will recommend us as a place to receive care
- ✓ People report easy access, positive experience and effective outcomes
- ✓ Shift of provision to community setting
- ✓ Shared awareness of all health and care provision available to the population of Gateshead

Strategic goal 1 – Excellent patient care

Ambition 3:



We will continually improve our services creating a restorative culture where learning, innovation and research can flourish

Continuous improvement will become part of daily practice. We will support staff across all roles to use improvement methods confidently, making changes that directly benefit patients. This will link with Alliance-wide approaches so that we share learning and avoid duplication.

Research and innovation will be central across services and teams. We will expand our research portfolio, giving more patients the chance to take part in trials and benefit from new treatments. Evidence-based practice will guide how we design services, making sure improvements are grounded in the best available knowledge.

We will build on our strengths in diagnostics and women's health, developing these areas into centres of excellence that serve not only our local population but the wider region.

Staff will be confident in using improvement tools, and patients will see the benefits of changes made closer to the front line. More patients will have access to research opportunities, with our Trust recognised as research-active and forward looking. Diagnostics and women's health will be strengthened as regional exemplars. The combination of research, innovation, and improvement will lead to better outcomes, greater efficiency, and a culture where learning never stops.

Executive owner

Carmen Howey

Trust Committee

Quality Governance

To achieve this goal we will:

- Embed our continuous improvement methodology seeking opportunities to align to Alliance methodology
- Expand our existing research capacity and increase our uptake of clinical trials embedding this as a core feature of continually improving our services
- Further strengthen our presence in regional services
- Seek opportunities to grow women's health and diagnostic services

What will be different

- ✓ Continuous improvement methodology adopted across all teams and services
- ✓ Increase in the number of services undertaking high quality research
- ✓ Establishment of the Northern Centre for Breast Research in 2025
- ✓ Maximised research and innovation opportunities including through the Alliance

Strategic goal 2 – Great Place to Work

Our aim:

To deliver outstanding and compassionate care to patients we must first care for our people.

We want to get the basics right for our people and to build on these to support our teams and help everyone to thrive in the workplace.

We want to create a sense of belonging where everyone is valued. We will train and develop all our people to ensure they continue to provide first class care to our patients.

Our ambitions:



We will care for our people, creating a fair, inclusive and respectful environment where everyone can thrive in their role



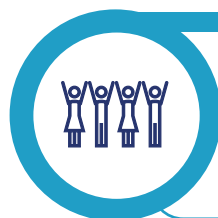
We will grow and develop our people with a focus on celebrating achievements and creating a culture of high performance and innovation



We will be an employer and training provider of choice within the local Community recognising our role as an anchor institution

Strategic goal 2 – Great Place to Work

Ambition 1:



We will care for our people, creating a fair, inclusive and respectful environment where everyone can thrive in their role

Caring for others is an intrinsically compassionate behaviour; however, the culture we work in is not always one that is truly compassionate.

We aim to build an inclusive culture that is built on civility and respect, where everyone's voice is heard, and our people feel proud to be part of the Gateshead team.

Alongside this, we will continue to embed our ICORE values and behavioural framework ensuring it enables us to live our values every day and makes a real difference to the experience of our teams and our people.

With more visible senior leaders and improved communication channels, we are passionate about truly engaging with as many staff as possible. We will refresh our engagement approach with an emphasis on providing more opportunities for conversations and developing understanding.

We will continue to promote a culture of speaking up, enabling and supporting colleagues to raise concerns. We will continue to promote and raise awareness of our route map for raising concerns, so staff know what routes are available to them to speak up.

We will prioritise our health and well-being offer based on need and proactively support our people to understand the support that is available and take personal responsibility for their own health and well-being within the work environment.

Executive owner

Amanda Venner

Trust Committee

People and OD

To achieve this goal we will:

- Further embed our ICORE values with an emphasis on ensuring these are consistently role-modelled throughout the organisation
- Be open and transparent in our communications
- Ensure a psychologically safe culture by encouraging speaking up and ensuring our people have a voice that is heard
- Prioritise our Health and Well-Being offer based on need
- Tackle poor behaviours and ensure all our people are role-modelling good behaviours and Trust values

What will be different

- ✓ Increase in people recommending us as a place to work to at least 75%
- ✓ Feel safe to speak up about anything that concerns me in this organisation, and feel organisation would address any concerns raised to 75% in Annual Staff Survey
- ✓ Closer parity in the overall positive engagement scores for disability and ethnicity
- ✓ Sickness absence remains consistently below 4.9%
- ✓ To maintain turnover below the NHS average <12% annually

Strategic goal 2 – Great Place to Work

Ambition 2:



**We will grow and develop
our people with a focus on celebrating achievements
and creating a culture of high performance and innovation**

We are committed to ensuring our people and teams have the skills and knowledge to be the best they can be. Our dedicated learning and development team will support with every step, from induction to core training, appraisals and a full management development offer.

Facilitating excellent clinical training will remain a key priority for us. We will develop a forward-thinking clinical leadership programme to give our clinical leaders the time, skills and experience to develop, learn and build on their existing approaches. This programme will support them as they move into leadership roles, giving them the tools they need to succeed and embed our Clinically Led, Management Supported ethos.

Underpinning all the work we do in People & OD is the aim of developing capacity and capability across our managers and colleagues. Providing expert advice and guidance enables us to upskill and train managers so that they have the confidence and capability to be great people managers. This will allow them to lead their teams compassionately ensuring direction, supporting alignment and nurturing commitment, which will lead to better patient outcomes and more motivated colleagues.

Robust workforce plans will ensure we take a more proactive, informed approach to our wider work, such as recruitment and retention, and ensure we can make informed decisions about future workforce needs. We will build internal skills on workforce planning and work with professional leads to plan across health and care ensuring we recognise the impact of digital advancements and automation on the workforce.

Working in partnership with clinical teams, we will move focus onto supporting resilience in our workforce developing innovative roles of the future and exploring more flexible ways of working.

Executive owner

Amanda Venner

Trust Committee

People and OD

To achieve this goal we will:

- Establish a leadership development framework to equip our current and aspiring future leaders
- Ensure all our people have the skills they need to provide excellent patient care
- Embed workforce planning, building on the six steps methodology
- Greater understanding of our future workforce demands with increased flexibility in roles and training to achieve this
- Define and develop our workforce of the future, by evolving roles across professional boundaries and supporting innovative ways of working and training

What will be different

- ✓ Increased proportion of people from diverse background progressing their career within the Trust. Organisation acts fairly regarding career progression
- ✓ All of our managers will have the opportunity to access leadership development training, with a target of 85% access the framework to develop their skills
- ✓ We will be recognised as a provider of excellent undergraduate and post graduate training
- ✓ Every business unit has a workforce plan, which identifies future workforce needs, flexible working, and clearly linking future operational and people requirements

Strategic goal 2 – Great Place to Work

Ambition 3:



We will be an employer and training provider of choice within the local Community recognising our role as an anchor institution

We have an important role to play in the Gateshead community as the largest employer as well as a health and care provider. Often referred to as 'Anchor Institutions' our size and scale means we can and will create new opportunities for local people to enter employment by expanding apprenticeships, providing routes into employment for volunteers and working more closely with schools, colleges and universities.

We are already working with other partners across the local authority and voluntary sector to encourage people into employment with the skills and support they need to make the first steps into a career in health and care. These new opportunities for local employment will bring benefits for people most at risk of the negative health effects of long-term unemployment while also helping health and care organisations in Gateshead.

The formation of the Great North Healthcare Alliance enables us to maximise the opportunities presented through the regional workforce programme. We want to grow the support and opportunities our teams have, and our work plan will have this at its heart. Key opportunities within this will include:

- Opportunities for joined up recruitment and workforce development programmes that supports local people into stretching careers.
- Adopting the Community promise that supports local growth - including promotion of health careers, social value, and a healthy green environment.

Executive owner	Amanda Venner
Trust Committee	People and OD

To achieve this goal we will:

- Continue to Increase our links with local colleges, schools and other community bodies to expand alternative routes to employment supporting t-level placements, work experience and apprenticeships.
- Maximise opportunities for our people to develop and work across organisations as part of the Great North Healthcare Alliance
- Promoting health careers to local populations, especially underrepresented groups
- Adopt the Community promise across all Alliance partners
- Be a training provider of choice

What will be different

- ✓ Increased breadth of pathways into employment
- ✓ Fully utilising the apprenticeship levy to support talent and supply pipelines for widening participation
- ✓ Aligned approach across the Alliance for recruitment and workforce development programmes
- ✓ Evidenced impact on the 5 component parts of the community promise

Strategic goal 3 – Working together for our healthier communities

Our aim:

To work collaboratively with our health and social care partners to improve population health by reducing inequalities and making the best use of collective resources to support the people of Gateshead have better life experiences which includes living well for longer.

To work with stakeholders and partners to co-design and co-produce a neighbourhood health care model aligned to the NHS 10 year plan focusing on the three radical shifts:

- Hospital to community
- Analogue to digital
- Sickness to prevention

Through neighbourhood health service co-design, shared leadership and delivery, we will create services that are inclusive, sustainable and rooted in the needs of our communities leading to improved health outcomes.

Our ambitions:



We will work in collaboration with our partners to improve the health of our population and reduce health inequalities



We will develop our neighbourhoods in line with the NHS 10 year plan



We will collaborate with system partners with an emphasis on maximising the efficient use of collective resources across health and care services

Strategic goal 3 – Working together for our healthier communities

Ambition 1:



We will work in collaboration with our partners to improve the health of our population and reduce health inequalities

Healthcare plays a significant role in preventing disease, promoting mental health and emotional wellbeing, enhancing quality of life and supporting economic and social stability. Improving the health of our local population through improved preventative measures and interventions, targeting those in greatest need or at greatest risk, improving health literacy and supporting navigation through our local health and social care systems, we aim to facilitate individuals to live longer and in better health. By collaborating with partners and stakeholders across the local and regional systems we will strive to deliver preventative and responsive intervention and treatments.

Particular focus will be paid to those in greatest need or at greatest risk as identified through local population health inequalities data derived from public health analysis, allowing the development of bespoke sub-population plans for prevention and early intervention to meet identified needs. By helping to focus resources on these sub-populations, we will look to close the gap in health inequalities (aligned to the CORE20PLUS5 targets and using locally identified deprivation data) and remove health variation.

Working with partners, we will maximise efforts to meet local population needs shifting focus onto prevention and key enablers for individuals to experience and sustain healthy lifestyles. These will include supporting environmental measures to create sustainable locality plans embracing Green plan targets. We will also involve all minority groups to ensure that communication channels are effective to achieve maximal engagement with all health care initiatives.

Executive owner
Neil Halford / Carmen Howey
Trust Committee
Quality Governance

To achieve this goal we will:

- Collaborate with partners to improve health literacy
- Work together with partners to improve the most profound health variances within Gateshead
- Play our role in supporting the population of Gateshead to improve their health and prevent illness
- Anticipate future health care requirements and consider health inequalities when prioritising developments

What will be different

- ✓ Holistic understanding across partners of our collective service offerings for our population
- ✓ Demonstrable impact on closing the gap in health inequalities (CORE20PLUS5)
- ✓ Progress towards achieving our Green plan targets which is proven to have a significant impact on population health
- ✓ Focus on making every contact count to promote positive health behaviours

Strategic goal 3 – Working together for our healthier communities

Ambition 2:



We will develop our neighbourhoods in line with the NHS 10 year plan

As the major healthcare provider and anchor institution within Gateshead, we will play a leading role in shaping and delivering healthcare into our local neighbourhoods to deliver the expected outcomes of the NHS 10 year plan. We will focus on current and future healthcare requirements using clinical evidence to drive forward service developments that create a healthcare system fit for the future. This will require us to work actively across interfaces with our partners and stakeholders to lead, co-design and deliver the new Neighbourhood models. This will include supporting the development of Neighbourhood Health services (particularly in areas of greatest need) and the support teams to deliver on the three radical shifts.

Clinical care will be evolved to focus on prevention, the management of need and the maintenance of wellbeing using treatment options to support individuals. We will look to develop new models of care for older people living with frailty including expanding our virtual ward capacity and reduce our bed inpatient base accordingly. Our outpatient service provision will be transformed to focus on prevention and support rather than intervention maximising the use of screening and diagnostic capacity. We will become more efficient removing duplication and ensure that we meet the right patient in the right place with the right staff first time. We will continue to evolve and deploy technologies to support a more flexible workforce meeting service user needs in a timely manner.

Workstreams will be developed with partners and stakeholders to develop actions to enable the three radical shifts to be delivered. We will through this work remain outcome focused looking to measure impact whilst seeking maximal benefit to the individual.

Executive owner
Neil Halford / Carmen Howey
Trust Committee
Finance and Performance

To achieve this goal we will:

- Anticipate future health care requirements and consider health inequalities when prioritising developments
- Improve our interface at Neighbourhoods and Place for example with General Practice and Primary Care Networks, Social Care and the broader Local Authority and voluntary sector (10 Year plan)
- Undertake a lead role within Gateshead, the Alliance and broader system, working collaboratively to develop a collective clinical and diagnostics service strategy
- Collaborate to identify system wide solutions to transform the way we design, deliver and sustain services across the region

What will be different

- ✓ Services will be redesigned and working within the parameters set by the 10 year plan
- ✓ Greater integration of services will be seen with previous hospital-based services shifting into the Neighbourhood Health delivery model
- ✓ The clinical model of care will be recognisably different focused on prevention and maintaining the wellness of the individual away from the hospital
- ✓ Our screening and diagnostic offers will expand to support prevention and early intervention when needed

Strategic goal 3 – Working together for our healthier communities

Ambition 3:



We will collaborate with system partners with an emphasis on maximising the efficient use of collective resources across health and care services

We will build upon existing relationships to evolve system working within Gateshead and across the Great North Healthcare Alliance, maximising the use of resources in health and social care in line with the NHS 10 year plan. Our focus will be on reducing duplication, improving impact on outcomes and supporting communities to live well.

To achieve this, we will help shape new governance arrangements that enable meaningful collaboration across organisational boundaries. We will lead and contribute to shared leadership and accountability across clinical pathways and services, ensuring service design reflects collective priorities and enables optimal workforce deployment.

We will engage with our supporting communities and populations to help shape our future services by developing consultation and feedback channels.

Through our position within the Great North Healthcare Alliance, we will unlock opportunities for transformation at scale, enhancing resilience and enabling more care to be delivered locally. We will seek to progress IT solutions across system partners focusing on patient data accessibility and system interoperability.

We will look to remove workforce barriers to help create Integrated Neighbourhood Teams and fully functional Neighbourhood Multidisciplinary teams supported by joined-up workforce training and development across health and social care.

Executive owner
Neil Halford / Kris Mackenzie
Trust Committee
Finance and Performance

To achieve this goal we will:

- Undertake a lead role within the Alliance and broader system, working collaboratively to develop a collective clinical and diagnostics service strategy
- Collaborate to identify system wide solutions to transform the way we design and deliver sustainable services across the region
- Trust and empower our teams to work in collaboration with others for the benefit of patient care enabling a one workforce approach

What will be different

- ✓ Collaboration will be the new expected norm within teams routinely working across organisational boundaries and embracing a one workforce approach
- ✓ Joint clinical strategy across the GNHA with lead provider arrangements supporting safe and sustainable service provision across the region
- ✓ Increased use of joint ventures and interface working
- ✓ Shared leadership arrangements across services and/or organisations where necessary and appropriate

Strategic goal 4 – Fit for the future

Our aim:

We will ensure our Trust is future-ready by making best use of public resources, embracing digital technology and transformation including the NHS App as the digital front door, and optimising our estate to deliver care in the right setting. Through data-informed decision-making, sustainable infrastructure, and a focus on productivity, we will build a resilient, efficient, and environmentally responsible health service.

We are committed to developing an estate that supports safe, high-quality, care. This includes optimising the use of our estate to support clinical activity and training, improving estate condition by tackling backlog maintenance and critical infrastructure and advancing our environmental sustainability goals. In support of our ambition to provide care as locally as possible, we will also prioritise the establishment of Neighbourhood Health Centres, working collaboratively with system partners to maximise the use of our collective estate.

Our ambitions:



We will ensure effective and efficient use of our resources identifying opportunities to improve productivity and ensure best use of public money



We will be a data informed, digitally enabled organisation using technology to transform the way we plan and deliver care



We will focus on productive utilisation of our estate to facilitate care in the right setting in an environmentally sustainable way

Strategic goal 4 – Fit for the future

Ambition 1:



We will ensure effective and efficient use of our resources identifying opportunities to improve productivity and ensure best use of public money

To be fit for the future, we must ensure that every pound spent delivers maximum value for our patients, staff, and communities. We will take a disciplined and transparent approach to financial sustainability, delivering recurrent cost efficiency savings and tackling our financial deficit with the ambition of achieving financial breakeven by 2027. This will enable us to reinvest in service improvement and innovation.

We will strengthen our commercial capabilities, maximising non-NHS income through our wholly owned subsidiary, QE Facilities, and broader commercial opportunities. Working closely with our Alliance partners, we will identify opportunities to share resources, reduce duplication, and improve system-wide productivity. We will also make full use of new commissioning arrangements under the ICB blueprint to secure funding and shape services that meet local needs.

Our corporate services will be efficient, resilient, and aligned to strategic priorities. Through robust planning, early development of delivery plans, and a strong accountability framework, we will build a financially sustainable base that supports long-term transformation and improved outcomes.

Executive owner
Kris Mackenzie / Jo Halliwell
Trust Committee

Finance and Performance

To achieve this goal we will:

- Deliver cost efficiency savings recurrently ensuring we are making the best use of public money to deliver the best possible care
- Tackle our deficit and become financially breakeven by 2027
- Be open and transparent about our difficult decisions
- Maximise our non-NHS income, both through our wholly owned subsidiary QE Facilities and via broader commercial opportunities
- Work with our Alliance partners to identify opportunities to make the best use of our collective resources
- Maximise opportunities open to us under new commissioning arrangements (ICB blueprint)

What will be different

- ✓ Achieve financial breakeven by 2027
- ✓ Recurrent delivery of our cost savings program
- ✓ Demonstrable financially sustainable base which enables us to focus on continued investment in service improvements
- ✓ Efficient and resilient corporate services

Strategic goal 4 – Fit for the future

Ambition 2:



We will be a data informed, digitally enabled organisation using technology to transform the way we plan and deliver care

Recognising the critical role data and digital play in today's health and care systems and processes, we are committed to ensuring that we have the right technology and digital systems to support our patients and teams in their everyday lives. This includes working under the principle that by 2028 the NHS App will be the 'front door' to all NHS services offering booking, care planning, communication and access to health data. Understanding the role the 5 big bets of data, artificial intelligence (AI), genomics & predictive analysis, wearables and robotics play in healthcare reform will be key to our strategy.

We will continue to focus our efforts on the accuracy of our data to ensure it supports our analysis, modelling and forecasting to support the provision and planning of clinical care.

Our ambition is to place data and technology at the centre of how we deliver care with a focus on efficient and effective communication. This includes optimising our electronic patient record (EPR). Making the best use of our existing investments and adopting shared technology opportunities including across the Alliance.

Via our paper record optimisation strategy we want to eliminate our reliance of paper and support efficiency improvements by embracing our digital health record.

We recognise that to deliver our digital ambition we need to get the basics right. This starts with infrastructure stability and performance. We want to modernise and enhance our foundational infrastructure by embracing relevant cloud solutions.

In support of our ambition to be a centre of excellence for diagnostics, we want to utilise investment opportunities in digital diagnostics to create modern and reliable platform to deliver services.

Executive owner

Dave Elliott

Trust Committee

Digital

To achieve this goal we will:

- Improve our use of data to make informed decisions around investment, productivity and ongoing improvements
- Maximise use of the NHS App to support the way our patients access our services and we deliver care
- Make the best use of our existing investments and adopt shared technology opportunities
- Develop our digital strategy, ensuring we have a robust infrastructure to support advances in technology and to facilitate digital interoperability across the Alliance
- Successfully implement our digital records programme across all our services

What will be different

- ✓ Improved BI capability enabling us to make informed decisions around service demand and productivity
- ✓ Sustainable digital infrastructure which supports greater use of digital solutions in the way we design and deliver services
- ✓ Reduction in our use of paper
- ✓ Infrastructure stability and performance

Strategic goal 4 – Fit for the future

Ambition 3:



We will focus on productive utilisation of our estate (assets) to facilitate care in the right setting in an environmentally sustainable way

We are committed to developing an estate which facilitates the delivery of safe, high-quality care. Key to this is proactively addressing our backlog, much of which relates to critical infrastructure due to the estate's condition and age. Our focus will be on creating facilities that advance our clinical strategy by maximising clinical space, enabling efficient service co-location, enhancing the experiences of our patients and people, and supporting our goal to be a training provider of choice.

To achieve these objectives, we will prioritise the regeneration and optimisation of the estate. This includes a clear plan for addressing backlog, along with the disposal of underutilised assets. We are also firmly committed to decarbonising our estate and delivering the goals set out in our Green Plan, ensuring our facilities contribute positively to the environment.

In support of our Women's Health ambitions, we aim to co-locate maternity and family health services at the heart of the hospital. We will expand diagnostic imaging capacity with an emphasis on improving access for the whole of our population.

We will also collaborate with system partners to maximise the use of our collective assets. This will be key to the provision of care in the community including the establishment of Neighbourhood Health Centres aligned to the needs of our population. Through this we will develop an estate that provides neighbourhood teams with the equipment, working space and technology they need to make our new care model a reality.

Through these initiatives, we will create an estate that is resilient, flexible, and aligned with the evolving needs of our patients, staff, and wider population.

Executive owner
Gavin Evans / Jo Halliwell
Trust Committee
Finance and Performance

To achieve this goal we will:

- Develop an estates strategy which focuses on efficient use of our estate, supports our clinical ambitions, and enables the provision of increased care in a community setting, replacing the status-quo of hospital by default
- Collaborate with partners across the region to maximise use of our collective estate to support the provision of care in the right setting aligned to the needs of our population
- Actively pursue initiatives that reduce waste and inefficiency, ensuring the management of our estate supports a greener, more sustainable future

What will be different

- ✓ Patient care will be supported by modern, accessible, high-quality facilities
- ✓ Establishment of integrated Neighbourhood Health Centres aligned with the needs of our most deprived populations and maximising collective estate across partners
- ✓ Capital investment planned across a rolling 5-year period, guided by a robust funding strategy
- ✓ Achievement of our Green plan targets in line with national guidance
- ✓ Greater collaboration with partners to maximise the collective estate

Keeping us on track

Enabling plans

Our corporate strategy is ambitious and reflects our commitment to improving health outcomes for the residents of Gateshead with a relentless focus on the quality and safety of our services.

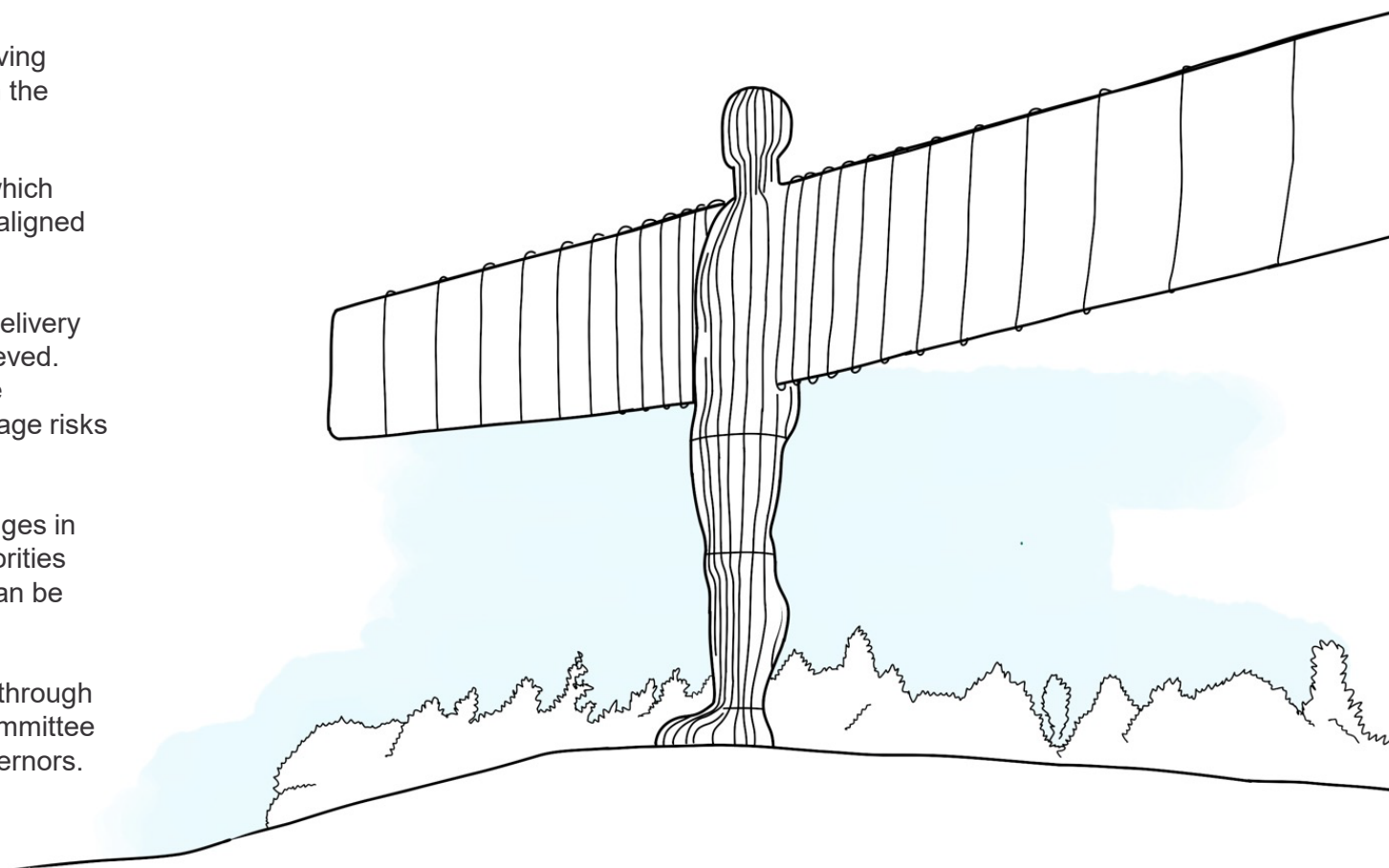
This document should be read in conjunction with our Clinical Strategy* which sets out how we intend to transform how we deliver high-quality services aligned to the national three shifts.

Each strategic goal within this strategy will also be supported by its own delivery plan providing more detail on how the ambitions in each area will be achieved. These along with this document will create the strategic framework for the organisation. Our Board Assurance Framework (BAF) will help us to manage risks associated with delivery of our strategy and the objectives within it.

To keep us on track each year we will review our progress, consider changes in the external environment and set priorities for the coming year. These priorities will be supported by defined performance indicators to ensure progress can be effectively monitored and the intended outcomes are clear.

Objectives will be cascaded throughout the Trust with progress reviewed through divisional team meetings, performance reviews, oversight through the Committee structure culminating in progress reports to the Board and Council of Governors.

*due for publication Autumn 2025



Report Cover Sheet

Agenda Item: 11

Report Title:	Winter plan			
Name of Meeting:	Trust Board			
Date of Meeting:	25 September 2025			
Author:	David Patterson - Head of Emergency Preparedness, Resilience and Response			
Executive Sponsor:	Joanne Halliwell - Group Chief Operating Officer			
Report presented by:	Carmen Howey - Group Medical Director			
Purpose of Report <i>Briefly describe why this report is being presented at this meeting</i>	Decision: ☐	Discussion: ☒	Assurance: ☒	Information: ☐
	This report provides the overview of the winter plan for 2025-26 and seeks to obtain endorsement of the Board Assurance Statement.			
Proposed level of assurance – <u>to be completed by paper sponsor:</u>	Fully assured ☐ <i>No gaps in assurance</i>	Partially assured ☒ <i>Some gaps identified</i>	Not assured ☐ <i>Significant assurance gaps</i>	Not applicable ☐
Paper previously considered by:	Internal Winter Oversight Group members (September 2025) External System Resilience Group members (September 2025) Executive Management Team (September 2025)			
Key issues: <i>Briefly outline what the top 3-5 key points are from the paper in bullet point format</i> <i>Consider key implications e.g.</i> • Finance • Patient outcomes / experience • Quality and safety • People and organisational development • Governance and legal • Equality, diversity and inclusion	This report aims to provide a follow up to the strategic overview for winter planning that was endorsed by Trust Board on 30 July 2025. As a reminder, Gateshead Health expects significant winter pressures due to: • Increased patient demand with an inability to match capacity without additional actions • Infectious disease outbreaks which reduce patient flow and increase length of stay • A need to maintain elective care • Financial constraints • Increased focus on patient safety and use of temporary escalation spaces Overview of winter planning approach Our winter plan approach 2025-26 at Gateshead Health aims to ensure timely access to appropriate care and treatment for all our patients and carers.			

The planning has been developed with the oversight of the national and local context that has been factored into our approach, with engagement from system partners.

The Group Chief Operating Officer is the identified **Executive accountable for the winter period** who has ensured mechanisms are in place to keep the Board informed on the response to pressures. The **strategic winter lead** is the Director of Operations for Medicine and Community supported by the Head of Emergency Preparedness, Resilience and Response and the Assistant to the Chief Operating Officer.

The requirements for meeting the challenges of winter are dynamic and iterative. To complement the Strategic Winter overview, an **internal Winter Tactical Plan** has been developed for 2025-26 that sets out the framework within which operational principles and processes will be implemented, and how any surge or extremis activity is effectively managed.

The internal Winter Tactical Plan is a key part of our planning to meet the challenges that the winter months bring. Working in conjunction with Gateshead Place, we are seeking to ensure that our operational teams are prepared for the challenges of winter 2025-26 and have a menu of tactical options that include:

- Development of principles to ensure **core operational winter service delivery** with supporting plans
- **Identified triggers and escalation plans** linked to dynamic risk assessment for surge and extremis using the existing operational frameworks
- **A winter testing plan** to identify respiratory viruses, a **clinical risk assessment** template to assess and isolate any infectious patients, an **isolation hierarchy** to prevent unnecessary spread of infection and a robust and a clear **cleaning methodology**.
- **A vaccination campaign** that will focus on providing flu vaccinations across the workforce with a key focus on improving uptake rates. Robust clinical led focus on vaccination delivery across all staff will be offered with a regionally wide communications campaign and an oversight of uptake data scrutinised to monitor uptake and improvement.
- An **internal and external exercising and testing schedule** is in progress to stress test plans, and a regionally led winter testing exercise was held in September 2025.
- The **internal Winter Oversight Group**, chaired by the Director of Operations for Medicine and Community, will oversee all key influencing factors and activity levels to ensure actions and resources are optimised and patient safety is maintained throughout the winter period.

	• A winter communication plan with a clear internal focus on productive messaging supporting the regional campaign and alignment with partners within the Great North Healthcare Alliance to align messaging. • Workforce planning is ongoing to review staffing rosters (medical, nursing and allied health professionals) across the winter period and in the event of a surge ward area being required. This will be informed by predicted surge and extremis planning in the first instance and planning for bank holiday periods. System collaboration and governance The requirement for system collaboration & governance is a key component of our winter planning and will be monitored through a number of governance channels: • the regional NENC ICB winter assurance and delivery group chaired by the Medical Director for the NENC ICB • the Great North Healthcare Alliance LADB (formerly North LADB) chaired by the Group Chief Operating Officer, Gateshead Health • the Gateshead Winter System Resilience Group chaired by the Group Chief Operating Officer, Gateshead Health Board assurance & national requirements There were a number of actions highlighted to Board in July 2025 to meet national assurance requirements (updates are in bold): • Submit a draft winter plan to the NENC ICB by 31 August 2025 – completed • Participate in an NHS England-hosted stress test in September 2025 based on the draft plans – completed • Mature and finalise the Gateshead Winter Plan for presentation at the 25 September 2025 Trust Board – completed, overview provided within this report • Ensure staff vaccination programmes and preparatory actions are underway – planned and in progress • Submit a Board Assurance Statement signed by the CEO and Chair by 30 September 2025 following Board review of the final winter plan – attached as appendix 1 for review and endorsement.	
Recommended actions for this meeting:	The Trust Board is requested to review the approach to winter planning, confirm that it offers the necessary assurance and endorse the Board Assurance Statement (BAS)	
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:	• <i>Strategic aim one: We will continuously improve the quality and safety of our services for our patients</i> • <i>Strategic aim three: We will enhance our productivity and efficiency to make the best use of our resources</i> • <i>Strategic aim four: We will be an effective partner and be ambitious in our commitment to improving health outcomes</i>				
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 is an organisational risk (ref 4768) which is currently at 16. There are several risks that are factors to the successful delivery of the winter plans that may impact the trust concurrently. This will be linked to the overarching risk and will influence the summary risk score accordingly.				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	Yes ☒	No ☐	Not applicable ☒		

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust



Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025**.

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes	The Strategic overview for winter planning 2025-26 was endorsed by the Board on 30 July 2025. An overview of the Winter Tactical Plan was presented to Board on 25 September 2025.
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	An Equality Impact Assessment has been completed with oversight from the Internal Winter Oversight Group members.
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	The trust plan was developed with input and engagement from Gateshead System Resilience Group members as part of the consultation.
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	The internal Winter Tactical Plan was tested at a regional event on 3 September 2025 with learning provided to the Internal winter oversight group on 17 September 2025.
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	The Group Chief Operating Officer is the identified Executive accountable for the winter period – referenced within the plans
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	Evidence to support assurance included within checklist and board report and referenced within the plans.

The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	There is an organisational risk (ref 4768) which is currently at 16 - there are several risks that are factors to the successful delivery of the winter plans that may impact the trust concurrently. This will be linked to the overarching risk and will influence the summary risk score accordingly. Risk oversight has been provided at the Executive Risk Management Group and will be monitored through the Internal Winter Oversight Group
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	Yes	Trajectories submitted in during the Planning cycle remain on target and risks to 4 hour and 12-hour positions have extensive mitigations in place working with partner agencies if appropriate. Modelling suggests that RTT and cancer performance recovery trajectories remain deliverable as we are not intending on a reduction in elective throughput during Q4.

Provider CEO name	Date	Provider Chair name	Date
Sean Fenwick		Alison Marshall	

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	A Vaccination campaign will focus on providing flu vaccinations across the workforce with a key focus on improving uptake rates. Robust clinical led focus on vaccination delivery across all staff will be offered with a regionally wide communications campaign and an oversight of uptake data scrutinised to ensure improvement.
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	Patients within the winter period have a higher prevalence of respiratory illness, seasonal illness and greater demand for urgent and emergency care. Patient cohorts are typically older, more clinically vulnerable and at a higher risk of health care associated infections. This can be modelled with the higher proportion of the patients typically attending and being admitted from late November until the beginning of February.
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	Workforce planning is ongoing to review staffing rosters (medical, nursing and allied health professionals) across the winter period and

		in the event of a surge ward area being established.
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	Discharge profiles are reviewed weekly at ward and Division level. Priorities for discharge on pathways 1-3 form part of the Better Care Fund plan.
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Additional elective capacity will be delivered in September & November to protect winter resilience. Modelling suggests that RTT and cancer performance recovery trajectories remain deliverable as we are not intending on a reduction in elective throughput during Q4. Diagnostic delivery remains strong and with the additional CDC capacity this will support elective and urgent care demand off the hot site over winter.
<i>Infection Prevention and Control (IPC)</i>		
6. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	IPC have been fully engaged in the learning and planning winter events both locally, regionally and nationally.
7. Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Yes	Provision for FIT testing continues to take place and all appropriate staff are continuously to book ongoing FIT testing across the trust - this is monitored for assurance through the IPC Group.
8. A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Yes	There is an organisational clinical risk assessment approach to isolating and cohorting infectious patients. This is with advice and guidance from Microbiology and IPC.

		Any relevant guidance can be accessed by the clinical teams (including Patient Flow) through the IPC intranet page or IPC Teams.
Leadership		
9. On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	On call arrangements exist for normal winter and surge scenarios.
10. Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	Monitored and reported through daily Patient Flow Meetings.
Specific actions for Mental Health Trusts		
11. A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	N/a	Not applicable
12. Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	N/a	Not applicable



Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 12

Report Title:	Green Plan			
Name of Meeting:	Trust Board of Directors			
Date of Meeting:	25 th September 2025			
Author:	Sarah Medhurst Sustainability, Waste & PAM Manager - QE Facilities Limited			
Executive Sponsor:	Dr Carmen Howey Group Medical Director			
Report presented by:	Dr Carmen Howey Group Medical Director			
Purpose of Report <i>Briefly describe why this report is being presented at this meeting</i>	Decision: ☒	Discussion: ☐	Assurance: ☐	Information: ☐
	To provide oversight as part of the required Board approval process prior to the publication of the plan in October 2025.			
Proposed level of assurance – to be completed by paper sponsor:	Fully assured ☐ <i>No gaps in assurance</i>	Partially assured ☒ <i>Some gaps identified</i>	Not assured ☐ <i>Significant assurance gaps</i>	Not applicable ☐
Paper previously considered by: <i>State where this paper (or a version of it) has been considered prior to this point if applicable</i>	The Greener NHS Group Finance and Performance Committee			
Key issues: <i>Briefly outline what the top 3-5 key points are from the paper in bullet point format</i> <i>Consider key implications e.g.</i> • Finance • Patient outcomes / experience • Quality and safety • People and organisational development • Governance and legal • Equality, diversity and inclusion	The new Green Plan is a full refresh of the current Green Plan in line with the latest Greener NHS Green Plan guidance. The plan covers the Groups legal duty to reduce our emissions and meet the net zero targets, whilst highlighting the impact of climate change upon health. It sets out the Group vision, aims and objectives around environmental sustainability linking in to the Trust ICORE values. The plan details current emissions and achievements to date in tackling climate change while also setting out actions and metrics to help reduce emissions in line with our required projections.			

	Progress against those metrics identified within the Plan will be managed via a tier 3 group with representation from both the Trust and QE Facilities with oversight provided by the newly established Bi-Annual Greener NHS Group chaired by the Group Medical Director.				
Recommended actions for this meeting: <i>Outline what the meeting is expected to do with this paper</i>	To approve the Green Plan prior to the NHSE mandated publication date of 31 st October 2025				
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 <u>strategic objectives</u> 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 ☒	

Green Plan 2025-28



Foreword

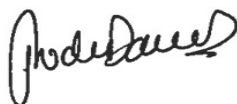
Gateshead Health NHS Foundation Trust recognises the enormity of climate change and its impact upon the health of local community. We see it daily with the increasing number of patients through our doors and this will only continue, unless we take action to address climate change.

It is recognised that climate change is the biggest threat to human health and one factor of this is air pollution. Although it might not be visible the impact cost of air pollutants on the NHS and social care system between 2017 and 2025 is estimated will be £1.6 billion. Approximately 3.5% of all road traffic in England is related to the NHS activity (6.7 billion road miles), reviewing our systems and pathways such as the Community Diagnostic Centre allows us to improve access to clinical services via public transport and active travel reducing emissions from both staff and patient travel.

Since the publication of our first Green Plan 3 years ago we've achieved success as we strive to reach our net zero targets, through the roll out of air source heat pumps and solar panels, increasing the use of electric vehicles and improving our green spaces. However this is just the beginning of our journey and we understand there is far more we must do and consider with every decision made.

As much as we can do as an organisation, it will take the engagement of everyone to meet the targets so please get involved and think about what changes you can make personally or as part of your role. Change often feels daunting but remember every small change will make a difference and this is not just for the benefit of our patients but our family, friends and community too. Our ambitions would not be possible without the help and support of every single one of you.

Trudie Davies
Group Chief Executive



Introduction

About Us

Gateshead Health provides a range of acute, community and older peoples' mental health services to our local community and beyond of around 450,000 people annually. We also provide a range of specialist services including bowel screening for a population of around 7 million people and specialist gynecological cancer treatments from the Scottish borders through to Cumbria & Whitby.

Gateshead Health Foundation Trust and QE Facilities (Group) employ 5,500 staff across numerous sites located within the Gateshead region and beyond. QE Facilities Transport Department operate facilities as far as Coventry and even into Scotland. This makes us unique as not only do we provide local services, but we are also providing services nationally too.

The North East is home to over two and half million people; over a third of which live in the 20% most deprived areas of England (North East Combined Authority 2024). The North East also has the lowest life expectancy in England (Office for National Statistics, 2024), a figure that has fallen in recent years. Gateshead specifically is ranked 47th most deprived out of 317 local authorities in England. Within Gateshead there are twenty one areas that fall within the 10% most deprived areas in England, equating to almost 32,700 people or 16% of the population.

In addition to this the geography of the area poses challenges with low lying areas at risk of flooding at Team Valley to areas rising to a height of 525 feet where the Queen Elizabeth Hospital is situated. This makes our community vulnerable to the impact of climate change on health outcomes, particularly extreme heat and cold weather events and the impact of air pollution. Health prevention and net zero are intrinsically linked, this must be priority objective.

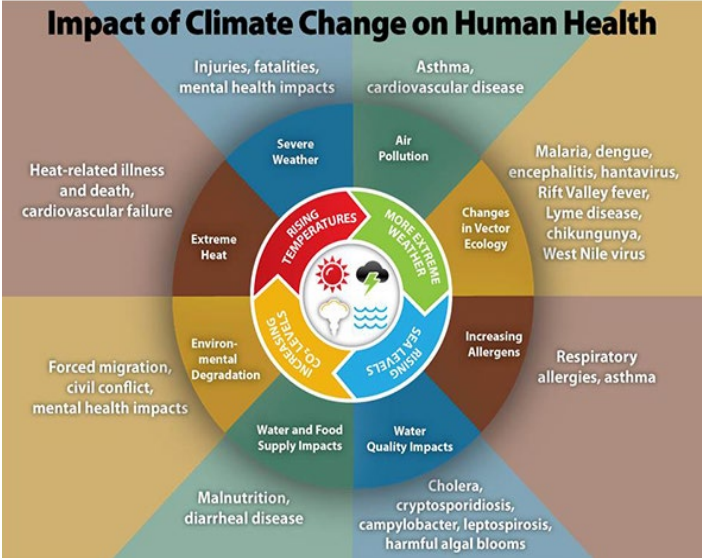
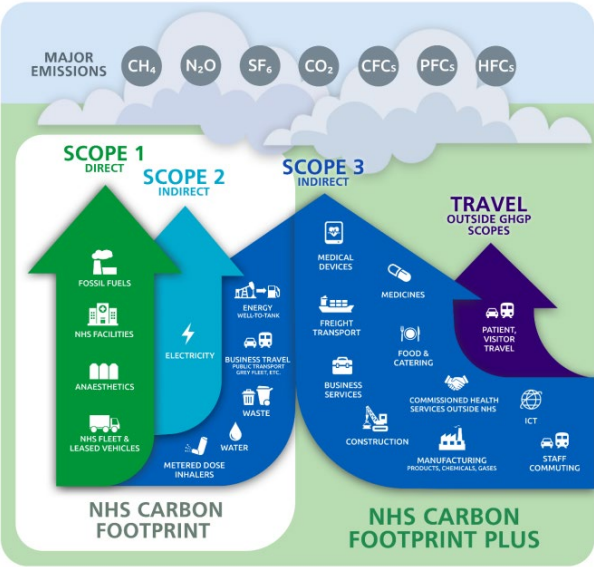
Why do we need a Green Plan?

In 2024 the global average temperature exceeded 1.5°C above pre-industrial levels for the first time, the original threshold set by the Paris Climate Agreement. Every fraction of a degree of global warming can bring more frequent and intense extreme weather.

The Climate Crisis is a health emergency with climate change known to be the biggest threat to human health and well-being from spread of disease, respiratory and cardiovascular issues to mental health impacts and malnutrition. With the NHS responsible for 5% of the UK’s carbon emissions, it is key that as part of the NHS Gateshead Health takes action to reduce emissions and the subsequent impact on our communities health and the wider region.

Not only is there a duty to improve the health outcomes of our communities through reducing emissions, there is also a legal obligation to meet net zero. The Health and Social Care Act 2022 made the requirement for the NHS to achieve net zero for the emissions it directly controls by 2040 (NHS Carbon Footprint) and 2045 for the emissions it influences (NHS Carbon Footprint Plus).

- Climate Change Act 2008
- Paris Agreement 2015
- The Environment Act 2021
- Health and Care Act 2022
- Statutory Guidance – Delivering a Net Zero NHS
- CQC - Well Led



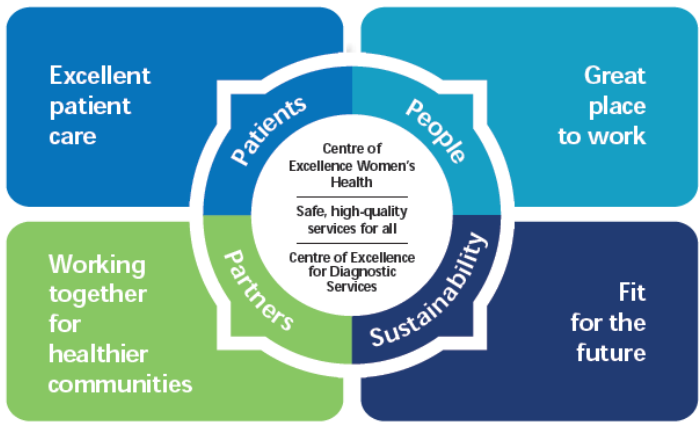
What will the Green Plan achieve?

The Green Plan will set our key targets and actions to reduce our emissions in line with the NHS targets of net zero by 2040 for the NHS Carbon Footprint and 2045 for the NHS Carbon Footprint Plus.

As a healthcare provider and one of the largest employers in the area we are ideally placed to lead by example and make the necessary change and drive wider change through the supply chain. There is also a moral duty placed on us as humans but also as healthcare professionals to ‘first, do no harm’ minimising our impact on the environment and reducing emissions will help improve the health of our patients and reduce unnecessary pressure on our services.

Our vision

To be a leader in sustainable healthcare within the NHS, to the benefit of our local community.



As part of our Corporate Strategy at Gateshead, as seen above, we have 4 goals, one of which is:

Working together for healthier communities.

This goal has its own objectives including; evidence reduction in health inequalities and work collaboratively to improve health and care outcomes to the Gateshead population. Both of these have clear links to the vision and aim of the Green Plan and sustainable healthcare for the future.

Objectives

By 2028	Reduce emissions from building energy by 20%.
	Reduce total waste volumes by 5%.
	Reduce emissions from grey fleet (business travel) by 20%.
	Reduce emissions from NOX by 15%.
By 2032	47% reduction in the NHS Carbon Footprint from the 2019/20 baseline.
By 2037	73% reduction in the NHS Carbon Footprint plus from the 2019/20 baseline.
By 2040	Net Zero for the emissions we control.
By 2045	Net Zero for all emissions.

Our aims:

- An educated and engaged workforce who embed sustainability in their everyday actions.
- Improve local air quality through reducing and eliminating (where possible) emissions from vehicles.
- Achieve net zero of our NHS Carbon Footprint by 2040 and NHS Carbon Footprint Plus by 2045.
- Ensure that our activities and care benefit the wider local community.

Our Current Carbon Footprint

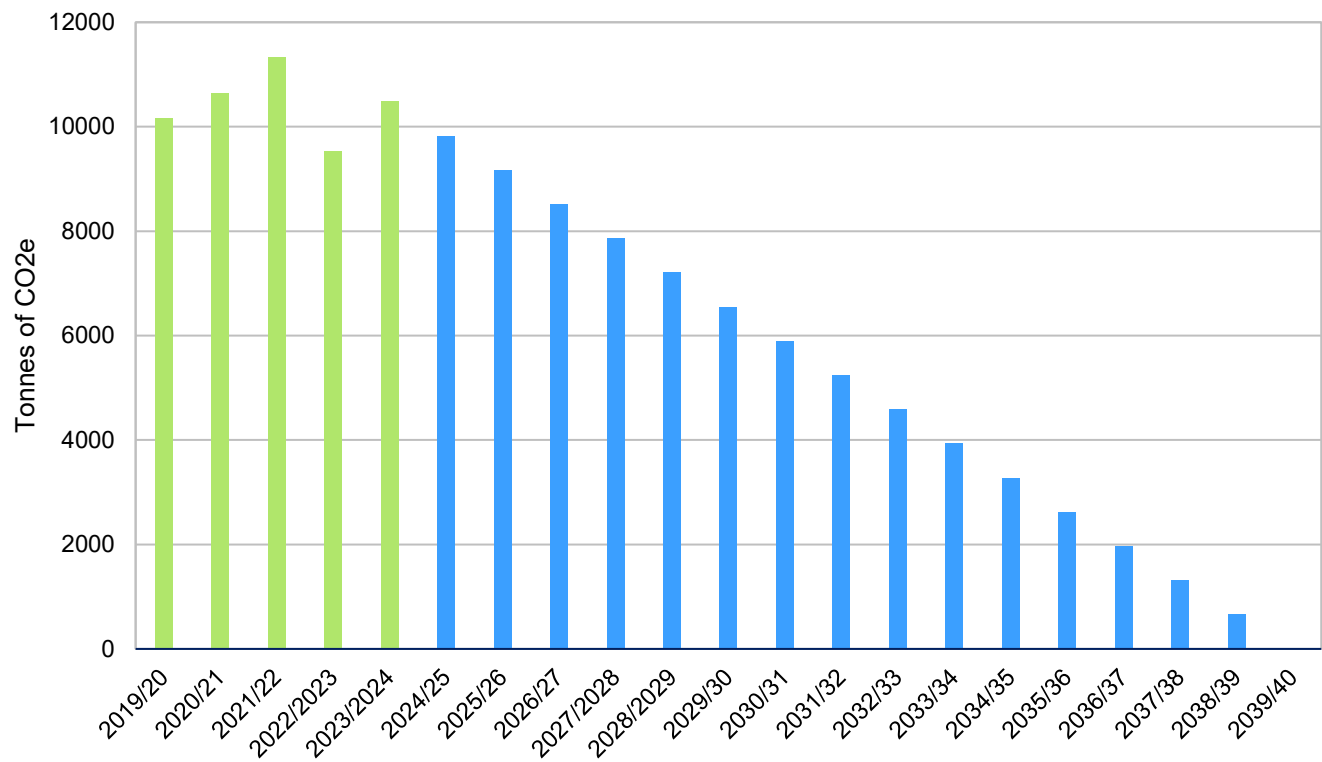
In order to understand the journey of how to reach net zero, there firstly needs to be an understanding of the Group’s current emissions and key focus areas moving forward.

Utilising internal data and conversion figures set by the UK Government we have calculated some aspects of our Carbon Footprint which can ben seen in the table and graph below:

Category	Sub Category	Total tCO2e					% Change from 2019/20
		2019/20	2020/21	2021/22	2022/23	2023/24	
GHNFT Carbon Footprint	Scope 1						
	Building Energy – Fossil Fuels	5565	5398	5695	4809	5564	0.02
	Volatile Anaesthetics & NOx	905	1032	813	657	674	-25
	Group Fleet	76	849	1168	619	160	110
	Scope 2						
	Building Energy – Purchased Electricity	3130	2892	3307	3028	3583	14
	Scope 3						
	Water	134	116	46	39	45	-66
	Waste	211	239	215	168	142	-33
	Business Travel	145	110	85	199	308	113
	TOTAL	10166	10636	11329	9518	10476	3

Please note – this report was written prior to data becoming available for 24/25.

GHNFT Carbon Footprint Net Zero Trajectory



The data shows that despite some progress in previous years, 2023/24 shows a 9% increase in emissions from 2022/23 and 3% increase from the 2019/20 baseline.

Since 2019/20 emissions have only decreased for water, waste and Nitrous Oxide with all other areas increasing particularly both fleet and business mileage.

It should be noted that the data for fleet for both the baseline year and 2020/21 is only estimated data as we do not have a true reflection of usage. Also the data excludes the scope 3 emissions we indirectly control as to our supply chain, medicines and chemicals etc. and therefore our carbon footprint will be significantly higher than what us shown.

Taking this into consideration and looking ahead at the trajectory year on year significant reductions are required if the Trust is to meet its legal requirement of net zero by 2040 and 2045 and this will likely require large capital investment to decarbonise the estate.

Key Successes

➤ **Reusable Sharps Bins – Annual CO₂e reduction 85 tonnes**

Since 2019/20 our high temperature incineration (HTI) waste has reduced by 50 tonnes per annum, this is as a result of the change to reusable sharps bins from Sharpsmart. The containers are emptied, decontaminated and returned to use over and over again eliminating the weight of a single use plastic container being incinerated each time. Based on the volume of waste generated this is estimated to be a saving of around 15 tonnes of single use plastic per annum.

In addition to the reduced weight of single use plastic Sharpsmart also process the sharps waste through effluent retention alternative treatment rather than the traditional HTI route leading to a 10% reduction of our total healthcare waste being treated this way. Overall the annual cost saving from the changes are estimated to be over £13,000 showing that moving to reusable can be cheaper.

➤ **Switch from single use plastic bowls to metal reusable bowls – Annual CO₂e reduction 924kg**

Theatres made the switch from single use plastic bowls to metal reusable, saving the cost of continuous purchase and disposal costs as offensive or clinical waste. Emissions will also be saved from reduced deliveries and no additional cleaning as the process is included within routine theatre cleans.

➤ **Switch from single use laparoscopic instruments to reusable alternatives – Annual CO₂e reduction 200kg**

Theatres switched to using a reusable laparoscopic instrument tray and it was found to reduce the consumption of single use instruments were reduced from an average of 12 items per procedure to 6. Over 12 months this saves around 240kg of waste from instruments and packaging.

Laparoscopic procedures previously used single use instruments which were disposed of after each use, however we introduced the RENU system eliminating the need for single use instruments. Based on the number of procedures over 12 months it is estimated to save 390kgs of waste.



Solar Panels at Queen Elizabeth Hospital

Air source heat pumps at Queen Elizabeth Hospital



Cargo Bikes at QE Facilities Transport Hub



Our Green Plan

The Plan will focus around the areas which address the Group vision and objectives as well as key areas highlighted from emission data.

The 10 key focus areas are :

- ▶ Workforce System & Leadership
- ▶ Sustainable Models of Care
- ▶ Digital Transformation
- ▶ Travel & Transport
- ▶ Estates & Facilities
- ▶ Waste & Circular Economy
- ▶ Medicines
- ▶ Supply Chain & Procurement
- ▶ Food & Nutrition
- ▶ Adaptation & Greening the Estate

Each area will detail achievements made so far and key actions to take us forward, as well as targets and key performance indicators to measure progress against for the duration of the Green Plan.

The majority of actions are within the Groups control, however it should be noted that some of the larger schemes may require external funding if the budget can not be found internally. Although these funding opportunities are limited and partnership with Local Authorities and other local Trusts could be considered.

The Green Plan will be refreshed every 12 months and 6 month interim reports can be provided.

Governance

Monitoring and tracking the targets and key performance indicators as set out in the Green Plan is key to ensure the Group remains committed and on track to reach net zero.

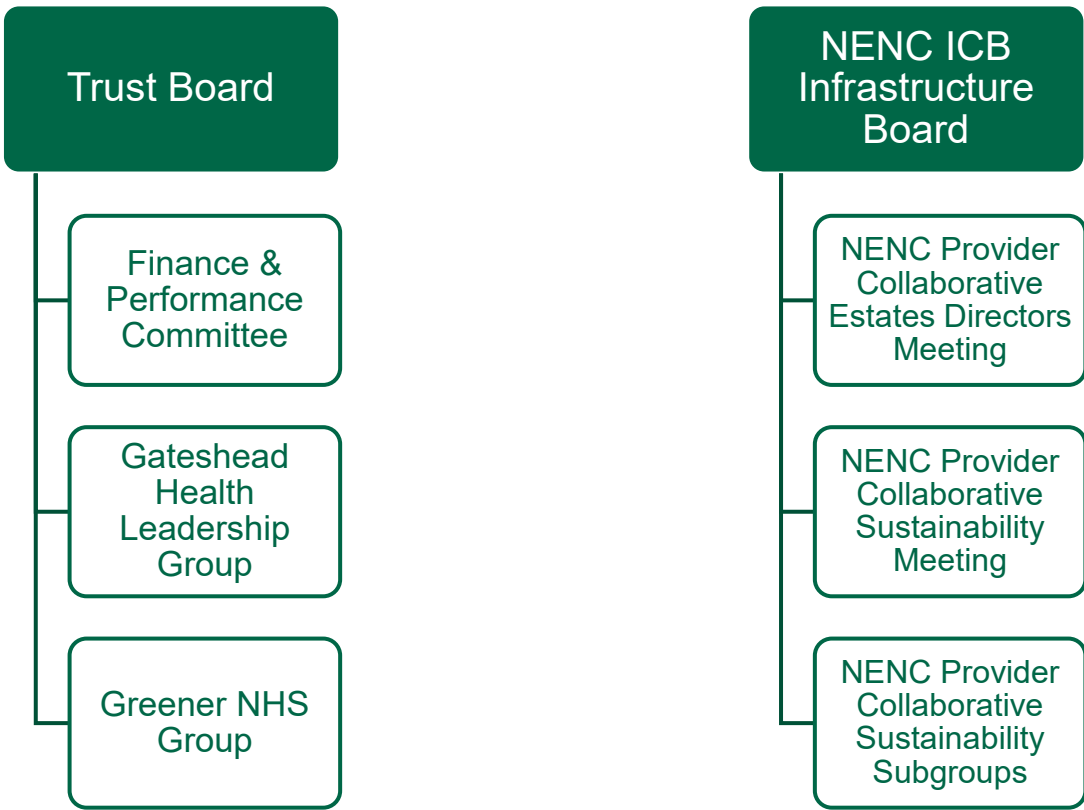
The current internal governance structure to monitor and oversee the delivery of the Green Plan can be found below, with the current staffing structure as:

Carmen Howey – Executive Board Lead for Sustainability

Genna Bulley – Head of SHEQ

Sarah Medhurst – Sustainability, Waste & PAM Manager

Externally the Group is a key member of the North East North Cumbria Provider Collaborative and works well in partnership with other Trusts on regional projects and the delivery of the ICB Green Plan and the structure can be found below:



Workforce, System & Leadership

Achievements

- In 2022 all Trust Board and QE Facilities Leadership team achieved Carbon Literacy accreditation.
- Over 2200 staff have completed Building a net zero NHS training, that's 40% of all staff.
- In 2020 we won an International Green Apple Environmental Award.
- In 2022 both the Procurement and Estates teams achieved Carbon Literacy accreditation.

Our Next Steps

- Assess workforce capacity and skill requirements for delivering the Green Plan and look to develop apprenticeships and fellowships in clinical areas, estates and procurement teams. As well as promoting specialist training available on ESR.
- Increase the percentage of staff to complete Building a Net Zero NHS training on ESR.
- Promote Carbon Literacy for Healthcare eLearning Pathway to those interested in developing their skills.
- Train and develop the Group Board and Leadership teams on Sustainability Leadership for Greener Health and Care and Carbon Literacy accreditation.
- Reestablish a Green Champions network with monthly meetings.
- Develop Gateshead branding for sustainability and provide regular communications updates.
- Continue to work with the Great North Healthcare Alliance and North East North Cumbria Provider Collaborative on joint projects and sharing best practice.



Sustainable Models of Care

Achievements

- Several clinical areas have formed sustainability groups to focus on tackling issues within their department and make change.
- The Emergency Department changed the medication they use for calming patients down before a procedure. It has several benefits including reducing emissions, reducing nursing hours for sedation, reduced patient stay in the department and improved pain relief for patients.

Next Steps

- Identify a clinical lead with oversight of net zero clinical transformation with formal links to board level leadership and governance.
- Focus on reducing emissions and improving quality of care in Emergency Department and Critical Care.
- Establish working groups in a key clinical areas to look reducing emissions
- Include Sustainable Quality Improvement training to clinical workforce training programmes.
- Consider net zero principles in all service change, reconfiguration programmes and pathway redesign. Where possible adopt social prescribing, green social prescribing and physical initiatives.
- Develop a Sustainability Impact Assessment to evaluate the potential impact a proposed project or policy might have on climate and the environment.



Digital Transformation

Achievements

- Consolidation of print services with Xerox reducing desktop printing.
- Nerve centre project, looking at reducing the need for paper written clinical records and ensures they are captured digitally.
- Implementation of the Patient Engagement Portal (PEP), which allows for the patient letters to be sent electronically.

Next Steps

- Implementation of hybrid mail, which ensures the most efficient way for letters to be printed and mailed.
- Curis project, the creation and storage of digital clinical correspondence following an outpatient appointment.
- Aim of ensuring end user devices are replaced within a 5 year lifecycle, and support from technology vendors to ensure new devices are energy efficient.
- Virtualization of our server environment using a hyper converged infrastructure solution, which reduces the needs for additional server and storage hardware.
- Implementation of remote monitoring products which allow for patient care to be monitored from their home and reduce the need for hospital visits.
- Establish a baseline for the ICT carbon footprint according to the guidelines.
- Implement a trial and eventually deploy "power down" software designed to automatically turn off unnecessary computer hardware when idle, leading to energy and cost savings.
- Prioritise the hosting of data in energy-efficient low carbon local or cloud-based data centres.



Travel & Transport

Achievements

- 15 electric vehicles in our fleet
- 27% of staff use sustainable modes of travel an increase of 9% since 2023.
- 12 electric charging bays for staff.
- Green Travel Plan in place since 2001 and reviewed regularly.
- Cycle to work Scheme with £5000 limit to allow for electric bikes.
- Additional secure cycle storage facilities increasing storage capacity by at least 50% since 2022.

Next Steps

- Increase fleet charging and only procure zero emission vehicles (leased or owned) from 2027.
- Support NEAS with the transition to electric ambulances.
- Review and update the Sustainable Green Travel Plan inline with the net zero travel and transport strategy.
- Promote and encourage sustainable travel options for staff highlighting the offers currently available and look to improve where possible.
- Review QEF Transport services to maximise sustainability of services provided to the Group and beyond to minimise impact.
- Promote No Idling on site for all vehicles.
- Reduce emissions from grey fleet mileage.



Estates & Facilities

Achievements

- Awarded £1.6m from the Public Sector Decarbonisation Fund for solar panels and air source heat pumps.
- 74% of the Trust use LED lighting.
- Water emissions have reduced by 66% from 2019/20.
- Replaced windows in the surgical block with to improve heat loss.
- Heat Decarbonisation Plans for all Group sites.

Next Steps

- Achieve 100% LED coverage.
- Develop business cases for implementing the measures outlined in the heat decarbonisation plans, along with complementary energy efficiency and renewable energy initiatives. In addition prepare funding applications for submission through the Public Sector Decarbonisation Scheme (PSDS) for larger schemes.
- Phase out all existing fossil fuel primary heating by 2032 and oil fuel heating by 2028.
- Ensure all applicable new building and major refurbishment projects are compliant with the NHS net zero building standard and utilise key principles where possible for smaller refurbishments.
- Explore the potential of a district heat network with the Local Authority and PSDS funding opportunities.



Waste & the Circular Economy

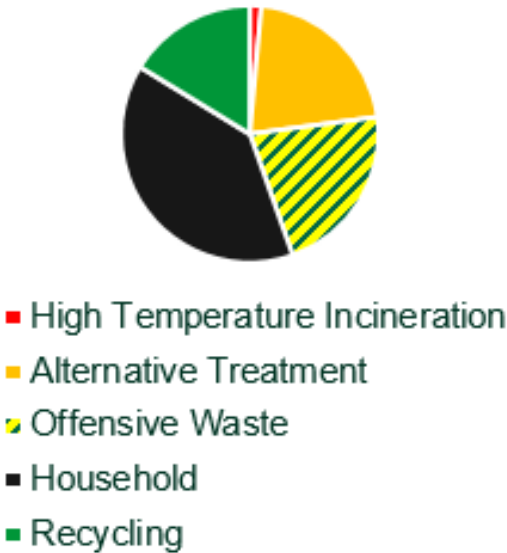
Achievements

- Emissions from waste have dropped by 33% since 2019/20 and have reduced year on year.
- Since 2019/20 household waste has reduced by 405 tonnes and recycling has increased by 215 tonnes (16% increase of total split).
- Since 2019/20 high temperature incineration waste has reduced by 50 tonnes primarily as a result of the introduction of reusable sharps bins saving around 16 tonnes of plastic being produced and incinerated every year. New technology processing our sharps waste as alternative treatment has also contributed.
- Even with this shift our alternative treatment waste has also reduced by 49 tonnes in the same time period and offensive waste has increased by 140 tonnes.

Next Steps

- Increase offensive waste to 60% or higher.
- Increase volume of waste recycled.
- Reduce overall volume of waste
- Increase reuse and repurposing of equipment.

Waste Totals for 2024/25



Medicines

Achievements

- Eliminated the use of desflurane across the Trust and reduced emissions from volatile anaesthetic gases by 81% from 2019/20.
- Reduced total emissions from Nitrous oxide (piped and cylinder) by over 14% from 2019/20.
- Reduced emissions from inhalers through increased prescription of dry powder inhalers.
- New robot in pharmacy to reduce drugs wastage and improve return and reuse of drugs from wards.
- Less than 0.1% of medication expired last year prior to use as stock is managed effectively with KPI's in place
- Installed multiple inhaler collection points to prevent used inhalers going for incorrect disposal in the community.
- Promoting insulin pen recycling schemes at community pharmacies to patients as part of dispensing process.

Next Steps

- Reduce waste from nitrous oxide utilizing the Nitrous Oxide Waste Mitigation Toolkit.
- Decommission nitrous oxide manifolds.
- Partnership working with NEAS to bring in patients drugs to site.
- Medicines assistant post to reduce unnecessary supply of medication as part of admissions and projects on elderly care wards to actively reuse medication for discharge where possible.
- Where possible support patients to choose the most appropriate inhalers in alignment with clinical guidelines, performing inhaler technique checks and promoting the appropriate disposal of inhalers with recycling facilities to be available on Trust premises.



Supply Chain & Procurement

Achievements

- Theatres switched from single use plastic bowls to metal reusable bowls saving around 924kg in waste from theatres and reduced emissions from deliveries. There will also be no additional energy or cleaning costs as it is included in the routine theatre cleans.
- Through switching to using the reusable laparoscopic instrument tray it was found that the consumption of single use items were reduced from an average of 12 items per procedure to 6. Through this reduction it is estimated that 240kg of instrument and packaging is saved per annum.
- Laparoscopic procedures previously used single use instruments disposed of after each use, however since the introduction of the RENU system, single use instruments will no longer be required. Over 12 months the estimated waste saved is 390kgs based on the number of procedures.
- In every relevant tender we include net zero and social value with a weighting of 10% in line with PPN 06/21.

Next Steps

- Annually measure emissions from purchases (scope 3), highlight key areas and set reduction targets.
- Explore other project options to reduce single use items i.e. reusable curtains, couch roll & reusable tourniquets in line with trusts in Great North Healthcare Alliance and NENC ICS.
- Ensure NHS net zero supplier roadmap requirements are embedded into all relevant procurements and implementation is monitored via KPIs.
- Train all finance and procurement staff in the application and development of social value criteria, as per PPN 06/20 and PPN 02/25.



Food & Nutrition

Achievements

- Food waste is collected, measured and sent for anaerobic digestion locally generating electricity. A dewatering system is used on site to reduce the volume sent which reduces the emissions from the number of collections required.
- Regular reviews of staff menu to increase seasonal produce.
- Improved access to vegetarian and vegan options.
- Refill water stations available for free access to water in public areas.

Next Steps

- Install electronic patient ordering system to reduce food wastage from over ordering of patient meals.
- Set targets to reduce food waste from patient meals and look to review the crockery used to serve meals on and potentially switch to blue ceramic to reduce plate waste.
- Expand water refill stations to Emergency Care Centre.
- Review criteria for contracts to source more local and seasonal produce.
- Review menus to look at healthier and lower carbon options by supporting the provision of seasonal menus with low use of heavily processed foods.
- Promote the NHS England Low Carbon Menu Bank.
- Look to participate in NHS Chef of the Year competition.

Adaptation & Greening the Estate

Achievements

- Full review and updated adverse weather plan.
- Over 60 trees planted across the QEH site
- Habitat Surveys completed at QEH, Bensham and Spire House.
- Courtyard development to improve patient access to green spaces as part of recovery.
- Community staff garden developing skills and providing a therapeutic outlet for staff.
- Garden of Hope – staff garden area of reflection.
- Annually participate in No Mow May.
- Several wildflower gardens across QEH site.

Next Steps

- Continue to develop and improve green spaces and increase bio diversity as per specific action plans.
- Develop an adaptation plan for Group Sites and engage relevant stakeholders.
- Continue to participate in No Mow May and other national campaigns.
- Review and monitor the effectiveness of adverse weather plans and communicate to staff. Set out actions to prepare for severe weather events and improve climate resilience of sites and services, including digital services.



Metrics

Focus Area	Benchmark Metrics	KPI's
Workforce, System & Leadership	Appoint board level lead for the Green Plan – in place – Carmen Howey	Ensure Annual sustainability updates are presented to the Trust Board.
	2019/20 NHS Carbon Footprint = 10,166 tonnes CO2e 2023/24 NHS Carbon Footprint = 10,476 tonnes of CO2e	Aim to reduce NHS carbon footprint by 7% year on year to meet net zero targets by 2040/45.
	Number of board level colleagues undertaken Carbon Literacy training – 1 currently	100% of Board members trained.
	Green Champions – 8 currently in place.	Number of Green Champions increases year on year over the Green Plan.
Sustainable Models of Care	Identify a clinical lead with oversight of net zero clinical transformation.	Clinical lead appointed.
	Sustainable Quality Improvement Training for clinical staff	% of clinical staff completed training.
	Achieve a green accreditation such as RCEM Green ED	Accreditation achieved.
Digital	Establish a baseline for our carbon footprint from digital and IT services.	Emission baseline established and reported.
	Reduce paper consumption	Paper consumption reduced 3% year on year over the Green Plan.

Metrics

Focus Area	Benchmark Matrix	KPI's
Travel & Transport	3% of owned and leased fleet that is ultra-low emission vehicle (ULEV) or Zero-emission vehicle (ZEV)	Increase the percentage of ZEV vehicles in line with 2027 target.
	Modal share of staff commuting (staff survey results 2025 63% Drive Alone including EV & Hybrid 13% Bus 8% Walk 4% Dropped Off 3% Car Share 2% Metro 2% Bus & Metro 2% Cycle	Reduce car single-occupancy commuting by 10%.
	Number of staff accessing sustainable travel incentives: 17 Current	Increase number of staff accessing sustainable travel incentives.
Estates & Facilities	Energy Consumption 39.13m KWh.in 2023/24	Reduce energy consumption by 7% year on year
	74% of Trust gross internal areas covered by LED lighting.	Increase trust gross internal area covered by LED lighting by 8% per annum.
	Water volume consumption 133,730 m³ in 2023/24	Reduce water consumption year on year.
	Onsite renewable generation – 5 in 2023/24	Increase on site renewable generation year on year.
	Number of sub meters in use across the estate – 70 in 2023/24	Install and use sub-metering at 100% of sites.

Metrics

Focus Area	Benchmark Metrics	KPI's
Waste & Circular Economy	Clinical Waste Split (60:20:20) 2024/25 – Offensive – 49% Clinical – 48% High Temperature Incineration – 3%	Achieve 60:20:20 clinical waste split within a year (or better)
	% non healthcare waste recycled 24/25 Household waste (Energy from Waste) -71% Recycled Waste – 29%	Increase non healthcare waste recycling rate by 5% year on year over the Green Plan.
	Total weight of waste 24/25 - 1321 tonnes	Reduce total waste generation each year.
Medicines	Volume and emissions of nitrous oxide and Entonox (gas and air) in 23/24. Nitrous Oxide – 183,600 Litres 89.8 tonnes CO2e Entonox – 2,231,588 litres 554 tonnes CO2e	Reduction in volume and emissions of both Nitrous oxide and Entonox
Supply Chain & Procurement	Number of trust suppliers signed up to NHS England's Evergreen Sustainable Supplier Assessment – 656. 411 – CRP via Evergreen Assessment. 245 Evergreen Level 1 plus aligned to CRP Requirements.	Increase number of trust suppliers signed up to the NHS England Evergreen Sustainable Supplier Assessment
	Establish a baseline of Trust emissions inline with NHS Carbon Footprint plus.	Reduce emissions year on year from baseline.

Focus Area	Benchmark Metrics	KPI's
Food & Nutrition	Install an electronic patient ordering system	Electronic ordering system installed and in use across QEH site.
	Establish a baseline of volume of food waste produced from catering department.	Reduce volume of food waste per annum.
Adaptation & Greening the Estate	Production of an Adaptation Plan	Adaptation Plan produced and board approved.
	Biodiversity metric score	Establish a biodiversity baseline score across all sites and review every 3 years with a view to increase score.



Report Cover Sheet

Agenda Item: 13

Report Title:	Gateshead Health NHS Foundation Trust – Premises Assurance Model (PAM) 2024-25			
Name of Meeting:	Trust Board of Directors			
Date of Meeting:	25 th September 2025			
Author:	Sarah Medhurst Sustainability, Waste & PAM Manager - QE Facilities Limited			
Executive Sponsor:	Gavin Evans Managing Director - QE Facilities Limited			
Report presented by:	Gavin Evans Managing Director – QE Facilities Limited			
Purpose of Report <i>Briefly describe why this report is being presented at this meeting</i>	Decision: ☐	Discussion: ☒	Assurance ☒	Information: ☐
	The PAM toolkit is a strategic framework of self-assessment questions that enables organisations to evaluate the efficiency, effectiveness, and safety of estates and facilities management, ensuring alignment with patient experience and overall healthcare quality outcomes.			
Proposed level of assurance – to be completed by paper sponsor:	Fully assured ☐ <i>No gaps in assurance</i>	Partially assured. ☒ <i>Some gaps identified</i>	Not assured ☐ <i>Significant assurance gaps</i>	Not applicable ☐
Paper previously considered by: <i>State where this paper (or a version of it) has been considered prior to this point if applicable</i>	QEF Board Gateshead Health Leadership Group			
Key issues: <i>Briefly outline what the top 3-5 key points are from the paper in bullet point format.</i> <i>Consider key implications e.g.</i> • Finance • Patient outcomes / experience • Quality and safety • People and organisational development	• The NHS Premises Assurance Model (PAM) is issued annually by NHSE and provides a structured self-assessment of estates and facilities performance across efficiency, effectiveness, safety, governance, and patient experience. • The 2024/25 assessment highlights strong levels of assurance overall, with 85% of domains rated 'good' or 'outstanding', consistent with or above national benchmarks.			

• Governance and legal • Equality, diversity and inclusion	• Improvements were recorded in Efficiency (+5%) and Effectiveness (+4%), demonstrating progress in estates optimisation and strategic planning. • Areas requiring further focus include Governance (–5%) and specific sub-domains within Safety Hard, Safety Soft, and Patient Experience, where targeted actions are being implemented. • An action plan has been developed to address identified gaps, with progress to be monitored through QE Facilities governance structures and reported to the Trust Board.				
Recommended actions for this meeting: <i>Outline what the meeting is expected to do with this paper.</i>	• Note the mandatory requirement: The NHS Premises Assurance Model (PAM) is a mandatory annual self-assessment required by NHS England, with submission due by the end of September 2025. • Approve the return: Review and approve the 2024/25 PAM self-assessment to enable timely submission to NHS England.				
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 ☒

GATESHEAD HEALTH NHS FOUNDATION TRUST (GHFT) Premises Assurance Model (PAM) Annual Report 2024-25

1. Introduction

This paper provides the Board with an update on any assurances against compliance with the NHS Premises Assurance Model (PAM) toolkit undertaken by QE Facilities on behalf of GHFT, and provides the results achieved for the year 2024-2025.

The PAM toolkit enables QE Facilities managers to assess the condition of GHFT built assets, provide premises assurance to the Trust's management boards, and assure patients, commissioners and regulators that robust systems are in place to ensure premises and associated services are safe. It also provides a consistent basis to measure compliance against legislation and guidance, benchmark performance against other NHS organisations, and provides a robust evidence base to underpin investment decision-making and prioritisation to raise assurance levels in the most advantageous way.

Since its launch, the toolkit has developed and changed in response to several changes in policy, strategy, regulations and technology to reflect a more holistic approach to the management of NHS estates and facilities services. However, the exercise is still enshrined in supporting the NHS constitution right:

"You have the right to be cared for in a clean, safe, secure and suitable environment."

2. Overview

The toolkit enables NHS organisations to better understand the efficiency, effectiveness and level of safety within which Estates and Facilities are managed, and how this links to patient experience. The PAM toolkit comprises extensive self-assessment questions that explore quality and safety compliance which require self-evaluation and supporting evidence. This self-evaluation is very subjective as it is up to the individual to determine their rating, and as a result of managerial and departmental changes across QE Facilities in the last twelve months this is likely to impact the scoring for 24/25. At a local level this is collated using a spreadsheet from which formal submissions are entered via a dedicated online portal direct to NHSE with any relevant comments on the ratings provided.

Self-assessment questions (SAQs) in the PAM toolkit relating to 2024-25 were completed over a period of three months. Across five key domains, QE Facilities scored an average of 85% in areas as 'good' or 'outstanding' assurance in each domain, which is an increase of 1% from the 2023-24 PAM exercise, and a 2% decrease from 2022/23.

Significantly anomalies or scores which differed significantly to the previous year's exercise have been internally audited, and the report summarising this exercise is appended at Appendix 2.

2.1 Self-Assessment Questions

The self-assessment questions are broken down into five key domains:

- 1) **Patient Experience** – PLACE Audits and other assessments which include privacy and dignity, cleanliness, grounds and gardens, catering and engagement with patients and visitors.
- 2) **Safety Hard & Safety Soft** – Estates & Facilities work streams including but not limited to electrical safety, lifting equipment, medical devices, decontamination, contractor management, pressure systems, ventilation and portering.
- 3) **Efficiency** – Financial efficiencies in how estates and facilities are managed.
- 4) **Effectiveness** – Effective estates strategy and planning and sustainability.
- 5) **Governance** – Board leadership, management and governance of estates and facilities services.

Each domain contains a series of questions covering a range of topics and services across estates and facilities. Each individual question is compliance rated after considering the level and quality of supporting evidence. The ratings are.

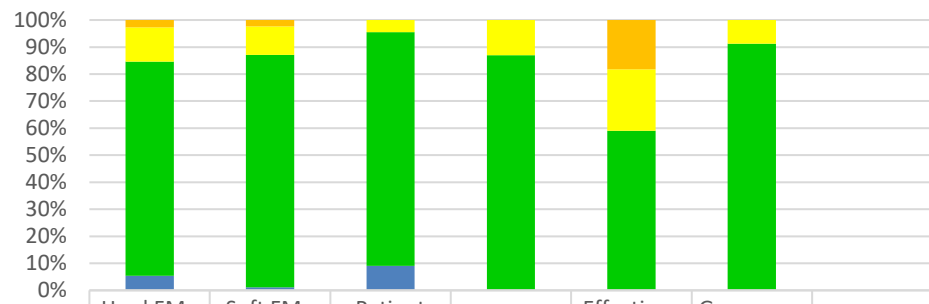
- **Outstanding** – compliant with no action required, plus evidence of high-quality services and innovation.
- **Good** – compliant, no action required.
- **Requires minimal improvement** – the impact on people who use services, visitors or staff is low.
- **Requires moderate improvement** – the impact on people who use services, visitors or staff is medium.
- **Inadequate** – action is required quickly – the impact on people who use services, visitors or staff is high.
- **Not Applicable** – not applicable or relevant to the organisation.

3. PAM Outcomes 2024-25

Across the five domains, QE Facilities scored an average of 85% as 'good' or 'outstanding' assurance in each, which is an increase of 1% from 2023-24, and a 2% decrease from 2022-23.

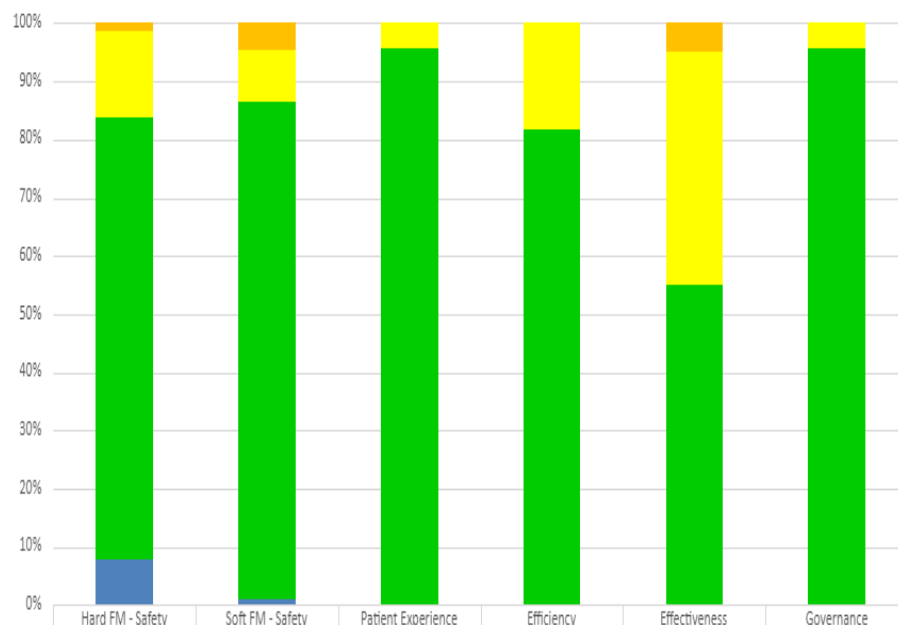
It should be noted that there have been significant changes to the questions issued for the exercise since last year, and QEF has also undergone structural, governance, and personnel changes over the same period. The high average score for 2024/25 demonstrates a good level of assurance in spite of these changes, however there are some specific areas that require some improvement where individual questions have rated at a lower level than 'good' within each domain. These areas are illustrated in the charts below: the first shows the outcome of the 2024/25 exercise, and the second from 2023/24 for comparison. The key domains that require more improvement than identified for 2023/24 are Safety Hard, Safety Soft, and Effectiveness.

Domains by SAQ Rating



5. Inadequate	0	0	0	0	0	0	0
4. Requires moderate improvement	4	2	0	0	4	0	0
3. Requires minimal improvement	19	9	1	3	5	2	0
2. Good	118	73	19	20	13	21	0
1. Outstanding	8	1	2	0	0	0	0

Domains by SAQ Rating 2023/24



5. Inadequate	0	0	0	0	0	0
4. Requires moderate improvement	2	4	0	0	1	0
3. Requires minimal improvement	21	8	1	4	8	1
2. Good	107	75	22	18	11	22
1. Outstanding	11	1	0	0	0	0

3.1 Safety Hard

The Safety domains are crucial for maintaining high standards and demonstrating to stakeholders that robust systems are in place to minimise risk of harm to service users including patients and staff.

QE Facilities has scored 85% of all relevant questions and sub questions as either 'good' or 'outstanding' (126 out of 149 questions) which is a 1% increase on 2023/24 scores, despite a significant increase in the number of questions and the inclusion of additional topics such as mortuaries.

23 specific areas have been identified as requiring minimal improvement and four that require moderate improvement – this is an increase from the 2023/4 exercise, all of which are identified in the Action Plan at Appendix 1.

3.2 Safety Soft

QE Facilities has scored 87% of all the applicable questions and sub questions as either 'good' or 'outstanding' (74 out of 85), an 1% increase on the 2023/24 exercise.

It should be noted there are additional sub questions this year compared to the previous year, and that question 10 has been amended to reflect compliance with the Terrorism Act 2025. Actions to improve these scores are detailed in the Action Plan. One area – decontamination – has received an 'outstanding' rating.

The changes to the questions within this category make comparisons to previous performance more challenging, however there is a clear demonstration of compliance with safety standards and robust plans are under development to make further improvements.

3.3 Patient Experience

The Patient Experience domain demonstrates assurance that the organisation ensures that patient experience is an integral part of estates & facilities service provision and how services are delivered.

QE Facilities scored over 95% of all applicable questions and sub questions as a rating of 'good' or 'outstanding' (21 out of 22), a 1% decrease on the 2023/24 exercise. This is attributed to a decrease in applicable questions in comparison to last year's exercise. In addition, two questions are rated as 'outstanding' in 2024/25 in comparison to zero in the previous year, demonstrating an overall improvement in some specific areas. Only one area – catering standards – is identified as requiring minimal improvement, and actions to address this will be detailed in the Action Plan.

Overall, the findings provide assurance to the Trust that the services provided by QEF are designed and delivered with patient experience as integral to provision.

3.4 Efficiency

The Efficiency domain provides assurance that space, activity, income and operational costs across estates and facilities services provide value for money, are economically sustainable, and meet clinical and organisational requirements.

QE Facilities has scored over 87% of all applicable questions and sub questions as a rating of 'good' (20 out of 23), a 5% increase on the 2023/24 exercise. Areas requiring minimal improvement have reduced from four to three, year on year, demonstrating ongoing

improvement, and overall, the findings provide assurance to the Trust that QEF services demonstrate value for money and efficiency.

3.5 Effectiveness

The Effectiveness domain assesses the design of estates and facilities services in terms of suitability, sustainability and effectiveness in the delivery of health outcomes.

QE Facilities has scored over 59% off all applicable questions and sub questions as a rating of good (13 out of 22), an increase of 4% from the 2023/24 exercise, although a 7% decrease from 2022/23. The slight increase in performance is likely attributable to changes in the organisation over the last year since the previous exercise, however overall, there is assurance that services are effective for purpose.

Five specific areas require minimal improvement and four require moderate improvement (in comparison to eight and one, respectively, the previous year), most of which relate to the estates strategy and its vision and values. Other areas identified for improvement include sustainability, adaption and sustainable procurement. Actions to ensure improvements are made are detailed in the Action Plan.

3.6 Governance

The Governance domain identifies assurance on strategic leadership and effective scrutiny of QEF's estates and facilities services as well as how the other five Domains are managed as part of the internal governance of the organisation.

QE Facilities has scored over 91% of all applicable questions and sub questions as a rating of 'good' (20 out of 22), a decrease of 5% from the 2023/24 exercise. This is attributed to a decrease in applicable questions in comparison to last year's exercise.

Two areas require minimal improvement, with both relating to estates and facilities leadership and culture, however overall, there is demonstration of assurance to the Trust that QEF provide well governed services.

4. Conclusion

This report highlights use of the PAM toolkit the Trust has an effective way to provide assurance of compliance with statutory requirements and good practice guidelines, which inform the delivery of Estates and Facilities services across all domains. In addition, the tool kit enables the identification and coordination of improvements through a monitored risk assessed action plan.

The overall scores across all of domains were rated as over 82% 'good' or 'outstanding', however there are also some areas identified where some level of improvement is required which are outlined in the Action Plan at Appendix 1.

NHSE have advised that the current PAM tool kit format and submission procedure is under a significant review with a pilot currently under testing by several NHS Trusts. It is believed that instead of the subjective ratings as it currently stands these will be replaced with more questions scored as 'Yes' or 'No' and a new scoring system. It is hoped that this will provide

a more accurate and comparable reflection on how Trust's compare to one another. The review will also reflect anticipated changes to policy and regulations and reduce duplication in the current format. As a result of the changes in 25/26 it will impact on the ability to meaningfully compare findings with previous years.

5. Recommendations

The board is asked to receive this report for information and assurance.

Mr G Evans
QE Facilities Managing Director

Appendix 1 - Action Plan

I D	Domain	SAQ	Prompt Question	Date Action Identified	Action detail	Responsible Department
1	Safety Hard	2 - Design, Layout & Use	1 - Policy & Procedures	May 2024	Develop, finalise, and secure approval for the Estates Strategy to provide a clear framework for estate management and service delivery.	Estates
2	Safety Hard	3 - Document Management	1 - Policy & Procedures	July 2025	Implement a centralised document management system and extend its application across all Estates & Facilities disciplines to improve governance and compliance.	SHEQ
3	Safety Hard	4 - Health & Safety	1 - Policy & Procedures	May 2025	Review and update the Health & Safety Policy in line with current legislation, HSE guidance, and industry best practice; ensure approval through the appropriate governance committee.	Health & Safety
4	Safety Hard	4 - Health & Safety	2 - Roles & Responsibilities	July 2025	Deliver a programme of Health & Safety audits and workplace inspections across all operational areas, ensuring findings are recorded, actioned, and closed out.	Health & Safety
5	Safety Hard	4 - Health & Safety	3 - Risk Assessments	May 2025	Review and update all risk assessments onto the new corporate template to ensure consistency, clarity, and compliance with statutory requirements.	Health & Safety
6	Safety Hard	4 - Health & Safety	4 - Training & Development	May 2025	Improve compliance with COSHH and risk assessment training through targeted delivery, monitoring, and escalation of non-compliance.	Health & Safety
7	Safety Hard	4 - Health & Safety	5 - Resilience & BCP	May 2025	Undertake a comprehensive review of the Health & Safety risk register to ensure accuracy, and alignment with organisational priorities.	Health & Safety

8	Safety Hard	4 - Health & Safety	7 - Review Process	July 2025	Strengthen incident reporting and investigation processes through revised SOPs and targeted training, ensuring quality, timeliness, and organisational learning.	Health & Safety
9	Safety Hard	7 - Natural Gas & Piped Systems	1 - Policy & Procedures	May 2025	Ratify the draft Natural Gas & Piped Systems Policy in line with HTM guidance and legislation, and update governance records accordingly.	Estates
10	Safety Hard	7 - Natural Gas & Piped Systems	6 - Resilience & BCP	May 2025	Assess and address resilience gaps in gas supply by installing dual burners in critical areas where required, or formally risk-assess deficiencies and escalate onto the risk register.	Estates
11	Safety Hard	7 - Natural Gas & Piped Systems	7 - Review Process	May 2025	Complete risk assessments for gas systems and update risk registers to ensure regular review and governance oversight.	Estates
12	Safety Hard	11 - Ventilation	1 - Policy & Procedures	May 2025	Ratify the draft Ventilation Policy and record it as current within governance systems to demonstrate compliance with HTM guidance.	Estates
13	Safety Hard	12 - Lifts, Hoists & Conveyance Systems	1 - Policy & Procedures	May 2025	Ratify the draft Lifts and Hoists Policy and record it as current within governance systems to demonstrate compliance with statutory requirements.	Estates
14	Safety Hard	13 - Pressure Systems	1 - Policy & Procedures	May 2025	Ratify the draft Pressure Systems Policy and record it as current within governance systems to demonstrate compliance with statutory requirements.	Estates
15	Safety Hard	14 - Fire Safety	6 - Maintenance	July 2025	Complete remedial works on fire dampers, fire doors, fire stopping, and compartmentation in line with external audit recommendations.	Estates
16	Safety Hard	17 - Safety Alerts	3 - Risk Assessments	May 2025	Review and update risk assessments as part of the ongoing compliance audit process linked to national safety alerts.	Patient Safety
17	Safety Hard	17 - Safety Alerts	4 - Training & Development	May 2025	Centralise the recording and reporting of safety alert-related training to improve assurance and compliance tracking.	Patient Safety
18	Safety Hard	17 - Safety Alerts	6 - Review Process	July 2025	Refresh the CAS Alert Policy to strengthen processes for receiving, disseminating, and closing alerts.	Patient Safety

1 Safety 9 Hard	18 - Safe & Suitable (Not Directly Responsible)	4 - Maintenance	May 2025	Hold regular review meetings with NHS Property Services to monitor and manage estates risks associated with external property provision.	Estates
2 Safety 0 Hard	18 - Safe & Suitable (Not Directly Responsible)	5 - Training & Development	July 2025	Complete a training gap analysis for staff managing properties not directly under QE Facilities control.	Estates & Facilities
2 Safety 1 Hard	19 - Contractor Management	5 - Maintenance	May 2024	Migrate contractor management information into the Micad CAFM system to improve oversight and compliance.	Estates
2 Safety 2 Hard	20 - Mortuaries	6 - Future Demand	July 2025	Replace existing mortuary fridges to increase capacity and meet projected demand.	Mortuary
2 Safety 3 Hard	22 - Building Information Systems	3 - Risk Assessment	July 2025	Complete a risk assessment on the migration of building information, in consultation with EPRR, Estates, and IT.	Estates
2 Safety 4 Hard	22 - Building Information Systems	7 - Technology Replacement Plan & Review Process	July 2025	Establish a working group to define software requirements for future building information systems.	Estates
2 Safety 5 Soft	1 - Catering Services	10 - Food Standards No. 3	May 2025	Appoint a Dietician Lead to oversee the refresh of patient menus, ensuring compliance with national food and nutrition standards.	Catering
2 Safety 6 Soft	3 - Waste & Recycling Management	6 - Resilience & BCP	July 2025	Review and update the Waste Contingency Plan into the Trust's EPRR format to ensure resilience.	Waste Manager & EPRR
2 Safety 7 Soft	4 - Cleanliness & Infection Control	3 - Risk Assessment	July 2025	Develop a Standard Operating Procedure (SOP) for Domestic Services covering infection prevention and cleanliness controls.	Domestic Services
2 Safety 8 Soft	4 - Cleanliness & Infection Control	4 - Maintenance	May 2025	Ensure all Domestic Services assets are logged on the capital replacement programme and have maintenance contracts in place.	Domestic Services

2 9	Safety Soft	4 - Cleanliness & Infection Control	10 - Cleaning Standards 2021 – Efficacy Audits	July 2025	Reinstate the Cleaning Standards 2021 efficacy audit programme to monitor performance and assure compliance.	Domestic Services
3 0	Safety Soft	6 - Security Management	3 - Risk Assessment	July 2025	Migrate all Security risk assessments onto the updated template to improve clarity, consistency, and regulatory compliance.	Security Manager
3 1	Safety Soft	6 - Security Management	4 - Maintenance	July 2025	Establish and deliver a scheduled maintenance programme for all security communication equipment.	Security Manager
3 2	Safety Soft	9 - Portering Services	1 - Policy & Procedures	July 2025	Conduct a full review and update of all Portering SOPs to reflect current operational practice and safety standards.	Portering Manager
3 3	Safety Soft	9 - Portering Services	3 - Risk Assessment	July 2025	Review and update all Portering risk assessments using the new corporate template.	Portering Manager
3 4	Safety Soft	9 - Portering Services	4 - Maintenance	July 2025	Service and maintain electronic tugs to ensure safe use and reduce manual handling risks.	Portering Manager
3 5	Safety Soft	9 - Portering Services	7 - Review Process	July 2025	Embed an annual review process for all Portering SOPs and risk assessments.	Portering Manager
3 6	Safety Soft	10 - Terrorism Act 2025	3 - Roles & Responsibilities	July 2025	Review the requirements of the Terrorism Act 2025 and incorporate compliance measures into Estates & Facilities policies and procedures.	Estates & Facilities
3 7	Safety Soft	10 - Terrorism Act 2025	3.1 - Roles & Responsibilities	July 2025	Ensure patient experience functions are aligned with requirements of the Terrorism Act 2025 through policy and training.	Patient Experience
3 8	Patient Experience	6 - NHS Catering Standards	2 - Regulation	May 2024	Secure ratification of the Food and Drink Strategy, incorporating new clinical data to ensure alignment with NHS Catering Standards.	Catering
3 9	Efficiency	2 - Improved Efficiency in Running E&F Services	1 - Business Planning	May 2023	Finalise the Estates Strategy to support efficient delivery of Estates & Facilities services (ongoing due to management restructuring).	Estates & Facilities

40	Efficiency	2 - Improved Efficiency in Running E&F Services	2 - Estate Optimisation	May 2025	Progress the Estates Strategy to optimise use of estate assets and resources.	Estates & Facilities
41	Efficiency	3 - Improved Efficiencies in Capital	6 - Net Zero Carbon	May 2025	Work with Gateshead Council to confirm funding for the District Heat Network and assess implications for QEH connection.	Estates & Facilities
42	Effectiveness	1 - Clear Vision & Credible Strategy	2 - Strategy	May 2025	Finalise and embed a clear Estates Strategy aligned with organisational goals.	Estates & Facilities
43	Effectiveness	1 - Clear Vision & Credible Strategy	3 - Development	May 2025	Develop the Estates Strategy to reflect service needs and future development plans.	Estates & Facilities
44	Effectiveness	1 - Clear Vision & Credible Strategy	4 - Visions & Values	May 2025	Align the Estates Strategy with QEF Visions & Values to ensure cultural integration.	Estates & Facilities
45	Effectiveness	1 - Clear Vision & Credible Strategy	5 - Strategy Understood	May 2025	Improve communication and engagement to ensure the Estates Strategy is understood across all staff groups.	Estates & Facilities
46	Effectiveness	1 - Clear Vision & Credible Strategy	6 - Progress	May 2025	Monitor and report progress against the Estates Strategy to governance forums.	Estates & Facilities
47	Effectiveness	3 - Management of Land & Property	4 - Costed Action Plan	July 2025	Manage accommodation moves through the Accommodation Group, ensuring all relocations are assessed, costed, and formally approved.	Estates & Facilities
48	Effectiveness	4 - Sustainability Approach	4 - Air Pollution	May 2025	Progress actions under the Clean Air Hospital Framework to reduce air pollution.	Waste & Sustainability
49	Effectiveness	4 - Sustainability Approach	7 - Climate Change Adaptation	May 2025	Develop and finalise a Climate Change Adaptation Plan, aligned with national guidance and sustainability governance.	EPRR
50	Effectiveness	4 - Sustainability Approach	8 - Procurement	May 2025	Monitor social value and net zero outcomes through contract KPIs, embedding training for procurement teams.	Procurement

5 Effectiveness	4 - Sustainability Approach	9 - Costed Action Plan	July 2025	Develop and cost actions within the Green Plan to support sustainability targets.	Estates & Facilities
5 Governance	2 - E&F Leadership & Culture	6 - Behaviours	July 2025	Ensure all Estates & Facilities staff complete the QEF Visions & Values training module as part of their mandatory core skills.	Estates & Facilities
5 Governance	2 - E&F Leadership & Culture	7 - Culture	July 2025	Implement a culture improvement programme within Estates & Facilities, informed by staff feedback and organisational development best practice.	Estates & Facilities

SAQ Domain : Safety Soft
Date of Audit : 15/08/2025
Audit completed by : Steve Morley

Question: SS2 Decontamination. 1: Policy and procedures

Rating submitted: Good
2023-2024 rating: Good

Evidence/comments submitted: Decontamination policy in place, quality policy in place, full QMS in place and effective. Endoscopy decontamination policy to be updated.

Confirmation of evidence: Group Decontamination policy, IC34, in place and effective from April 2024 – April 2027. Quality manual stored on Q-Pulse with regular review periods. Standard operating procedures for all aspects of the decontamination process with regular reviews.

Comments: Sterile services and Endoscopy decontamination are accredited to ISO 13485 medical devices. The department is audited yearly but an external accreditation body, SGS. Internal audits

Question: SS2 Decontamination. 4: Maintenance

Score submitted: Good
2023-2024 rating: Good

Evidence/comments submitted: All equipment maintenance and testing is fully up to date, this is verified by the external AE(D) and SGS during the external audit. All test reports are held electronically by the decontamination team, these are reviewed during multiple audits.

Confirmation of evidence: Test and calibration certificate supplied

Comments: All the test and calibration records stored at local level. Planned preventative maintenance contracts are in place. Quarterly servicing of equipment by the manufacturer.

Question: SS5 Laundry and linen. 3: Risk Assessment

Score submitted: Good

2023-2024 rating: Requires Moderate Improvement

Evidence/comments submitted: Risk assessments relating to linen services are reviewed annually and refresher training carried out when required. All incidents are recorded on the Trust Inphase system and any necessary actions are agreed and carried out.

Confirmation of evidence: Risk assessment for the linen room provided.

Comments: Risk assessment is of a good standard and department specific.

Question: SS5 Laundry and linen. 6: Resilience, Emergency & Business Continuity Planning

Score submitted: Good

2023-2024 rating: Good

Evidence/comments submitted: Within the Procurement, Logistics and Linen Service. There is a combined BCP which identifies key actions to be carried out in the first hours and following days of the emergency occurring thus mitigating against service disruption. This BCP refers to a number of risks relating to levels of severity and possible escalation. The action plans within this BCP are structured in a way which reflects these action levels.

Confirmation of evidence: BCP submitted as evidence.

Comments: BCP has been approved by the Business resilience group and by the QE Facilities Ltd directors T.Pratt and P.Glasgow.

SAQ Domain : Safety Hard
Date of Audit : 18/08/2025
Audit completed by : Sarah Medhurst

Question: SH4 Health & Safety. 3: Risk Assessment

Score submitted: Moderate Improvement
2023-2024 rating: Minimal Improvement

Evidence/comments submitted: COSHH assessments largely complete, awaiting several departments to confirm products. DSE sporadic, stress risk assessments on an ad-hoc basis. General risk assessments are not adequate.

Confirmation of evidence: COSHH Site now live and H&S audit results continually show issues in adequacy of risk assessments. This is reported to Group Health and Safety Group.

Comments: New Risk Assessment template has been approved at Group Health & Safety Group and compliance training with new template is being held monthly for staff to book onto and attend.

Question: SH14 Fire Safety. 6: Maintenance

Score submitted: Moderate Improvement
2023-2024 rating: Minimal Improvement

Evidence/comments submitted: Passive fire safety system are tested, serviced and maintained in line with their relevant British Standard. PPMs are in place to ensure all the site is covered. Systems such as backtraq are in place to ensure the estates department is operating effectively. Remedial work is still required on fire dampeners, fire doors, fire stopping and compartmentation.

Confirmation of evidence: External Audit Report with OFR (Fire AE).

Comments: The work requires significant investment and this has been costed by an external company.

Question: SH15 Medical Devices. 3: Risk Assessment

Score submitted: Good

2023-2024 rating: Minimal Improvement

Evidence/comments submitted: Risks related to medical devices are managed via the InPhase system which is the organisations risk register. Risks are regularly reviewed and discussed at the Medical Devices Management Group where any necessary actions are agreed. Assurance paper presented to MDMG in June 2024 with a status of full assured.

Confirmation of evidence: Assurance Paper to MDMG.

Comments: Assurance paper accepted by MDMG and actions agreed and undertaken.

Question: SH18 Estates & Facilities Services are safe and suitable when the organisation is not directly responsible for providing these services. 1: Policy and Procedures

Score submitted: Good

2023-2024 rating: Minimal Improvement

Evidence/comments submitted: No specific policy in place relating to externally serviced property.

Confirmation of evidence: Minutes and notes of meetings with external providers.

Comments: Assurance that risks are managed centrally via InPhase and alongside this there are regular meetings with external property providers.

SAQ Domain : Patient Experience
Date of Audit : 18/08/2025
Audit completed by : Sarah Medhurst

Question: P3 Cleanliness of the estate and facilities services to be satisfactory. 1: PLACE Assessment

Score submitted: Outstanding
2023-2024 rating: Good

Evidence/comments submitted: The 2024 PLACE inspection was a success with increased scores across the board. Out of 9 areas of inspection QE were ranked above the national average in 7 areas. Weekly PLACE lite inspections continue. Environmental audits continue in line with National Cleaning Standards, star ratings are displayed in all areas.

Confirmation of evidence: PLACE Report and results published.

Comments: Gateshead ranked in the top 5 for PLACE Scores.

Question: P6 NHS Catering Standards are provided effectively and efficiently. 6: PLACE Assessment

Score submitted: Outstanding
2023-2024 rating: Good

Evidence/comments submitted: The 2024 PLACE inspection was a success with increased scores across the board. Out of 9 areas of inspection QE were ranked above the national average in 7 areas with ward food scoring 100%. Weekly PLACE lite inspections continue.

Confirmation of evidence: PLACE Report and results published online.

Comments: Gateshead ranked in the top 5 for PLACE Scores.

SAQ Domain : Efficiency
Date of Audit : 18/08/2025
Audit completed by : Sarah Medhurst

Question: F2 Well managed approach to improved efficiency in running estates and facilities services. 8: Property

Score submitted: Good

2023-2024 rating: Minimal Improvement

Evidence/comments submitted: Accommodation Group has been reinstated. The Group is well attended and clinically led.

Confirmation of evidence: TOR and minutes of meetings.

Comments: Accommodation Group working well and good attendance across the Trust and QEF.

SAQ Domain : Effectiveness
Date of Audit : 18/08/2025
Audit completed by : Sarah Medhurst

Question: E1 Clear vision and credible strategy to deliver good quality estates and facilities services. 4: Visions and Values

Score submitted: Requires Moderate Improvement
2023-2024 rating: Minimal Improvement

Evidence/comments submitted: Whilst the current values are well known, the refreshed strategy is due to be completed and approved during 25/26. A full communication plan to disseminate the strategy along with actions such as refreshing the annual planning progress will then be undertaken to cascade the strategy throughout the organisation.

Confirmation of evidence: Draft copy of refreshed strategy.

Comments: Current values are well known which should be taken into account for the period this covers 24/25 with the new strategy looking ahead to the next year, therefore the rating might not reflect the time period PAM is looking at. This could apply to 2 further sub questions which have also been ranked down relating to work on the new strategy.

Question: E3 Well managed robust approach to management of land and property. 4: Costed Action Plans

Score submitted: Requires Moderate Improvement
2023-2024 rating: Not Applicable

Evidence/comments submitted: Accommodation moves are assessed through the accommodation group meetings. Clinical teams, people and services moving around the hospital are now part of a formal process. Each move is considered by the property services manager with consultation with other departments. The proposal is costed and specification drawn up to identify cost. This either falls within Revenue spend, under £5000 or capital spend, over £5000. Each move is costed and considered by the Accommodation Group.

Confirmation of evidence: TOR and minutes of meetings

Comments: No other sub question was rated as minimal or moderate improvement and therefore a costed action plan is not necessarily required. The comments and evidence suggest that the costs are related to the decisions of the Group and not the overall management.

Question: E4 Suitable sustainability approach in place and being actioned. 4: Costed Action Plans

Score submitted: Requires Minimal Improvement

2023-2024 rating: Not Applicable

Evidence/comments submitted: Actions in place and listed through the Green Plan, however not everything has been costed.

Confirmation of evidence: Green Plan

Comments: Previous year focused on energy sub questions and therefore more work had been done to cost these areas through the heat decarbonisation plans, however the question this year covers a much broader range of sustainability in line with the majority of areas in the Green Plan and therefore not all areas have been costed as will varies from department and priorities in terms of actions and mitigation.

Report Cover Sheet

Agenda Item: 14

Report Title:	Illustrative Designated Body Annual Board Report and Statement of Compliance (Reporting Period 1 April 2024 – 31 March 2025)			
Name of Meeting:	Board of Directors Meeting			
Date of Meeting:	25 th September 2025			
Author:	Dr Catherine Kirkley – Associate Medical Director for Workforce Ross Peddie – Associate Director of Medical Staffing Ferne Clements – Medical Staffing Manager Carol O’Flaherty – Head of People Services			
Executive Sponsor:	Dr Carmen Howey – Group Medical Director			
Report presented by:	Dr Carmen Howey – Group Medical Director			
Purpose of Report <i>Briefly describe why this report is being presented at this meeting</i>	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
	Review the content of this report and confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).			
Proposed level of assurance <i>– to be completed by paper sponsor:</i>	Fully assured ☒ <i>No gaps in assurance</i>	Partially assured ☐ <i>Some gaps identified</i>	Not assured ☐ <i>Significant assurance gaps</i>	Not applicable ☐
Paper previously considered by: <i>State where this paper (or a version of it) has been considered prior to this point if applicable</i>	Medical Workforce Group – 17 th September 2025			
Key issues: <i>Briefly outline what the top 3-5 key points are from the paper in bullet point format</i> <i>Consider key implications e.g.</i> • Finance • Patient outcomes / experience • Quality and safety • People and organisational development • Governance and legal • Equality, diversity and inclusion	This report sets out the information and metrics that the Trust is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards for the period of the 1st April 2024 – 31st March 2025. The Trust continues to run a robust process for appraisal and revalidation, which it has done since the revalidation process was introduced, and the Trust has made strong progress against the actions in the 2023/24 assurance report, with only 4 actions deemed outstanding from the 2023/24 report. The 2023/24 RO report highlighted the issue sickness and vacancies within the medical staffing team and that the			

	People & Information Systems Team Manager was brought in to provide interim support for the medical appraisal and revalidation process for the 2023/24 period. The process was handed back over to the medical staffing team during the 2024/25 cycle, and the handover process did lead to the issues related to GMC Connect Data as highlighted in the report. The Trust acknowledges that it did not maintain an accurate GMC listing for 2024/25, however rapid action was taken, and this was discussed with the GMC ELA and reported into the board for assurances. The Trust also does not have a named professional standards function, and these duties are supported by an administration assistant position in the medical staffing team. This structure is to be reviewed for the 2025/26 reporting cycle.										
Recommended actions for this meeting: <i>Outline what the meeting is expected to do with this paper</i>	The Board of Directors is asked to review the content of this report and confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013). Following this the statement of compliance (section 4) can be completed and the RO report can be submitted for the deadline (30/10/2025).										
Trust Strategic Aims that the report relates to:	<table border="1"> <tr> <td data-bbox="627 1055 758 1137"> Aim 1 ☒ </td><td data-bbox="758 1055 1481 1137"> We will continuously improve the quality and safety of our services for our patients </td></tr> <tr> <td data-bbox="627 1137 758 1220"> Aim 2 ☒ </td><td data-bbox="758 1137 1481 1220"> We will be a great organisation with a highly engaged workforce </td></tr> <tr> <td data-bbox="627 1220 758 1303"> Aim 3 ☐ </td><td data-bbox="758 1220 1481 1303"> We will enhance our productivity and efficiency to make the best use of resources </td></tr> <tr> <td data-bbox="627 1303 758 1395"> Aim 4 ☒ </td><td data-bbox="758 1303 1481 1395"> We will be an effective partner and be ambitious in our commitment to improving health outcomes </td></tr> <tr> <td data-bbox="627 1395 758 1491"> Aim 5 ☐ </td><td data-bbox="758 1395 1481 1491"> We will develop and expand our services within and beyond Gateshead </td></tr> </table>	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
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 <u>strategic objectives</u> that the report relates to:	The RO report provides assurances to the Trust Board and to NHS England that the Trusts compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards is achieved. Professional Standards are key to achieve a number of the Trusts strategic aims. Aim 1: We will continuously improve the quality and safety of our services for our patients: By supporting doctors in identifying and addressing areas for improvement, medical appraisals ultimately contribute to enhanced patient care.										

	• The focus on professional development and quality improvement helps doctors to refine their skills, update their knowledge, and provide the best possible care to their patients. • The appraisal process also encourages doctors to consider feedback from colleagues and patients, which can further inform their practice and improve the quality of care they deliver. Aim 2: We will be a great organisation with a highly engaged workforce: • Medical appraisals are a cornerstone of the revalidation process, which is how doctors demonstrate to the General Medical Council (GMC) that they are fit to practice. • The appraisal process helps doctors gather the necessary supporting information for revalidation, such as evidence of continuing professional development (CPD), quality improvement activity (QIA), and feedback from colleagues and patients. • By participating in regular appraisals, doctors can proactively address any potential areas for improvement and demonstrate their ongoing commitment to professional development. Aim 4: We will be an effective partner and be ambitious in our commitment to improving health outcomes: • Participating in medical appraisals is a mandatory requirement for all licensed doctors in the UK. • By engaging with the appraisal process, doctors demonstrate their commitment to meeting the professional standards set by the GMC. • Appraisals help doctor to demonstrate they are up-to-date with best practice, maintaining competence, and providing safe and effective care.				
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 ☐		

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative

Section 2 – Metrics

Section 3 - Summary and conclusion

Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2024 – 31 March 2025

1A – General

The board/executive management team of:

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	A new Medical Director, Dr Carmen Howey/Consultant Community Paediatrics, has been appointed and took up the substantive post on 1st July 2024. Dr Howey is now the RO for the Trust. In the interim period between Mr Beeby's retirement and Dr Howey's appointment Mr Neil Halford was the

	Responsible Officer. Dr Catherine Kirkley – Associate Medical Director for Medical Workforce became the Clinical Appraisal Lead.
Comments:	Dr Carmen Howey, Group Medical Director and Consultant Community Paediatrics, has been appointed and took up the substantive post on 1st July 2024. Dr Howey is now the Responsible Officer for the Trust. Communications sent to clinical colleagues and appropriate medical workforce groups updated that the Trusts responsible officer was Dr Carmen Howey. Mr Neil Halford was the Responsible Officer for the start of the reporting period in the interim period between the Trusts previous Medical Directors retirement and Dr Howey's appointment. Dr Catherine Kirkley – Associate Medical Director for Medical Workforce became the Clinical Appraisal Lead and has undertaken RO training to assist in her role.
Action for next year:	Dr Carmen Howey, Group Medical Director to continue as Responsible Officer, Dr Catherine Kirkley – Associate Medical Director for Medical Workforce to continue as the Clinical Appraisal Lead.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	The 3rd party appraisal software has been taken out on a 3-year contract. The Trust continues to recruit to the appraiser co-hort.
Comments:	3rd party appraisal software licence run until December 2026. Review of Trust appraiser capacity ongoing, with individual numbers reviewed with the Clinical Appraisal Lead.
Action for next year:	Review of the appraisal software and procurement exercise to run in next reporting window beginning in December 2025.

	Appraisal delivery against PAs to be monitored and feedback to individuals and number of recruited appraisers to continue to be monitored.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	No
Action from last year:	GMC Connect is kept up to date on a monthly basis with the People, Data and Information team providing medical staffing with a 'Staff in Post' listing on the first working day of the month
Comments:	The accuracy of the data for medical practitioners connections during the reporting window was not accurate. This was flagged in April 2025 when an index case revealed that the Trust's GMC Connect list was inaccurate. Several doctors who had joined the Trust were not connected, while others who had left remained on the list. This issue arose following the transfer of the GMC Connect process from the People, Data and Information Team to the Trust's Medical Staffing Team. Unfortunately, the full Standard Operating Procedure (SOP) was not handed over which resulted in parts of the process not being implemented. This covered a period of July 2024 - April 2025. The rapid review conducted in April 2025 identified 34 connections to be removed (doctors who had left the Trust but still had a connection), 27 connections to be added (Doctors who had joined the Trust who did not have a connection), and 2 connections to be corrected. This was actioned to ensure the GMC Connect was accurate and highlighted to the GMC and the Regional MD. An internal follow-up review assessed the impact of the data inaccuracies. It confirmed that no revalidations were missed, and no revalidation deferrals occurred as a result of the issue. The GMC and regional MD recognised that there would be implications for other organisations and, across the region, all Trusts were asked to review their connections with other organisations finding lower rates of inaccuracy. An assurance report was presented to the People and OD Steering Group in June 2025 highlighting the actions taken and the actions for the next reporting window.
Action for next year:	To ensure new starters are connected on the start date, the start date added to MST calendar once this is confirmed with medical recruitment and connection made on the day. For

	leavers People Data and Information team inform MST once a medical termination has been processed and the disconnect is actioned on this date. When doctors connect or disconnect notifications are received into centralised inbox which is monitored daily to ensure these can be checked for accuracy. A monthly check is then completed using the monthly starters and leavers report which is sent to the Medical Staffing Team. This report is used to ensure that the starters are connected to GMC Connect, and the leavers are disconnected (if already not actioned). This process has been shared with the GMC ELA for assurances. This process is currently managed by the Medical Staffing Team administrator as the Trust currently does not have a formal professional standards team. A Medical Staffing Team restructure to be action to establish a dedicated substantive professional standard function in the Medical Staffing Team.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	Review PP33 Revalidation and Appraisal Policy for Senior Medical Staff referencing additional domains of the Good Medical Practice.
Comments:	Trust Policy PP33 Revalidation and Appraisal Policy for Senior Medical Staff is monitored in line with Trust Guidance (last review and update was 22nd February 2024).
Action for next year	Review PP33 Revalidation and Appraisal Policy for Senior Medical Staff.

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Yes

Action from last year:	Explored with alliance partners at the next regional lead workshop if other Trusts are undertaking peer review exercises. No other local Trusts actively participating in peer review. To be discussed with the Regional MD NHSE.
Comments:	Regional Trusts via the workforce medical directors contacted with invitation to complete peer review of the appraisal and revalidation processes.
Action for next year:	Engage with alliance partners and attend and support any regional peer review exercises. If no formal peer review exercises planned for the reporting window Associate Medical Director for Workforce to continue to network and discuss with regional peers.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	The standard process would be followed as outlined in the comments above. No deviation would take place from this.
Comments:	Those medical staff be it in a locum or Locally Employed Doctor post follow the same appraisal, revalidation and governance processes. For locum Doctors approval is always requested from the agency for the Trust to undertake this on the agency's behalf.
Action for next year	The standard process would be followed as outlined in the comments above. No deviation would take place from this.

1B – Appraisal

1B(i) Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	To change over to the new medical appraisal input form in line with the Good Medical Practice domain review. Good medical practice 2024 – GMC.
Comments:	Each Senior Medical Staff member is provided with the relevant reports to cover their scope of practice which may include: - Complaints report - Clinical Incidents report - Clinic and / or theatre activity - Healthcare Evaluation Data (HED) revalidation report - Core skills report And if required private practice reports from either Newcastle Nuffield, Washington Spire and Tyneside Surgical Services (TSS). Appraisal 2020 model had been incorporated into the IT software solution to support the annual appraisal and revalidation process. Appraisers have been trained on the use of this model and the change in emphasis to highlight the health and wellbeing conversation.
Action for next year:	Medical Staffing Team to review structure and plan to substantiate a professional standard post to support with the appraisal process for doctors and ensure the reporting and information is provided to cover the doctors whole practice.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	Ensure that there is systematic recording of the reasons why a doctor has not had an annual appraisal in order to identify concerns about health, wellbeing, non-engagement or other issues at an early stage.
Comments:	The standard recording would be followed as outlined in the comments above. No deviation would take place from this.
Action for next year:	Continue with the standard recording of reasons above.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	Review PP33 Revalidation and Appraisal Policy for Senior Medical Staff referencing additional domains of the Good Medical Practice.
Comments:	Trust Policy PP33 Revalidation and Appraisal Policy for Senior Medical Staff is monitored in line with Trust Guidance (last review and update was 22nd February 2024).
Action for next year:	Review PP33 Revalidation and Appraisal Policy for Senior Medical Staff.

1B(iv) Our organisation has the necessary number of trained appraisers¹ to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes

¹ While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Action from last year:	The Trust continue to look to recruit further appraisers to add to the Trust medical appraiser faculty.
Comments:	At present the Trust has 31 trained appraisers for approximately 257 Senior Medical Staff and 91 Locally Employed Doctors across the cycle. This would require an average of 11 appraisals undertaken per year. This would meet the benchmark set out in the statement of compliance (5 – 20, footnote 1). However, the internal Trust number is a minimum of 7 appraisals undertaken per year, this does pose a risk as this would not be a sufficient number of appraisers if every appraiser only completed the minimum. At 7 appraisals per year this would be capacity for 217 appraisals per year.
Action for next year:	The Trust to continue to look to recruit further appraisers to add to the Trust medical appraiser faculty. Medical appraiser's numbers to be monitored and feedback annually.

1B(v) Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent).

Y/N	Yes
Action from last year:	Further Quality Assurance / Appraiser Support Working Groups will be arranged for the 24/25 cycle.
Comments:	All appraisal output forms are reviewed and returned where not appropriately completed. Feedback from the appraisee is collected and inputted into the system via a feedback survey. The report is not released until the feedback is provided.
Action for next year:	Plan to standardise appraisers quality assurance statement to ensure appraisers are fulfilling the professional standards expected from the appraiser role. Feedback to be quantified and reported back into Medical Workforce Group as part of the groups core metrics to measure the quality of appraisals.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	All appraisal input forms and output forms are reviewed as part of the standard practice around the process the Trust has adopted since introduction of revalidation on 1 st Dec 2012. Further work will be completed to strengthen this process with quality assurance information reporting established via the Medical Workforce Group.
Comments:	All input forms are quality assured to make sure the relevant Supporting Information is included within an individual's annual appraisal. All output forms are monitored by the Medical Staffing Team to ensure meeting expected standards. A standard template has been provided to all appraisers so there is an expectation in terms of output for commentary.
Action for next year:	Quality assurance information to be reported via Medical Workforce Group as part of the standard agenda and escalated via the trusts assurance reports.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	To maintain GMC Connect listings to make sure all relevant recommendations within the 24/25 and onwards are made in a timely manner.
Comments:	Action not completed as GMC Connect listings had data quality issues in 2024/25, however no impact on appraisal and revalidation reported from the review. There was 2 late recommendations in the 24/25 appraisal / revalidation cycle, all other recommendation were made in a timely manner during the 24/25 appraisal / revalidation cycle.
Action for next year:	Ensure new SOP for GMC connect listings is followed and GMC Connect listings are all updated and relevant.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the

doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Continue standard practice which is for the Responsible Officer to review the information relevant to the doctor one month prior to the due date of revalidation and for the doctor to be advised of the recommendation on the same working day.
Comments:	Once the relevant recommendation has been decided upon the Doctor is advised of this information the same working day.
Action for next year:	Continue standard practice which is for the Responsible Officer to review the information relevant to the doctor one month prior to the due date of revalidation and for the doctor to be advised of the recommendation on the same working day.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	Standard practice over the time of revalidation introduction as outlined above.
Comments:	The Trust has various departments where information is held for effective governance for Doctors which culminates in all the relevant Supporting Information being provided to a Doctor for appraisal. Departments include People, Data and Information, Complaints, PALs, Patient Safety and a number of other reports are 'pulled' by the Medical Staffing team from internal Business Intelligence systems.
Action for next year:	Continue to hold and provide supporting information for doctors appraisal related to clinical governance.

1D(ii) Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	Train additional MHPS Case Investigators and ensure that Clinical Leads across the organisation are appropriately trained in Fitness to Practice. Review the current MHPS policy following external and internal feedback to ensure that it reflects best practice.
Comments:	5 case investigators and 5 case managers trained in 2024/25 reporting cycle. MHPS Policy (PP55) reviewed in 2024/25 for policy ratification in 2025/26 reporting cycle. Systems are in place to alert the Medical Directors office should conduct or performance fall out of professional requirement. Where there are any initial concerns relating to conduct or performance local procedures would be followed in line with 'Maintaining High Professional Standards' PP55. Relevant reporting for medical appraisal and governance can be seen in section 1Di as above.
Action for next year:	Ratify MHPS Policy following review in 2024/25. Review number of MHPS Case Investigators and Case Managers and provide recommendations for future training. Flow chart being developed to ensure consistency of approach of management of local concerns, storage of information about concerns and escalation to Medical Director.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	Standard practice over the time of revalidation introduction as outlined below.

Comments:	Each Senior Medical Staff member is provided with the relevant reports to cover their scope of practice which may include: Complaints report, Clinical incidents report, Clinic and / or theatre activity, Healthcare Evaluation Data (HED) revalidation report, core skills report and if required private practice reports from either Newcastle Nuffield, Washington Spire and Tyneside Surgical Service (TSS).
Action for next year:	Continue standard practice for providing information for revalidation introduction.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns [policy](#) that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	Review the current MHPS policy following external and internal feedback to ensure that it reflects best practice.
Comments:	MHPS Policy (PP55) reviewed in 2024/25 for policy ratification in 2025/26 reporting cycle. A process is in place by the Medical Director's office where any concerns would be investigated and intervention for capability, conduct, health and fitness to practise concerns reviewed in line with 'Maintaining High Professional Standards' PP55.
Action for next year:	Ratify MHPS Policy following review in 2024/25. Flow chart being developed to ensure consistency of approach of management of local concerns, storage of information about concerns and escalation to Medical Director.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	Continue with the above confidential reporting of concerns and issues via Executive Management Team (EMT) to the Trust Board as part of the Reportable Issues Log in relation to Doctors who are subject to Maintaining High Professional Standards review. In addition strengthen oversight by incorporating into the next Annual Report further details regarding the following: • Total number of concerns managed at a local level following discussion with the MD Office, type of concerns, resolution, area of practice, country of primary medical qualification any protected characteristics. • Total number of cases discussed with GMC ELA and PPAS where a referral to the GMC was not made or when the doctor self-referred. • Total number of cases which progressed to a Decision Making Group where the decision was not to progress to an MHPS investigation. • Any cases where it was recognised by the MD Office that there was a Conflict of Interest or Appearance of Bias risk in relation to managing concerns regarding a doctor's practice or in relation to a revalidation recommendation and how these were managed.
Comments:	Maintaining High Professional Standards (MHPS) Assurance Report reporting via the People and OD Committee outlining a breakdown of concerns raised. Concerns and issues are reported confidentially via Executive Management Team (EMT) to the Trust Board in relation to Doctors who are subject to Maintaining High Professional Standards review. Any member of staff can raise concerns through local routes regarding any aspect of a Doctors performance or 10 professionalism. There is an additional mechanism for any staff member to raise concerns confidentially via the Freedom to Speak up Guardian.
Action for next year:	Continue with the above confidential reporting of concerns and issues via Executive Management Team (EMT) to the Trust Board as part of the Reportable Issues Log in relation to Doctors who are subject to Maintaining High Professional Standards review. In addition strengthen oversight by incorporating into the next Annual Report further details regarding the following:

	• Total number of concerns managed at a local level following discussion with the MD Office, type of concerns, resolution, area of practice, country of primary medical qualification any protected characteristics. • Total number of cases discussed with GMC ELA and PPAS where a referral to the GMC was not made or when the doctor self-referred. • Total number of cases which progressed to a Decision Making Group where the decision was not to progress to an MHPS investigation. Any cases where it was recognised by the MD Office that there was a Conflict of Interest or Appearance of Bias risk in relation to managing concerns regarding a doctor's practice or in relation to a revalidation recommendation and how these were managed.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with [appropriate governance responsibility](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	Standard procedures would be followed as above using the MPfIT form.
Comments:	The MPfIT form is used when necessary to transfer information to other Responsible Officers. The region has an effective network between ROs to allow information to be released and shared when necessary. Also the excellent relationship between Medical Director's office and the GMC ELA allows timely intervention and action.
Action for next year:	Standard procedures would be followed as above using the MPfIT form.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref [GMC governance handbook](#)).

Y/N	Yes
Action from last year:	Continue with above and strengthen the wording in the revised MHPS policy in relation to ensuring that processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination.
Comments:	MHPS Policy (PP55) reviewed in 2024/25 for policy ratification in 2025/26 reporting cycle. Designated Board member (NED) provides a point of contact and support to any doctor being investigated as part of MHPS and holds the Case Manager to account regarding the progress of the investigation. PPAS are consulted in relation to any doctor being investigated through MHPS as is the GMC ELA. This provides a level of external scrutiny of our internal processes.
Action for next year:	Ratify policy that has been reviewed to strengthen the wording in the MHPS policy in relation to ensuring that processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	After a completed MHPS process a de-brief and lessons learned review to improve any further cases.
Comments:	Current best practice recommendations are followed by the Medical Director's office and the supporting People & OD team. 'Maintaining High Professional Standards' is adhered to when pursuing necessary disciplinary actions
Action for next year:	Continue to follow best practice recommendations and following MHPS when pursuing necessary disciplinary actions. Ensure reviewed policy is ratified in next reporting cycle.

1D(ix) Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

Action from last year:	Where professional concerns are raised for other regulated professions in the organisation and these are managed through the Investigations and Disciplinary Policy there will also be a de-brief and lessons learnt with the learning feeding into the MHPS process.
Comments:	Professional standards for all healthcare professionals are managed in accordance with the following policies: • Professional Registration Policy • Revalidation and Appraisal Policy for Senior Medical Staff • Appraisal policy (for all non-medical colleagues) • Managing Performance Policy Concerns where professional standards may not be being met due to conduct are managed through the Investigations and Disciplinary Policy.
Action for next year:	Continue to implement highlighted policies and review alongside policy review timeline.

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	All employment checks will continue to be undertaken via the recruitment team through TRAC as standard practice.
Comments:	All necessary employment checks are undertaken by the Trusts recruitment team

Action for next year:	All employment checks will continue to be undertaken via the recruitment team through TRAC as standard practice.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	Implement structure to embed 'clinically led, management supported' model and governance structures. Complete Clinical Leadership Review to enable additional investment to the role of Clinical Lead complemented by a fit for purpose Job Description. Start a programme of development for Clinical Leads to build capability in the role across the Trust. Promote "Civility Saves Lives" across the organisation as an evidenced based approach which links conduct with patient safety.
Comments:	The Trust has a culture which encourages colleagues to speak up and raise concerns, this is outlined in our Freedom to Speak up policy. The Trust has a Culture Programme Board to support the development of a zero tolerance culture and enable an environment where clinical care can flourish and be continually enhanced. The Trust has embedded an approach of 'Clinically led, management supported' to ensure that clinical voices are heard and supported to shape the excellence of our care. The Trusts clinical leadership review has been completed with resource identified to support clinical leadership structures across the Trust. A new Trust AMD for Patient Safety and Quality has been appointed. They have supported engagement with the Civility Saves Lives agenda including a dedicated session at Clinical Strategy Group.

Action for next year:	Continue to implement the 'clinically led, management supported' model and governance structures. Continue to develop the clinical leads development programme to support clinical leaders across the Trust.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	Launch the new Zero Tolerance policies, revised Bullying and Harassment policy, a new Sexual Safety policy and a revised Violence and Aggression policy and then upskill managers and promote the new policies through a communications campaign. Continue to promote and engage with the Staff Networks to ensure that the voice of all of our workforce is heard.
Comments:	The Trust set up a working group with a focus on Zero tolerance with a focus on ensuring policies and processes align with a zero tolerance approach to instances of bullying and harassment from staff or violence and aggression from patients/service users. Group Sexual Safety Policy (New Policy) Ratified August 2024 Group Harassment and Bullying Policy reviewed and ratified August 2024
Action for next year:	Group Violence at Work Policy to be reviewed. Trust reducing violence and aggression meeting now set up and running. Continue to promote and engage with the Staff Networks to ensure that the voice of all of our workforce is heard. Staff networks at the Trust current include: LGBT+ Network GEM (Global Ethnic Majority) Network Women's Network D-Ability Network Neurodiversity Network

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of

whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	Continue to raise awareness of the Freedom to Speak Up Guardian and champions, explore opportunities for anonymous reporting of incidents to encourage more colleagues to speak up. A continued focus on raising the visibility of the executive team so colleagues feel empowered to escalate concerns if needed. Review relevant policies to ensure consistency across those which reference "Speaking Up".
Comments:	The Trust have implemented policy PP35 Freedom to Speak up and appointed a freedom to speak up guardian, alongside freedom to speak up champions to ensure that there are multiple avenues available for individuals to speak up. Freedom to Speak Up guardian awareness continues to be promoted across the Trust. Implementation of the patient safety incident response framework. Executive management team being more visible and hosting regular sessions where colleagues can raise their concerns directly to the executive team. CEO Roadshow and Exec roadshows taken place across the Trust to ensure visibility of the executive team. Interactive exec team brief meetings running on teams.
Action for next year:	Begin review of the Trust PP35 Freedom to Speak up policy in accordance with review period. Continue with exec team brief, CEO roadshows, and other methods to increase visibility of the Trusts executive team. Continue to promote the Trusts Freedom to Speak Up Guardian and champions.

1F(iv) Mechanisms exist that support feedback about the organisation's professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	Update Complaints and Concerns Policy in accordance with review period.

Comments:	There are clear mechanisms in place to support feedback about the organisation's professional standards processes by its connected doctors. Managing Concerns and Complaints Policy reviewed and ratified January 2025. There is also a Grievance Policy and Appeal Procedure for internal complaints.
Action for next year:	Begin review of the Group Grievance Policy in accordance with review period.

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

Y/N	Yes
Action from last year:	Include in Chair briefs the clarity of the role of the Cultural Ambassador in the meetings. Ensure that country of primary medical qualification and protected characteristics are recorded in the processes associated with addressing concerns for doctors and ensure that this is collated as part of the Annual Report and any issues of potential discrimination are explored.
Comments:	When a Decision Making Group is stood up for doctors involved in concerns, there may be circumstances which would prompt the inclusion of the EDI Manager or a Cultural Ambassador to support the Decision Making Group. This is to assist with parity, consistency and a fully considered decision-making process. In templates for formal processes, including disciplinary, colleagues are asked if they would like to be supported by a Cultural Ambassador during the meeting. Last board assurance on MHPS did not contain the protected characteristics, plan to action in next reporting window.
Action for next year:	Include in Chair briefs the clarity of the role of the Cultural Ambassador in the meetings. Ensure that country of primary medical qualification and protected characteristics are recorded in the processes associated with addressing concerns for doctors and ensure that this is collated as part

	of the Annual Report and any issues of potential discrimination are explored.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	Continue to review via the RO network.
Comments:	This would be reviewed via the Responsible Officer network held on a regional / quarterly basis.
Action for next year:	Continue to review via the RO network.

Section 2 – metrics

Year covered by this report and statement: 1 April 2024 – 31 March 2025 .

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	263
Total number of appraisals completed	219
Total number of appraisals approved missed	3
Total number of unapproved missed	20
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	79
Total number of late recommendations	2
Total number of positive recommendations	70
Total number of deferrals made	9
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	16
Total number of trained case managers	10
Total number of concerns received by the Responsible Officer ²	8
Total number of concerns processes completed	8
Longest duration of concerns process of those open on 31 March (working days)	171 days
Median duration of concerns processes closed (working days) ³	114 days
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0

² Designated bodies' own policies should define a concern. It may be helpful to observe <https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/>, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

³ Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of appeals against the designated body's professional standards processes made by doctors	0
Total number of these appeals that were upheld	0
Total number of new doctors joining the organisation	78*
Total number of new employment checks completed before commencement of employment	78
Total number claims made to employment tribunals by doctors	2
Total number of these claims that were not upheld ⁴	2

*Excluding Bank and LET Doctors

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
The Trust continues to run a robust process for appraisal and revalidation, which it has done since the revalidation process was introduced, and the Trust has made strong progress against the actions in the 2023/24 assurance report, with only 4 actions deemed outstanding from the 2023/24 report.
Actions still outstanding
GMC Connect is kept up to date on a monthly basis with the People, Data and Information team providing medical staffing with a 'Staff in Post' listing on the first working day of the month. & To maintain GMC Connect listings to make sure all relevant recommendations within the 24/25 and onwards are made in a timely manner. The accuracy of the data for medical practitioners connections during the reporting window was not accurate. This was flagged in April 2025 when an index case revealed that the Trust's GMC Connect list was inaccurate. Several doctors who had joined the Trust were not connected, while others who had left remained on the list. This issue arose following the transfer of the GMC Connect process from the People, Data and Information Team to the Trust's Medical Staffing Team. Unfortunately, the full Standard Operating Procedure (SOP) was

⁴ Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

not handed over which resulted in parts of the process not being implemented. This covered a period of July 2024 - April 2025.

The rapid review conducted in April 2025 identified 34 connections to be removed (doctors who had left the Trust but still had a connection), 27 connections to be added (Doctors who had joined the Trust who did not have a connection), and 2 connections to be corrected. This was actioned to ensure the GMC Connect was accurate and highlighted to the GMC and the Regional MD. An internal follow-up review assessed the impact of the data inaccuracies. It confirmed that no revalidations were missed, and no revalidation deferrals occurred as a result of the issue. The GMC and regional MD recognised that there would be implications for other organisations and, across the region, all Trusts were asked to review their connections with other organisations finding lower rates of inaccuracy.

An assurance report was presented to the People and OD Steering Group in June 2025 highlighting the actions taken and the actions for the next reporting window.

The Trust will continue to recruit to the appraiser co-hort.

In the previous reporting window, the Trust had 35 trained appraisers, in this reporting window the Trust has 31 which is a reduction in trained appraisers. Actions for next year to focus on increasing the number of Trust appraisers.

Explored with alliance partners at the next regional lead workshop if other Trusts are undertaking peer review exercises. No other local Trusts actively participating in peer review. To be discussed with the Regional MD NHSE.

No formal peer reviews undertaken within the region. Associate Medical Director for Workforce has actively reached out to peers in the alliance, however no formal review exercises taken place over the reporting period.

Current issues

The 2023/24 RO report highlighted the issue sickness and vacancies within the medical staffing team and that the People & Information Systems Team Manager was brought in to provide interim support for the medical appraisal and revalidation process for the 2023/24 period. The process was handed back over to the medical staffing team during the 2024/25 cycle, and the handover process did lead to the issues related to GMC Connect Data as highlighted in the report. The Trust acknowledges that it did not maintain an accurate GMC listing for 2024/25, however rapid action was taken, and this was discussed with the GMC ELA and reported into the board for assurances.

The Trust also does not have a named professional standards function, and these duties are supported by an administration assistant position in the medical staffing team. This structure is to be reviewed for the 2025/26 reporting cycle.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

General:

An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

- Dr Carmen Howey, Group Medical Director to continue as Responsible Officer, Dr Catherine Kirkley – Associate Medical Director for Medical Workforce to continue as the Clinical Appraisal Lead.

Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

- Review of the appraisal software and procurement exercise to run in next reporting window beginning in December 2025.
- Appraisal delivery against PAs to be monitored and feedback to individuals and number of recruited appraisers to continue to be monitored.

An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

- To ensure new starters are connected on the start date, the start date added to MST calendar once this is confirmed with medical recruitment and connection made on the day. For leavers People Data and Information team inform MST once a medical termination has been processed and the disconnect is actioned on this date.
- When doctors connect or disconnect notifications are received into centralised inbox which is monitored daily to ensure these can be checked for accuracy.
- A monthly check is then completed using the monthly starters and leavers report which is sent to the Medical Staffing Team. This report is used to ensure that the starters are connected to GMC Connect, and the leavers are disconnected (if already not actioned). This process has been shared with the GMC ELA for assurances.
- This process is currently managed by the Medical Staffing Team administrator as the Trust currently does not have a formal professional standards team. A Medical Staffing Team restructure to be actioned to establish a dedicated substantive professional standard function in the Medical Staffing Team.

All policies in place to support medical revalidation are actively monitored and regularly reviewed.

- Review PP33 Revalidation and Appraisal Policy for Senior Medical Staff.

A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

- Engage with alliance partners and attend and support any regional peer review exercises. If no formal peer review exercises planned for the reporting window Associate Medical Director for Workforce to continue to network and discuss with regional peers.

A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

- The standard process would be followed as outlined in the comments above (Those medical staff be it in a locum or Locally Employed Doctor post follow the same appraisal, revalidation and governance processes. For locum Doctors approval is always requested from the agency for the Trust to undertake this on the agency's behalf.). No deviation would take place from this.

Appraisal

Doctors in our organisation have an [annual appraisal](#) that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

- Medical Staffing Team to review structure and plan to substantiate a professional standard post to support with the appraisal process for doctors, and ensure the reporting and information is provided to cover the doctors whole practice.

Where this does not occur, there is full understanding of the reasons why and suitable action is taken.

- Continue with the standard recording of reasons. This is systematic recording of the reasons why a doctor has not had an annual appraisal in order to identify concerns about health, wellbeing, non-engagement or other issues at an early stage.

There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group). Review PP33 Revalidation and Appraisal Policy for Senior Medical Staff.

- Review PP33 Revalidation and Appraisal Policy for Senior Medical Staff.

Our organisation has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

- The Trust to continue to look to recruit further appraisers to add to the Trust medical appraiser faculty. Medical appraiser's numbers to be monitored and feedback annually.

Medical appraisers participate in ongoing performance review and training/development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements ([Quality Assurance of Medical Appraisers](#) or equivalent).

- Plan to standardise appraisers quality assurance statement to ensure appraisers are fulfilling the professional standards expected from the appraiser role. Feedback to be quantified and reported back into Medical Workforce Group as part of the groups core metrics to measure the quality of appraisals.

The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

- Quality assurance information to be reported via Medical Workforce Group as part of the standard agenda and escalated via the trusts assurance reports.

Recommendations to the GMC

Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

- Ensure new SOP for GMC connect listings is followed and GMC Connect listings are all updated and relevant.

Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

- Continue standard practice which is for the Responsible Officer to review the information relevant to the doctor one month prior to the due date of revalidation and for the doctor to be advised of the recommendation on the same working day.

Medical Governance

Our organisation creates an environment which delivers effective clinical governance for doctors.

- Continue to hold and provide supporting information for doctors appraisal related to clinical governance.

Effective [systems](#) are in place for monitoring the conduct and performance of all doctors working in our organisation.

- Ratify MHPS Policy following review in 2024/25.
- Review number of MHPS Case Investigators and Case Managers and provide recommendations for future training.
- Flow chart being developed to ensure consistency of approach of management of local concerns, storage of information about concerns and escalation to Medical Director.

All relevant information is provided for doctors in a convenient format to include at their appraisal.

- Continue standard practice for providing information for revalidation introduction (Each Senior Medical Staff member is provided with the relevant reports to cover their scope of practice which may include: Complaints report, Clinical incidents report, Clinic and / or theatre activity, Healthcare Evaluation Data (HED) revalidation report, core skills report and if required private practice reports from either Newcastle Nuffield, Washington Spire and Tyneside Surgical Service (TSS)).

There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns [policy](#) that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

- Ratify MHPS Policy following review in 2024/25.
- Flow chart being developed to ensure consistency of approach of management of local concerns, storage of information about concerns and escalation to Medical Director.

The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

- Continue with the confidential reporting of concerns and issues via Executive Management Team (EMT) to the Trust Board as part of the Reportable Issues Log in relation to Doctors who are subject to Maintaining High Professional Standards review. In addition strengthen oversight by incorporating into the next Annual Report further details regarding the following:
- Total number of concerns managed at a local level following discussion with the MD Office, type of concerns, resolution, area of practice, country of primary medical qualification any protected characteristics.
- Total number of cases discussed with GMC ELA and PPAS where a referral to the GMC was not made or when the doctor self-referred.

- Total number of cases which progressed to a Decision Making Group where the decision was not to progress to an MHPS investigation.
- Any cases where it was recognised by the MD Office that there was a Conflict of Interest or Appearance of Bias risk in relation to managing concerns regarding a doctor's practice or in relation to a revalidation recommendation and how these were managed.

There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with [appropriate governance responsibility](#)) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

- Standard procedures would be followed as above using the MPfIT form. (The MPfIT form is used when necessary to transfer information to other Responsible Officers. The region has an effective network between ROs to allow information to be released and shared when necessary. Also the excellent relationship between Medical Director's office and the GMC ELA allows timely intervention and action.)

Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref [GMC governance handbook](#)).

- Ratify policy that has been reviewed to strengthen the wording in the MHPS policy in relation to ensuring that processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination.

Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

- Continue to follow best practice recommendations and following MHPS when pursuing necessary disciplinary actions. Ensure reviewed policy is ratified in next reporting cycle.

Systems are in place to review professional standards arrangements for [all healthcare professionals](#) with actions to make these as consistent as possible (Ref [Messenger review](#)).

- Continue to implement highlighted policies (Professional Registration Policy, Revalidation and Appraisal Policy for Senior Medical Staff, Appraisal policy (for

all non-medical colleagues), Managing Performance Policy), and review alongside policy review timeline.

Employment Checks

A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

- All employment checks will continue to be undertaken via the recruitment team through TRAC as standard practice.

Organisational Culture

A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

- Continue to implement the 'clinically led, management supported' model and governance structures.
- Continue to develop the clinical leads development programme to support clinical leaders across the Trust.

A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

- Group Violence at Work Policy to be reviewed.
- Trust reducing violence and aggression meeting now set up and running.
- Continue to promote and engage with the Staff Networks to ensure that the voice of all of our workforce is heard. Staff networks at the Trust current include:

LGBT+ Network
GEM (Global Ethnic Majority) Network
Women's Network
D-Ability Network
Neurodiversity Network

A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

- Begin review of the Trust PP35 Freedom to Speak up policy in accordance with review period.
- Continue with exec team brief, CEO roadshows, and other methods to increase visibility of the Trusts executive team.
- Continue to promote the Trusts Freedom to Speak Up Guardian and champions.

Mechanisms exist that support feedback about the organisation's professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

- Begin review of the Group Grievance Policy in accordance with review period.

Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the [Equality Act](#).

- Include in Chair briefs the clarity of the role of the Cultural Ambassador in the meetings. Ensure that country of primary medical qualification and protected characteristics are recorded in the processes associated with addressing concerns for doctors and ensure that this is collated as part of the Annual Report and any issues of potential discrimination are explored.

Calibration and networking

The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

- Continue to review via the RO network.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

The Trust continues to run a robust process for appraisal and revalidation, which it has done since the revalidation process was introduced, and the Trust has made strong progress against the actions in the 2023/24 assurance report. In the reporting window the 219 appraisals were undertaken. Revalidation operates at the trust, with continued co-operation between the Medical Staffing Team and Medical Directors Office to ensure recommendations are sent in a timely manner. 79 recommendations to the GMC were made in the reporting window. The Trust has identified a risk and challenge associated with the lack of a dedicated professional standards function within the Medical Staffing Team, and actions have been set to review the team structure and establish this post to better advance the process for appraisal and revalidation.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Gateshead Health NHS Foundation Trust.

Name:	
Role:	
Signed:	
Date:	

Name of the person completing this form:	
Email address:	

Report Cover Sheet

Agenda Item: 15

Report Title:	Update on 2025-26 NHS Pay Award			
Name of Meeting:	Trust Board			
Date of Meeting:	25 th September 2025			
Author:	Wendy Griffiths, Asst Director of Finance – Strategic Finance			
Executive Sponsor:	Mrs Kris Mackenzie, Group Director of Finance			
Report presented by:	Mrs Kris Mackenzie, Group Director of Finance			
Purpose of Report <i>Briefly describe why this report is being presented at this meeting</i>	Decision:	Discussion:	Assurance:	Information:
	☐	☒	☒	☐
	To provide an update on the financial impact of the 2025-26 NHS Pay Award			
<u>Proposed level of assurance – to be completed by paper sponsor:</u>	Fully assured ☐ <i>No gaps in assurance</i>	Partially assured ☒ <i>Some gaps identified</i>	Not assured ☐ <i>Significant assurance gaps</i>	Not applicable ☐
Paper previously considered by: <i>State where this paper (or a version of it) has been considered prior to this point if applicable</i>	Financial and Performance Committee Financial Planning Performance and Assurance Group			
Key issues: <i>Briefly outline what the top 3-5 key points are from the paper in bullet point format</i> <i>Consider key implications e.g.</i> • Finance • Patient outcomes / experience • Quality and safety • People and organisational development • Governance and legal • Equality, diversity and inclusion	In May 2025 the government announced the 2025-26 pay award for staff under the remit of the NHS Pay Review Body and Doctors' and Dentists Review Body. With effect from 1st April 2025 the following pay uplifts were agreed: Agenda for Change (AfC) • 3.6% for all bands, Medical and Dental (M&D) • Consultants – 4% • Specialty and Specialist (SAS) doctors – 4% • Resident doctors / doctors in training – average 5.4% (4%, plus £750) Senior NHS Managers 3.25% The increase is funded by an additional 0.68% uplift in the tariff applied to NHS contracts, in addition to the 2.15% given at the start of the financial year.			

	This paper provides a breakdown the associated income and various elements of the award which results in cost pressure in 2025/26 of £0.593m as detailed in table 2 of this report.				
Recommended actions for this meeting: <i>Outline what the meeting is expected to do with this paper</i>	The Trust Board is requested to: - Note the detail of the 2025-26 pay award and how it has been applied to delegated budgets; - Note the in year and recurrent impact on the Trust's underlying deficit position; - Support the recommendation of increasing Cost Reduction Plan to mitigate any further deterioration to the underlying finance outturn; which is in line with our corporate objective to achieve financial sustainability. - Approve the pay award				
Trust Strategic Aims that the report relates to:	Aim 1 ☐	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:	Achieving financial sustainability				
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)	Overall risk of not meeting current and future year's financial plan				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	Yes ☐	No ☐		Not applicable ☒	

1 Introduction

- 1.1 This report provides an update on the 2025-26 nhs Pay Award and its impact on the approved financial plan for 2025-26 and underlying financial position.

2 Background

- 2.1 In May 2025 the government accepted the recommendations of the pay review bodies for Doctors' and Dentists, Agenda for Change, and other NHS staff confirming pay awards from 1st April 2025 as follows :

- **Agenda for Change (AfC)** - 3.6% for all bands,
- **Medical and Dental (M&D)**
 - Consultants – 4%
 - Specialty and Specialist (SAS) doctors – 4%
 - Resident doctors / doctors in training – average 5.4% (4%, plus £750)
- **Senior NHS Managers** - 3.25%

3 Income and Expenditure Impact of Pay Award

- 3.1 Overall the Trust received 4.83% increase in its NHS funding to support inflation of pay and non-pay budgets and 2.83% after applying a 2% efficiency requirement
- 3.2 The amount attributable to pay is estimated at £9.825m.
- 3.3 The cost of increasing funded establishment equates to £11.712m and is £1.887m higher than anticipated funding being received; of which, £1.404m was within our approved (May 2025 submission) financial plan and underlying position, and a new pressure of £0.483m therefore arises from the approved pay award paid to the majority of staff during August.
- 3.4 The recurrent shortfall i.e. excluding non-recurrent ICB funding is £2.103m.
- 3.5 This shortfall in funding is in part is higher owing to the Trust carrying a material underlying deficit i.e. all funded establishments are not supported by income, and the skills mix, and pay to non-pay ratios not aligning to NHS weighted averages.
- 3.6 Table 1 below shows the sources of income and the budgeted cost of the various elements of the pay award deal.

Cost Uplift Factor vs. Pay Award BUDGET	Rec	Non-Rec	Total
	£000s	£000s	£000s
Funding source			
ICBs	-7,677	-216	-7,893
NHSE	-1,077		-1,077
Other ICB LVA	-14		-14
Provider to Priovider	-475		-475
Other WGA	-5		-5
Health Education (estimated)	-320		-320
Other	-41		-41
Total Income	-9,609	-216	-9,825
Cost of Pay award			
Consultant & SAS	1,682		1,682
Resident doctors in training	1,666		1,666
Agenda for Change	7,092		7,092
VSM	34		34
Apprentices	20		20
Apprentice Levy	34		34
QEF	1,025		1,025
Provider to Provider contracts	160		160
Total Cost	11,712	0	11,712
25-26 financial impact (positive = deficit)	2,103	-216	1,887

Table 1 – Sources and application of pay budgets

- 3.7 Table 2 below shows the sources of income and the estimated actual cost of the various elements of the pay award deal. Actual costs associated with the pay award are estimated to be less than budget owing to vacancies seen since 1st April and the assumption they will continue at similar rate.

Cost Uplift Factor vs. Pay Award ACTUAL	Rec	Non-Rec	Total
	£000s	£000s	£000s
Funding source			
ICBs	-7,677	-216	-7,893
NHSE	-1,077	0	-1,077
Other ICB LVA	-14	0	-14
Provider to Priovider	-475	0	-475
Other WGA	-5	0	-5
Health Education (estimated)	-320	0	-320
Other	-41	0	-41
Total Income	-9,609	-216	-9,825
Cost of Pay award			
Consultant & SAS	1,524		1,524
Resident doctors in training	1,503		1,503
Agenda for Change	5,795		5,795
VSM	36		36
Apprentices	20		20
Apprentice Levy	34		34
Bank	413		413
QEF	1,025		1,025
Provider to Provider contracts	69		69
Total Cost	10,417	0	10,417
25-26 financial impact (positive = deficit)	809	-216	593

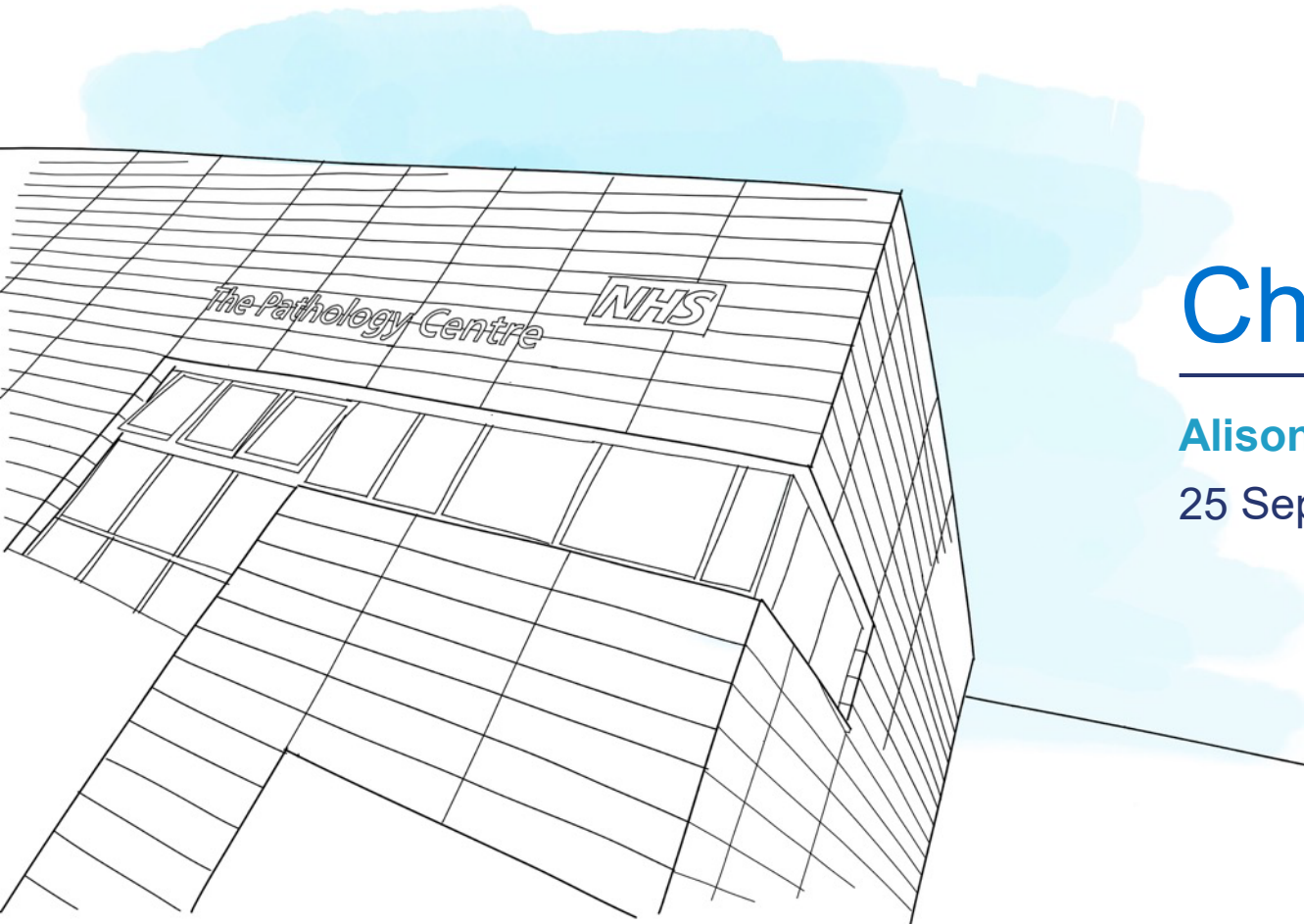
Table 2 – Sources and application of pay actual cost

- 3.8 Overall actual costs are expected to be £0.809m more than income received recurrently, and £0.593m less after the receipt of non-recurrent income, on the basis that locally determined medical bank and waiting lists rates remain at current rates.
- 3.9 In order that the forecast financial outturn is not deteriorated additional CRP and / or non-recurrent mitigations totalling £0.593m will need to be identified in year and £0.699m recurrently (£2.103m less £1.404m already within underlying position).

4 Recommendations

4.1 The Board is requested to:

- Note the detail of the 2025-26 pay award and how it has been applied to delegated budgets;
- Note the in year and recurrent impact on the Trust's underlying deficit position;
- Support the recommendation of increasing Cost Reduction Plan to mitigate any further deterioration to the underlying finance outturn; which is in line with our corporate objective to achieve financial sustainability.
- Approve the pay award



Chair's Report

Alison Marshall, Chair of the Board of Directors

25 September 2025

Gateshead Health Leadership Arrangements

- On 18 August Dr Sean Fenwick formally commenced in post as Acting Chief Executive, whilst Trudie Davies is seconded to North Cumbria Integrated Care NHS Foundation Trust (NCIC).
- Sean has joined the Board on secondment from South Tyneside and Sunderland NHS Foundation Trust where he was the Director of Operations and Deputy Chief Executive.
- Sean has worked in the NHS for over 30 years, combining a clinical background as a consultant nephrologist with senior executive roles across operations, governance and clinical transformation.
- This is my last Board meeting as Chair of Gateshead Health as I reach the end of my six year tenure on 30 September 2025.
- It has been an honour and a privilege to be your Chair during this time and I am incredibly proud of the work that all colleagues, volunteers and Governors have delivered to ensure that our patients receive the best care possible.
- Sir Paul Ennals will commence as Chair on 1 October 2025, as previously communicated. Dr Gerry Morrow will take on the role of Vice Chair to support Paul in his role – an appointment made by our Council of Governors. We would like to record our thanks to Maggie Pavlou for her dedication to the role of Vice Chair.

Governor and Member Updates

- Since the last update we have welcomed Professor Barry Hill as the appointed Governor for Northumbria University, taking over from Professor Joanne Atkinson. We extend our thanks to Joanne for her commitment to the Council.
- The elections for staff and public Governor positions are currently underway with the following seats available:

Constituency	Seats
Public: Central and Eastern Gateshead	3 seats (3 year terms)
Public: Western Gateshead	2 seats (3 year terms) 2 seats (2 year terms) 1 seat (1 year term)
Public: Out of Area	1 seat (1 year term)
Staff	1 seat (1 year term)

- The deadline for nominations is 5pm Thursday 25 September. Further information can be found here: www.cesvotes.com/gateshead25
- Monthly meetings have been held with the Lead and Deputy Lead Governor.

Star of the Month Nominations

August

- Amy Patterson
- Lee Bannon
- Pam Phillips
- Abbie McKie
- Becca Williams
- Leah Purdham
- Larissa Glasgow



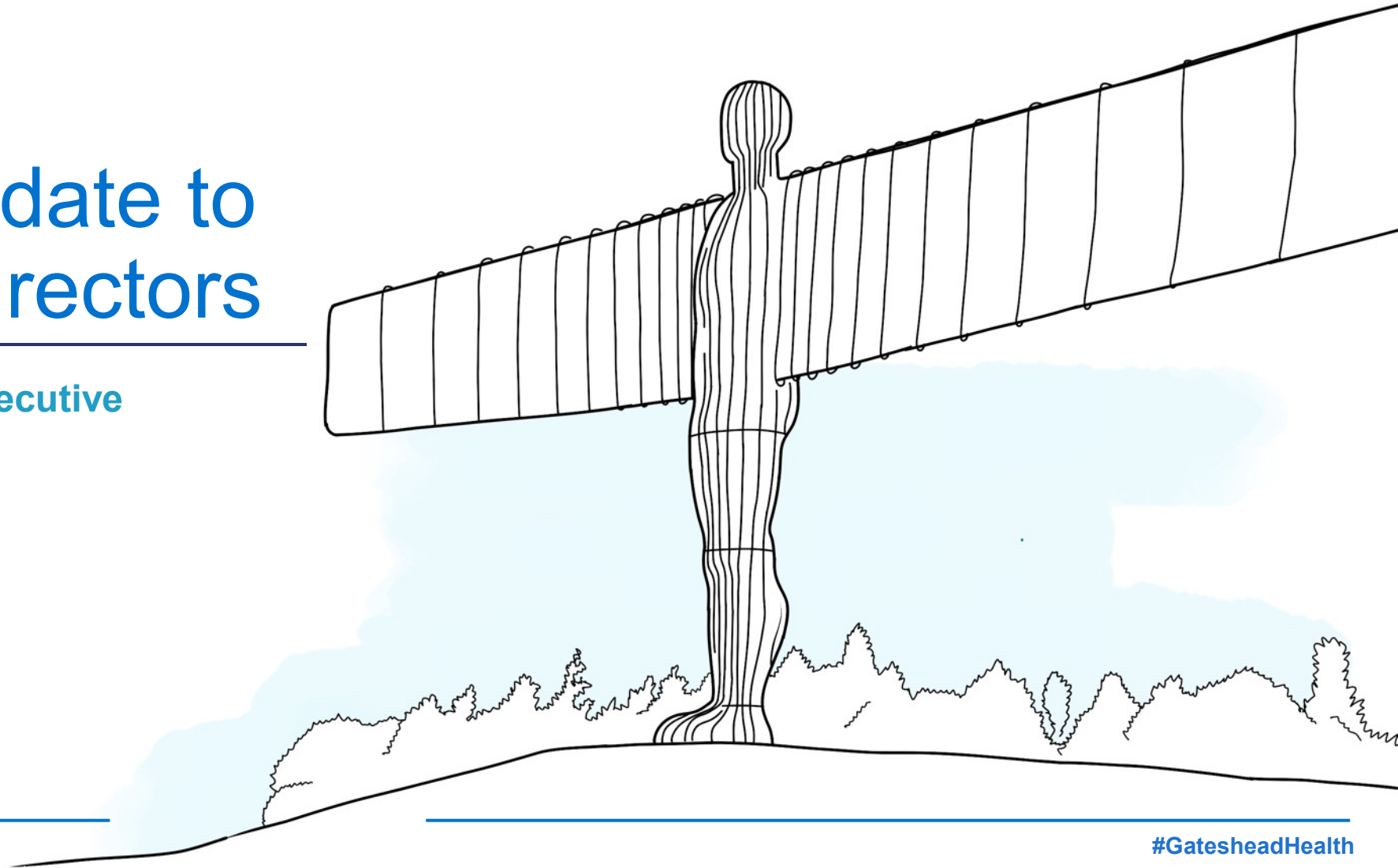

**You're
a Star Winner**

Samuel Oshagbami
(April winner)

Acting Chief Executive's Update to the Board of Directors

Sean Fenwick, Acting Chief Executive

25 September 2025



National statistics and context

National policy, context and operating models

Publication of the NHS 10 Year Plan

Publication of the NHS Oversight Framework segments and 'league tables'

Resident doctors strike nationally

NHS England launch 10 Point Plan – a national programme to improve resident doctors' working lives

Assessing Provider Capability – new guidance for Boards with self-assessment required

National flu vaccination campaign commences

Work continues nationally and regionally to reduce the running costs of Integrated Care Boards (ICBs) – some new ICB footprints come into effect from 1 April 2026 – no North East and North Cumbria impact

Announcement that 14 trusts will be investigated as part of a rapid review of maternity care. This doesn't include any trusts in the North East and North Cumbria

National performance headlines

National performance – July & August 2025

The number of 12-hour waits rose in August and is nearly 100 times higher than pre-pandemic levels.

Performance against the four-hour target stood at 75.9% in August, lower than last year.

The size of the elective waiting list increased slightly for the second month in a row to 7.4 million cases in July. The number of cases waiting more than 52 weeks for treatment are down by 34% compared to last year.

A record high 2.61 million diagnostic tests were carried out in July. Despite this, the size of the waiting list remains elevated and is now over 60% larger than in 2019.

The community health services waiting list increased by 9% from last year to a record high 1.2 million in July 2025. Long waits of over 52 weeks for children and young people's community services are now 86% higher than a year ago.

Monthly number of patients recorded across all three cancer pathways (28-day, 31-day and 62-day) as meeting their respective standards were the highest on record in July.

Demand continues to rise, with new referrals to mental health services the highest on record (499,830) and open referrals to adult services at an all-time high.

League tables show that 75% of trusts are in deficit

Our key operational performance headlines

- **A&E 4 hour performance** for August 2025 was 82.3%, ahead of the national target for 78% and our planned performance of 81%.
- The total Type 1 A&E attendances spending **greater than 12 hours in the department** in August was 0.23% (an improved position), which was below the national threshold of 2% and above our plan of 0.2%. Additionally, there were no 12 hour trolley waits during the month.
- The Trust remains a top performer in **ambulance handover** times with average hand-over time of 13 minutes 29 seconds in August against the national standard of <15 minutes. One handover in August exceeded 30 minutes but was not more than 45 minutes.
- The number of patients waiting over **52 weeks** increased in August (from 35 in the previous month to 55). This relates to capacity challenges in trauma and orthopaedic services. Actions are in progress to address this including the appointment of a locum, insourcing and mutual aid from neighbouring trusts.
- The average **length of stay** for non-elective patients remained consistent with the previous month at 7.66 days. This is above our threshold of 4 days. The discharge liaison nurses continue to support educational work around discharge processes, including discharge workshops. The criteria led discharge pilot is awaiting evaluation. Further work is ongoing around supporting clinicians out of hours with discharge, as well as escalation processes for delayed discharges relating to social care.
- The Trust continues to benchmark well across the region against key **cancer** measures, although the increase in volumes of referrals for urgent suspected cancer in breast continues to affect performance.
- In respect of diagnostics the **waiting list** at the end of August reduced to 6,244 – this represents a decrease of 502 waiters.
- The Trust reported zero cases of **C. difficile** in August. The Trust's annual threshold has been set at 36 and year-to-date cases stand at 13.

Excellent patient care



- Following the **Surgical Site Infections (SSIs)** relating to patients who have received trauma and orthopaedic surgery at Gateshead we have developed a comprehensive action plan to minimise risk and address potential contributory factors.
- Our Children's Bladder and Bowel department have been awarded the '**Gold Standard for Autism Acceptance**' from the North East Autism Society. Over the past year, the team has worked closely with NE Autism Society to enhance their environment, communication approaches, and care pathways to better support neurodivergent children and their families.
- Our cancer care has been highly praised by patients in the **National Cancer Patient Experience Survey**. Patients gave the Trust a rating of 9.2 out of 10, above the national average of 8.9. We achieved above average scores across all areas, reflecting our commitment to delivering exceptional and compassionate care to our patients.
- We have also performed well in the **Adult Inpatient Survey**, which is conducted by Picker on behalf of 61 trusts. The survey captures feedback from patients who stayed overnight in our hospitals between January and April 2025. Overall we were ranked 12th out of 61 organisations. 98% of patients felt treated with respect and dignity and 98% had confidence and trust in our doctors. We improved our scores in areas such as helping patients eat meals and identified some areas for further focus, such as ensuring that colleagues explain the reasons for ward changes at night to our patients.



Great place to work

- We have relaunched our **leadership and management programme**, Leading Forward. Many colleagues have asked for opportunities to grow their leadership skills and this programme has been designed to support this.
- The **voluntary severance scheme** (VSS) that was launched earlier in the summer has now concluded. Managers are working closely with colleagues who have chosen to voluntarily leave the Trust to support them and their teams through the transition. This forms part of our Securing Our Sustainable Future work – our commitment to restore financial balance whilst safeguarding high quality care and reducing waiting times for patients.
- Two members of our maternity support team have received the **Chief Nursing Officer Award** in recognition of their exceptional contribution to maternity care. Jane Puntin, Maternity Support Worker and Sheila Hayes, Diabetes Healthcare Assistant, have been recognised for their dedication, and unwavering commitment to providing high quality care to our patients and their families.
- Our **Occupational Health** service has received SEQOHS accreditation – the nationally recognised benchmark for a Safe, Effective, Quality Occupational Health Service (SEQOHS). This reflects the team's commitment to delivering outstanding care, maintaining high standards and continuously improving the health and wellbeing support provided to our people.



Working together for healthier communities

- 56 runners took part in the Great North Run and Junior and Mini Great North Runs, raising £17,792 for the **Gateshead Health Charity**. Thank you to all participants – we are very proud of you!
- The NHS is about to commence its annual **flu vaccination** programme. Governors can help us by encouraging friends and family who are eligible for the free flu vaccinations to take up the opportunity. From 1 October free vaccines are available for:
 - Over 65s
 - People aged 18-64 in clinical risk groups
 - Long-stay care home residents and staff
 - Carers and close contacts of high risk individuals
- Work is underway to deliver improved facilities to enhance care for women, children and young people across the region. QE Facilities is managing the delivery of the project to redevelop wards 3 and 4 which will soon become the **new colposcopy department and children and young people's unit**. The facilities will open this autumn and will provide modern, welcoming spaces designed around the needs of patients and families. The project also includes strong social value commitments. All contractors were required to demonstrate support for local employment, skills development, community engagement and sustainability.



Fit for the future

- As Governors have been advised we have been placed in **Segment 3 of the NHS Oversight Framework** (where Segment 1 is the best performing and Segment 5 is the most challenged). Being in Segment 3 means we may receive targeted support and some additional oversight, particularly around finance. We were ranked as 83rd out of 134 acute / specialist trusts in the national league tables. No trusts with a planned deficit can be placed in Segment 1 or 2. We are committed to reviewing our performance against all the metrics measured within the Oversight Framework to understand where we can strive to continue to improve our service delivery for our patients.
- Work has continued on the development of the detailed chapters behind the **5 year strategy**, following approval of the outline at the Board earlier in the summer. This will be publicly launched in the autumn. Thank you to all Governors who contributed to the development of the strategy through workshops and Council meetings.
- We are working hard to ensure that we have robust **winter plans** in place to protect our patients and our people over what we know can be one of the most difficult times of the year. This includes testing our escalation plans and confirming clear leadership and staffing models are in place to support colleagues.
- This month we are undertaking targeted work on reducing our waiting lists and meeting key performance targets. '**Super September**' is about providing better care for our patients, especially those who have been waiting the longest. We are reviewing waiting lists, adapting appointments and testing new ways of working, with the aim to reduce backlogs and help patients to be seen more quickly.
- We have been selected as one of 30 trusts nationally to join the **Getting It Right First Time (GIRFT) Further Faster** programme. This focuses on 4 key areas: ambulance handovers, the 4-hour target, 12 hour stays in the department and length of stay. Our teams are working with the national GIRFT teams and building on improvements we have already made.
- Our new **Green Plan** has been developed and will be presented to the Board for approval this month. This outlines the priorities of the Group for reducing environmental impact. The Plan includes initiatives on biodiversity and further electrification of the fleet.

Report Cover Sheet

Agenda Item: 18i

Report Title:	Board Assurance Framework															
Name of Meeting:	Board of Directors															
Date of Meeting:	25 September 2025															
Author:	Jennifer Boyle, Company Secretary Executive Directors															
Sponsor:	Executive Directors															
Report presented by:	Jennifer Boyle, Company Secretary															
Purpose of Report <i>Briefly describe why this report is being presented at this meeting</i>	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐												
	To review the new Board Assurance Framework (BAF), triangulating its content against the items discussed on the agenda.															
Proposed level of assurance – to be completed by paper sponsor:	Fully assured ☐ <i>No gaps in assurance</i>	Partially assured ☒ <i>Some gaps identified</i>	Not assured ☐ <i>Significant assurance gaps</i>	Not applicable ☐												
Paper previously considered by: <i>State where this paper (or a version of it) has been considered prior to this point if applicable</i>	A Board Development session was held to engage Board Members on the summary risks and their scores The BAF extracts will be presented to the relevant committees at every meeting.															
Key issues: <i>Briefly outline what the top 3-5 key points are from the paper in bullet point format</i> <i>Consider key implications e.g.</i> • Finance • Patient outcomes / experience • Quality and safety • People and organisational development • Governance and legal • Equality, diversity and inclusion	• This is the first iteration of the Board Assurance Framework mapped to the new 5 year strategy and strategic objectives. • The controls and assurances will continue to be populated by the leads. • The BAF key is as follows: <table border="1"> <thead> <tr> <th>Key</th><th>Description</th></tr> </thead> <tbody> <tr> <td></td><td>Not yet started</td></tr> <tr> <td></td><td>Started and on track no risks to delivery</td></tr> <tr> <td></td><td>Plan in place with some risks to delivery</td></tr> <tr> <td></td><td>Off track, risks to delivery and or no plan/timescales and or objective not achievable</td></tr> <tr> <td></td><td>Complete</td></tr> </tbody> </table>				Key	Description		Not yet started		Started and on track no risks to delivery		Plan in place with some risks to delivery		Off track, risks to delivery and or no plan/timescales and or objective not achievable		Complete
Key	Description															
	Not yet started															
	Started and on track no risks to delivery															
	Plan in place with some risks to delivery															
	Off track, risks to delivery and or no plan/timescales and or objective not achievable															
	Complete															
Recommended actions for this meeting:	To review the BAF for completeness, accuracy and triangulation against the assurances and risks discussed															

<i>Outline what the meeting is expected to do with this paper</i>	as part of the Board meeting, being assured that works continues to populate the controls, assurances and associated gaps.				
Trust strategic priorities that the report relates to:	☒	Excellent patient care			
	☒	Great place to work			
	☒	Working together for healthier communities			
	☒	Fit for the future			
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	All – as outlined on the BAF itself.				
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):	Risks identified on the BAF				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	Yes ☐	No ☐		Not applicable ☒	

EXCELLENT PATIENT CARE							
Strategic objective:	1) We will be a clinically-led organisation focused on delivering safe, high-quality care and improving health outcomes for our patients						
Executive Owner:	Chief Nurse & Medical Director						
Board Committee Oversight:	Quality Governance Committee						
Date of Last Review:	-						
Summary risk							
There is a risk that decisions relating to the provision of care are made which are not reflective of the clinical voice. This may be due to the new model of clinical leadership not being fully embedded and therefore impacting upon the ability to inform strategic decision-making. This would result in a detrimental impact on patient care, safety and outcomes and disharmony amongst clinical leaders.	Graph to be added here once the Committee has reviewed the BAF twice	CURRENT RISK SCORE			TARGET RISK SCORE		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		4	4	16	2	4	8
Links to risks on the ORR:	4713 - The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis (16) 4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (20) 4705 - Risk of considerable clinical and operational impact to patient care due to failure of PACS environment (15) 4525 - Risk of Lack of a strategic workforce planning (9) 2341 - There is a risk to ongoing business continuity of service provision due to ageing trust estate (16)						
Controls		Gap in controls and corrective action	Owner	Timescale	Update	Action status	
New leadership and management programme - Leading Forward - launching imminently							
Clinically-led and management supported ethos embedded into decision-making principles within the governance structure - e.g. Gateshead Health Leadership Group (GHLG)							
Clinical Strategy Group (CSG) in place to ensure decision-making is clinically-led							
Assurance (Level 1: Operational Oversight)		Gaps in assurance and corrective action (all levels)	Owner	Timescale	Update	Action status	

Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
CSG 3A reporting to GHLG					
Assurance (Level 3 – external)					

EXCELLENT PATIENT CARE

Strategic objective:	2) We will ensure our patients experience the best possible compassionate care and make every contact count						
Executive Owner:	Chief Nurse, Medical Director and Chief Operating Officer						
Board Committee Oversight:	Quality Governance Committee						
Date of Last Review:	-						
Summary risk							
There is a risk that patients do not have the best possible experience due to a number of potential contributory factors. This would lead to patient dissatisfaction, poor reputation and poor staff morale.	Graph to be added here once the Committee has reviewed the BAF twice	CURRENT RISK SCORE			TARGET RISK SCORE		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		4	3	12	2	3	6
Links to risks on the ORR:	4705 - Risk of considerable clinical and operational impact to patient care due to failure of PACS environment (15) 4713 - The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis (16) 2341 - There is a risk to ongoing business continuity of service provision due to ageing trust estate (16) 4734 - Risk of patient harm due to variability in meeting 4 hour ED Emergency Care standard (12) 4704 - Risk of failure to review appropriate clinical information due to multiple sources of data stored across a variety of digital systems (16)						
Controls		Gap in controls and corrective action	Owner	Timescale	Update	Action status	
Quality Improvement Plan in place							
Falls workstream in place							
New learning forum in place							
Patient experience team and PALS team in place							
Assurance (Level 1: Operational Oversight)		Gaps in assurance and corrective action (all levels)	Owner	Timescale	Update	Action status	
Oversight of key metrics through the Patient Experience Group		Surgical Site Infections - consolidated action plan developed and a formal report to be presented to the Quality Governance Committee	Chief Nurse	Oct-25			
Oversight of key metrics through the Safecare Steering Group							

Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Patient experience metrics reported to Quality Governance Committee					
Patient experience metrics reported to the Board as part of the performance report					
Safecare Steering Group reports to Gateshead Health Leadership Group through the 3A report with opportunity to escalate any significant patient experience issues					
PLACE visits conducted weekly with representation from volunteers and Governors					
15 Step programme in place					
Patient stories featured at Board					
Assurance (Level 3 – external)					
Cancer Patient Experience Survey - 9.2 out of 10					
CQC Maternity patient survey - top performing trust					
Adult Inpatient Survey - 12th of out 61 organisations					
Children's Bladder and Bowel Service awarded Gold Standard for Autism					

EXCELLENT PATIENT CARE								
Strategic objective:	3) We will continually improve our services creating a restorative culture where learning, innovation and research can flourish							
Executive Owner:	Medical Director							
Board Committee Oversight:	Quality Governance Committee							
Date of Last Review:	-							
Summary risk								
There is a risk that we do not achieve continuous improvement in the quality and safety of our services. This could be caused by poor organisational culture and a poor adoption / embedding of learning, research and development. This would impact on patient safety and our credibility and reputation as an innovative and quality-driven organisation.	Graph to be added here once the Committee has reviewed the BAF twice		CURRENT RISK SCORE			TARGET RISK SCORE		
			Likelihood	Impact	Score	Likelihood	Impact	Score
		Patient safety risk:	3	4	12	2	4	8
		Risk of not embedding R&D and innovation	4	4	16	2	4	8
Links to risks on the ORR:	4713 - The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis (16) 4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (20) 4772 - Risk of Potential instability of the Board of Directors due to secondment of Chief Executive Officer.(12) 4417 - Increase in incivility and disrespectful behaviours being reported (15)							
Controls		Gap in controls and corrective action			Owner	Timescale	Update	Action status
EQIA process in place for all policies and major service changes								
Innovation Manager is a dedicated post in the Trust								
New learning forum in place								
Research and development team in place								
Clinical audit programme in place								
Clinical audit processes revised to include new escalation process and increased resource								
Assurance (Level 1: Operational Oversight)		Gaps in assurance and corrective action (all levels)			Owner	Timescale	Update	Action status
Audit and Effectiveness Group reports to Safecare Steering Group								
Research and Development tier 3 meeting reporting to CSG								

Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Clinical audit reporting to Quality Governance Committee on outcomes, learnings and improvements					
Clinical audit reporting to Group Audit Committee on the processes and controls for the development and delivery of the clinical audit plan					
Safecare Steering Group reports to Gateshead Health Leadership Group through the 3A report with opportunity to escalate any significant issues relating to this remit					
Assurance (Level 3 – external)					
Children's Bladder and Bowel Service awarded Gold Standard for Autism					

GREAT PLACE TO WORK							
Strategic objective:	4) We will care for our people, creating a fair, inclusive and respectful environment where everyone can thrive in their role						
Executive Owner:	Executive Director of People & OD						
Board Committee Oversight:	People and OD Committee						
Date of Last Review:	-						
Summary risk							
There is a risk that the Trust's culture does not reflect the organisational values. This may be caused by poor behaviours which are not appropriately addressed and a lack of confidence that issues raised will be listened to and acted on. This could lead to low morale, high sickness absence, an inability to attract and retain staff and poorer patient outcomes.	Graph to be added here once the Committee has reviewed the BAF twice	CURRENT RISK SCORE			TARGET RISK SCORE		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		4	4	16	2	4	8
Links to risks on the ORR:	3132 - Exposure to incidents of violence and aggression (16) 4417 - Increase in incivility and disrespectful behaviours being reported (15) 4772 - Risk of Potential instability of the Board of Directors due to secondment of Chief Executive Officer.(12)						
Controls		Gap in controls and corrective action	Owner	Timescale	Update	Action status	
Health and wellbeing offer in place		FTSU Guardian temporarily absent - recruitment of an interim Guardian underway	Executive Director of POD	Sep-25			
Zero tolerance campaign continues to be delivered							
FTSU Champions in place							
Absence taskforce in place							
New prevention of violence at work policy developed							
Staff networks in place							
EQIA process in place for all policies and major service changes							
People policies in place re: absence and leave provisions							
Assurance (Level 1: Operational Oversight)		Gaps in assurance and corrective action (all levels)	Owner	Timescale	Update	Action status	
Staff Experience and EDI Group to seek assurance over culture at Tier 3 level							

POD team meetings to review metrics and indicators					
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Assurance reports to POD Committee re: staff survey outcomes and action plans					
POD Committee receives deep dive assurance reports on sickness absence					
POD Committee receives assurance reports on the actions as a result of recent cultural reviews					
EDI reporting to POD Committee including progress against the EDI strategy					
Assurance (Level 3 – external)					
Occupational Health SEQOSH accredited					

GREAT PLACE TO WORK								
Strategic objective:	5) We will grow and develop our people with a focus on celebrating achievements and creating a culture of high performance and innovation							
Executive Owner:	Executive Director of People & OD							
Board Committee Oversight:	People and OD Committee							
Date of Last Review:	-							
Summary risk								
There is a risk that there is a failure to deliver equity in access to staff experience and career development opportunities. This may be caused by inequalities, financial constraints and other operational pressures to deliver performance. This could lead to a lack of capable and diverse talent pipelines and a failure to build sustainable leadership capacity at all levels and into the place, alliance and system.	Graph to be added here once the Committee has reviewed the BAF twice	CURRENT RISK SCORE			TARGET RISK SCORE			
		Likelihood	Impact	Score	Likelihood	Impact	Score	
		3	4	12	2	3	6	
Links to risks on the ORR:	4713 - The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis (16) 4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (20) 4525 - Risk of Lack of a strategic workforce planning (9)							
Controls		Gap in controls and corrective action			Owner	Timescale	Update	Action status
New leadership and management programme - Leading Forward - launching imminently								
People plan in place as part of annual planning								
Medical staffing function strengthened								
Controls in place to prevent unintentional workforce growth								
Reinvigoration of Star Awards to celebrate success								
Monthly You're a Star award presented by the Chair								
Recruitment process ensures appropriate focus on minimising bias								
Assurance (Level 1: Operational Oversight)		Gaps in assurance and corrective action (all levels)			Owner	Timescale	Update	Action status

POD team meetings to review metrics and indicators					
POD Steering Group and supporting groups in place					
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
POD Committee receives assurance updates on key workforce and employment metrics through the People Metrics report					
Assurance (Level 3 – external)					

GREAT PLACE TO WORK							
Strategic objective:	6) We will be an employer and training provider of choice within the local community recognising our role as an anchor institution						
Executive Owner:	Executive Director of People & OD						
Board Committee Oversight:	People and OD Committee						
Date of Last Review:	-						
Summary risk							
There is a risk that the Trust is not seen as an employer or training provider of choice within the local community. This may be due to limited ability and reduced capacity to work with system partners. This may result in an inability to attract and retain talent from diverse backgrounds that reflect our community and could have a negative impact on patient outcomes.	Graph to be added here once the Committee has reviewed the BAF twice	CURRENT RISK SCORE			TARGET RISK SCORE		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		4	3	12	2	3	6
Links to risks on the ORR:	4525 - Risk of Lack of a strategic workforce planning (9) 4713 - The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis (16) 4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (20) 2341 - There is a risk to ongoing business continuity of service provision due to ageing trust estate (16)						
Controls		Gap in controls and corrective action	Owner	Timescale	Update	Action status	
New leadership and management programme - Leading Forward - launching imminently							
People plan in place as part of annual planning							
Medical staffing function strengthened							
Assurance (Level 1: Operational Oversight)		Gaps in assurance and corrective action (all levels)	Owner	Timescale	Update	Action status	
POD team meetings to review metrics and indicators							
POD Steering Group and supporting groups in place							

Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
POD Committee receives quarterly assurance from the Guardian of Safe Working					
GMC survey results reviewed by POD Committee for assurance					
Assurance (Level 3 – external)					

EXCELLENT PATIENT CARE

Strategic objective:	7) We will work in collaboration with our partners to improve the health of our population and reduce health inequalities						
Executive Owner:	Medical Director (& Medical Director of Strategic Relations)						
Board Committee Oversight:	Quality Governance Committee						
Date of Last Review:	-						
Summary risk							
There is a risk that the Trust does not effectively collaborate with partners to maximise impact on health improvement in a way which reduces health inequalities for our Gateshead population. This may be caused by a lack of enabling access to data and resource due to historical and organisational barriers, cultural resistance, capacity and ability or appetite to make difficult decisions. This results in poor patient outcomes and an inability to deliver against the NHS 10 Year Plan sickness to prevention shifts	Graph to be added here once the Committee has reviewed the BAF twice	CURRENT RISK SCORE			TARGET RISK SCORE		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		3	4	12	2	4	8
Links to risks on the ORR:	4713 - The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis (16) 4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (20) 4704 - Risk of failure to review appropriate clinical information due to multiple sources of data stored across a variety of digital systems (16) 4772 - Risk of Potential instability of the Board of Directors due to secondment of Chief Executive Officer.(12)						
Controls		Gap in controls and corrective action	Owner	Timescale	Update	Action status	
Health Inequalities Group in place							
Core20plus5 ambassadors in place							
Health inequalities workplan in place							
Board Development session held to commence discussions on strategic positioning re: health inequalities and neighbourhood health							
Key priorities identified following a review by the Specialty Registrar in Public Health Medicine							
Public Health engagement and involvement in health inequalities within the Trust							
Assurance (Level 1: Operational Oversight)		Gaps in assurance and corrective action (all levels)	Owner	Timescale	Update	Action status	

Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Health Inequalities Group reports to Gateshead Health Leadership Group (GHLG) via 3A reporting					
Health inequalities assurance reporting to Quality Governance Committee					
Assurance (Level 3 – external)					

WORKING TOGETHER FOR HEALTHIER COMMUNITIES							
Strategic objective:	8) We will develop our neighbourhoods in line with the NHS 10 year plan						
Executive Owner:	Medical Director (& Medical Director of Strategic Relations)						
Board Committee Oversight:	Finance and Performance Committee						
Date of Last Review:	-						
Summary risk							
There is a risk that the ability to deliver care and prevention at neighbourhood and place level is not fully maximised. This may be caused by a lack of internal strategic resource to engage at this level or a lack of internal understanding of the neighbourhood concept resulting in a failure to co-create Neighbourhood health services . This results in poor patient outcomes and an inability to deliver against the NHS 10 Year Plan hospital to community shift	Graph to be added here once the Committee has reviewed the BAF twice	CURRENT RISK SCORE			TARGET RISK SCORE		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		4	4	16	3	4	12
Links to risks on the ORR:	4713 - The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis (16) 4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (20)						
Controls		Gap in controls and corrective action	Owner	Timescale	Update	Action status	
Medical Director of Strategic Relation and Director of Strategy in place to provide senior leadership							
Board Development session held to commence discussions on strategic positioning re: neighbourhood health							
Appropriate director level attendance at Gateshead Overview and Scrutiny and Health and Wellbeing Boards							
Assurance (Level 1: Operational Oversight)		Gaps in assurance and corrective action (all levels)	Owner	Timescale	Update	Action status	

WORKING TOGETHER FOR HEALTHIER COMMUNITIES								
Strategic objective:	9) We will collaborate with system partners with an emphasis on maximising the efficient use of collective resources across health and care services							
Executive Owner:	Group Director of Finance (& Medical Director of Strategic Relations)							
Board Committee Oversight:	Finance and Performance Committee							
Date of Last Review:	-							
Summary risk								
There is a risk that we are unable to utilise our collective resources across health and care services in a way that delivers value for money and the best outcomes for patients. This may be caused by a lack of effective engagement and collaboration within the Great North Healthcare Alliance, Place arrangements and wider partnerships. Contributing factors may include unclear governance arrangements, lack of clarity on leadership, differing organisational priorities and operational complexity in aligning resources and decision-making. This may result in missed opportunities to optimise service delivery, reduced ability to attract future funding and potential reputational impact if collaborative ambitions are not realised	Graph to be added here once the Committee has reviewed the BAF twice		CURRENT RISK SCORE			TARGET RISK SCORE		
			Likelihood	Impact	Score	Likelihood	Impact	Score
		Place aspect of risk:	4	4	16	3	4	12
		Wider system aspect of risk:	4	4	16	3	4	12
Links to risks on the ORR:	4713 - The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis (16) 4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (20) 4734 - Risk of patient harm due to variability in meeting 4 hour ED Emergency Care standard (12)							
Controls		Gap in controls and corrective action	Owner	Timescale	Update		Action status	
Appropriate director level attendance at Gateshead Overview and Scrutiny and Health and Wellbeing Boards		Work is underway to align constitutions around Chair provisions	Company Secretary	Jan-26	Sept 25 - collaborative working with NUTH and NHCT supported with legal advice			
Senior engagement in Gateshead Cares meetings								
Gateshead Health CEO chairing Gateshead Cares Board								
Direct engagement with GPs and PCNs through PCN meetings and GP weekly meetings								
Systems approach taken to winter planning								
Strong representation at the Alliance for GHFT - Committee in Common, Joint Committee, Alliance Formation Team								
Weekly meetings of Alliance CEOs								
Shared Chair in place from 1/10/25								
Governor events held across the Alliance								
Alliance risk management framework in place								
Governor engagement across the Alliance through Lead Governors								

Assurance (Level 1: Operational Oversight)		Gaps in assurance and corrective action (all levels)	Owner	Timescale	Update	Action status
Regular updates to internal leadership forums on place, Alliance and system working - e.g. via Gateshead Health Leadership Group						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Alliance updates shared at Board						
Committee in Common and Joint Committee minutes and 3A reports presented at Trust Board						
Assurance (Level 3 – external)						

FIT FOR THE FUTURE							
Strategic objective:	10) We will ensure effective and efficient use of our resources identifying opportunities to improve productivity and ensure best use of public money						
Executive Owner:	Group Director of Finance / Chief Operating Officer						
Board Committee Oversight:	Finance and Performance Committee						
Date of Last Review:	-						
Summary risk							
There is a risk that the Trust does not improve its financial sustainability and therefore fails to utilise public money to best effect. This may be caused by limited access to, or inconsistent understanding of, data, trends, forecasts, and improvement methodologies or lack of improvement culture / financial governance & accountability. This would result in reduced responsiveness to patient needs, an inability to meet financial targets and a loss of reputation and organisational autonomy.	Graph to be added here once the Committee has reviewed the BAF twice	CURRENT RISK SCORE			TARGET RISK SCORE		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		4	5	20	2	5	10
Links to risks on the ORR:	4713 - The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis (16) 4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (20) 4714 - 2025-26 planned activity is not achieved resulting in the Trust not achieving planned income targets (12) 4704 - Risk of failure to review appropriate clinical information due to multiple sources of data stored across a variety of digital systems (16)						
Controls		Gap in controls and corrective action	Owner	Timescale	Update	Action status	
Annual plan developed and in place							
Agreed budgets in place for each division and corporate area							
SFIs and Scheme of Delegation updated in 2025							
Securing Our Sustainable Future work programme developed							
Post recruited to to lead the Sustainable Future work							
Assurance (Level 1: Operational Oversight)		Gaps in assurance and corrective action (all levels)	Owner	Timescale	Update	Action status	
New Key Indicators report circulated to leadership team on a weekly data to provide timely insight into performance		Target operating models for all corporate functions not yet signed off - to be presented through CRP Steering Group	DoF	Oct-25			
CRP Steering Group in place to seek assurance over plans and their delivery							

Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Monthly finance and CRP reporting to Finance and Performance Committee					
Quarterly reporting to the Council of Governors on finance and wider performance, including updates on the Sustainable Future work					
Reporting to Board on financial, operational, quality and people performance against plan					
QEF financial performance reported to F&P Committee					
Assurance (Level 3 – external)					
NHS Oversight Framework ratings and league tables now published & provide benchmarking information					

FIT FOR THE FUTURE

Strategic objective:	11) We will be a data informed, digitally enabled organisation using technology to transform the way we plan and deliver care						
Executive Owner:	Chief Digital Officer						
Board Committee Oversight:	Digital Committee						
Date of Last Review:	n/a						
Summary risk							
There is a risk that the Trust does not utilise digital technology effectively. This may be caused by a lack of a clear digital strategy, a lack of effective business continuity a lack of resource (e.g. financial, skilled people) and a lack of appropriate clinical input into decision-making. This may result in a lack of ability to utilise digital technology to support cultural transformation, productivity, efficiency, clinical safety and patient experience.	Graph to be added here once the Committee has reviewed the BAF twice	CURRENT RISK SCORE			TARGET RISK SCORE		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		5	4	20	3	4	12
Links to risks on the ORR:	4402 - Inability to support legislation and best practice associated with records management (15) 4405 - Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure (8) 4704 - Risk of failure to review appropriate clinical information due to multiple sources of data stored across a variety of digital systems (16) 4705 - Risk of considerable clinical and operational impact to patient care due to failure of PACS environment (15) 4554 - Cyber threats and vulnerabilities (10)						
Controls		Gap in controls and corrective action	Owner	Timescale	Update	Action status	
Chief Digital Officer in place across the Alliance		Digital Committee membership, scope and terms of reference to be revisited in light of recent new appointments (including a new Chair of the Committee)	Chief Digital Officer / Chair of the Committee	Oct-25			
Associate Director of Digital appointment made		Digital chapter to be developed to provide a clear digital strategy as part of the Trust's new 5 year strategy - for sign off at September Board	Chief Digital Officer	Sep-25			
Digital Committee in place with supporting groups at Tier 2 and Tier 3							
Assurance (Level 1: Operational Oversight)		Gaps in assurance and corrective action (all levels)	Owner	Timescale	Update	Action status	
		Following discussion at the June Digital Committee further work is needed to develop a recommended position on the Digital Records Programme and provide assurance over resource allocation and prioritisation	Chief Digital Officer	Sep-25			
		To enhance assurance reporting to the Digital Committee to ensure that the patient care impact on developments, risks and proposals is clearly articulated in papers to the Committee	Chief Digital Officer	31/03/2026			

Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Digital service KPIs reviewed at every Digital Committee					
Assurance (Level 3 – external)					
Internal Audit: Cyber Assurance Framework (CAF) Aligned Data Security Protection Toolkit (DSTP) Independent Assessment - outcome High / Low assessment rating.					
Internal Audit: Clinical Safety System Changes - Reasonable Assurance rating					

FIT FOR THE FUTURE							
Strategic objective:	12) We will focus on productive utilisation of our estate to facilitate care in the right setting and providing our services in an environmentally sustainable way						
Executive Owner:	QEF Managing Director and Group Director of Finance						
Board Committee Oversight:	Finance and Performance Committee						
Date of Last Review:	-						
Summary risk							
There is a risk that the Group will be unable to develop its estate in line with changing clinical requirements and may experience failure of critical infrastructure, as a result of insufficient capital investment, This could result in compromised patient safety, disruption to business continuity, reduced staff morale, non-compliance with statutory obligations, and failure to deliver on environmental sustainability commitments.	Graph to be added here once the Committee has reviewed the BAF twice	CURRENT RISK SCORE			TARGET RISK SCORE		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		4	5	20	4	4	16
Links to risks on the ORR:	2341 - There is a risk to ongoing business continuity of service provision due to ageing trust estate (16) 4713 - The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis (16) 4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (20)						
Controls		Gap in controls and corrective action	Owner	Timescale	Update	Action status	
Capital plan in place for 25/26		Outline capital plan in place for 26-27 but not yet fully approved	QEF MD	Jan-26			
Governance structure includes strengthened focus on capital and estates through 1 single Capital Oversight Group at Tier 3 and the accommodation group							
SFIs and Scheme of Delegation provisions re: capital strengthened in 2025 review							
New Green Plan developed							
New Greener NHS Group established							
Assurance (Level 1: Operational Oversight)		Gaps in assurance and corrective action (all levels)	Owner	Timescale	Update	Action status	

Capital Oversight Group meets monthly to review capital plans, spend and reprioritisation					
Capital Oversight Group reports to the Operational Oversight Group via 3A reporting					
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Capital reporting and monitoring to F&P Committee and Board of Directors via finance reports					
Assurance (Level 3 – external)					

Agenda Item: 18ii

Report Title:	Organisational Risk Register (ORR)			
Name of Meeting:	Board of Directors			
Date of Meeting:	25 th September 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 <i>Briefly describe why this report is being presented at this meeting</i>	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 – to be completed by paper sponsor:	Fully assured ☒ <i>No gaps in assurance</i>	Partially assured ☐ <i>Some gaps identified</i>	Not assured ☐ <i>Significant assurance gaps</i>	Not applicable ☐
Paper previously considered by: <i>State where this paper (or a version of it) has been considered prior to this point if applicable</i>	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: <i>Briefly outline what the top 3-5 key points are from the paper in bullet point format</i> <i>Consider key implications e.g.</i> • Finance • Patient outcomes / experience • Quality and safety	Risks on the ORR were comprehensively discussed at previous ERMG meetings in August and September 2025. The following updates and movements agreed: ➤ In the period of 19th July - 17th September 2025, there were 4 risks added to the ORR, 0 escalations, 1 reduction, 0 risks closed or removed from the ORR. ➤ 19 risks in total on the Organisational risk register			

• People and organisational development • Governance and legal • Equality, diversity and inclusion	➤ Risks with no movement in 6-month period are highlighted for information and discussion. ➤ Summary of Movements over 12-month period is shown within the attached report. Compliance with reviews has improved in period and sits at 95% for risks and 88% for associated actions. (This is in comparison to 87% for both risks and associated actions within previous 2 months data set.)				
Recommended actions for this meeting: <i>Outline what the meeting is expected to do with this paper</i>	The Board are asked to: • Review the risks on the report and discuss and seek further information as appropriate. • Note movements over 12-month period listed in the attached report. • Note risks with 0 movement in the previous 6-month period. • Take assurance that risks are reviewed in line with risk management arrangements. • Be sighted on the top risks for the organisation.				
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 look to utilise our skills and expertise beyond Gateshead			
Trust corporate objectives that the report relates to:	Each risk is linked to a corporate objective, see report.				
Links to CQC KLOE	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and InPhase reference)	Included in report				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	Yes ☐	No ☐	Not applicable ☒		

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, top ORR risks and provides details of review compliance, and risk movements, including movement over the previous 12 months.

This report covers the period 19th July- 17th September (extraction date for this report, Via inphase).

Organisational Risk Register

2. Movements in period

Following ERMG meetings in August and September 2025, 4 risks has been added to the ORR.

There have been 0 escalations, 1 reduction, and 0 closures or de-escalations 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 have been 4 risks escalated to the ORR in period.

- **4704 (Digital)** Risk of failure to review appropriate clinical information due to multiple sources and lack of interoperability of data stored across a variety of digital systems and in paper format. This could result in patient harm or sub optimal care. (16)
 - Business case underway for moving to an integrated patient record.
 - Disparate documentation and multiple sources of information remain a significant clinical risk for the organisation.

- **4702 (Finance)** The Group's cash balance is reducing due to the Organisation operating with an underlying deficit. Reducing cash balance increases the risk of the Group having to access revenue cash support during 2025-26. (16)
 - Increased from 12 to 16
 - Deterioration in current position
- **4763 (MD Office)** Risk of significant and cumulative impact to services due to industrial action of resident Doctors which could impact on patient safety, experience and outcomes. (12)
 - Risk refers to both clinical safety and reduction in performance that could manifest as a result of cumulative industrial action that is uncertain and unknown at present.
- **4772 (CEO)** There is a risk in relation to the stability of the Executive Team as well as the ability of the Board to develop its unitary function due to external secondment of our Chief Executive Officer and changes to board members. This may impact the capability of the Board and Executive Team to make effective decisions, manage risk, deliver core objectives and operate to full effectiveness and in line with well-led principles. (12)
 - This is expected to be a short-term risk following appointment of Acting CEO and new chair arrangements.

Risks escalated:

0 risk has been escalated in period.

Risks reduced:

1 risk has reduced in period:

- **4734 (Medicine)** Risk of patient harm due to extended lengths of stay within the Emergency Department resulting in poor patient outcomes and an increase in clinical risk. Monitored and evidenced by variable compliance with the national four-hour emergency care standard. (12)
 - reduced from 16 to 12
 - Sustained Improvement in performance metrics noted has supported reduction in likelihood.

Risks removed from the ORR

0 risks in total have been removed in period.

Risks closed:

0 Risks have been closed.

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

There are 13 risks on the ORR with no movement in the past 6 months (April- September 2025) [excluding newly raised risks].

The board are asked to be fully cognisant that lack of movement with scores could pose threat to the achievements of the Organisations aims and objectives, noting however, that mitigating actions have been applied during this time.

Changes to Current Score over 6 Months											
Risk ID	Risk Stage	Risk Title	Owner	Business Unit	Service	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025
4694	Current Risk	Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m	Kris Mackenzie	Finance	Finance	20	20	20	20	20	20
2341	Current Risk	There is a risk to ongoing business continuity of service provision due to ageing trust estate	Anthony Pratt	QE Facilities	Estates	16	16	16	16	16	16
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
4713	Current Risk	The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis	Kris Mackenzie	Finance	Finance	16	16	16	16	16	16
4704	Current Risk	Risk of failure to review appropriate clinical information due to multiple sources of data stored across a variety of digital systems.	David Thompson	Digital	Systems	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	Karen Parker	Surgical Services	Obstetrics	15	15	15	15	15	15
4417	Current Risk	Increase in incivility and disrespectful behaviours being reported	Amanda Venner	People & OD	Workforce Development	15	15	15	15	15	15
4714	Current Risk	2025-26 planned activity is not achieved resulting in the Trust not achieving planned income targets	Kris Mackenzie	Finance	Finance	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
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
4554	Current Risk	Cyber Threats and Vulnerabilities	David Thompson	Digital	IT	10	10	10	10	10	10
4525	Current Risk	Risk of Lack of a strategic workforce planning	Natasha Botto	People & OD	Human Resources	9	9	9	9	9	9
4405	Current Risk	Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure.	Dianne Ridsdale	Digital	Digital Transformation and Assurance	8	8	8	8	8	8

4. Top Organisational Risks:

The following 3 risks were agreed in both August and September's meeting:

- 1- Finance-** non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m
- 2- Digital-** Risk of failure to review appropriate clinical information due to multiple sources of data stored across a variety of digital systems.
- 3- POD-** Increase in incivility and disrespectful behaviours being reported.

- **4694 (Finance).** Risk that the Trust will not achieve its 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)
- **4704 (Digital)** Risk of failure to review appropriate clinical information due to multiple sources and lack of interoperability of data stored across a variety of digital systems and in paper format. This could result in patient harm or sub optimal care. (16)
- **4417 (POD)** Risk that promoting an environment that encourages speaking out and creating a psychologically safe culture has led to increased reports of poor behaviour. This could have a negative impact on staff and require additional time and capacity to appropriately address the concerns. This could result in further health and well-being concerns and staff absence. (15)

5. Current compliance with Risk reviews:

Risk review compliance is currently at 95%. Action review compliance is 88%.

This is an improvement on both risk and action compliance for the reporting period. Previous reporting period was (87% for both risks and their associated actions.)

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

6. Recommendations

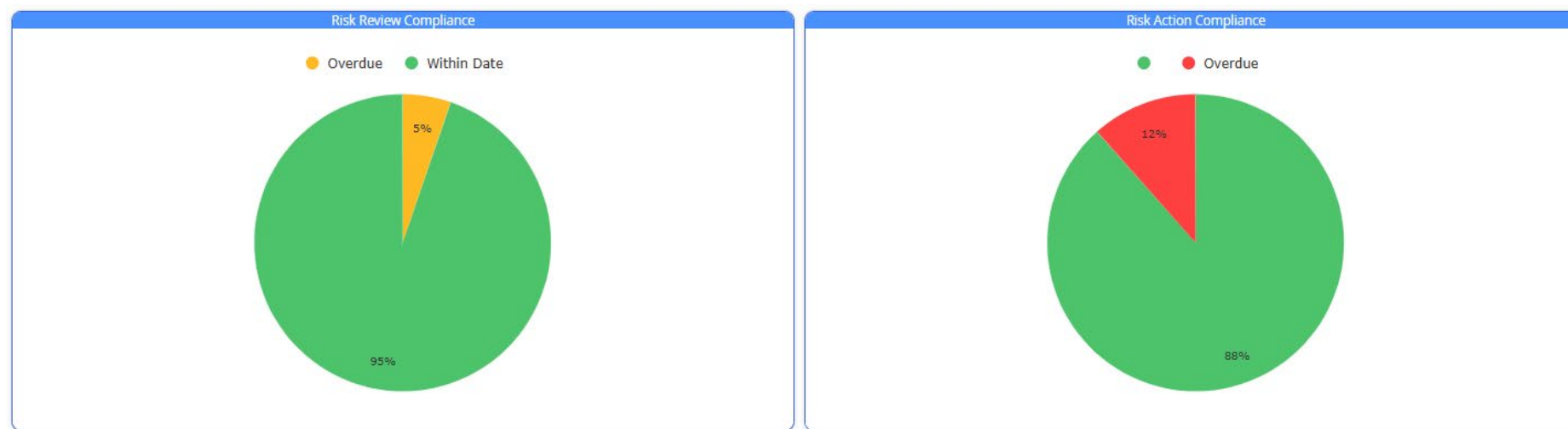
The Board of Directors are asked to:

- Review the risks and discuss and seek further information relating to risks as appropriate.
- Note lack of movement of ORR risks in the 6-month period
- Have full sight of the agreed top 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. September 2025.



Risk review and action review compliance- September 2025



Top Organisational Risks- September 2025

Risk Id	Division	Description	Initial Risk Grade	Grade▼	Target Grade
4694	Finance	Risk that the Trust will not achieve its 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
4704	Digital	Risk of failure to review appropriate clinical information due to multiple sources and lack of interoperability of data stored across a variety of digital systems and in paper format. This could result in patient harm or sub optimal care.	20	16	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

Committee Escalation and Assurance Report

Name of Board Committee	Finance and Performance Committee
Date of Board Committee:	26 August 2025
Chair of Board Committee:	Mr M Hedley

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:

- **Cash Position** – the cash position continues to deteriorate in line with the plan, but more scenario modelling is needed and there are risks in relation to CRP and the capital programme.
- **CRP** - to be aware that the forecast is showing a shortfall on CRP and there is a need to identify further mitigations to close the gap for this year and reduce the impact on future years.

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 items:

- **Aseptic Service** – there are gaps in aseptic service due to unexpected unavailability of key individual within the service – mutual aid is being requested via the Mutual Aid Group.
- **T and O** – there were 35 T&O 52+ week waiters at the end of the month – a lower limb locum has been appointed.
- **ED Performance** – positive improvements in ED Performance
- **PACS** – recovery in performance following the PACs incident is now being seen in the metrics.
- **Premises Assurance Model (PAM)** – the Committee received the PAM self-assessment and action plan – the action plan to be updated and re-submitted to the Committee in September for onward referral to the Trust Board for approval. This report to be reported via Quality Governance Committee in future, subject to confirmation with the Company Secretary.
- **CDC Activity Level** – The Committee remained concerned about activity levels in relation to phase 1 of the CDC – it was noted that it is envisaged that recovery will start to be seen by next month and the Committee will continue to monitor and escalate if necessary.

• CDC Phase 2 Business Case – the development of the phase 2 business case is flowing through the governance processes, but to highlight awareness of a heightened risk of national funding claw back.
Assure <i>(key assurances received and any highlights of note for the Board)</i>
The Committee received assurances in relation to the following: • Front of house model • Internal audits
Risks (any new risks / proposed changes to risk scores)
• There were no changes to risks.
Cross-referrals to other Committees (by significant exception only)
• To cross refer to the Digital Committee to highlight the risk in relation to virtual wards relating to the use of multiple systems and paper files and ensuring staff have access to the information they need in the right place. This links back to the top 3 organisational risks.

Committee Escalation and Assurance Report

Name of Board Committee	Finance and Performance Committee
Date of Board Committee:	22 September 2025
Chair of Board Committee:	Mr M Hedley

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:

- **Bank and Agency Spend** – there is continued exposure in relation to bank and agency spend, with mitigation work underway.
- **Finance Report** – risk in relation to CRP delivery of £5m that needs to be mitigated.
- **Cash Position** – cash balances are above plan but are expected to reduce significantly by year end with monthly monitoring and scenario modelling being put in place.
- **Managed Laboratory Services (MLS) Project** – timescales slippage by approximately 6 months.
- **52 week waits** – deteriorating position with 55 T&O 52+ week waiters.
- **Community Diagnostic Centre phase 1** – risk share agreement not yet finalised.

Recommendations to Board:

- **Community Diagnostic Centre phase 2** – the recommendation to pause the project to develop a revised strategic vision for the Metro Centre CDC was approved for onward recommendation to the Board.
- **Pay Award** – the in-year and recurrent impact of the pay award was noted, with the recommendation to increase the Cost Reduction Plan to mitigate any further deterioration to the underlying financial position approved for onward recommendation to the Board.
- **Green Plan** – The committee approved the Green Plan for onward recommendation to the Board.
- **Premises Assurance Model** – The Committee approved the Premises Assurance Model and revised action plan for onward recommendation 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)

The Committee identified the following advisory items:

• Replacement of Gamma Cameras: Business Case – this was received, and as part of the discussion it was agreed for it to return to EMT for further work to be undertaken. • Board Assurance Framework (BAF) – The Committee had a discussion around the new BAF extract for the Committee and suggested further consideration may be needed around the risks and target scores.
Assure <i>(key assurances received and any highlights of note for the Board)</i>
The Committee received assurances in relation to the following: • Green Plan – assurance provided through the full refresh of the Green Plan in line with the latest Greener NHS Green Plan guidance. • Premises Assurance Model and action plan – strong levels of assurance overall noted with 85% of domains rated ‘good’ or ‘outstanding’. • CRP - Significant achievements made in relation to CRP. • Finance Report – report is demonstrating delivery to plan. • Urgent and Emergency Care Performance – strong performance in relation to 4hr, 12hr and ambulance handovers. • Sickness Absence – improved sickness absence rates reported in August. • QEF Finance Report
Risks (any new risks / proposed changes to risk scores)
• The Committee suggested ERMG consider the underlying risks for BAF objective 10 – ensuring effective and efficient use of resources – and to recommend whether the BAF risk likelihood score should be reduced.
Cross-referrals to other Committees (by significant exception only)
• There were no cross referrals.

Committee Escalation and Assurance Report

Name of Board Committee	Quality Governance Committee
Date of Board Committee:	27 August 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)

- Clinical Lead for Obstetrics – There is a risk of being non-compliant with the Maternity Incentive Scheme due to having no Clinical Lead for Obstetrics. A commitment was given that this will be in place ahead of the next Quality Governance Meeting in November 2025.
- Surgical Site Infections Report – all actions are being consolidated into an action plan and a formal report to be provided to the next meeting of the Committee.
- Cancer Patient Experience Survey – to report a positive alert highlighting the excellent results received by the Trust from the Cancer Patient Experience Survey.

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:

- Emergency Department waits for mental health patients – the terms of reference for the mental health review are still under review – the Committee identified a need to escalate work on this review.
- CDDFT Breast Services – the increase in referrals is being managed but this needs to be monitored closely given the potential impact on standards.
- Maternity and Neonatal Voices Partnership (MNVP) attendance – potential impact on MIS Compliance – this has been escalated.
- Quality Improvement Plan – the Committee agreed with the principles of the report but impacts and targets to be added into the report and the report brought back to the next meeting for approval.
- Transition legacy incidents - 62 Day Cancer breaches – to look to take forward outstanding cases on a thematic basis.
- Falls – there has been a sustained increase in falls, but actions are in place.
- Out of date guidelines – to be reported through safecare.
- Health and Safety alert about Jubilee external switch – the correlation to backlog maintenance and the impact for patient safety noted.
- Internal audit - the action on complaints training has been signed off

Violence and Aggression – there has been a sustained increase in incidents.
Assure <i>(key assurances received and any highlights of note for the Board)</i>
Positive assurances were agreed in relation to: - Violence and Aggression – action being taken to address the issue. - MIS Compliance. - Front of house performance and waiting times. - Safecare Steering Group assurances. - Falls Group work - Children in Care Annual Report - Health Inequalities - Safe Staffing Report - Reduction in open investigations - Health and Safety Annual Report - EPRR - Dash Review
Risks (any new risks / proposed changes to risk scores)
There were no new risks identified.
Cross-referrals (by exception only)
There were no cross referrals.

Escalation and Assurance Report

Name of Committee / Group:	Digital Committee
Date of Committee / Group:	15 September 2025
Chair of Committee / Group:	Mr Andrew Besford

Alert

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

- Digital Records Programme – The Committee discussed a potential route to take things forward.
- System C Contract Extension - committee recommendation to renew into the second-year extension from December. This will require reporting through Supplies and Procurement Committee, and will follow internal governance approval routes in line with Trust SFIs

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)

- Subject Access Requests – compliance has dropped due to vacant posts but a Band 2 recruitment has been approved.
- Freedom of Information (FOI) Requests – there is a need for broader consideration of FOI requests across the organisation.
- PACs upgrade – this will take place on Monday 22 September 2025. The Committee received reassurance about the plans for the upgrade.
- Next steps on clinical safety – review of 63 exempted systems.
- Data and business intelligence – an update was received but more work is needed to clarify the organisational ambition.

Assure

(key assurances received and any highlights of note)

The Committee received assurance in relation to:

- Benefits realisation – articulating the benefits of digital – presentation received and consideration to be given as to how this could be disseminated to other Committees possibly as a Board Development topic.
- Internal audit – internal audit of Clinical Safety in Systems Changes received a reasonable rating and follow-up actions in progress.
- Board Assurance Framework – consideration given to the BAF for Digital and the new strategic objective.

Risks (any new risks / proposed changes to risk scores)
• The new top 3 organisational risk relating to multiple sources of clinical information was noted and it was recognised that the Digital Records Programme is part of the solution to addressing this risk. • The cross referral of the risk around Virtual wards was noted, and the Committee will be looking to improve assurances in relation to this.
Cross-referrals to Tier 1 Board Committees (by exception)
• To highlight the following to POD Committee: Low attendance at Information Governance/Information Risk Management training sessions was reported via the Digital Data and Technology Steering Group Triple A report, and there is a need for better communication and monitoring to ensure staff complete the necessary training.

Committee Escalation and Assurance Report

Name of Board Committee	Group Audit Committee
Date of Board Committee:	2 September 2025
Chair of Board Committee:	Mr R Hughes

Alert

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

- **Failure to Prevent Fraud Offence** – to alert Board to a new corporate offence of Failure to Prevent Fraud which came into effect from 1 September 2025. This will apply to the Group and means that the Trust / QEF could be criminally liable for fraud offences committed by employees / agents if they are intended to derive benefit for the organisation and there were not reasonable fraud prevention procedures in place. This is classified as an alert for the Board to ensure all Board Members are aware of this important corporate responsibility. The Committee will receive a briefing on this at the next meeting in December 2025 including on how assurance on compliance will be reported through the Audit Committee.

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)

- **Reference Costs – Mandated Return** – The Committee, as the delegated Committee, reviewed the costing plan and supporting information for assurance that the Trust had complied with the approved costing guidance and associated assurance requirements. The paper identified areas where the Trust was unable to comply fully with the healthcare costing standards. Plans are in place to develop a Trust Costing Strategy to enhance compliance and support improvements in scores for the next annual exercise.
- **Internal Audit Plan** – The Committee approved the revised Internal Audit Plan, subject to the allocation of 98 contingency days which will be allocated in September/October to specific audits. The paper identified areas where the Trust was unable to comply fully with the healthcare costing standards.
- **Clinical Audit** – a report on the processes and controls around the development and delivery of the clinical audit plan was received. This provided an overview of the new supporting structure in place, assurance over the reduction in overdue audits, assurance over the plans for increased resource and assurance that a new escalation process is in place.

- **Corporate Governance Manual** – The proposed changes to the Corporate Governance Manual were approved for onward ratification by Trust Board. It was noted that the compliance assurance map to support the Corporate Governance Manual would be developed in time for the next Audit Committee meeting.
- **Freedom to Speak Up Guardian** – The Committee acknowledged there is not an interim Freedom to Speak up Guardian in place at the current time but arrangements are in train to appoint an interim in the near future and the report had been deferred to the next meeting.
- **Effectiveness reviews for Internal Audit and Counter-fraud, External Audit and the Audit Committee** – positive responses received to the effectiveness surveys, but response rates were relatively low and this is something to address going forward.
- **Board Assurance Framework (BAF)** - the review of the process for the development and monitoring of the BAF was deferred until the next meeting. The Committee understood that the development of the BAF for this year was delayed until the new 5 year strategy and objectives were approved by Board. The Committee was assured that risks associated with this were mitigated by the continuation of the prior year BAF.

Assure

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

- **QEF Audit** – the Committee received reassurance that the QEF Audit is on track for the accounts to be signed off ahead of the deadline at the end of December 2025.
- **Internal Audit Progress Report** – compliance with internal audit recommendations is improving with only 6 overdue actions and all have revised dates. Seven audits have been completed and concluded since the last Audit Committee meeting – the reports will flow through to the relevant Board committees.
- **Executive Risk Management Group Update** – assurance received of dynamic use of the risk register.
- **Action log** – updates had been populated ahead of the meeting which is helpful and is reflected in the number of actions that were able to be closed.

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

Freedom to Speak Up Guardian – the absence of the Freedom to Speak Up Guardian at the current time was highlighted as a possible risk to be noted given the link to one of the top 3 organisational risks (Culture).

Cross-referrals to Tier 1 Board Committees
The following cross referral was agreed: • Schedule of losses and special payments – Action re costs for storing patient embryos – this action is a cross referral to the Finance and Performance Committee

Committee Escalation and Assurance Report

Name of Board Committee	Group Remuneration Committee
Dates of Board Committee:	15 July, 30 July and 2 September 2025
Chair of Board Committee:	Martin Hedley, Chair

Alert <i>(matters of significant concern requiring escalation to the Board for further action or to bring to the attention of the full Board)</i>	
There were no matters of concern to alert to the Board.	
Advise <i>(areas subject to ongoing monitoring where some assurance has been noted / further assurance sought or emerging developments that the Committee is seeking assurance over)</i>	
The Committee received a paper outlining a proposal relating to QE Facilities' future Board composition, following consideration at the QE Facilities' Remuneration Committee. The Group Remuneration Committee supported the recommendations and will make appropriate representations to the shareholder (Trust Board) in due course. This is noted as an advisory item, as the decision-making rests with the shareholder.	
Assure <i>(key assurances received and any highlights of note for the Board)</i>	
- The Committee approved the approach to the recruitment of the Acting Chief Executive and delegated authority to the voting members of the interview panel to make the appointment within agreed parameters (including remuneration and terms and conditions of the secondment). - The Committee received assurance over the completion of the performance appraisal process for the Chief Executive and Executive Directors on both the Trust and QE Facilities' Boards of Directors. Assurance was provided that the process followed was in line with the new appraisal process approved by the Committee in June 2025. This enabled appropriate consideration and decision-making regarding the NHS England Very Senior Manager 2025/26 pay award letter.	
Risks (any new risks / proposed changes to risk scores)	
No new risks had been identified during the meeting.	
Cross-referrals	
None	

Report Cover Sheet

Agenda Item: 20

Report Title:	Consolidated Finance Report – Part 1			
Name of Meeting:	Board of Directors			
Date of Meeting:	25 th September 2025			
Author:	Ms Jane Fay, Deputy Director of Finance			
Executive Sponsor:	Ms Kris Mackenzie, Group Director of Finance			
Report presented by:	Ms Kris Mackenzie, Group Director of Finance			
Purpose of Report <i>Briefly describe why this report is being presented at this meeting</i>	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
	The purpose of this paper is to provide assurance against financial corporate objectives and address financial risks			
Proposed level of assurance – to be completed by paper sponsor:	Fully assured ☐ <i>No gaps in assurance</i>	Partially assured ☒ <i>Some gaps identified</i>	Not assured ☐ <i>Significant assurance gaps</i>	Not applicable ☐
Paper previously considered by:	N/A			
Key issues: <i>Briefly outline what the top 3-5 key points are from the paper in bullet point format</i> <i>Consider key implications e.g.</i> • Finance • Patient outcomes / experience • Quality and safety • People and organisational development • Governance and legal • Equality, diversity, and inclusion	The Trust has an approved 2025-26 planned deficit of £8.621m before adjustments for donated asset depreciation, and £8.381m after. As of August 2025, the Trust has reported an actual deficit of £5.845m after adjustments for donated asset depreciation. This is a favourable variance of £0.027m from the year-to-date target for reasons detailed in the body of this report. The Trusts 2025-26 capital plan totals £20.076m, including £9.008 PDC supported. As of August 2025, the Trust has capital spend on schemes totalling £4.580m. Cash balances are £31.240m at 31st August 2025 and £22.897m above planned levels for the reasons detailed in the body of this report.			
Recommended actions for this meeting:	The recommendation to the Board of Directors is to receive the report and record partial assurance for the achievement of its 2025-26 planned financial targets.			

Trust Strategic Aims that the report relates to:	Aim 1 ☒	We will continuously improve the quality and safety of our services for our patients			
	Aim 2 ☐	We will be a great organisation with a highly engaged workforce			
	Aim 3 ☒	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:	Achieving financial sustainability				
Links to CQC KLOE	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)					
Has a Quality and Equality Impact Assessment (QEIA) been completed?	Yes ☐	No ☐	Not applicable ☒		

1 Introduction

- 1.1 This report intends to provide assurance against delivery of the approved 2025-26 revenue and capital plan.
- 1.2 Reporting for 2025-26 is against the Trusts approved financial plan, updated for in year contract variations and agreed service changes.

2 Key Financial Performance Indicators

- 2.1 Performance against key performance indicators for August 2025 is detailed in Table 1.

Finance KPIs	Month 05 - Aug-25				YTD			
	Budget £ '000	Actual £ '000	Variance £ '000	RAG	Budget £ '000	Actual £ '000	Variance £ '000	RAG
I&E (Surplus) / Deficit (adjusted perf.)	941	577	(364)	●	5,872	5,845	(27)	●
Operating Income	-35,950	-35,999	(48)	●	-179,748	-178,596	1,152	●
Pay Expenditure	23,931	23,583	(348)	●	122,871	120,812	(2,060)	●
Non Pay Expenditure	12,443	12,523	80	●	60,162	61,337	1,175	●
Non Operating Income	-56	-115	(59)	●	-278	-670	(393)	●
Non Operating Expenditure	600	617	17	●	3,001	3,124	122	●
Remove capital donations / grant I&E Impact	-90	-33	58	●	-170	-160	10	●
Balancing adj to NHSE Plan	64	0	(64)	●	33	-1	(34)	●
Agency Expenditure	95	112	17	●	311	478	167	●
CRP Delivery	2,405	2,543	138	●	11,516	11,512	(4)	●
Capital Expenditure	2,251	946	(1,305)	●	8,998	4,580	(4,418)	●
Cash position	-1,590	6,837	8,427	●	8,343	31,240	22,897	●
Liquidity (days)	17	14	(3.3)	●	17	14	(3.3)	●
Better Payment Practice Code (BPPC)								
NHS	95.0%	57.3%	-37.7%	●	95.0%	70.0%	-25.0%	●
Non NHS	95.0%	93.6%	-1.4%	●	95.0%	96.8%	1.8%	●
Aged Debt								
Receivables over 90 days NHS	10.0%	61.1%	51.1%	●	10.0%	61.1%	51.1%	●
Receivables over 90 days non NHS	10.0%	31.1%	21.1%	●	10.0%	31.1%	21.1%	●

Table 1: Finance KPIs

- 2.2 The Trust has reported a **£0.577m** deficit for the month of August; which is a favourable variance of **£0.364m** against plan.
- 2.3 Year-to-date the trust position is **£5.845m** deficit, a favourable variance from plan of **£0.027m**. This is mainly due to overspends on medical staffing within Medicine and Community Business Unit and the costs associated with recovering the PACS outage issues currently being offset by pay underspends elsewhere within the trust.
- 2.4 As at M5 the key risks to the delivery of the plan are summarised as medical pay overspends within Medicine and Community and slippage against the cost reduction target.
- 2.5 A Statement of Comprehensive Income is presented in Appendix A.

3. Cost Reduction Programme

3.1 Performance against the year to date target is currently on plan at £11.512m and is summarised in table 2.

Scheme Thense	Target as at M5 Aug 25 £000	Actual as at M5 Aug 25 £000	Variance as at M5 Aug 25 £000	Annual Achieved as at M5 Aug 25 £000	Annual Achieved		
					Recurring £000	Non Recurring £000	Total £000
Commercial	601	1,399	798	1,650	1,607	43	1,650
Corporate Restructure	326	368	43	904	831	72	904
Cost Reduction - Productivity	1,717	1,701	(16)	4,065	4,065	0	4,065
Cost Reduction - Workforce	540	917	377	1,536	1,434	102	1,536
Drugs	135	0	(135)	0	0	0	0
Income	833	667	(166)	596	596	0	596
Income - Productivity	333	422	89	357	357	0	357
Non Pay Spend Controls	940	1,079	139	1,930	984	945	1,930
Procurement	155	14	(141)	240	235	4	240
Service Change	42	104	63	287	287	0	287
Skill Mix Workforce	73	20	(53)	48	48	0	48
Technical Adjustment	2,500	2,653	153	6,286	0	6,286	6,286
Vacancy Control	2,010	1,608	(402)	1,608	0	1,608	1,608
Unidentified	1,305	563	(742)	0	0	0	0
Total	11,511	11,516	5	19,505	10,445	9,060	19,505

Table 2 Cost Reduction Performance

3.2 The Trust has achieved annually **£19.505m** of its £32.871m cost reduction target of which **£10.445m** (32%) achieved on a recurring basis.

3.3 Performance against the CRP Programme will be reported and monitored via the Cost Reduction Steering Group and in accordance with the CRP Governance Framework.

4 Underlying Trust Financial Position

4.1 The Trust objective is to improve its underlying deficit by the end of March 2026 to £26.4m as summarised in Table 15. As at August the Trust is reporting an improvement in its underlying deficit of £11.1m comprising of recurring CRP totalling £10.4m and elective recovery income of £1.5m offset by the 25-26 pay award pressure of £0.7m and IFRS16 funding which has been confirmed as non-recurring.

	Plan		Actual				
	25-26 £m	Recurring £m	Apr-25 £m	May-25 £m	Jun-25 £m	Jul-25 £m	Aug-25 £m
Opening Deficit	(61.2)	(61.2)	(61.2)	(61.2)	(61.2)	(61.2)	(61.2)
Recurring FFYE CRP Achieved	32.8	32.8	5.9	6.6	8.1	8.1	10.4
Deficit Support Funding	5.3						
ICB Support Funding	9.0						
Non-Recurring Savings	3.9						
ERF Ceiling	2.0	2.0	1.5	1.5	1.5	1.5	1.5
25-26 Pay Award						(0.7)	(0.7)
IFRS 16 Funding - ICB Confirmed NR Income							(0.1)
Total Exit Deficit	(8.2)	(26.4)	(53.8)	(53.1)	(51.6)	(52.3)	(50.1)
In month improvement			7.4	0.7	1.5	-0.7	2.2
Cumulative improvement							11.1

Table 3: Underlying Deficit

5. Capital

- 5.1 The 2025-26 capital plan was approved as part of the overall Trust plan at £20.076m.
- 5.2 As at August 2025 the Trust has reported capital spend totalling £4.580m mainly against the Colposcopy and Paediatrics schemes, £0.743m of IT hardware and £0.474m of Backlog Maintenance as summarised in Table 4.
- 5.3 The revised timeline for the CDC Phase 2 business case to be presented to Trust Board is September, resulting in a delay to the completion of the scheme and slippage against the PDC funding. The Trust has already written to NHSE to ask for support in managing and mitigating the misalignment between capital funding and spending profiles.
- 5.4 No other risks to the delivery of the capital programme are identified as at the end of August.

Capital Scheme	2025/2026 Annual Plan £000's	Spend to Aug 25 £000's
CDC Phase 2	5,468	28
Physiological Sciences	106	0
Day Care Service Improvements	50	0
UEC Creation of a Surgical Assessment Area	562	0
EPAC Expansion	700	0
Same Day Emergency Care (SDEC)	585	0
Sub-total Constitutional Standards	7,471	28
Sub-total Estates Safety - Backlog Maintenance	5,000	412
Sub-total Medical Equipment Replacement	941	0
Sub-total Digital	800	743
Colposcopy	2,319	1,450
Paediatrics	2,945	1,872
X-Ray Room 5	600	0
Sub-total Strategic Schemes	5,864	3,322
IFRS16	0	13
Charitable Funded Schemes	0	62
Total Capital Programme	20,076	4,580
Funded By:		
Depreciation	11,004	4,078
Cash	64	0
Public Dividend Capital	9,008	440
Charitable Funds	0	62
Total Funding	20,076	4,580

Table 4: 2025-26 Capital Plan

6. Cash Balances

- 6.1 Group cash as of 31st August 2025 totalled **£31.240m**, **£22.897m** more than planned. This favourable variance is due to improvements on working capital balances specifically an increase in trade / other payables of **£14.498m** and slippage against the capital programme . This is offset by an increase in receivables of **£0.570m**.
- 6.2 A position of cash and working balances is presented in Appendix B.

7. Conclusion

- 7.1 The Trust has reported an adjusted deficit of **£0.577m** for the period ending 31st August 2025 against a plan of £0.941m resulting in a favourable variance of **£0.364m**. Year-to-date the Trust reported an adjusted deficit of **£5.845m** against a plan of £5.872m resulting in a favourable variance of **£0.027m**.
- 7.2 The Trust has reported total capital spend of **£4.580m**, against a plan for the year to date of £8.998m.
- 7.3 The Trust has reported achievement of £11.516m cost reduction, which is on target for the year to date. On an annual basis, £19.505m (59%) has been achieved against the target of £32.8m, of which £10.445m (32%) has been achieved on a full year effect recurring basis.
- 7.4 The Trusts is reporting a forecast cost reduction achievement of £27.786m, and shortfall of £5.085m, this shortfall is a risk to the Trust achieving its 25-26 financial plan.
- 7.5 As this stage in the financial year, the Trust is forecasting achievement of both its revenue and capital plan, but has highlighted unmitigated risk of £5m aligned to the forecast shortfall against the 2025-26 cost reduction target.
- 7.6 Cash balances at the end of August total £31.240m, however current liabilities total over £71m which when realised, alongside catch up of the capital programme and repayment of PDC and loans will reduce cash balances throughout 2025-26.
- 7.7 The Trust underlying deficit has improved by £11.1m with a current underlying exit deficit totalling £50.1m.

Kris Mackenzie, Group Director of Finance
September 2025

Appendix A – Statement of Comprehensive Income (SOCl)

Statement of Comprehensive Income	Month 05 - Aug-25			YTD		
	Budget £ '000	Actual £ '000	Variance £ '000	Budget £ '000	Actual £ '000	Variance £ '000
Operating Income from Patient Care activities						
Income From NHS Care Contracts	-32,781	-32,799	(18)	-163,819	-162,787	1,032
Income From Local Authority Care Contracts	-30	-30	0	-150	-159	(9)
Private Patient Revenue	-66	-76	(11)	-329	-359	(30)
Injury Cost Recovery	-42	-22	19	-208	-152	56
Other non-NHS clinical revenue	-14	-8	7	-72	-60	12
Total Operating Income From Patient Care activities	-32,933	-32,935	(2)	-164,578	-163,517	1,062
Other Operating Income						
Education and Training Income	-1,024	-1,052	(28)	-5,151	-4,836	315
R&D Income	-92	-98	(6)	-461	-454	7
Funding outside of System Envelope	0	0	0	0	0	0
Other Income	-1,901	-1,914	(13)	-9,558	-9,790	(232)
Donations & Grants Received	0	0	0	0	0	0
Cost Improvement Programme - Income	0	0	0	0	0	0
Total Other Operating Income	-3,018	-3,064	(46)	-15,170	-15,080	91
Total Operating Income	-35,950	-35,999	(48)	-179,748	-178,596	1,152
Operating Expenses						
Employee Expenses - Substantive	23,160	22,562	(597)	118,819	115,690	(3,128)
Employee Expenses - Bank	556	788	232	3,145	4,051	906
Employee Expenses - Agency	95	112	17	311	478	167
Employee Expenses - Other	119	121	1	597	593	(5)
Cost Improvement Programme - Pay	0	0	0	0	0	0
Total Employee Expenses	23,931	23,583	(348)	122,871	120,812	(2,060)
Purchase of Healthcare - NHS bodies	706	804	98	3,830	4,233	402
Purchase of Healthcare - Non NHS bodies	269	184	(85)	743	858	116
Purchase of Social Care	0	0	0	0	0	0
NED's	15	16	0	76	79	3
Supplies & Services - Clinical	3,370	4,391	1,022	18,699	19,410	711
Supplies & Services - General	259	247	(11)	1,285	1,259	(26)
Drugs	2,071	1,995	(76)	10,381	10,629	248
Research & Development expenses	2	4	2	3	3	(1)
Education & Training expenses	282	101	(181)	1,033	615	(418)
Consultancy costs	35	12	(23)	229	92	(137)
Establishment expenses	334	382	47	1,777	2,035	257
Premises	1,473	1,446	(27)	7,617	7,848	231
Transport	146	153	8	852	662	(190)
Clinical Negligence	783	789	6	3,914	3,680	(234)
Operating Leases	221	141	(80)	1,180	778	(401)
Other Operating expenses	1,730	615	(1,114)	2,694	3,259	565
Cost Improvement Programme - Non Pay	0	0	0	0	0	0
Reserves	0	0	0	0	0	0
Operating Expenses included in EBITDA	11,695	11,283	(413)	54,314	55,439	1,125
Depreciation & Amortisation - Purchased / Constructed	1,269	715	(554)	4,933	4,795	(138)
Depreciation & Amortisation - Donated / Granted	90	33	(58)	170	160	(10)
Depreciation & Amortisation - Finance Leases	-93	606	699	1,264	1,506	242
Impairment & Revaluation	-518	-113	404	-518	-562	(45)
Operating Expenses excluded from EBITDA	748	1,240	492	5,849	5,898	50
Total Operating Expenses	36,374	36,106	(268)	183,034	182,149	(885)
(Profit)/Loss from Operations	423	107	(316)	3,285	3,552	267
Non-Operating Income						
Finance Income	-56	-115	(59)	-278	-670	(393)
Total Non-Operating Income	-56	-115	(59)	-278	-670	(393)
Non-Operating Expenses						
Finance Expense	70	87	17	351	479	128
Gains / (Losses) on Disposal of Assets	0	0	0	0	0	0
PDC dividend expense	426	426	0	2,129	2,130	1
Total Finance Costs (for non-financial activities)	496	513	17	2,480	2,609	129
Other Non-Operating Expenses						
Misc. Other Non-Operating expenses	0	0	0	0	0	0
Total Non-Operating Expenses	496	513	17	2,480	2,609	129
(Surplus) / Deficit Before Tax	864	505	(358)	5,488	5,491	3
Corporation Tax	104	104	(0)	521	514	(7)
(Surplus) / Deficit After Tax	968	610	(358)	6,009	6,006	(3)
Balancing Adjustment to NHSE Plan	64		(64)	33	-1	(34)
(Surplus) / Deficit After Tax from Continuing Operations	1,032	610	(422)	6,042	6,005	(37)
Remove capital donations / grants I&E impact	-90	-33	58	-170	-160	10
Adjusted Financial Performance (Surplus) / Deficit	941	577	(364)	5,872	5,845	(27)

Appendix B Statement of Financial Position

	2025/2026	2025/2026	
	August 2025 Plan	August 2025 Actual	Variance from Plan
	£000's	£000's	£000's
Assets			
Non-Current Assets			
Investments	80	80	0
Property, Plant and Equipment, Net	175,139	169,283	(5,856)
Right of Use Assets	11,775	12,332	557
Trade and Other Receivables, Net	2,272	2,237	(35)
Finance Lease - Intragroup			
Trade and Other Receivables - Intragroup Loan	0	0	0
Total Non Current Assets	189,266	183,932	(5,334)
Current Assets			
Inventories	5,110	4,117	(993)
Trade and Other Receivables - NHS	6,161	3,119	(3,042)
Trade and Other Receivables - Non NHS	15,067	5,543	(9,524)
Trade and Other Receivables - Intragroup			
Trade and Other Receivables - Other	0	0	0
Prepayments		8,473	8,473
Cash and Cash Equivalents	8,343	31,239	22,896
Other Financial Assets - PDC Dividend	0	0	0
Accrued Income - NHS		3,407	3,407
Accrued Income - Other		1,291	1,291
Finance Lease - Intragroup			
Trade and Other Receivables - Intragroup Loan			
Total Current Assets	34,681	57,190	22,509
Liabilities			
Current Liabilities			
Deferred Income	2,310	5,373	3,063
Provisions	2,276	2,857	581
Current Tax Payables		6,862	6,862
Trade and Other Payables - NHS		5,453	5,453
Trade and Other Payables -Intragroup			
Trade and Other Payables - Other	44,951	16,811	(28,140)
Lease Liabilities		1,690	1,690
Trade and Other Payables - Capital	250	2,579	2,329
Other Financial Liabilities - NHS Accruals		6,468	6,468
Other Financial Liabilities - Accruals		19,288	19,288
Other Financial Liabilities - Borrowings FTFF	2,583	999	(1,584)
Other Financial Liabilities - Other Borrowings		12	12
Other Financial Liabilities - PDC Dividend		2,238	2,238
Other Financial Liabilities - Intragroup Borrowings		0	0
Finance Lease - Intragroup		0	0
Total Current Liabilities	52,370	70,630	18,260
NET CURRENT ASSETS (LIABILITIES)	(17,689)	(13,440)	4,249
Non-Current Liabilities			
Deferred Income	1,983	0	(1,983)
Provisions	2,445	2,143	(302)
Trade and Other Payables - Other	0	0	0
Lease Liabilities		11,746	11,746
Other Financial Liabilities - Accruals	0	0	0
Other Financial Liabilities - Intragroup Borrowings	0	0	0
Other Financial Liabilities - Borrowings FTFF	20,964	10,014	(10,950)
Other Financial Liabilities - Other Borrowings		96	96
Finance Lease - Intragroup			
Total Non-Current Liabilities	25,392	24,000	(1,488)
TOTAL ASSETS EMPLOYED	146,185	146,492	403
Tax Payers' and Others' Equity			
PDC	167,478	168,316	838
Taxpayers Equity	0	0	0
Share Capital	0	0	0
Retained Earnings (Accumulated Losses)	(34,572)	(34,593)	(21)
Other Reserves	0	0	0
Revaluation Reserve	13,180	12,671	(509)
Misc Reserve	99	99	0
TOTAL TAXPAYERS EQUITY	146,185	146,492	307
TOTAL ASSETS EMPLOYED	146,185	146,492	307



Gateshead Health
NHS Foundation Trust

Report Cover Sheet

Agenda Item: 21

Report Title:	Strategic Objectives & Constitutional Standards			
Name of Meeting:	Board of Directors			
Date of Meeting:	Thursday 25 th September 2025			
Author:	Deborah Renwick: Associate Director of Planning & Performance			
Executive Sponsor:	Kris Mackenzie: Group Director of Finance & Digital			
Report presented by:	Kris Mackenzie: Group Director of Finance & Digital Joanne Halliwell: Chief Operating Officer			
Purpose of Report <i>Briefly describe why this report is being presented at this meeting</i>	Decision: ☐	Discussion: ☒	Assurance: ☐	Information: ☒
	This report presents progress, risk, and assurance in relation to our Strategic Objectives & Constitutional Standards for M3 2025/26			
Proposed level of assurance – to be completed by paper sponsor:	Fully assured ☐ <i>No gaps in assurance</i>	Partially assured ☐ <i>Some gaps identified</i>	Not assured ☐ <i>Significant assurance gaps</i>	Not applicable ☐
Paper previously considered by: <i>State where this paper (or a version of it) has been considered prior to this point if applicable</i>				
Key issues: <i>Briefly outline what the top 3-5 key points are from the paper in bullet point format</i> <i>Consider key implications e.g.</i> • 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 to report 100% compliance with Ockenden recommendations and Maternity Incentive Scheme. Quality Improvement Plan: August's performance is 84%, below planned levels of key delivery areas and actions on track. Areas requiring improvement or remain challenging are Trustwide appraisal rates, Staff retention, local induction checklist compliance, Implementation of falls PSIRP workstream plan and Reduction of harm from falls of 5%. PSIRP: The volume of falls and falls harm rates has slightly increased in August, bi-monthly meetings are now in place to improve engagement. In support of identification and prevention of Venous Thromboembolisms (VTE) 99.0% of all patients admitted in August were risk assessed (in accordance with NICE guidance criteria). Exceeding the national standard of 95%.			

• <i>Equality, diversity, and inclusion</i>	QA: The Trust reported zero cases of C. difficile in August. The Trust's annual threshold has been set at 36, YTD cases stand at 13. In-month rates per 100k bed days were 0. A ten point action plan is in place. QA: Performance against learning disability and autism training has increased to 80.86% in month but remains below target levels of 85%. Work regarding interactive training is currently paused, as we await further feedback from government regarding next steps. Mental Health Act Policy training has decreased slightly in month to 86%, below target levels of 90%. Delivery challenges remain evident in releasing ward staff and allocating time to train coupled with rotational issues and availability of Allied Health Professionals. Additional training dates continue to be released. The agreed strategic approach to EPR and the outline business case (OBC) has been approved and went to Board in May. A review of alternative solution from Northumbria is currently being conducted and updated options appraisal to be developed. 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: • In August, a total of 20 estate risks with a combined critical infrastructure risk score of 234. Representing one closed risk and four reduced risks. • There were two patient safety incidents reported linked to estate issues, both were related to issues with lifts. • Multi-disciplinary PLACE audits have taken place in four areas across the Trust in August. There were concerns raised with regards to ward 10 privacy and dignity and clutter on the ward. We will be a great organisation with a highly engaged workforce. • Vacancy rates in August reduced slightly to 6.3%. • The quarterly pulse survey result for July 25 was 5.63 with a 11.0% completion rate. The engagement score has decreased since it was last reported at 6.17 in April 25, with a 2% increase in completion rates from 9% completion rate for the group. • Turnover decreased slightly to 11.7% in August. Promotion as a voluntary leaving reason has shown an increasing trend since February indicating possible lack of opportunities / career advancement in the Trust.

- Sickness absence rates of 5.6% remain above target levels of 4.9%.
- Temporary staffing spend as a proportion of pay bill stands at 0.5% and is still 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.

- The ED 4-hr standard was maintained in August with performance at 82.3%, above the 78% standard.
- Reducing time in department is improving with 0.23% of our Type 1 patients spent more than 12 hours in ED. Staying within the national tolerance of <2% and slightly above the planned target of 0.2%.
- There were no reportable 12-hr delays for admission.
- The Trust remains a top performer in Ambulance Handover times with average hand-over time of 13 mins 29 seconds in August against the national standard of <15mins. One handover in August exceeded 30 mins, this was not more than 45minutes.

Improvement activities are well underway to support further recovery going into 2025/26 focusing on (i) Model of Care in ED & UTC, (ii) Same Day Emergency Care (iii) Virtual Ward.

- Average NEL length of stay in August remained at 7.7 days, 0.77 days higher than planned levels.
- 60.1% of patients were discharged on their discharge ready date.
- Discharge remains problematic, a daily average of 45 patients no longer meet the criteria to reside.
- In August there were 430 beds open, six beds more than planned.

The waiting list increased by 188 patients in month to 13,533.

- Current waiting list is 2,315 (20.6%) above planned trajectory.
- Key Waiting list pressures remain in all services.

August RTT performance is 67.4%.

There were 55 T&O 52+ week waiters at the end of the month.

The revised Elective Recovery Programme combines multiple approaches to ensure waiting times, and the volume of waiters are reduced, themes for recovery include demand management, targeted validation, and capacity realignment.

The Trust continues to benchmark well across NENC & all Trusts against key cancer measures, although the increase in volumes of referrals for urgent suspected cancer in Breast from Durham continues to affect performance.

The unvalidated 28 Day Faster Diagnosis performance in August was 77% slightly below the expected national position of 78% by the end of March 2026.

The unvalidated 62 day performance was 75.3% in July. Challenges in breast pathways are ongoing re: impact of PACS and increased referrals and mutual aid.

Diagnostics: Waiting List at the end of August is 6,244 representing a decrease of 502 waiters. DM01 performance is 71.06%, below planned levels of 93.8%. Challenges remain in the following modalities: NOUS with performance at 58.42% against a plan of 92.1% and Audiology with performance at 75.38% against a plan of 95.5%.

Evidence of reduction in cost base & an increase in patient care related income by the end of March 2026 to achieve the financial plan for 2025/26.

Plan: At the end of August, the Group had a planned deficit of £5.872m and reported an actual deficit of £5.845m demonstrating a favourable variance of £0.27m against plan. Risks remain around overspending against delegated budgets and identification and delivery of recurrent CRP targets on a recurring basis.

Cost Reduction Plan (CRP) delivered in month is at £11,512m, against a plan of £11.512m of which £4.841m delivered recurrently. Focus remains on identifying recurrent savings schemes to support future financial sustainability.

Cash throughout 2025-26 financial year is expected to remain within the £5m target set within the trust plan. However, the headroom between current cash balance and future run rate commitments, should CRP plans not be cash releasing in next seven months, is challenging.

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

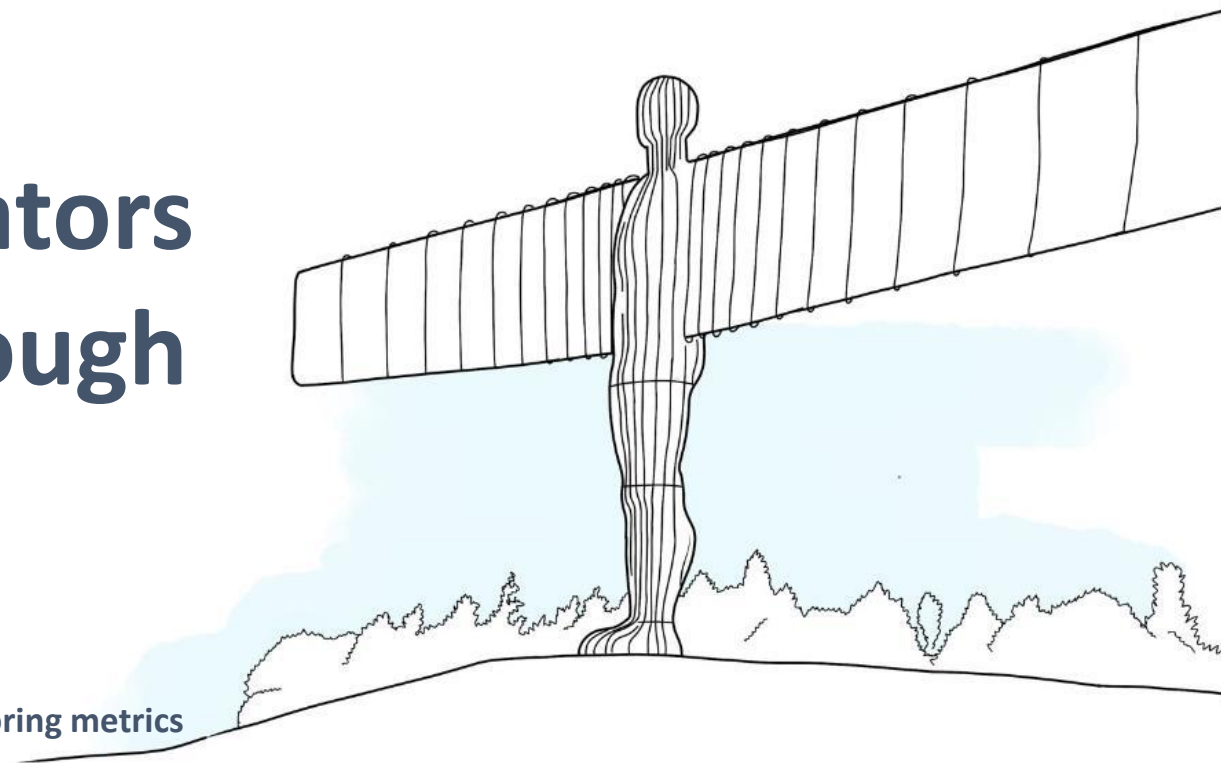
The Group continues to be an effective partner in the Great North Care Alliance: highlights include collaboration to maintain a system wide balanced financial plan. The appointment of a shared Digital Director to support standardised technical infrastructure, and

	collaboration across clinical services networks to improve patient access and clinical outcomes. Gynaecology outpatient median waiting times decreased to 32 weeks. Service plans to support recovery are in development to improve waiting times. Paediatric autism assessments and diagnosis waiting times have increased to a median wait of 69 weeks. We will develop & expand our services within and beyond Gateshead. Work is ongoing to increase external income as part of business efficiency plans. QEF generated income is up in August from the previous 12 months due to additional revenue from the NuTH Courier contract				
Recommended actions for this meeting: <i>Outline what the meeting is expected to do with this paper</i>	The recommendations to the Committee 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):					
	Areas requiring attention: Quality & Safety: - Quality Improvement Plans - Mental Health Act & Disability & Autism Training Workforce: Staff engagement, turnover rates, vacancy & sickness absence rates. Productivity & Efficiency risks: - PACS system outage continued impact on cancer and RTT pathways				

	• Increase in Urgent suspected of =cancer Breast referrals from Durham • Higher than planned waiting lists • Staffing gaps in key operational areas • Maintaining financial sustainability, reducing expenditure, and achieving CRP.		
Has a Quality and Equality Impact Assessment (QEIA) been completed?	Yes ☐	No ☐	Not applicable ☒

Strategic Objectives 2025/26

Leading Indicators and Breakthrough Objectives



Including Constitutional standards monitoring metrics

Reporting Period: August 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 2025/26

Executive Summary

Improved

No Change

Needs further attention

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

C.Difficile rate

Scoring in domains in areas of PLACE inspection not available

Ockenden recommendations

Maternity Incentive Schemes

Reduction in patient safety incidents linked to estate issues

Strategic approach to development of EPR

Mental Health Act Training for all registered staff

Severity of risk scores linked to estates

Quality Improvement Plans

Harm rate from falls

Compliance with Level 1 training plans for learning Disability & Autism

We will be a great organisation with a highly engaged workforce

Reduction in temporary staffing spend 0.5% of pay bill

Achievement of the internal turnover standard

Improve the staff engagement score

Internal sickness absence standard

Maintain the vacancy rate at <=2.5%

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

Achievement of 4-hr A&E target (Below planned trajectory and target)

Review and revise Green Plans

Average non-elective length of Stay < 4 Days

Reduce the number of patients with no Criteria to Reside

Reduce New & Follow up non value added activity to 67%

Achievement of the trajectory to achieve 60% RTA to Bed within 1 hour

Achievement of Zero 52 weeks.

Reduce >12 hour total time in Emergency Department

Risk in achievement of financial plans including CRP

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

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

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

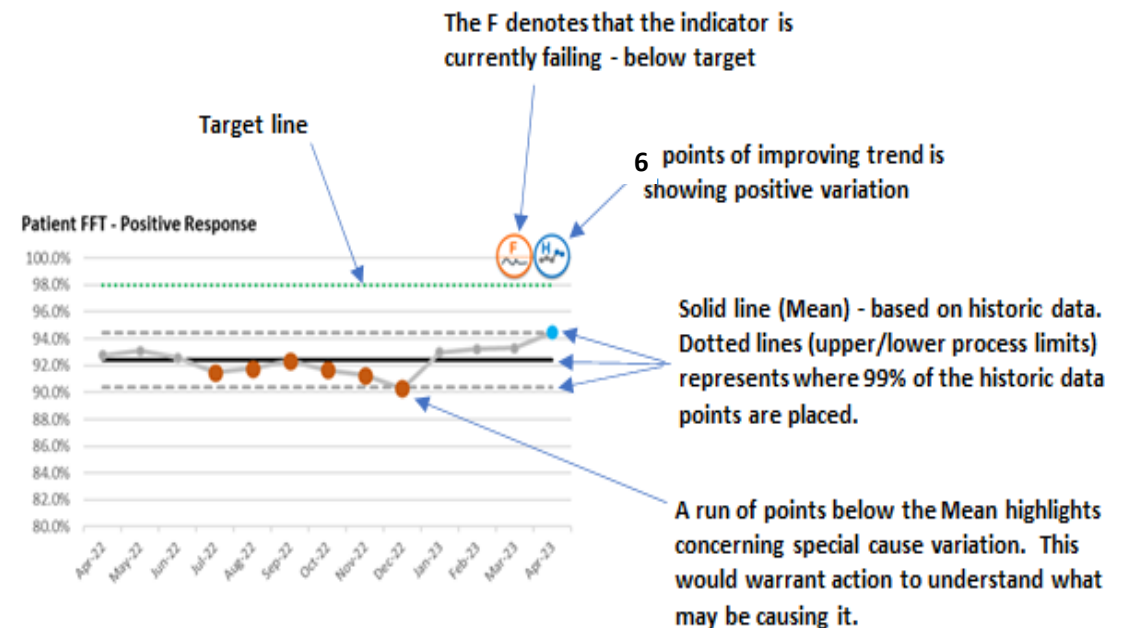
We will develop and expand our services within and beyond Gateshead

Increase in QEF externally generated turnover

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

What are Statistical Process Control (SPC) charts

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



SPC Rules

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

Strategic Objectives 2025/26

Leading Indicator and Breakthrough Objectives Assurance Heatmap

				
Improving		Ockenden Recommendations % compliance with Total Recommendations Achievement of the 4 hours trajectory Achievement of the % to reduce >12 hour total time in Emergency Department Achievement of the trajectory to reduce >12 hour total time in Emergency Department	Achievement of the 52 week RTT standard Maternity Incentive schemes % compliance with Total Recommendations Achievement of the internal sickness absence standard of 4.9% 85% compliance Level 1 learning disability and autism training Achievement of the trajectory to achieve RTA to Bed within 1 hour 90% of staff to complete Mental Health Act training	 
Neither improving or deteriorating	Venous thromboembolism (VTE) risk assessment Reduction in temporary staffing spend of pay bill evidenced month on month	Harm falls rate per 1000 bed days Average Length of Stay Non-Elective <4 days Reduction in the wait for gynaecology outpatients to no more than 26 weeks Increase % of Outpatient % with procedures C.Diff Healthcare associated rate per 100,000 occupied bed days Reduction in patient safety incidents related to estates issues	Achievement of the internal turnover standard of 9.7% Reduce the number of patients with no Criteria to Reside Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients by March 2025 Compliance with the quality improvement plan indicated by the % of actions on track Increase in the number of digital devices repurposed to the local community Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 by March 2025	
Deteriorating		Reduction in severity of risk score linked to estates	Maintain the vacancy rate at <=2.5%	 
	Consistency in PASSING the target	Inconsistency in HITTING, PASSING and FALLING SHORT of the target	Consistency in FAILING the target	

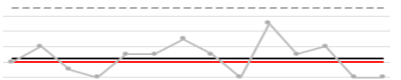
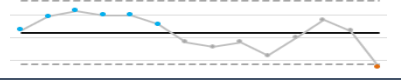
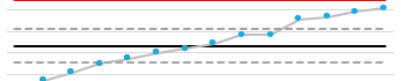
Strategic Objectives 2025/26**We will continuously improve the quality and safety of our services for our patients**

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

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

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

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

Metric	Target	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Ass/Var	Trend
LEADING INDICATORS																	
Ockenden Recommendations % compliance with Total Recommendations	100%	74.0%	89.0%	90.0%	95.2%	97.4%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Maternity Incentive Schemes % compliance with Total Recommendations	100%	77.5%	83.0%	89.0%	89.0%	89.0%	96.0%	96.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Reduction in patient safety incidents linked to estate issues	<=4	4	6	3	2	5	5	7	5	2	9	5	6	2	2		
Compliance with the quality improvement plan indicated by the % of actions on track	100%	84%	88%	84%	72%	68%	56%	68%	64%	68%	76%	80%	80%	76%	84%		
BREAKTHROUGH OBJECTIVES																	
Scoring in domains in areas of PLACE inspection composite score > 95%	> 95%																
Reduction in severity of risk score linked to estates	TBA	267	279	284	280	280	272	256	252	256	244	260	276	266	234		
Harm falls rate per 1000 bed days (5% reduction)	3.2	3.57	3.43	3.99	3.37	4.38	4.43	3.11	3.81	4.70	3.49	4.27	3.93	4.54	4.77		
C.Diff Healthcare associated rate per 100,000 occupied bed days	<=3.20	28.4	27.8	42.0	6.7	28.6	13.2	26.7	31.4	70.1	28.7	7.1	28.3	28.9	0.0		
90% of staff to complete Mental Health Act training.	90%	78.9%	77.6%	81.8%	84.2%	84.2%	84.2%	84.0%	83.0%	85.0%	86.0%	88.0%	86.0%	88.0%	86.0%		
Venous thromboembolism (VTE) risk assessment	95%	99.2%	98.8%	98.9%	99.0%	99.0%	98.9%	99.2%	99.2%	99.0%	99.0%	99.5%	98.9%	99.1%	99.0%		
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%	41.53%	46.93%	50.76%	54.95%	57.36%	59.97%	61.80%	64.21%	68.31%	68.31%	75.74%	76.83%	79.39%	80.86%		

Strategic Objectives 2025/26

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



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	Compliance 100%, Ongoing work to maintain full compliance including updates to website & personalised care plans in collaboration with our own Maternity & Neonatal Voices Partnership (MNVP) & the Local Maternity & Neonatal System (LMNS). Required audits embedded into ongoing audit plan. No further updates required by LMNS to evidence full compliance with this report.
	Maternity incentive schemes % compliance with total recommendations	The Trust is reporting compliance at 100%. Reported & confirmed by NHS Resolution that Gateshead Maternity Service satisfied the standards for full compliance with Year 6 of the MIS. Year 7 standards released in April 2025.
2	Compliance with the quality improvement plan indicated by the % of actions on track.	Latest reported data relates to August 2025 with 84% of the Improvement Plan actions delivered. August's performance shows progress is below planned levels. Action Plans are in place with the relevant action owners for actions that are reporting risk of non achievement. Non compliant areas: Trustwide appraisal rates, Staff retention, local induction checklist compliance, Implementation of falls PSIRP workstream plan and Reduction of harm from falls of 5% . Develop a Quality Oversight Report for Allied Health Professionals in line with Trust strategic aims and ambitions, the Trust AHP 3yr strategy, the national AHP strategy and the NHS long-term workforce plan. Due to organisation change process this work has not yet been enacted. Work to bring all AHP staff together is still ongoing and until this is complete we wont have access to the right data to develop this report. This Action will be reviewed as part of the 2025/26 QIP planning work. Future actions/developments: Complaints process - The number of overdue complaints continues to fluctuate between 15-20 at any one time. The Transformation team are undertaking a formal review of the new process (started July 2025). A further review has taken place by the Deputy Chief Nurse who is piloting a new triage approach reviewing complaints when received - at present this hasn't impacted on the number overdue but is supporting the current early resolution process. Complaints training facilitated by an external provider has been developed and the first session was delivered on 23rd July. Reduction in harm caused by falls. The trusts Falls prevention group now meets monthly, Work ongoing work to reduce falls across the organisation, as well as nationally and across the region. A national Enhanced Care program has now been established to support with how we engage with patients to reduce falls. Janet Thompson, Corporate Matron is now strategic lead for this work.
	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.	The Trust is currently 4.14% below the desired target of 85% but is increasing, work remains ongoing to target and escalate areas of low compliance, and monitoring via the Education and Training Group on compliance learning. Work regarding interactive training is currently paused, as we await further feedback from government regarding next steps.
	Improve Mental Health Act Policy Training Compliance to 90% for all registered staff via training and audit.	Mental health staff trained is currently at 86% which is a slight drop from 88% in July. There has been an increase in compliance from 90% to 91% in training for qualified staff. Compliance for HCAs & support workers has dropped from 87% to 80%. Cragside are 79% compliant with training. Sunnyside are 71% compliant. The CPN team, Younger Persons Memory Service, memory hub, mental health liaison team and OT team are currently all at 100% compliance with training. Training dates have been set for 2025, bespoke training is available on request. Additional training sessions were arranged for the Mental Health Liaison Team, and OT staff to support compliance. It is identified that training compliance for 13 staff will expire during 2025. Staff on Sunnyside and Cragside have been booked onto training sessions throughout this year. Due to staffing pressures on the wards, some staff have had training cancelled at short notice. 47 acute staff have been trained. Training session in July did not run as staff did not attend the session. There were no training sessions arranged for August due to annual leave within the MHA team.
	Improve our IPC C.Difficile infection rates per 100 000 occupied bed days.	Rates per 100 000 bed days have decreased to 0%, due to no cases being recorded in August, 13 cases YTD in 25/26 against a target of 36. A 10 point c-diff reduction plan is in place, with a drive to 'back to basics' for clinical areas particularly around hand hygiene, AMP and learning. A review into antimicrobial prescribing is ongoing. Community prevalence continues to be higher than normal levels, reflecting national and local elevated levels of C.Diff.
	Medicines	The Women's Health and Children's Services Pharmacist, work to review IV iron infusions, development of mandatory e-Learning for syringe drivers and the development of a Palliative Care presentation for preceptorship training were completed last financial year.
	Venous thromboembolism (VTE) risk assessment	Healthcare associated venous thromboembolism (VTE), commonly known as blood clots, is a significant international patient safety issue. The first step in preventing death and disability from VTE is to identify those at risk so that preventative treatments (prophylaxis) can be given. This data collection quantifies the numbers of hospital admissions (aged 16 and over at the time of admission) who are being risk assessed for VTE to identify those who should be given appropriate prophylaxis based on guidance from the National Institute for Health and Care Excellence (NICE). The Trust continuously performs well against the standard of 95% with August performance reported at 99%.
	Harm related falls will reduce by 5% by March 2025.	There has been an increase in falls this month, including falls with harm. The falls steering group continue to meet and progress the current action plan. There was a discussion around the way the data is collated, which may be out of line with national reporting. A paper with a suggested change is being produced by the group to highlight the proposed changes, and will assist in determining new targets for falls prevention.
3	Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.	Outline Business Case was presented to the Digital Committee 02/04/25 and the recommended option supported. The case was also presented to trust board in May 2025, who supported the principle but asked for further information regarding the financial implications of the proposed stages. A review of alternative solution from Northumbria is currently being conducted and updated options appraisal to be developed. Affordability and lack of available funding remains a barrier, indicative benefit profiles have been developed specifically regarding potential cash releasing and cost avoidance benefits. Recommended option has been developed 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 - additional resources have been included in the case to progress this activity. There is a risk associated with the current timescales for the existing PAS contract which expires in Dec 2027 - it has been noted that this current provision will need to be extended. Emerging alliance digital strategy and plans could impact on the programme delivery - the total programme has been broken down into stages to futureproof proposed investments and minimise the impact of any emerging plans; this is currently being worked through with the Chief Digital Officer for the GNHA. 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	August position, 20 Risks with combined critical infrastructure risk score of 234 (decreased from 266 in July). 1 risk closed (score of 16) (ref CSS , Roche system). 4 risks reduced (reduction of 16) (ref CSS, MLS, ventilation mortuary, bariatric storage, loss of ultra pure water system)
	Reduction in patient safety incidents linked to estate issues	2 patient safety incidents related to estates issues in August 2025. Both incidents related to issues with lifts. A lift failure in the Surgery Centre and lifts being out of order in the Jubilee wing Figures exclude incidents related to pressure damage and incidents reported as Harm not related to Gateshead on Inphase.
	Scoring in domains in areas of PLACE inspection composite score > 95%	PLACE lite implementation is still awaited to produce percentage scores. In August there were 4 visits, pre assessment, Wards 19 & 20, Ward 10 and Ward 22. After assessment on ward 10 it was noted that the PLACE team did not feel very confident, this was due to clutter, visual overview of damage to walls etc. Dignity was not assured as a consultant was treating a patient in full view and a doctor was also conducting treatment no curtains drawn at the time of this and everyone could see including patients.
	Reduction in value of backlog maintenance score as reported via the ERIC return	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 2025/26

We will be a great organisation with a highly engaged workforce



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

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

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

Metric	Target	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Ass/Var	Trend
LEADING INDICATORS																	
Maintain the vacancy rate at <=2.5%	<=2.5%	3.2%	3.1%	2.7%	3.4%	3.2%	3.5%	5.0%	5.2%	5.0%	3.2%	5.8%	5.9%	6.6%	6.3%		
Improve the staff engagement score to 7.3	>=7.3	6.63						6.20			6.17			5.63			

BREAKTHROUGH OBJECTIVES

Achievement of the internal turnover standard of 9.7%	<=9.7%	11.7%	11.7%	11.7%	11.2%	11.4%	11.5%	11.7%	11.3%	11.5%	11.8%	11.9%	11.9%	12.0%	11.7%		
Achievement of the internal sickness absence standard of 4.9%	4.90%	5.8%	5.7%	5.6%	5.6%	5.6%	5.7%	5.7%	5.7%	5.7%	5.7%	5.6%	5.6%	5.6%	5.6%		
Reduction in temporary staffing spend of pay bill evidenced month on month	<=2.3%	0.4%	0.5%	0.4%	0.6%	0.5%	0.4%	0.5%	0.5%	0.5%	0.4%	0.2%	0.5%	0.5%	0.5%		

Measures requiring focus this month

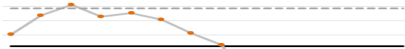
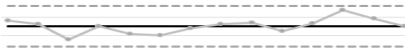
Measure	Summary
Maintain the vacancy rate at <=2.5%	Vacancy rate stands at 6.3% in August 2025, a 0.3% decrease compared to June 25. Budget WTE decreased between July and August 2025 whereas contracted WTE increased resulting in a lower vacancy rate.
Improve the staff engagement score to 7.3	The quarterly pulse survey result for July 25 was 5.63 with a 11.0% completion rate. The engagement score has decreased since it was last reported at 6.17 in April 25, with a 2% increase in completion rates from 9% completion rate for the group.
Achievement of the internal turnover standard of 9.7%	Turnover decreased to 11.7% in August 2025. Promotion as a voluntary leaving reason has shown an increasing trend since February indicating possible lack of opportunities / career advancement in the Trust. The retirement leaving reason has shown a mostly decreasing trend over the past few years although is still one of the top reasons recorded for staff leaving the Trust.
Achievement of the internal sickness absence standard of 4.9%	Sickness remained at 5.58% for a rolling 12 months in Aug 2025, a decreasing trend was observed month on month from April 2025 to July 2025. In-month long term sickness absence has shown largely decreasing trend since December 2024, in-month short term sickness had a similar trend until June and July when short term sickness increased from 1.1% in May to 1.4% in July. In-month short term sickness decreased by 0.2% in August however not enough to decrease the rolling 12m sickness absence rate.
Reduction in temporary staffing spend evidenced month on month reduction and no higher than 2.3 % of pay bill.	Agency spend remains under target at 0.5% and has been consistently over the last 12 months.

Strategic Objectives 2025/26

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

Metric	Target	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Ass/Var	Trend
LEADING INDICATORS																	
Average Length of Stay Non-Elective <4 days <i>Reset April 2025 to align with 2025/26 operational guidance definitions</i>	<=4	7.17	7.73	7.96	7.24	8.26	7.24	7.88	7.31	7.18	8.70	8.38	8.65	7.66	7.66		
Achievement of the 4 hours trajectory	>78%	71.0%	72.2%	71.4%	67.8%	73.0%	65.6%	71.2%	73.6%	74.5%	72.5%	79.0%	76.7%	82.2%	82.3%		
Achievement of the 52 week RTT standard	0	81	108	123	106	111	102	83	66	0	16	1	18	35	55		
Achievement of 2025/26 financial Plan - Variance (£k)	Figure in brackets favourable	(0.004)	(0.073)	(0.042)	0.026	(0.143)	(0.1)	(0.1)	(0.167)	(0.046)	0.272	0.224	0.261	0.337	-0.027		
Finance - Forecast Out-turn Deficit (Plan)	tbc	12,650	12,650	7,088	7,088	7,088	7,088	2,192	2,192	2,146	8,381	8,381	8,381	8,381	8,381		
BREAKTHROUGH OBJECTIVES																	
Achievement of the trajectory to reduce >12 hour total time in Emergency Department (Type 1) <i>Reset April 2025 to align with 2025/26 operational guidance definitions</i>	0	531	391	395	749	495	1036	466	208	71	52	31	47	16	13		
	0.2%	5.4%	4.4%	4.4%	7.6%	5.1%	10.5%	5.2%	2.5%	0.7%	0.9%	0.5%	0.8%	0.3%	0.23%		
Reduce the number of patients with no Criteria to Reside	<10	48	46	38	45	41	40	44	46	47	43	46	54	49	45		
Achievement of the trajectory to achieve RTA to Bed within 1 hour	60.0%	5.2%	5.6%	6.3%	3.7%	4.7%	4.2%	4.3%	5.7%	6.3%	6.4%	16.1%	10.8%	19.1%	16.9%		
Reduce % of Follow up Outpatient without procedures <i>Reset April 2025 to align with 2025/26 operational guidance definitions</i>	<=67%	70.8%	71.7%	71.3%	69.6%	67.2%	66.3%	66.9%	67.3%	67.6%	67.5%	66.2%	64.6%	66.3%	68.9%		
2024-25 CRP Delivery Variance	Figure in brackets favourable	0	(570)	680	1,157	2,539	2,994	2,082	73	0	517	523	19	0	0		
No less than £5m cash as per forecast at March 2026	>=£5m	£5m	£5m	£5m	£5m	£5m	£5m	£5m	£5m	£5m	£32m	£28m	£16m	£24m	£31m		

Strategic Objectives 2025/26**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 remained constant from July, working on previous discharge transformation work, Gill Findley is leading a piece of work to further improve this. The discharge liaison nurses continue to support educational work around discharge processes, including discharge workshops. The criteria led discharge pilot is awaiting evaluation. Further work is ongoing around supporting clinicians out of hours with discharge, as well as escalation processes for delayed discharges relating to social care.
	Achievement of the 4 hours trajectory	ED performance increased slightly to 82.3% and weekly four hour meetings continue to be held, alongside the future model of care work for UEC. We are involved in the GIRFT "Further Faster" program for UEC which is directing programmes of work to ensure improvement. There has been a consistent and progressive improvement in the achievement of the target which we are keen to embed over winter.
	Achievement of the trajectory to reduce >12 hour total time in Emergency Department	This reduced further in August, however there are ongoing challenges with mental health patients who require longer than 12 hours to get to the next right place for their care.
	Achievement of the trajectory to achieve 60% RTA to Bed within 1 hour	Performance of 16.1% represents a decrease, with further work required to understand availability of beds.
	Reduce the number of patients with no Criteria to Reside	August average patients was 45 - actions to improve this will be incorporated into the discharge program work, and the education from the DLN team to support discharge processes.
	Achievement of the 52 week RTT standard and delivery of the trajectory for 40 weeks	Achievement of the 52 week RTT standard and delivery of the trajectory for 40 weeks Unfortunately the number of patients waiting over 52 weeks increased in August. This continues to be driven by capacity challenges within the Lower Limb Trauma & Orthopaedic service. There are currently 2 consultants currently not operating (25% of the workforce). Actions in progress: Appointed a locum with a start date of Sept 25, insourcing option approved at GHLG, mutual aid from neighbouring Trusts (Northumbria taking 25 new referrals) and maximising all available capacity within the current team.
	Increase in New Outpatient activity	The target has been changed in 25/26 to reduce the % of follow up outpatient without procedure. We continue to scope alternative ways of working to reduce this and noted a deterioration in August. Reviewing at service level with plans to achieve standard.
2	Evidence achievement of the 24-25 financial plan	The Trust has a planned deficit at M5 of £5.872m and actual performance of £5.845m deficit which is a favourable variance of £0.27m. Risks remain around overspending against delegated budgets and identification and delivery of recurrent CRP targets on a recurring basis. The Trust planned CRP target at M5 is £11.512m and actual performance of £11.512m; of which £4.841m is delivered recurrently. Focus remains on identifying recurrent savings schemes to support future financial sustainability. Cash throughout 2025-26 financial year is expected to remain within the £5m target set within the trust plan. However, the headroom between current cash balance and future run rate commitments, should CRP plans not be cash releasing in next 7 months, is challenging.
3	Review & revise the 2022/25 green plan & align with the group structure by the end of Q2.	Plans to embed the Green plan governance structure and align with group governance. 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. Plans include a survey of understanding across the Board/EMT and Senior Leadership Group members.

Strategic Objectives 2025/26

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



Work at place with public health, place partners and other providers to ensure that reductions in health inequalities are evidenced with a focus on women's health

Work collaboratively as part of the Gateshead system to improve health and care outcomes to the Gateshead population

Work collaboratively with partners in the Great North Healthcare Alliance to evidence an improvement in quality and access domains leading to an improvement in healthcare outcomes demonstrating 'better together'

Metric	Target	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Ass/Var	Trend
BREAKTHROUGH OBJECTIVES																	
Increase in the number of digital devices repurposed to the local community	>300	58	0	0	10	0	0	0	0	0	0	30	64	0	0		
Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients	>=98%	90.5%	88.8%	91.6%	89.9%	90.0%	86.5%	88.4%	91.7%	92.8%	90.6%	88.8%	94.1%	95.4%	94.0%		
Reduction in the wait for gynaecology outpatients to no more than 26 weeks	<=26	35.1	6.4	31.4	37.7	40.3	38.3	37.0	32.6	28.9	28.9	31.1	31.7	33.0	32.0		
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30	<=30	87	83	79	78	61	61	65	70	74	61	52	65	42	69		

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 2025/26 to support planning for 2026/27.
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 2025/26.
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. In 24/25 318 devices reached end of life, the Trust will continue to recycle equipment as swiftly and efficiently as possible with 94 devices being recycled in Q1 2025/26.
Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients	Smoking status recording on admission decreased to 94.0% (1579/1680) from 95.5% (1686/1765) last month, 101 patients without a smoking status recorded. GHNFT has the highest performing smoking status recorded on admission in the NENC ICB region (Q1 2025), this has been consistent for >12 months. Ongoing actions to improve compliance are - Training of all staff on Nervecentre. Regular focused Tobacco dependency training on wards both ad hoc and planned. Communication Strategy. The Tobacco Dependency Treatment Service is providing an equitable service for all patients with 7 day a week coverage although sickness absence is a temporary challenge to this. A new team member is joining the QUIT team this month.
Reduction in the wait for gynaecology outpatients to no more than 26 weeks	The median wait has decreased slightly to 32 weeks in August due to consultant absence. Continue to focus on reducing waits through the elective care transformation group with key workstreams on increasing PIFU, A&G, Reducing DNA's and clinic template review to increase new patient capacity
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 weeks	Current median wait has increased to 69 weeks due to identifying patients eligible for the new pathway but our overall waiting list size continues to decrease significantly each month. Monitored weekly through Access & Performance meetings.

Metric	Target	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Ass/Var	Trend
LEADING INDICATORS																	
0.5% increase in QEF externally generated turnover from previous financial year	>=0.5%	0.8%	1.8%	2.2%	3.0%	4.0%	5.0%	6.0%	0.0%	0.0%	0.0%	7.5%	19.3%	24.0%	28.6%		

Measure	Summary
0.5% increase in QEF externally generated turnover	Work is ongoing within QEF to target increases in external income as part of Business Efficiency plans within the service, this is across VAT Consultancy, Courier services and Pharmacy in the first instance. August is up compared to prior year mainly due to the NUTH Courier Contract £0.9m additional revenue.

Constitutional Standards 2025/26



Reporting Period: August 2025

Constitutional standards 2025/26

Constitutional Standards metrics Assurance Heatmap

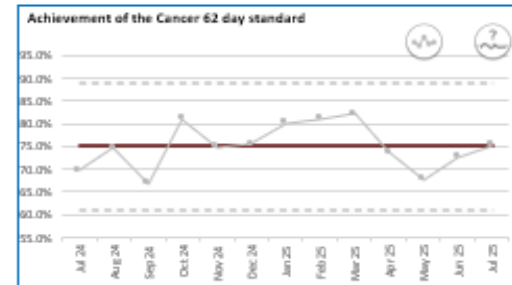
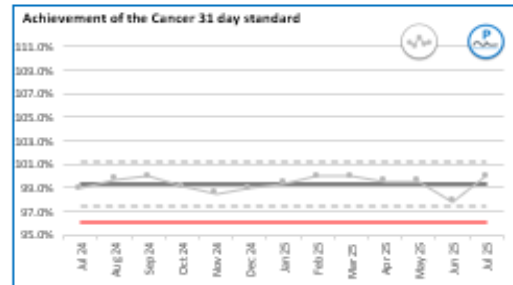
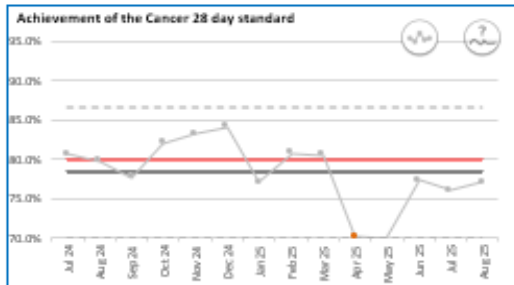
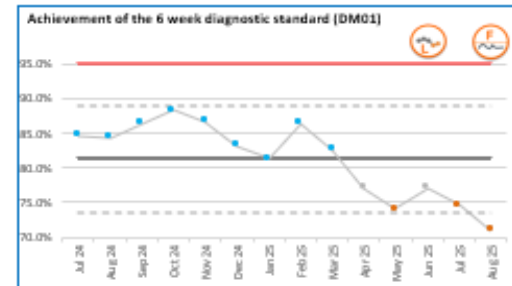
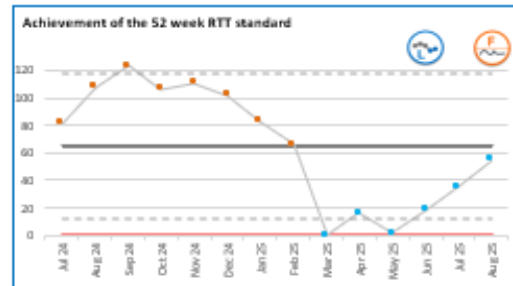
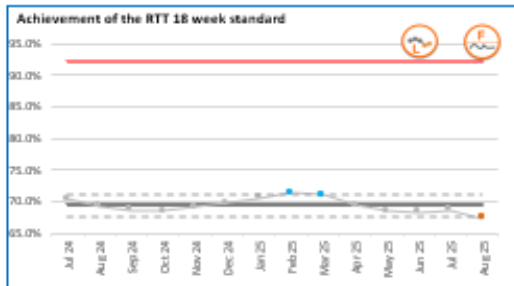
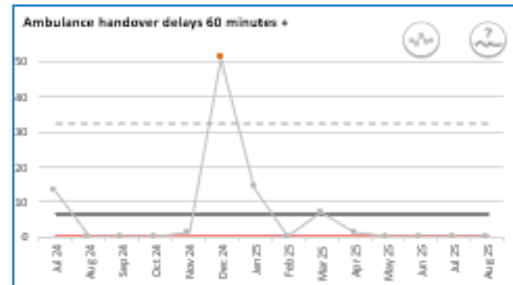
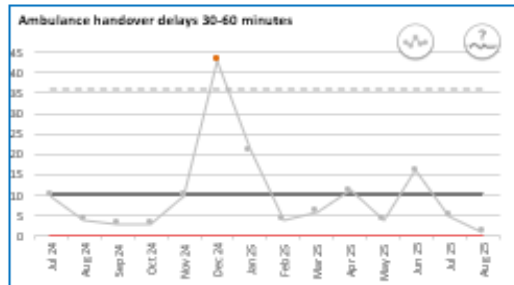
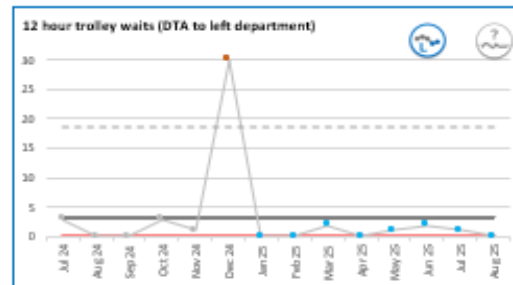
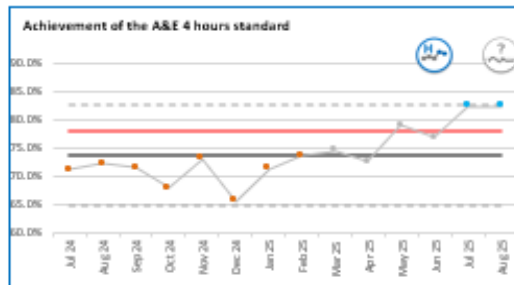
				
Improving		12 hour trolley waits (DTA to left department) % of ED attendances >12 hours in department Achievement of the A&E 4 hour standard	Achievement of the 52 week RTT standard	 
Neither improving or deteriorating	Achievement of the 31 day cancer standard	Ambulance handover delays 30 - 60 minutes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

Constitutional Standards		Metrics														 Gateshead Health NHS Foundation Trust	Ass/Var
Metric	Target	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25		
Achievement of the A&E 4 hour standard	>78%	71.0%	72.2%	71.4%	67.8%	73.0%	65.6%	71.2%	73.6%	74.5%	72.5%	79.0%	76.7%	82.2%	82.3%		
12 hour trolley waits (DTA to left department)	0	3	0	0	3	1	30	0	0	2	0	1	2	1	0		
% of ED attendances > 12 hours in department (Type 1) <i>Reset April 2025 to align with 2025/26 operational guidance definitions</i>	0.2%	5.4%	4.4%	4.4%	7.6%	5.1%	10.5%	5.2%	2.5%	0.7%	0.88%	0.52%	0.77%	0.25%	0.23%		
Ambulance handover delays 30-60 minutes	0	10	4	3	3	10	43	21	4	6	11	4	16	5	1		
Ambulance handover delays over 45 minutes	0										3	1	5	0	0		
Ambulance handover delays 60 minutes +	0	13	0	0	0	1	51	14	0	7	1	0	0	0	0		
Achievement of the RTT 18 week standard	>92%	70.3%	69.2%	68.6%	68.5%	69.2%	69.8%	70.6%	71.3%	71.0%	69.4%	68.5%	68.3%	68.6%	67.4%		
Achievement of the 52 week RTT standard	0	81	108	123	106	111	102	83	66	0	16	1	18	35	55		
Achievement of the 6 week diagnostic standard	>95%	84.7%	84.3%	86.4%	88.3%	86.8%	83.3%	81.4%	86.4%	82.6%	77.1%	74.0%	77.1%	74.6%	71.1%		
Achievement of the Cancer 28 day standard <i>Reset April 2025 to align with 2025/26 operational guidance standard</i>	>80%	80.5%	79.7%	77.7%	82.0%	83.2%	84.1%	77.0%	80.7%	80.5%	70.1%	69.9%	77.2%	76.0%	77.0%		
Achievement of the Cancer 31 day standard	>96%	98.9%	99.8%	100.0%	99.1%	98.5%	98.9%	99.4%	100.0%	100.0%	99.5%	99.5%	97.9%	100.0%			
Achievement of the Cancer 62 day standard <i>Reset April 2025 to align with 2025/26 operational guidance standard</i>	>75%	69.8%	74.7%	66.8%	81.0%	74.8%	75.6%	80.2%	81.0%	82.1%	73.7%	67.7%	72.7%	75.3%			

Validated data unavailable at time of report

Constitutional Standards

Metrics (SPC)



Report Cover Sheet

Agenda Item: 22

Report Title:	NHS EPRR Core Standards self-assessment 2025-26			
Name of Meeting:	Trust Board			
Date of Meeting:	25 September 2025			
Author:	David Patterson, Head of Emergency Preparedness, Resilience and Response			
Executive Sponsor:	Jo Halliwell, Group Chief Operating Officer and Accountable Emergency Officer			
Report presented by:	Carmen Howey, Group Medical Director			
Purpose of Report <i>Briefly describe why this report is being presented at this meeting</i>	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
	The purpose of this report is to provide an overview of the NHS EPRR Core Standards assurance process and timelines for 2025-26.			
Proposed level of assurance – to be completed by paper sponsor:	Fully assured ☒ <i>No gaps in assurance</i>	Partially assured ☐ <i>Some gaps identified</i>	Not assured ☐ <i>Significant assurance gaps</i>	Not applicable ☐
Paper previously considered by:	Accountable Emergency Officer and Group Chief Operating Officer (July 2025) Business Resilience Group (July 2025) Operations Oversight Group (August 2025) Quality Governance Committee (August 2025)			
Key issues: <i>Briefly outline what the top 3-5 key points are from the paper in bullet point format</i> <i>Consider key implications e.g.</i> • Finance • Patient outcomes / experience • Quality and safety • People and organisational development • Governance and legal • Equality, diversity and inclusion	• It is a requirement that NHS Providers submit an annual self-assessment statement of assurance against the EPRR core standards to their board. • The EPRR Annual Assurance Process and timeline for submission 2025-26 was received by the trust from NHS England on 18 July 2025 (attached as an appendix to this report). • There are no significant changes to the standards and no thematic deep dive to undertake • A robust internal governance process to check, challenge and seek external peer review of the trust submission has been implemented with executive oversight from the Accountable Emergency Officer prior to submission • The external submission date for the self-assessment is 31 October 2025. • The trust compliance rating for 2024 was substantial compliance - there were a number of identified			

	priority areas and a clear direction of travel for 2025 was developed that has had oversight from Business Resilience Group and the Operations Oversight Group. • Our strategic intention is to sustain a substantial compliance rating and strengthen the quality of evidence for the 2025 self-assessment submission. • As per the format of previous years, the final core standards submission and annual report will be presented at Trust Board in January 2026.				
Recommended actions for this meeting:	Trust Board are asked to note the assurance process for 2025-26 provided within this report and to receive the final core standards submission and annual report at Trust Board in January 2026.				
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 aim one: we will continuously improve the quality and safety of our services for our patients Strategic aim three: we will enhance our productivity and efficiency to make the best use of our resources Strategic aim four: we will be an effective partner and be ambitious in our commitment to improving health outcomes				
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:	Ref 4571 – a risk of failing to substantially comply with the NHS EPRR Core Standards due to external requirements and internal resource				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	Yes ☐	No ☐		Not applicable ☒	

To: • North East & Yorkshire ICB AEO's

NHS England

C7.41

cc. • North East & Yorkshire ICB EPRR
leads

Leeds Hub

• Caroline Wood Director of
Operations & Delivery

7-8 Wellington Place

LS1 4AW

2 July 2025

Dear Colleagues

2025-2026 EPRR Core Standards Assurance Process

Dear Colleagues,

As the NHS landscape continues to shift and develop, our commitment to ensuring a resilient and prepared system remains unchanged. While the system adapts and transforms, the need for robust Emergency Preparedness, Resilience and Response (EPRR) is more critical than ever. It is in this context that I write to confirm the arrangements for the 2025/26 EPRR Core Standards Assurance Process.

Following confirmation from the national NHS England Resilience team and our recent discussions at the Regional Health Resilience Partnership (RHRP), I am pleased to outline the regional expectations and timescales for this year's assurance process.

Assurance Timescales

The assurance timelines remain broadly consistent with previous years and are detailed in the accompanying EPRR Assurance Proposal, please see appendix below.

Assurance Expectations

Integrated Care Boards (ICBs) are responsible for determining and documenting their local assurance approach. This process must be clearly defined, formally agreed, and signed off at the Local Health Resilience Partnership (LHRP). Each ICB will be asked to present a summary of their agreed methodology at the September 2025 Regional Health Resilience Partnership (RHRP) meeting.

As part of the 2025/26 assurance process, the following expectations apply:

- Each ICB must have a clearly documented local assurance process, formally agreed and signed off at their LHRP.
- Evidence reviews must take place, with a specific focus on standards that have moved to “green” (fully compliant) since the 2023/24 submission.
- The format of evidence reviews may vary to suit local system needs. This could include the use of evidence portals, face-to-face “show and tell” sessions, or dip sampling. However, the method chosen must be clearly documented and aligned with the agreed local process.
- Peer review should be included where providers have found it to be a valuable tool for reflection and improvement.
- ICBs should facilitate supportive assurance meetings to guide providers through the process, ensuring clarity, consistency, and a shared understanding of expectations.

NHS England will seek assurance that these local processes are robust, transparent, and enable meaningful evaluation of progress—particularly for standards previously assessed as non-compliant or partially compliant that are now reported as fully compliant.

Regional Support and Moderation

To support this process, the regional EPRR team will continue to offer guidance and facilitation as requested. We will also arrange assurance meetings with each ICB during Q3, focusing on:

- **Provider-Level Assurance:** Moderation discussions to review provider self-assessments and the assurance received by ICBs ahead of regional confirm & challenge sessions.
- **ICB-Level Assurance:** Moderation discussions to review ICB self-assessments and confirm resolution of feedback from the 2024/25 evidence review period.

Assurance Guidance

Importantly, NHS England has confirmed that there will be **no national thematic deep dive** as part of the 2025/26 assurance process. This provides systems with greater flexibility to focus on local priorities and consolidate progress against the core standards. However, the absence of a deep dive should not reduce the rigour of local assurance processes. We

encourage ICBs and providers to continue using the updated guidance to support meaningful self-assessment and ensure that confirm & challenge sessions are underpinned by a consistent and evidence-based methodology.

We recognise the significant effort that the assurance process demands of EPRR professionals across the region. Our shared focus on continuous improvement and system-wide resilience does not end with the assurance cycle—it is an ongoing commitment. On behalf of the regional team, I want to thank you and your teams for your dedication and hard work throughout the year. Your continued engagement and support are vital to the success of our regional assurance efforts.

Please do not hesitate to reach out if you require any further support or clarification.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'P. Dickens', with a long horizontal flourish extending to the right.

Paul Dickens
Deputy Director of EPRR & System Resilience
NHS England (North East & Yorkshire region)

Appendix 1 – EPRR Assurance Timeline for Submission



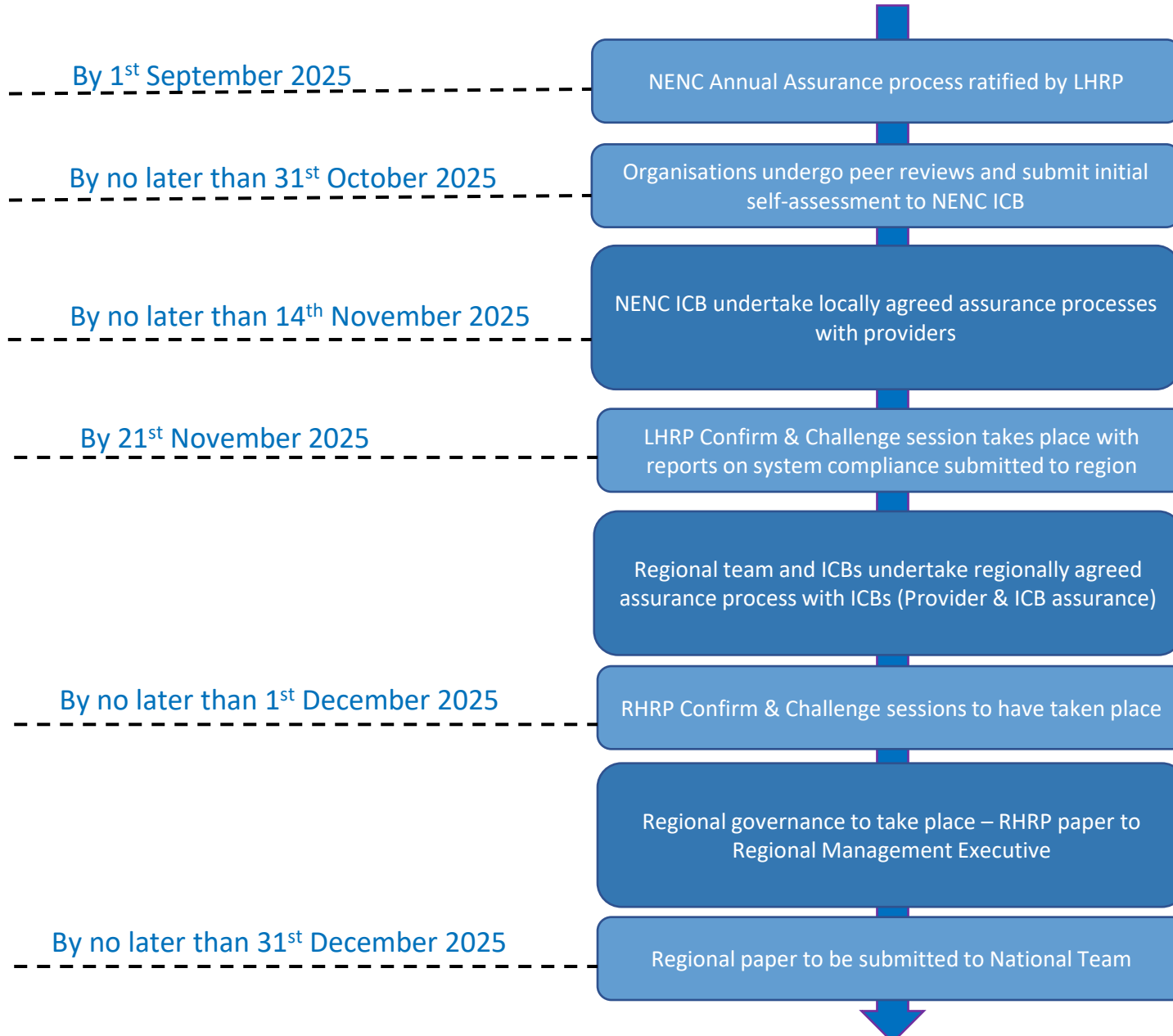


**North East and
North Cumbria**

EPRR Annual Assurance Process 2025

Overview

Based on proposed NHSE timeframes



2. Annual EPRR Assurance Process

- NHSE regional team has informed us that there will be no significant changes to the core standards assurance process nationally in 2025.
- NENC ICB have set out a timeline and a paper will be presented to, and ratified, by the NENC ICB Executive Committee and Board.
- The process set out in these slides will be proposed to, and ratified, by the NENC LHRP on 1st September 2025
- As usual, organisations will need to complete the national core standards template and rate themselves as red, amber or green against each of the standards that are applicable to their category of organisation

2a. Peer Reviews

- Peer review meetings to take place between provider organisations

(1 – 31st October 2025)

Peer Review Groups	
NUTH	STHFT
GHFT	NTHFT
NHCT	NCIC
CDDFT	STSFT
TEWV	CNTW
NEAS	YAS

2b/c. Self-Assessment

(1 – 31st October 2025)

In NEY all ICBs have agreed, there will not be an evidential review of all core standards as took place in 2024

- Instead, the focus will be on core standards where an organisation has assessed that their compliance has increased from red (non-compliant) or amber (partially compliant) to green (compliant).
- Organisations to share details of the standards where they have increased their compliance from amber/red to green.
- Provide examples of the documents and the rationale that supports the increase in rating
 - N:B. NHSE NEY regional team will undertake an in-depth review on a sample of organisational submissions where ratings have changed from amber or red to green to confirm whether there is agreement in the organisational and NHSE assessment
- Organisations submit their core standards ratings to NENC ICB
(end of October 2025)

2d. Trust & ICB 1:1

- Provider AEOs and EPRR teams meet with NENC ICB to discuss their core standards submission. This is the opportunity for the ICB to request further information to provide confidence in the organisational self-assessment.
- The review process is to support Trusts to demonstrate that they are making progress on the journey to full compliance.
(Between 3 Nov and 14 November)

2e. Check & Challenge / LHRP

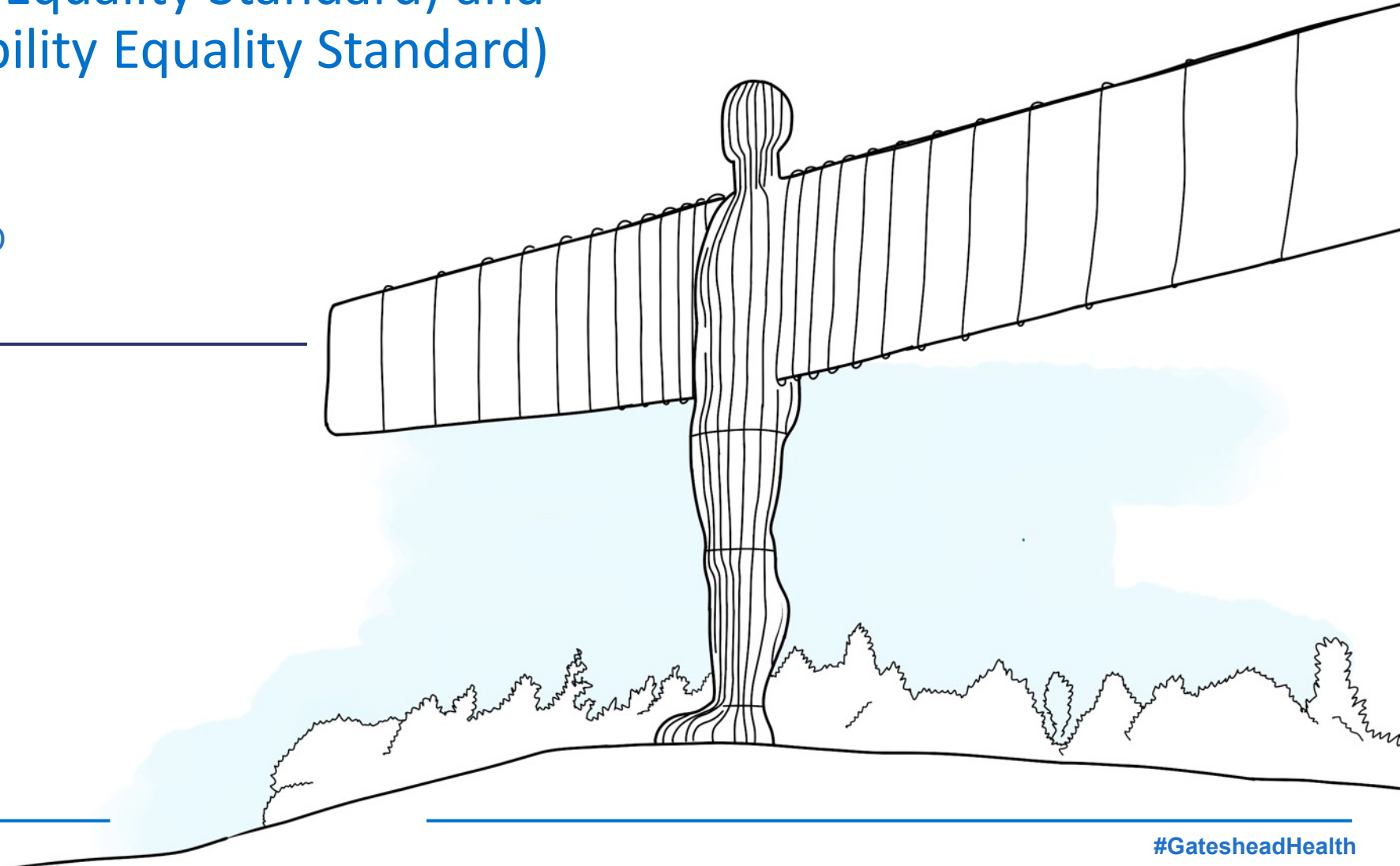
- Organisations present their core standards ratings at the NENC LHRP **November 2025 (TBC date to be brought forward to be inline with NHSE timeline)**

RHRP

- NHS NENC ICB presents the core standards ratings for NENC to the NEY Regional Health Resilience Partnership (RHRP)
1st December 2025

WRES (Workforce Race Equality Standard) and WDES (Workforce Disability Equality Standard) Reports 2024 - 2025

Amanda Venner
Executive Director of People and OD
September 2025



Introduction and context

- Slides for each report included in the papers
- Process - Data submission in May 2025 and Full report with actions published to October 2025
- Engagement
 - EDI group
 - Engagement with the networks
 - PSG
- Timeline - challenge with PODC moving to 30th September 2025
- Next steps - agree today, share with POD Committee on 30th Sept, then publish

Context

- Current civil unrest and protests both regionally, nationally and internationally – we have no control over this outside the workplace
- We have dismissed a number of staff this year for poor behaviours linked to marginalised groups and have seen an increase in ER cases related to unacceptable behaviours being tackled
- Have addressed these issues at numerous team briefs, but acknowledge there is always more we can do
- This cultural change, and will take many years

Context and Executive summary

There are huge amounts of data in these reports and also many gaps and areas not reported on. The intersectionality between our marginalised groups of colleagues is also an area where we know there will be real inherent disparity in experiences. However the data is the data we have is clear and to summarise what colleagues are telling us, there are 3 **main areas of decline**:

1. **Bullying and harassment** continues against our disabled and BME colleagues, from patients, from managers and from colleagues
2. Disabled and BME colleagues are more likely to enter into **formal disciplinary or capability process** than their white, non-disabled comparators
3. 1 in 5 Disabled colleagues have felt **pressure to come to work** despite not feeling well enough to do their job



Format and detail included in the reports

9 WRES indicators

- Four of the indicators focus on **workforce data**
- Four are based on data from the **national NHS Staff Survey** questions
- One indicator focuses on **BME representation on boards**.

10 WDES indicators

- Four of the indicators focus on **workforce data**
- Four are based on data from the **national NHS Staff Survey** questions
- One indicator is around the **Staff Engagement** score
- One indicator focuses on **BME representation on boards**.

Summary of the WRES findings

Red indicates – Declining Score **Green** indicates Improving Score **Amber** indicates no movement

Workforce Data

1. **Percentage of BME Staff** has increased by **0.31** from last year, however there are **no VSM**
2. Relative likelihood of **white applicants being appointed from shortlisting** across all posts compared to BME applicants has **decreased** to 0.59 meaning that white applicants are only 59% as likely as BME applicants to be appointed from shortlisting - The closer the figure towards 1 shows equity
3. Relative likelihood of **BME staff entering the formal disciplinary** process compared to white staff also shows an **increase** to 1.1 although with a small sample size this isn't significant
4. Relative likelihood of **white staff accessing non-mandatory training** and CPD compared to BME staff shows an **increase** to 1.03 (equates to white staff are 3% more likely to access training)

Staff Survey indicators specifically, around **harassment, bullying or abuse** for both White and BME members of staff. The 2024 show that:

5. From patients/ relatives or Public - for BME staff there has been an **increase** of 0.9% , for White staff a decrease of 1.9% **xxxxxx swing**
6. From staff - for BME staff **decreased** of 3% , for White staff increased of 0.8%
7. From Managers/ colleagues - for BME staff **increased** of 2.5% , for White staff increased of 0.1% **xxxxxxxxxx**
8. The percentage of staff believing the Trust provides **Equality around career progression / promotion** both groups remain static

WRES - Key Achievements and forward actions (Priority Actions)

- Refreshed Recruitment and Selection training delivered – Further courses for members of staff being offered from September 2025 onwards
- Detailed EDI metrics dashboard produced and updated on a quarterly basis - discussed at the HREDI group meetings and POD Committee
- FTSU Guardian continues reporting experiences of BME staff pertaining to disciplinarys (formal and informal)
- Zero Tolerance training delivered to over 300 Staff. Civility Saves Lives and Inclusivity training session delivered. Further training dates to be offered from September onward
- Diversity metrics around staff attending training / accessing CPD / Study leave all captured – any differentials across staff groups by ethnicity assessed, appropriate support offered
- Cultural ambassadors involved in any relevant Grievances and Harassment cases.
- Gender and Ethnicity Pay Gap reports produced – actions dovetailed within the overarching EDI action plan.
- South Asian Heritage Month – stories of IEN's working in the Trust published and shared with staff.

Work to be undertaken in respect of the staff survey indicators around harassment

- Analyse the pattern of bullying, identifying areas where aspects of this metric are more prevalent so that appropriate interventions can be made.
- **Ensure message around Incivility and Z tolerance are consistently updated, applied and are visible in all areas of the Trust, including contact details for reporting.**
- Create a space for safe conversations around inequality and diversity for both Staff and Managers so that appropriate interventions can be made to reduce the number of cases of harassment in the next Staff Survey as well as improved response rates.
- Work with our L and D team and other colleagues to ensure that the 'golden thread of Equality' is threaded throughout all training delivery
- **Encourage staff to attend the Inclusivity and Zero Tolerance training**
- **Continue to robustly manage those whose behavior is unacceptable, and communicate outcomes where appropriate**
- Assess the viability of delivering bespoke EDI training across wards and specialisms
- Ensure that cultural festivals are celebrated across the Trust to reflect inclusion.

Summary of the WDES Findings

Red indicates – Declining Score **Green** indicates Improving Score **Amber** indicates no movement

Workforce Data

1. There was a **rise of 0.1%** in staff indicating a disability, rising from 5.2% in 2024 to 5.3% in 2025 However, for 311 members of staff disability is unknown
 - Highest number of non-clinical staff indicating a disability are in Band 2 to Band 4, those declaring no disability are in Band 2 through to Band
 - Highest number of disabled clinical staff are in Bands 5 and 6
2. Relative likelihood of non-disabled applicants being appointed in comparison with their disabled candidates was **virtually equal** at 0.95
3. Relative likelihood of disabled staff entering the formal capability process compared to non disabled staff shows an **increase** to 3.24 (4 members of staff) going through the process although with a small sample size this isn't significant

Staff Survey indicators specifically, around harassment, bullying or abuse for disabled and Non – Disabled members of staff show that:

- From patients/ relatives or public. A higher proportion of Disabled staff experienced harassment, bullying or abuse (**increased** to 25%) than Non-disabled staff (19.5%) The difference between both groups in 2024 stood at 5.5% (Disabled staff have experienced more harassment, bullying or abuse than Non-disabled staff)
Harassment, bullying or abuse from Managers. **Increased** from 12.2% to 13.1%
- Harassment, bullying or abuse from colleagues - was significantly higher for Disabled staff, **increasing** from 20.9% to 24.6%, than for non-disabled staff 14%
The percentage of staff who indicated that they or a colleague reported an incident of harassment, bullying or abuse experienced at work **decreased** by 1% for Disabled staff to 49.4%, and **decreased** by 3.1% for non-disabled staff to 50.7%
- 80.7% of staff with disabilities indicated that the Trust had made adequate adjustments for them to carry out their work, a decrease of 2.1%. This figure suggests that for nearly a 1/5 of disabled staff the Trust may not have made appropriate adjustment.
- *Both disabled and Non -Disabled groups reflected a lower level of confidence in the Trust providing equal opportunities for their career progression or promotion (Disabled staff 19.5% fewer and for Non –Disabled staff 32.1%)*
- The percentage of staff who felt pressure from their manager to come to work despite not feeling well enough to perform their duties shows an **increase** for staff who have a Disability up by 3.9%. (from 21.4% to 25.3%) **1 in 4**

WDES - Key Achievements and forward actions (Priority Actions)

- Detailed EDI metrics dashboard produced and updated on a quarterly basis and discussed at the HREDI group meetings
- Learning disability passport agreed and in use with disabled patients
- Level 2 Disability Confident accreditation.
- Neurodiversity Pledge signed. 2 training sessions around this programme delivered.
- Engagement with Local college and Project Search re employment for individuals with disabilities.
- Promotion of ESR self service to encourage staff to update details
- Promoting Disability rights and Neurodiversity month and general EDI initiatives with the D-ability network.
- Unconscious bias added in the refreshed Recruitment and Selection training to be rolled out from September.

Work to be undertaken in respect of the staff surveys indicators around harassment

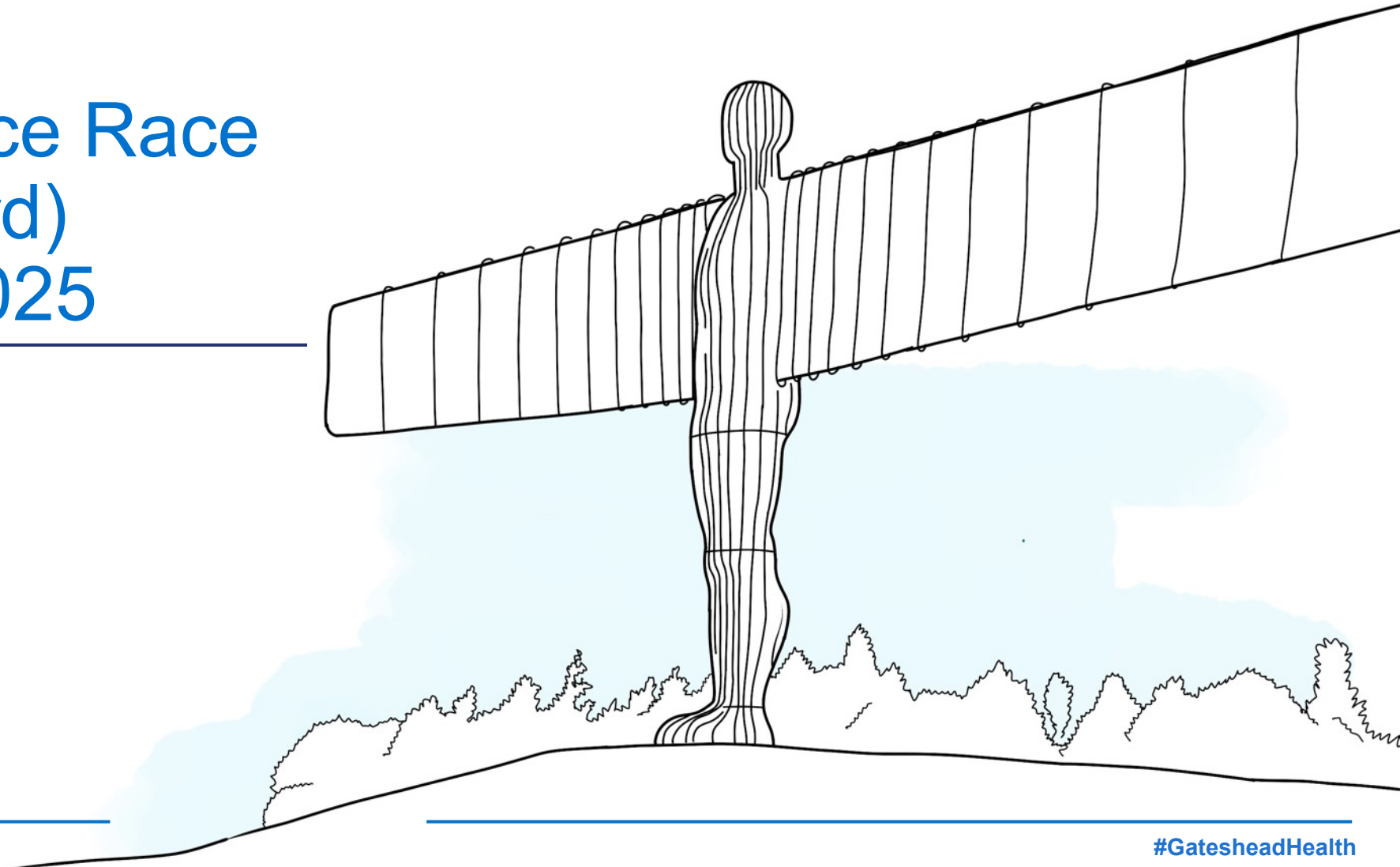
- Analyse the pattern of bullying, identifying areas where aspects of this metric are more prevalent so that appropriate interventions can be made.
- **Ensure message around Incivility and Zero tolerance are consistently updated and applied and are visible in all areas of the Trust, including contact points for reporting.**
- Undertake a Disability pay gap report
- **Encourage staff to attend the Inclusivity and Zero Tolerance training**
- Create a space for safe conversations around inequality and diversity for both Staff and Managers so that appropriate interventions can be made to reduce the number of cases of harassment in the next Staff Survey as well as improved response rates.
- **Continue to robustly manage those whose behavior is unacceptable, and communicate outcomes where appropriate**
- Work with our L and D team and other colleagues to ensure that the 'golden thread of Equality' is threaded through all training delivery.
- Assess the viability of bespoke EDI training pertinent to Neurodiversity and Disability as a whole

Summary



- Incorporate the use of SPC charts to look at broader trends and not just month on month and look ahead
- Prioritise actions for maximum effect
- Plan longer term actions and outcomes – 3-5 years
- Be 'stronger' in our comms and use the statistics in these reports to demonstrate the size and scale of the issues
- Acknowledge its cultural change and will take many years
- Future Bard development session

WRES (Workforce Race Equality Standard) Report 2024 - 2025



Contents

Introduction	Introduction - Equality Diversity Inclusion and Engagement Manager
WRES Indicator 1	Headcount Clinical and Non Clinical
WRES Indicator 2	Recruitment (Appointments from Shortlisting)
WRES Indicator 3	Disciplinary
WRES Indicator 4	Non-Mandatory Training
WRES Indicator 5	Percentage of staff experiencing harassment, bullying or abuse from patient’s relatives or public in the last 12 months
WRES Indicator 6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months
WRES Indicator 7	Percentage of staff experiencing discrimination at work from a manager / team leader or other colleagues
WRES Indicator 8	Percentage of staff believing that the trust provides equal opportunities for career progression or promotion
WRES Indicator 9	Percentage difference between the organisations’ Board membership and its overall workforce disaggregated, by voting membership of the Board and executive membership of the Board

Introduction

Gateshead NHS Trust is continuously working to improve everyday experiences for patients and staff who are BME as well as those who are disabled. From a variety of national information and data collected, it is clear that the lived experiences of colleagues from a Black, Asian and Minority Ethnic background, have poorer experience of working within the NHS.

Gateshead Health is committed to improving those lived experiences and strive towards creating a culture where race and ethnicity are not barriers to progression, individuals feel safe in the workplace and difference is embraced. As a Trust we want to focus on working in partnership with our patients, service users and workforce, to change our workforce systems, our mentality of one size fits all, and embrace the individuals lived experiences to ensure equity in its own right.

Gateshead Trust wrote its Equality strategy which is in the process of being reviewed and will be updated later this year. The Strategy will also incorporate the High Impact Actions that all Trusts are mandated to follow. The importance of race equality is embedded into the NHS People Plan 2020 where it states ‘The NHS must welcome all, with a culture of belonging and trust. We must understand, encourage and celebrate diversity in all its forms’. The People Promise declares ‘a commitment to creating and maintaining a compassionate and inclusive culture where diversity is valued and celebrated as a critical component, and not just a desirable one. The Trust must also meet its legal obligations under the Equality Act 2010 and The Human Rights Act 1998.

Each year the Trust is required to publish Workforce Race Equality Standard (WRES) and the Workplace Disability Equality Standard (WDES). These standards provides a framework for NHS organisations to report, demonstrate and monitor progress against specific indicators to ensure equity for all. The indicators are a combination of workforce data and results from the NHS national staff survey and help to ensure that employees receive fair treatment in the workplace and have equal access to career opportunities.

We recognise there is ongoing need and continuous focus on ensuring that aspects pertaining to bullying, harassment, and discriminatory behaviours are checked, challenged and appropriate actions are undertaken. Utilising the data from WRES/ WDES / Staff surveys will help in leveraging, enhancing and prioritising the individual , as well as the intersectional Equity agenda. Mainstreaming the Equity agenda is supported and endorsed by the Board and through various accountability mechanisms. We want to ensure that all of us working at Gateshead are part of the Gateshead family and believe in our EDI commitment: Diversity enriches, Inclusion empowers, United we are Gateshead Health

Kuldip Sohanpal
Equality Diversity Inclusion and Engagement Manager
Gateshead Health Foundation Trust
September 2025

WRES indicators

- There are nine WRES indicators.
- Four of the indicators focus on **workforce data**
 - Four are based on data from the **national NHS Staff Survey** questions and
 - One indicator focuses upon **BME representation on boards**.
 - Based on the requirement from the National team, the Trust submitted the WRES data for Indicators 1 -4 and indicator 9 on the National Data Collection Framework (DCF) on 31st May 2025. The staff survey results for Indicators 5 to 8, are taken directly from the WRES publications available on the NHS Staff Survey website.
 - Included within the indicators is information taken from the National Benchmarking report produced for the Trust 2023/ 2024. The next Benchmarking report i.e. 2024/ 2025 will not be available until October / November 2025.
 - The comparators in the National Benchmarking report are tabled as follows: The Trust, North East and Yorkshire, Acute and National as well as identifying a Rank. This reflects our Trust’s ranking from 0% (best in the country) to 100% (worst in the country) on each indicator, based on effect size.

WRES METRICS

Workforce indicators : For each of these four workforce Indicators, compare the data for white and BME staff - [DATA SOURCE ESR](#)

1. Percentage of staff in each of the AfC Bands 1-9, VSM (including executive board members), Medical and Dental and other staff , compared with the percentage of staff in the overall workforce
- disaggregated by: Non-Clinical staff, Clinical staff -of which Non-Medical staff and Medical and Dental staff
2. Relative likelihood of staff being appointed from shortlisting across all posts (both external and internal posts). [DATA SOURCE ESR](#)
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. [DATA SOURCED FROM PEOPLE AND OD RECORDS](#)
4. Relative likelihood of staff accessing non-mandatory training and CPD. [DATA SOURCED FROM PEOPLE AND OD RECORDS](#)

National NHS Staff Survey indicators For each of the four staff survey indicators, compare the outcomes of the responses for white and BME staff. [DATA SOURCED FROM NHSS](#)

5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7. In the last 12 months have you personally experienced discrimination at work from a Manager/team leader or other colleagues
8. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion

Board representation indicator: For this indicator, compare the difference for white and BME staff [DATA SOURCE ESR](#)

9. Percentage difference between the organisations’ Board membership and its overall workforce disaggregated by: voting membership of the Board and executive membership of the Board

Key findings 2024 – 2025

Workforce representation

- There was a **0.31%** increase of BME staff, rising from **9.97%** in 2023/ 2024 to **10.28%** in 2024/2025
- There is no representation at Very Senior Managers.
- Of the total 502 members of staff in Medical staff, **66% are White** and **28.9% are BME**, **5.2%** have not declared their ethnicity.
- **BME representation** was virtually half across all Medical and Dental roles, compared with **White Staff**

Harassment and Bullying

- In 2024 staff experiencing harassment, bullying or abuse from patients' relatives or public increased from **25.6% to 26.55%**. - -
- Very small decrease for White staff but still around 20% across all the reporting years.
- In 2024 - Harassment bullying or abuse from staff for BME groups has decreased by **3%** . For White staff, this figure increased by **0.8%**
- In 2024 - Harassment bullying or abuse from Managers / team leader or other colleagues for BME groups has increased by **2.5%** . For White staff, this figure has increased by **1.0%** over the same period

Career Progression

The likelihood of staff accessing Non- Mandatory training and CPD was virtually the same for BME and White staff as well as staff who did not declare their ethnicity (97.5% , 100% and 100% respectively)

Recruitment

The relative likelihood of appointment for White staff has increased by 0.14 between **2023** and **2024**. However, the **2024/ 2025** figures show that the relative likelihood of appointment has decreased by 0.24 to **0.59**

Disciplinary Process

The relative likelihood of BME staff entering the formal disciplinary process increased from 0.51 to 1.1

Percentage of staff believing that the trust provides equal, opportunities for Career Progression or promotion

- Data from past **5 years** shows that for BME staff opportunities have **increased** by **10.6%**
- Opportunities for White staff have increased by **3.1%**.

Board Representation

- Out of the total 14 White Board members, 7 are Executive Board members and 7 Non- Exec Board Members. There is no BME representative

Key achievements from 2024 - 25

FTSU Guardian to continue reporting experiences of BME staff who have:

- Reported issues pertaining to disciplinary (formal and informal)
- Outcomes of who have been through the Disciplinary process

Recruitment and Selection programme revised, new programme tailored and piloted. **Dates for new delivery from Sept onwards.**

- **Work still to be done - Ensure that our recruitment adverts have a diversity statement**
- **Assessment around accessibility for employment (Partial undertaken – moved into 2025 work plan)**
- Recruitment activities across diversity metrics ongoing and continues into the refreshed action plan for 2025

Zero tolerance training delivered. Addressing and scoping areas where there may be perceived systemic racism and inequalities taking place partially undertaken (this is an ongoing action). Assessment via Staff Survey results

EDI Dashboard, capture diversity data for member of staff referred to any capability and performance management procedure, both formal and informal. Information provided on a quarterly basis to the HREDI Group regarding performance and capability cases across diversity metrics (**this is an ongoing action**)

Ethnicity and gender pay gap reports undertaken – Action plans in respect of these incorporated in the overarching EDI action plan

Proposed delivering Cultural competency learning / training for all staff and managers . Not fully delivered – discussions around delivery being incorporated via other programmes e.g. Inclusive training, Civility Saves Lives **Moved to 2025 for delivery**

Promoting SAHM, BHM and general EDI initiatives with GEM network. Ongoing and also part of the **2025 action plan.**

Update management guidance and appraisal training for managers to include intersectional approach and unconscious bias in the context of objective setting and career development – **Moved to this year's action plan**

Diversity metrics captured of staff attending training/accessing CPD funding/Study leave/Managing well/leading well etc. Quarterly report into HREDI Programme Board. **This element of work is being refreshed and is part of the 2025 actions**

Roll out reverse / reciprocal mentoring - **Being re assessed at for 2026**

Summary of all Indicators Yearly Comparison

Red indicates – Declining Score Green indicates Improving Score Amber indicates no movement

The **WRES (Workforce Race Equality Standard)** is a set of indicators used to track and improve workforce equality in the NHS. It aims to identify and address disparities in the experience of black, Asian, and minority ethnic (BAME) staff compared to white staff.

The data period for submission of the 4 WRES indicators below is via the NHS data Collection Framework and is made available to Trusts from May 1st until 31st of May. The data captured is within the time frame references - 1st April to the 31st March every year. All data collected has followed the NHS Technical guidance for all calculations and applies to 1st April 2024 to 31st March 2025.

Indicator	WRES Indicator		2018/19	2019/20	2020/2021	2021/2022	2022/2023	2023/2024	2024/2025
1	Percentage of BME Staff	Overall	5.4%	5.68%	5.68%	5.77%	7.62%	9.97%	10.28%
		VSM	0	0	0	0	0	0	0
2	Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants		3.08	1.8	0.70	0.72	0.69	0.83	0.59
3	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff.		0.97	0	1.27	0	0	0.51	1.1
4	Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff		Not available	1/18	0.96	0	1	0.99	1.03
9	BME Board Membership		0	0	1 Associate NED	1 Associate NED	0	0	0

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Summary of all Indicators Yearly Comparison

Red indicates – Declining Score **Green** indicates Improving Score **Amber** indicates no movement

Staff Survey Indicators. Each autumn, NHS staff in England are invited to take part in the NHS Staff Survey. The survey offers a snapshot in time of how people experience their working lives, gathered at the same time each year. The Annual Staff Survey is open to employees to complete for 8 weeks throughout October/November each year. The questions and information collected is for the calendar year (Jan to Dec). The results are received and embargoed until March. The data is cascaded to colleagues, BIU and Managers - internally throughout January to March in the following year.

The figures below are reflective of the data collected over each calendar year. The numbers under the % figures equates to the total number of responses

Indicator	Staff Survey Indicators		2019	2020	2021	2022	2023	2024	
5	Percentage of staff experiencing harassment, bullying or abuse from patient's relatives or public in the last 12 months	BME	29.5% (78%)	16.5% (85)	21% (105)	20.3% (133)	25.6% (164)	26.5% (262)	↑
		White	21.2% (1429)	22.9% (1394)	23.7% (1742)	23.9% (1935)	21.1% (1961)	20.2% (2099)	↓
6	Percentage of staff experiencing harassment, bullying or abuse from Staff the last 12 months	BME	35.9% (78)	32.9% (85)	29.5% (105)	19.1% (131)	29.4% (164)	26.4% (262)	↓
		White	19.9% (1431)	20.8% (1396)	19.4% (1735)	18.7% (1935)	18.5% (1961)	19.3% (2099)	↑
7	Percentage of staff experiencing discrimination at work from a manager / team leader or other colleagues	BME	11.55% (78)	17.1% (82)	17.1% (105)	11.4% (132)	14.6% (164)	17.1% (262)	↑
		White	4.2% (1418)	4.7% (1393)	6.2% (1733)	4.7% (1937)	4.8% (1961)	5.8% (2099)	↑
8	Percentage of staff believing that the trust provides equal opportunities for career progression or promotion	BME		44.1% (8)	44.8% (105)	48.8% (129)	52.5% (164)	54.7% (262)	↑
		White		62.9% (1401)	63% (1725)	65.2% (1927)	65.8% (1961)	66% (2099)	↑

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WRES Indicator 1 (1 of 3)
Percentage of BME staff vs VSM AFC Non-Clinical (headcount)



Pay Band	BME		White		Unknown	
VSM	0	0%	14	1.4%	0	0%
Band 9	0	0%	3	0.3%	0	0%
Band 8d	0	0%	6	0.6%	0	0%
Band 8c	0	0%	6	0.6%	0	0%
Band 8b	0	0%	25	2.4%	0	0%
Band 8a	1	2.8%	22	2.1%	0	0%
Band 7	2	5.6%	56	5.4%	1	11.1%
Band 6	5	19.9%	69	6.7%	0	0%
Band 5	7	19.4%	108	10.5%	0	0%
Band 4	2	5.6%	173	16.8%	0	0%
Band 3	7	19.4%	268	26.0%	7	77%
Band 2 and under	12	33.3%	280	27.2%	1	11.1%
Total	36	3.3%	1030	95.8%	9	0.8%

As of 31st March 2025, the total Headcount of BME staff (not including QE Facilities) represented **3.3%** compared with **95.8%** White staff across all Non-Clinical AfC roles.

Band 4 and under (administrative and technical support roles, estates officer) show that:

- BME representation was **58.3%** , White was **70%**
- BME staff were proportionately represented by pay band.

Band 5 till Band 8 (graduate and management level roles) shows:

- BME representation was **47.7%**, White was **24.7%**
- BME staff were proportionally represented by pay band
- No BME representation above 8a.

- The data shows that as the Banding increases, the representation of **BME Staff** decreases. **Bands 2 - to Band 7 the total figure is 35 staff.** White staff at the same Bands have a high representation with total figure equating to **954 staff**

- **Representation of White staff at Bands 8a and 8b**, are virtually equal (**22 / 25 staff**)

- BME staff at VSM level are not represented

WRES Indicator 1 (2 of 3)
Percentage of BME staff vs VSM AFC Clinical (headcount)



Pay Band	BME		White		Unknown	
VSM	0	0%	0	0%	0	0%
Band 9	0	0%	2	0.01%	0	0%
Band 8d	0	0%	4	0.14%	0	0%
Band 8c	0	0%	4	0.14%	0	0%
Band 8b	0	0%	28	0.99%	1	0.03%
Band 8a	3	0.8%	123	4.3%	0	0%
Band 7	18	5%	413	14.6%	6	0.2%
Band 6	52	14.5%	662	23.4%	7	0.2%
Band 5	246	68.5%	691	24.4%	24	0.5%
Band 4	7	1.9%	144	5.1%	1	0.2%
Band 3	29	8.1%	610	21.6%	2	0.1%
Band 2 and under	4	1.1%	149	5.3%	3	0.2%
Total	359	11%	2830	87.5%	44	1.36%

- There are no BME staff above **Band 8a**.
- Highest number of BME staff are in **Bands 5 and 6** and very low numbers in **7**. The representation at **Band 8** is miniscule.
- **Band 4** and under (e.g., clinical support workers and healthcare assistants), shows BME representation at **11.1%** in comparison to White representation **32%**
- BME representation is lower than their White counterparts across all Bands, except in **Band 5**.
- The data shows that as the Banding increases, the representation of **BME Staff** decreases. **Bands 2 to Band 7 the total figure is 356** White staff at the same Bands have a high representation with total figure equating to **2669 staff**
- **BME staff** are significantly lower in **Bands 5 to Band 8**
- **There is no BME representation Bands 8b upwards.**

WRES Indicator 1 (3 of 3)
Medical staff

Seniority	BME		White		Unknown	
Other	14	9.7%	137	41.3%	5	19.2%
Senior medical manager	0	0%	1	0.3%	0	0%
Consultant	77	53.1%	144	43.5%	8	23%
Non Consultant specialist	45	31%	39	11.8%	4	15.3%
Resident Doctors	9	6.2%	10	3%	9	34.6%
Total	145	28.9%	331	66%	26	5.2%

Amongst Medical and Dental staff there the breakdown shows that:

- There is **1** White member of staff and **0** BME Senior Medical Manager
- At Consultant Level there are virtually double the numbers of White staff compared with BME staff (**144 v 77**)
- The **‘Unknown’** category overall shows **26 staff who have not indicated their ethnicity.**
- Across all Medical and Dental roles BME representation was **28.9% versus 66% of White** representation

Across the whole staff group, our BME colleagues make up **10.28%** of the workforce, an increase of **0.31%** from last year. From the data you can see this is driven by clinical staff, primarily in Band 5, and our Medical staff. This is likely a reflection of the IEN recruitment that the Trust undertook.

The information below is a summary from the 2023/2024 National bench-marking report. The 2024/2025 benchmarking report will not be available until after October 2025

Indicator number and description			Trust	North East and Yorkshire	Acute	National	Rank*
1: BME representation in the workforce by pay band							
Workforce BME representation			10.0%	17.9%	31.1%	28.6%	
Pay band at which %BME drops off	Non-clinical	Band 4 - Band 5 +	Equitable	Band 3 Band 8A	Band 3 Band 8A	Band 3 Band 8A	
	Clinical	Band 4 - Band 5 +	Equitable	Band 3 Band 6	Band 3 Band 6	Band 3 Band 6	
	Medical		Consultant	Consultant	Consultant	Consultant	

Action overall for this indicator

- Improve ethnicity data collection on ESR to eliminate the unknowns across all sections of indicator 1
- Ensure that panels are representative and that there is transparency in the recruitment processes across all posts.

Indicator 2

Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants



Metric 2	2023	2024	2025	Difference (2024 vs 2025)
Recruitment Relative likelihood of White staff being appointed from shortlisting across all posts	Incremental rise by 0.14 0.69	0.83	0.59	0.24

A relative likelihood over a figure of 1 indicates that white applicants have a greater likelihood of being appointed

- Previous data shows that BME were more likely to be appointed in comparison with their white colleagues.
- The relative likelihood of appointment for White staff has increased by 0.14 between **2023** and **2024**. However, the 2024/ 2025 figures show that the relative likelihood of appointment has decreased by 0.24

In National Benchmarking report of 2023/2024 our Trust was ranked at 9% (where 0% indicates the best in the country to 100% indicating the worst in the country). This places our Trust in the upper quartile.

Action

- Ensure all members of staff on a any recruitment exercise are fully trained and the employee criteria are assessed prior to interview to ensure responses meet the requirement of the post. This will be picked up by our offer of the refreshed Recruitment and Selection training.
- Questions and scoring of responses are based on workplace competencies and / or the potential demonstrated by the candidate to develop these.
- All responses should reflect the ICORE values and demonstrate confidence and competence in addressing the needs of different groups.

Indicator 3

Relative likelihood of BME staff entering the formal disciplinary process compared to white staff.



Metric 3 - Disciplinary	2023	2024	2025	Difference (2024 vs 2025)
Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	0	0.51	1.1 (3 members of staff)	0.59

This data is captured form our internal reporting mechanisms.

- Data collected pertains to a formal capability process on grounds of Ill Health and Performance. These figures do not capture the informal process.
- The Data shows that the figure has increased from 0.51 to 1.1 (reflecting 3 cases)

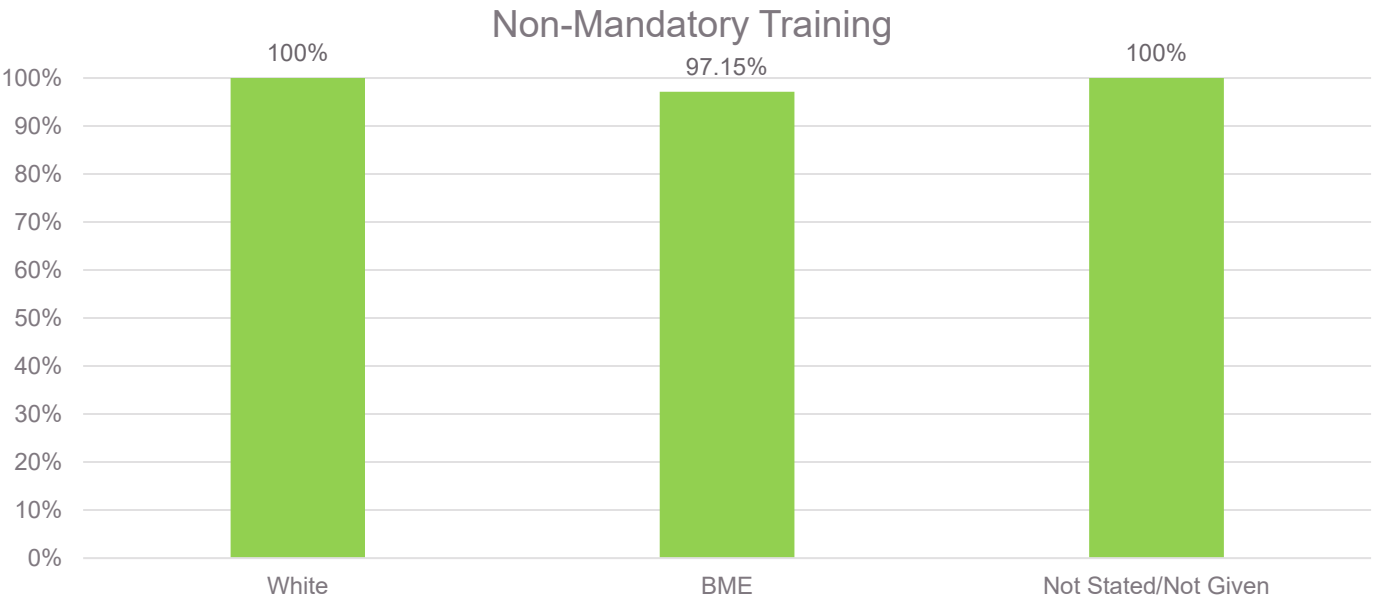
In the National Benchmarking report of 2023/2024 there was no ranking given for our Trust.

Action

- Identify from which specific service areas of the Trust this data refers to.
- Capture the data from informal processes by ethnicity.
- Conduct detailed analysis of the data collected to understand what has triggered the increase.
- Ensure that the Cultural Ambassadors are involved in any Disciplinary process and contribute to associated actions.

Indicator 4 - Non-mandatory Training

Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff



Actions :

- With Learning and Development undertake an audit to identify the reasons for the small gap in accessing Non- Mandatory training by BME staff
- Identify why 74 members of staff have either not ascribed their ethnicity or it has not been recorded.
- Improve the accuracy of ethnicity data captured on ESR

At March 2024 the likelihood ratio was 0.99; not significantly different from "1.0" or equity.

Specifically, 4534 out of 4749 white staff undertook non-mandatory training (95.5% of the white workforce) compared to 518 out of 538 BME staff (96.3% of the BME workforce).

From the information captured we can show that there is equity across all groups, including those in the 'Not stated / Not Given' category.

The 2025 data shows that this year slightly fewer BME staff (2.85%) accessed non mandatory training and CPD compared to the two other categories of staff.

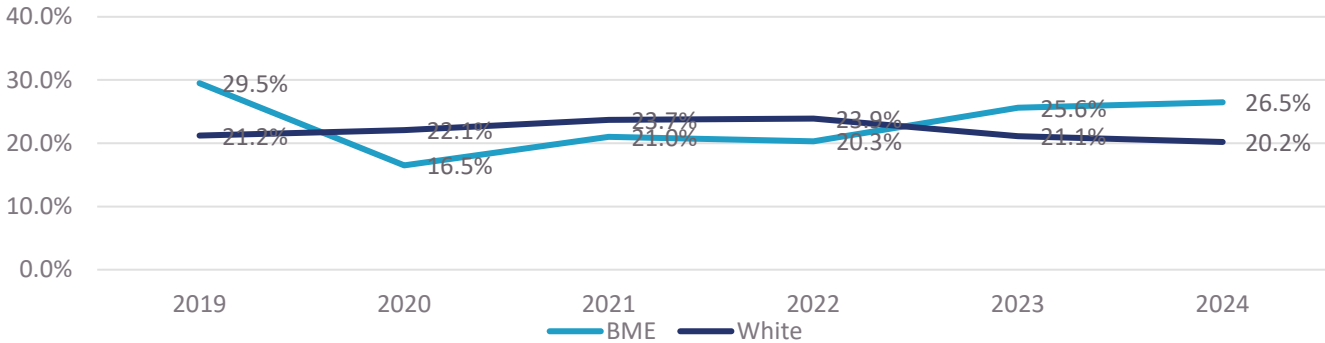
In National Benchmarking report of 2023/2024 our Trust was ranked at 27% (where 0% indicates the best in the country to 100% indicating the worst in the country).

Indicator 5 WRES Staff Survey Data 2024

Percentage of staff experiencing harassment, bullying or abuse from patient’s relatives or public in the last 12 month



	2019	2020	2021	2022	2023	2024
BME	29.5% (78)	16.5% (85)	21% (105)	20.3% (133)	25.6% (164)	26.5% (262)
White	21.2% (1429)	22.1% (1394)	23.7% (1742)	23.9% (1935)	21.1% (1961)	20.2% (2099)



The figures over the last 5 years show:

- that BME and White staff tend to experience similar percentage of harassment/ abuse in respect of this metric.
- For BME staff after the dip from **29.5% in 2019 to 16.5% in 2020**, the data trend shows a general increase from 2021 onwards. **There was a 0.9% increase from 2023 to 2024**. The figure for White staff has been relatively stable in comparison. The 2023/2024 figures show a **0.9% decrease**.
- Whilst the percentage increase from **2023 to 2024** for BME staff is very small (**0.9%**), it is a worry that across both groups, the percentage rates of staff experiencing harassment are consistently above the 20% mark
- On a positive note, the increased number of respondents could well be accounted for by increasing knowledge and confidence in reporting processes. The Trust’s signing up to and providing Zero Tolerance training may be the reason for this.

Action

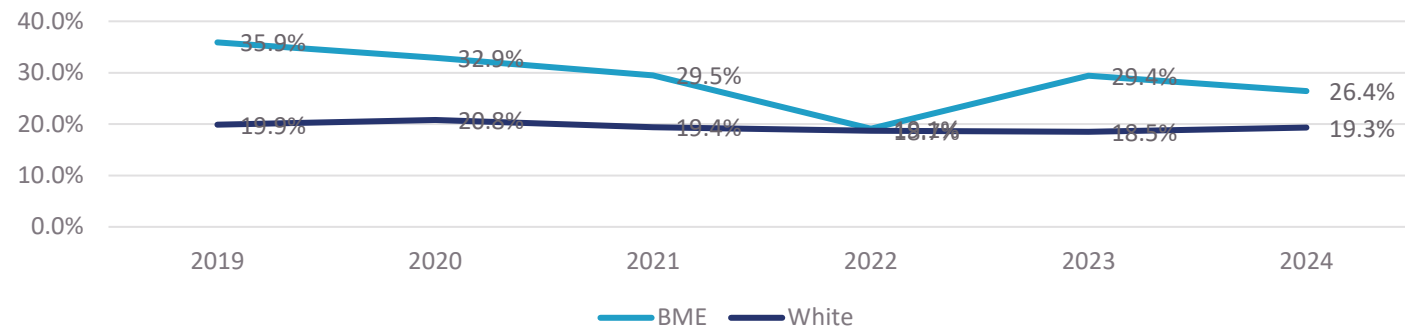
- Working with the FTSU guardian, analysis will be undertaken to understand the pattern of bullying and assess areas where aspects of this metric are more prevalent so that appropriate interventions can be made.
- Ensure message around Incivility and Z tolerance are consistently updated and applied and are visible in all areas of the Trust, including contact points for reporting.

Indicator 6 WRES Staff Survey Data 2024

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months



	2019	2020	2021	2022	2023	2024
BME	35.9% (78)	32.9% (85)	29.5% (105)	19.1% (131)	29.4% (164)	26.4% (262)
White	19.9% (1431)	20.8% (1396)	19.4% (1735)	18.7% (1935)	18.5% (1961)	19.3% (2099)



This indicator shows that in the last 3 years:

- BME staff experiences of harassment, bullying or abuse shows a **decrease** from **2019 until 2021** by **6.4%** and dropped significantly by **10.4%** between **2021 and 2022**. **However staff harassment increased by 10.3% in 2023** and **decreased by 3%** in **2024**.
- For White staff experiences of harassment, bullying or abuse shows an **increase of 0.9%** in **2020**, and this remains relatively consistent. The variance is between plus or minus less than 1%.

These figure equate roughly with the regional figures. For BME staff the trajectory could reflect the backdrop of the riots, polarisation in the migration debate and increased tensions in respect of unrest across the middle east. This discourse is reflected through conversations with staff who have family and friends in areas of ongoing conflict whether here or abroad . Tensions within the local communities and BME groups have increased since this unrest and may contribute to the trend of abuse against BME staff

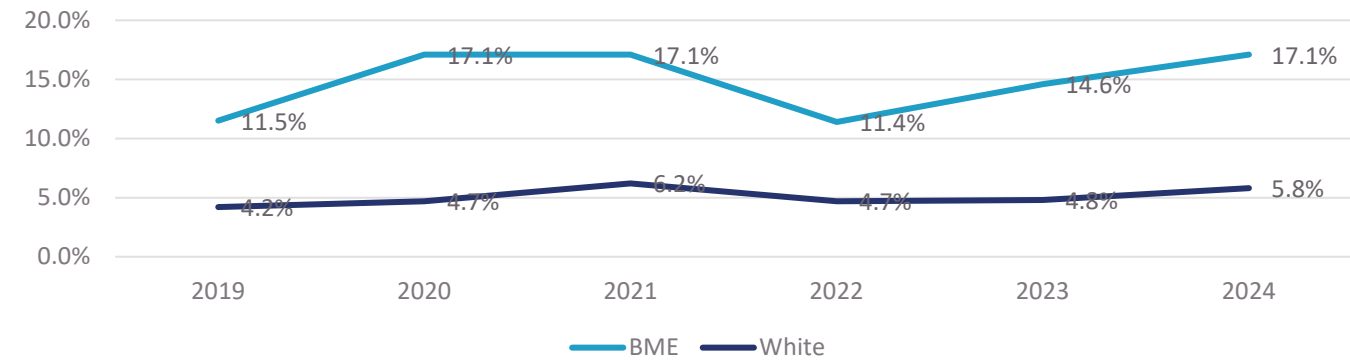
Action
To ensure message around Incivility and Z tolerance are consistently updated and applied and training is available.
Managers to monitor staff relations and intervene with challenge and /or support as appropriate and is integrated as part of the Appraisal process so that senior managers are aware and can take any action required.
Ensure that all / any abuse is recorded on appropriate systems (e.g. Selinity) and the FTSU Cultural Ambassadors and the EDI manager.

Indicator 7 WRES Staff Survey Data 2024

Percentage of staff experiencing discrimination at work from a manager / team leader or other colleagues



	2019	2020	2021	2022	2023	2024
BME	11.5% (78)	17.1% (82)	17.1% (105)	11.4% (132)	14.6% (164)	17.1% (262)
White	4.2% (1418)	4.7% (1393)	6.2% (1733)	4.7% (1937)	4.8% (1961)	5.8% (2099)



The figures over the last 5 years show that BME and White staff continue to experience harassment/ abuse in respect of this metric.

For both, BME and White staff experiences of harassment have been fairly consistent with BME staff being roughly 3 times more likely to experience this than their White colleagues.

The responses from both groups have increased.

On a positive note, the increased number of respondents could well be accounted for by increasing knowledge and confidence in reporting processes.

- Having undertaken the Z tolerance training, colleagues may feel more confident in reporting as identified in Indicator 5.
- Tensions within the local communities and BME groups have increased since this unrest and may contribute to the trend of abuse against BME staff as identified in Indicator 6.

Actions

To ensure the message around Incivility and Z tolerance are consistently updated and applied and training is available.

Managers to monitor staff relations and intervene with challenge and /or support as appropriate.

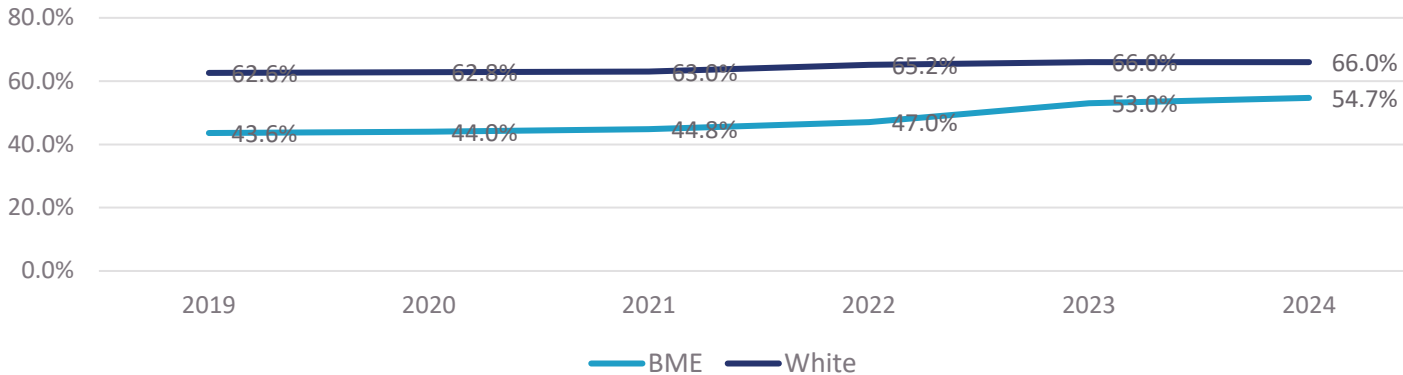
Ensure that all / any abuse is recorded and shared via appropriate systems e.g. Selinity, the FTSU, Cultural Ambassadors and EDI manager for monitoring and intervention / support as required.

Indicator 8 WRES Staff Survey Data 2024

Percentage of staff believing that the trust provides equal opportunities for career progression or promotion



	2019	2020	2021	2022	2023	2024
BME	43.6% (78)	44% (84)	44.8% (105)	47% (129)	53% (164)	54.7% (262)
White	62.6% (1427)	62.8% (1401)	63% (1725)	65.2% (1927)	66% (1961)	66% (2099)



The figures over the **last 5 years** show that both BME and White staff have high percentages in accessing career progression in terms of this metric.

- Data shows that for BME staff opportunities have **increased** by **11.1%**
- Opportunities for White staff have increased by **3.4%**.
- For both groups the number of respondents have also increased.

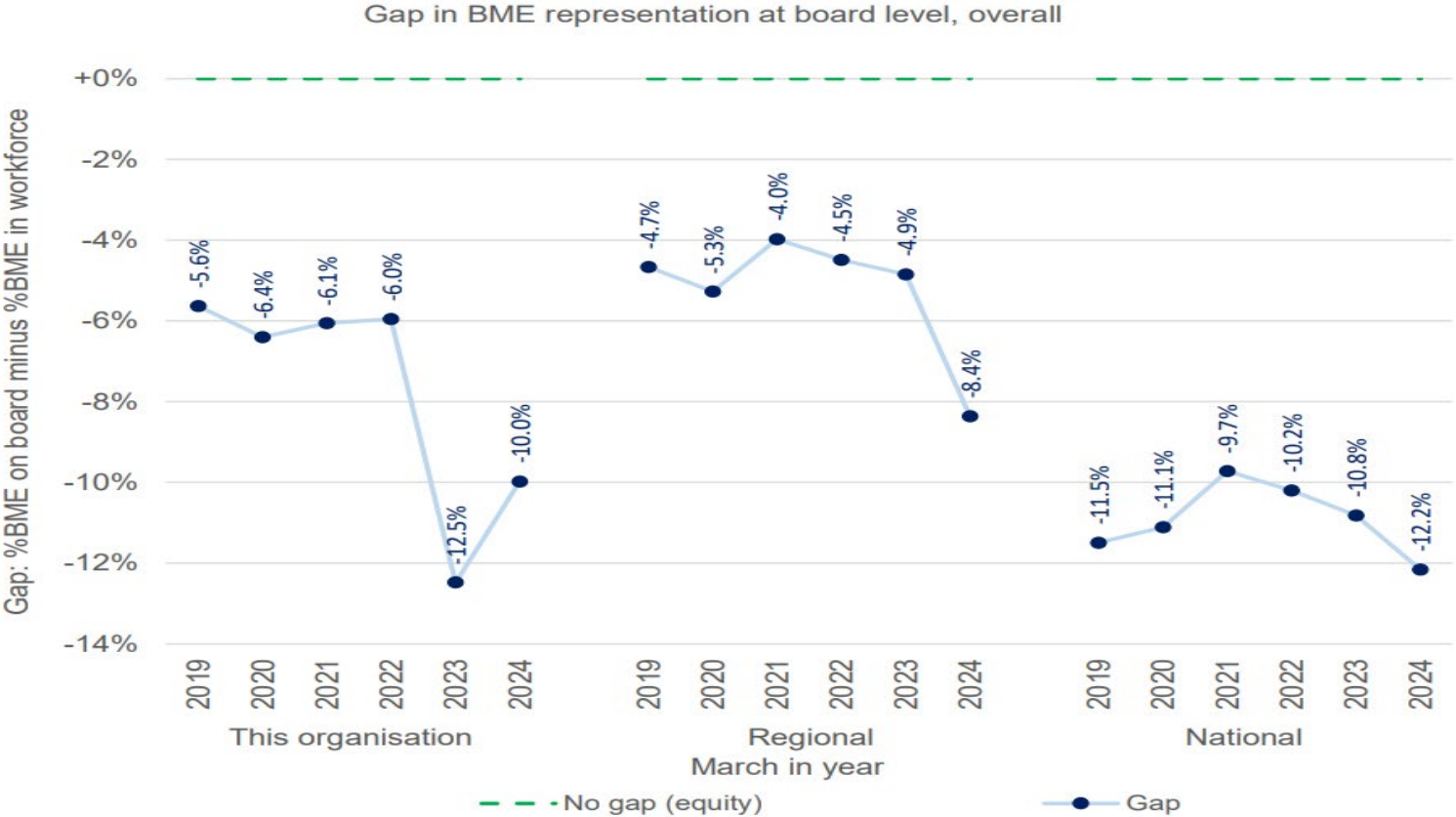
In National Benchmarking report of 2023/2024 our Trust was ranked at 11% for career progression for White colleagues and 26% for BME colleagues (where 0% indicates the best in the country to 100% indicating the worst in the country).

Action
Further work will be undertaken to understand what may hinder colleagues accessing promotion across all groups in different Bands. This will include detailed analysis to determine:

- where there may have been advantages / inequalities in career promotion
- advantages / inequalities in respect of learning and development opportunities
- any linkages to reported bullying, harassment or abuse

So that any perceived or actual barriers can be addressed.

WRES Indicator 9
BME Board membership



Overall Board membership shows that as of March 2024, the difference between BME representation on the Board and the workforce was -10%. BME members were underrepresented by 1 as member of the Board.

In the National Benchmarking report of 2023/2024 our Trust was ranked at:

- 51% Overall**
- 50% Voting Members**
- 37% Executive members.**

(where 0% indicates the best in the country to 100% indicating the worst in the country).

Action

- Ensure that the EQIA process has been applied to guarantee that all external companies involved in Executive Search appointments have a proactive approach to engaging with BME groups and can show transparency and equality in their process of shortlisting
- Stakeholders and members of Trust are consistently included and involved in the initial discussions
- An external BME representative is present as part of the recruitment panel

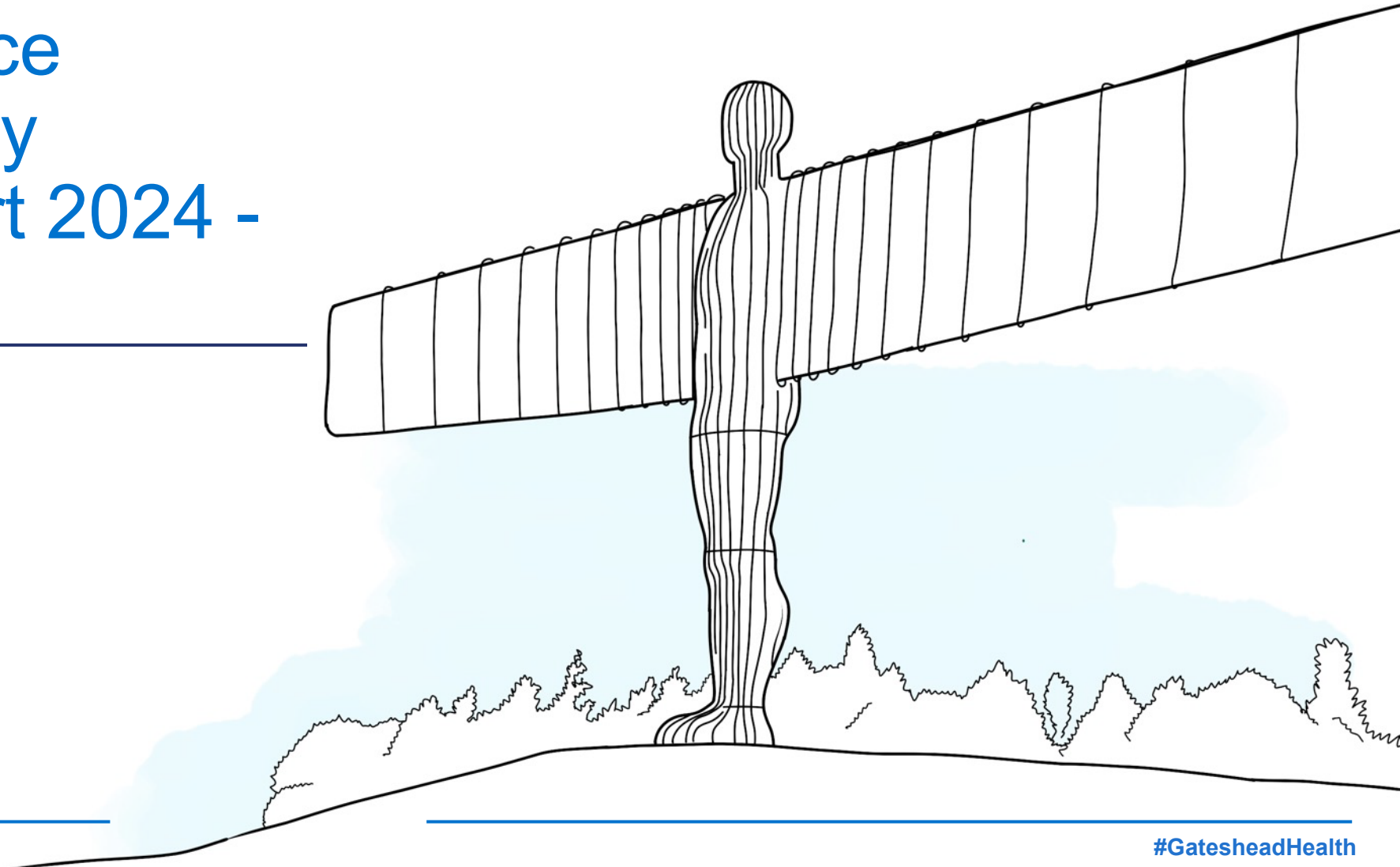
WRES action plan 2025 26

Mitigation / Actions: Indicators 3/ 5/6/7	Risk	Lead	Time frame	WRES Metric
FTSU Guardian to continue reporting on a quarterly basis experiences of BME staff who have: - Reported issues and outcomes pertaining to disciplinary (formal and informal) - Analyse pattern(s) of bullying, and harassment assess to understand reasons for the increase so that appropriate interventions can be made. Involve Cultural Ambassadors in any relevant Disciplinary process and contribute to associated actions. Ensure message around Incivility and Z tolerance are consistently updated and applied, are visible in all areas of the Trust and training is available. Managers monitor staff relations and intervene with challenge and /or support as appropriate. This is integrated within the Appraisal process so that Senior Managers are aware and can take any action required. We will record all / any abuse is recorded on appropriate systems (e.g. Selinity) and the FTSU Cultural Ambassadors and the EDI manager are regularly updated.	Our staff fail to experience any significant improvement in the amount of harassment, bullying or abuse in the workplace. Staff Survey Indicators 5, 6 7 do not show an improvement	Head of People Services / FTSU/ POD Lead	November 2025 to November 2026	Indicator 3 5/6/7 and HIA 6
- Mitigation / Actions: Indicators 1/ 2/4/8	Risk	Lead	Time frame	WRES Metric
Assess targeted initiatives around Career progression / Talent Management / Positive action initiatives. All members of staff undertaking any recruitment exercise are fully trained and representative Questions and scoring of responses are based on workplace competencies, reflect the ICORE values and demonstrate confidence and competence in addressing the needs of different groups and / or the potential demonstrated by the candidate to develop these. Undertake a detailed analysis to determine: - where there may have been advantages / inequalities in career promotion - advantages / inequalities in respect of learning and development opportunities Improve ethnicity data collection on ESR to eliminate the 'unknowns' across all sections of indicator 1 - Deliver cultural competency learning for staff and managers	Employee criteria and marking is not transparent, and choice of candidate may reflect unconscious bias as candidate's responses do not reflect the requirement of the post	Resourcing and EDI Manager and Head of People Services Land D	October 2025 to October 2026	Indicators 1 2/ 4/ 8

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Mitigation / Actions: Indicators 8	Risk	Lead	Time frame	WRES Metric
Update management guidance and appraisal training for managers to include intersectional approach and unconscious bias in the context of objective setting and career development. Assess targeted initiatives around Career progression / Talent Management / Positive action initiatives. - Diversity metrics captured of staff attending training/accessing CPD funding/Study leave/leading well. Quarterly report into EDI Oversight group. With Learning and Development undertake an audit to identify the reasons for the gap in accessing Non- Mandatory training by BME staff - Identify and improve the accuracy of ethnicity data captured on ESR	Metrics do not capture information broken down by PC's leading to unconscious bias in assessment around career opportunities. Staff Survey Indicators 8, shows no improvement	Land D	November 2025 to November 2026	Indicator 8
- Mitigation / Actions:	Risk	Lead	Time frame	WRES Metric
Collect and analyse ethnicity and gender pay gap report. Positive action around understanding at which pay Band, inequalities may occur for both gender and ethnicity as well as supporting GEM network staff highlighting different aspects of race inequalities	Ongoing proactive assessment around pay and ethnic gaps not undertaken resulting in a greater disparity amongst staff	Head of People Services and ED! Manager	October 2025 to October 2026	HIA 3
Mitigation / Actions: Indicators 10	Risk	Lead	Time frame	WRES Metric
- All external companies involved in Executive Search appointments can show a proactive approach and transparency around engaging with BME groups and equity in their process of shortlisting - The Network members are consistently included and involved in the initial discussions - An external BME representative is present as part of the recruitment panel	There is no improvement in representation of communities served and the Board representation remains the same		Ongoing	HIA 2

WDES (Workforce Disability Equality Standard) Report 2024 - 2025



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WDES Indicator 4b	In the last 12 months, percentage of staff experiencing harassment, bullying or abuse from managers
WDES Indicator 4c	In the last 12 months, percentage of staff experiencing harassment, bullying or abuse from colleagues
WDES Indicator 4d	In the last 12 months, percentage of staff experiencing harassment, bullying or abuse they or their colleague reported it
WDES Indicator 5	The percentage of staff who believed that their organisation provided equal opportunities for career progression or promotion
WDES Indicator 6	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
WDES Indicator 7	The percentage of staff who were satisfied with the extent to which their organisation values their work
WDES Indicator 8	The percentage of Disabled staff whose employer had made reasonable adjustments to enable them to carry out their work
WDES Indicator 9	The NHS staff survey-based staff engagement score
WDES Indicator 10	Overall board membership



Introduction

Gateshead NHS Trust is continuously working to improve everyday experiences for patients and staff who are BME as well as those who are disabled. From a variety of national information and data collected, it is clear that the lived experiences of colleagues from a Black, Asian and Minority Ethnic background, have poorer experience of working within the NHS.

Gateshead Health is committed to improving those lived experiences and strive towards creating a culture where race and ethnicity are not barriers to progression, individuals feel safe in the workplace and difference is embraced. As a Trust we want to focus on working in partnership with our patients, service users and workforce, to change our workforce systems, our mentality of one size fits all, and embrace the individuals lived experiences to ensure equity in its own right.

Gateshead Trust wrote its Equality strategy which is in the process of being reviewed and will be updated later this year. The Strategy will also incorporate the High Impact Actions that all Trusts are mandated to follow. The importance of race equality is embedded into the NHS People Plan 2020 where it states ‘The NHS must welcome all, with a culture of belonging and trust. We must understand, encourage and celebrate diversity in all its forms’. The People Promise declares ‘a commitment to creating and maintaining a compassionate and inclusive culture where diversity is valued and celebrated as a critical component, and not just a desirable one. The Trust must also meet its legal obligations under the Equality Act 2010 and The Human Rights Act 1998.

Each year the Trust is required to publish Workforce Race Equality Standard (WRES) and the Workplace Disability Equality Standard (WDES). These standards provides a framework for NHS organisations to report, demonstrate and monitor progress against specific indicators to ensure equity for all. The indicators are a combination of workforce data and results from the NHS national staff survey and help to ensure that employees receive fair treatment in the workplace and have equal access to career opportunities.

We recognise there is ongoing need and continuous focus on ensuring that aspects pertaining to bullying, harassment, and discriminatory behaviours are checked, challenged and appropriate actions are undertaken. Utilising the data from WRES/ WDES / Staff surveys will help in leveraging, enhancing and prioritising the individual , as well as the intersectional Equity agenda. Mainstreaming the Equity agenda is supported and endorsed by the Board and through various accountability mechanisms. We want to ensure that all of us working at Gateshead are part of the Gateshead family and believe in our EDI commitment: Diversity enriches, Inclusion empowers, United we are Gateshead Health

Kuldip Sohanpal
Equality Diversity Inclusion and Engagement Manager
Gateshead Trust
September 2025

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WDES Metrics



Workforce indicators : For each of these four workforce Indicators, compare the data for Disabled and Non Disabled staff - [DATA SOURCE ESR](#)

- 1. Percentage of staff in each of the AfC Bands 1-9, VSM (including executive board members), Medical and Dental and other staff , compared with the percentage of staff in the overall workforce disaggregated by: Non-Clinical staff, Clinical staff -of which Non-Medical staff, Medical and Dental staff
- 2. Relative likelihood of staff being appointed from shortlisting across all posts (both external and internal posts). [DATA SOURCE ESR](#)
- 3. Relative likelihood of staff entering the formal capability process. [DATA SOURCED FROM PEOPLE AND OD RECORDS](#)

National NHS Staff Survey indicators For each indicators, compare the outcomes of the responses for Disabled and Non Disabled staff. [DATA SOURCED FROM SURVEY](#)

- 4a. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- 4b. Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months
- 4c. Percentage of staff experiencing harassment, bullying or abuse from colleagues in last 12 months
- 4d. Percentage of staff experiencing harassment, bullying or abuse and they or their colleague reported it
- 5. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion
- 6. The percentage of staff who have felt pressure to come to work when not well enough to carry out their role
- 7. The percentage of staff who were satisfied with the extent to which the organisation values their work
- 8. The percentage of staff whose employer has made reasonable adjustments
- 9. Staff engagement score for disabled staff compared to non-disabled staff and the overall organisation

Board representation indicator: For this indicator, compare the difference for Disabled and Non Disabled [DATA SOURCE ESR](#)

- 10. Percentage difference between the organisations’ Board membership and its overall workforce disaggregated by: voting membership of the Board and By executive membership of the Board

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Key findings 2023 – 2024

Workforce representation

- There was a rise of 0.1% in staff indicating a disability, rising from 5.2% in 2024 to 5.3% in 2025
- **In Non Clinical Bands** Highest number of staff indicating a disability are in Band 2 to Band 4 . Highest number of staff indicating they do not have a disability are in Band 2 through to Band 7
- **Out of the 3751 Clinical staff overall:**
Highest number of disabled staff are in Bands 5 and 6
Highest number of nondisabled staff fall in Bands 3, 5, 6 and 7
For 311 members of staff disability unknown

Harassment and Bullying

- A higher proportion of Disabled staff experienced **harassment, bullying or abuse (25%)** than Non-disabled staff (**19.5%**)
- Increase of 0.9% **abuse from Managers**
- Increase of 10.6% **abuse from Colleagues**
- Decrease of 1.5% of **individuals or colleagues reporting harassment / abuse**

Capability Process

The relative likelihood of Disabled staff entering the formal capability process rose from 0 to 3.24

Career Progression

Since 2022 both disabled and Non-disabled staff reflected a lower level of confidence in the Trust **providing equal opportunities for their career progression or promotion** (Disabled staff a drop of **19.5%** and for **Non –Disabled staff 32.1%**)

Staff satisfaction with the extent to which the Trust values their work

Disabled staff continue to feel that their work is less valuable to the organisation than Non Disabled staff, with a difference of **7.6%** between the two groups (2024).

Pressure to come to work

- The percentage of staff who felt pressure from their manager to come to work, despite not feeling well enough to perform their duties shows an increase for staff who have a Disability by **3.9%**. (up from **21.4%** to **25.3%**)
- For non-disabled staff, this figure has dropped by **1.6%** to **14%**

Recruitment

Data collected shows that the likelihood of Non-Disabled applicants being appointed compared with Disabled applicants was 0.95; not significantly below "1.0" or equity with non-disabled staff

Board Representation

The difference between Disabled representation on the board and in the workforce was +1.8%.

Reasonable adjustments are undertaken

80.7% of staff with disabilities stated that the Trust had made adequate adjustments for them to carry out their work.

Organisation valuing their work

The percentage of staff who were satisfied with the extent to which their organisation values their work: has decreased by **4.2%** for Disabled staff, and by **5.3%**, for non-disabled staff from 2023

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Key achievements from 2024

EDI Dashboard, capture diversity data for member of staff referred to any capability and performance management procedure, both formal and informal. Information provided on a quarterly basis to the EDI Group regarding performance and capability cases across diversity metrics (**this is an ongoing action**)

Learning disability passport agreed and is used with disabled patients. The disability passport is with the individual in their hospital journey.

Neurodiversity Pledge signed. 2 Sessions around this project delivered. Reassessing how this can be rolled out in the current financial constraints. Level 2 Disability Confident accreditation. Engagement with Local college and Project Search re employment for individuals with disabilities. Promotion of ESR self service to encourage staff to update details.

Recruitment and Selection programme revised, new programme tailored and piloted incorporating reasonable adjustments. **Dates for new delivery from Sept onwards.**

- **Work still to be done - Ensure that our recruitment adverts have a diversity statement ,**
- **Assessment around accessibility for employment (Partial undertaken – moved into 2025 work plan)**
- Recruitment activities across diversity metrics ongoing and continues into the refreshed action plan for 2025

Scoping areas where there may be perceived systemic inequalities taking place specifically around reasonable adjustments - partially undertaken (this is an ongoing action).
Assessment via Staff Survey results

Promoting Disability rights and Neurodiversity month and general EDI initiatives with the D-ability network. Ongoing and part of the **2025 action plan**. The Children's Bladder and Bowel Team awarded the 'Gold Standard for Autism Acceptance' from the North East Autism Society (NE Autism Society).

Update management guidance and appraisal training for managers to include intersectional approach and unconscious bias in the context of objective setting and career development – **Moved to this year's action plan**

Diversity metrics captured of staff attending training/accessing CPD funding/Study leave/Managing well/leading well etc. Quarterly report into EDI Programme Board. This element of work is being refreshed and is part of the 2025 actions

Roll out reverse / reciprocal mentoring - **Being re assessed at for 2025/26**

Summary of all Indicators - Yearly Comparison Table

Red indicates – Declining Score **Green** indicates Improving Score **Amber** indicates no movement

WDES Indicators			2018	2019	2020	2021	2022	2023	2024	Trajectory
1	Percentage of Disabled staff in AfC paybands or medical and dental subgroups and VSM (including Executive Board members) compared with the percentage of staff in the overall workforce	Overall	6.5%	5.7%	5.28%		5.24%	5.24%	5.3%	↑
		VSM	0%	0%	7.7%		0%	0%	0%	↔
2	Relative likelihood of Non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts.		1.33	1.53	0.3*		1.09	1.09	0.95	↓
3	Relative likelihood of Disabled staff compared to non-Disabled staff entering the formal capability process, as measured by entry into the formal capability procedure		*	0.0*	0.01		0	0	3.24	↑

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Summary of all Indicators Yearly Comparison Table

4										
In the last 12 months, percentage of staff experiencing harassment, bullying or abuse from:			2018	2019	2020	2021	2022	2023	2024	Trajectory
a)	Patients/service users, their relatives or other members of the public	Disabled (with LTC)	25% (280)	23% (320)	26% (365)	31% (504)	25.5% (534)	24.8% (603)	24.9% (664)	↑
		Non Disabled (without LTC)	22% (1096)	21% (1195)	21% (1123)	21% (1339)	22.9% (1529)	18.1% (1485)	19.5% (1694)	↑
B)	Managers	Disabled (with LTC)	18% (28)	13% (319)	16% (367)	15% (499)	11.7% (532)	12.2% (603)	13.1% (664)	↑
		Non Disabled (without LTC)	9% (1090)	8% (1191)	8% (1120)	6.5% (1330)	6.1% (1519)	5.7% (1485)	6% (1694)	↑
C)	Colleagues	Disabled (with LTC)	24% (280)	25% (311)	24% (360)	22% (496)	23.9% (527)	20.9% (603)	24.6% (664)	↑
		Non Disabled (without LTC)	15% (1082)	14% (1184)	14% (1105)	14% (1323)	12.2% (1513)	14.1% (1485)	14.0% (1694)	↓
D)	They or their colleague reported it	Disabled (with LTC)	37% (101)	43% (126)	41% (148)	45% (195)	43.5% (193)	50.5% (603)	49.4% (664)	↑
		Non Disabled (without LTC)	30% (299)	39% (341)	42% (310)	44% (367)	45.3% (419)	53.8% (1485)	50.7% (1694)	↑

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Summary of all Indicators Yearly Comparison Table

			2018	2019	2020	2021	2022	2023	2024	
5	Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	Disabled (with LTC)	55% (277)	54% (322)	55% (367)	57% (500)	58.5% (537)	61% (603)	61% (664)	↔
		Non Disabled (without LTC)	66% (1092)	64% (1191)	64% (1127)	64% (1328)	66.1% (1515)	66% (1485)	65.8% (1694)	↓
6	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	Disabled (with LTC)	34 % (199)	34% (219)	34% (228)	33% (343)	28.2% (397)	21.4% (603)	25.3% (664)	↑
		Non Disabled (without LTC)	21% (540)	19% (610)	22% (420)	21% (633)	15% (824)	15.6% (1485)	14% (1694)	↓

NB. The numbers under the % figures in (brackets) in all of the information presented in the report are the numbers of total responses

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Summary of all Indicators Yearly Comparison Table

			2018	2019	2020	2021	2022	2023	2024	Trajectory
7	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which the organisation values their work.	Disabled (with LTC)	42% (282)	42% (323)	38% (364)	36% (506)	39.1% (537)	38.8% (603)	34.6% (664)	
		Non Disabled (without LTC)	53% (1089)	54 % (1191)	51% (1120)	45% (1333)	45% (1528)	47.5% (1485)	42.2% (1694)	
8	Percentage of disabled staff saying that their employer has made adequate adjustments to enable them to carry out their role.	Disabled (with LTC)	81% (171)	85% (179)	75% (221)	78% (290)	78.8% (450)	82.8% (603)	80.7% (664)	
		Non Disabled (without LTC)	0%	0 %	0%	0%	0%	0%	0%	
9	Staff engagement score for disabled staff compared to non-disabled staff and the overall engagement for the organisation (out of 10).	Disabled (with LTC)	6.9% (283)	6.9 (324)	6.9 (367)	7 (508)	6.5 (539)	6.8 (603)	6.5 (664)	
		Non Disabled (without LTC)	7.3% (1102)	7.3 (1201)	7.3 (1130)	7 (1341)	7.1 (1532)	7.2 (1485)	7.0 (1694)	

NB. The numbers under the % figures in (brackets) in all of the information presented in the report are the numbers of total responses

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WDES Indicator 1 (1of 3) Overall
Percentage of Staff declaring a disability compared to percentage of Staff not declaring their disability status

	19/20	20/21	21/22	22/23	23/24	24/25
Disabled	5.19%	5.21%	4.92%	5.11%	5.27%	5.18%
Non - Disabled	80.96%	83.58%	82.91%	85.64%	85.75%	81%
Unknown	14.14%	11.27%	12.21%	9.29%	9.01%	6.37%

Action

- Engaging with the D-ability network and POD / PIT and the EDI manager to improve disclosure rates on ESR
- Work with the D-ability group to promote the social model of disability and regularly promote positive messages relating to Disability and show a reduction in year-on-year data reported in Indicator 4 which relates to bullying, harassment and abuse

The NHS Staff Survey offers another estimate of the representation of Disabled staff in the workforce. Typically, a greater percentage of survey respondents declare whether they have a disability or not than do staff through ESR although not all staff respond to the staff survey (nationally, 48% in 2023).

The NHS Staff Survey asks, “Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?”

- In the 2024 Staff Survey, **the overall staff results** in respect of this **metric** show that:
- **5.18% of staff** declared that they had a disability.
 - **81%** of respondents declared that they did not have a disability.
 - **Disabled and Non-Disabled** members of staff declaring a disability has decreased **(0.99% / 4.7%)**
 - The Unknown category reflecting the percentage of staff not declaring their disability status has consistently decreased, showing improvement.

In National Benchmarking report of 2023/2024 our Trust was ranked at **31% for Disability non-declaration rate** (where 0% indicates the best in the country to 100% indicating the worst in the country).

WDES Indicator 1(2 of 3) Non clinical

Percentage of Staff declaring a disability compared to percentage of Staff not declaring their disability status

Pay Band	Disabled		Non-Disabled		Unknown	
VSM	0	0.0%	10	0.6%	0	0.0%
Band 9	0	0.0%	4	0.2%	0	0.0%
Band 8d	0	0.0%	5	0.3%	1	0.06%
Band 8c	0	0.0%	6	0.4%	0	0.0%
Band 8b	2	0.12%	24	1.5%	0	0.0%
Band 8a	4	0.2%	19	1.2%	1	0.06%
Band 7	6	0.4%	50	3.1%	2	0.12%
Band 6	5	0.3%	65	4%	4	0.6%
Band 5	5	0.3%	105	6.4%	7	0.43%
Band 4	10	0.6%	152	9.3%	10	0.6%
Band 3	27	1.7%	249	15.3%	13	0.8%
Band 2	27	1.7%	251	15.4%	17	1.04%
Band 1	0	0%	0	0%	0	0%
Under Band 1	0	0%	0	0%	0	0%
Other	17	1.0%	498	30.6%	32	1.96%
Total	103	6.32%	1438	88%	87	5.67%

Highest number of staff indicating a **disability** are in

- **Band 2 to Bands 4**
- Highest number of staff indicating they **do not have a disability** are in **Band 2 through to Band 7**
- Within the Unknown grouping, the highest number of staff , whose disability is unknown fall in the Other category.

Overall:

- **6.32 %** of staff have declared that they have a disability
- **88%** indicate they are **not disabled** and
- The disability of **5.67%** is unknown

Action - In addition to the actions identified on the previous page

- Further work to understand why there are large numbers of staff who have not declared their disability and agree a proactive approach to changing the data in this indicator.
- Investigate if the non declaring rates are also indicative of non reasonable adjustment and what if any appropriate actions are required.

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WDES Indicator 1(3 of 3) Clinical
Percentage of Staff declaring a disability compared to percentage of Staff not declaring their disability status

Pay Band	Disabled		Non-Disabled		Unknown	
VSM	0	0.0%	0	0 %	0	0.0%
Band 9	0	0.0%	2	0.1%	0	0.0%
Band 8d	0	0.0%	5	0.13%	0	0%
Band 8c	0	0.0%	4	0.1%	0	0.0%
Band 8b	2	0.1%	25	0.66%	2	0.1%
Band 8a	6	0.16%	117	3.1%	6	0.16%
Band 7	20	0.53%	397	10.6%	24	0.6%
Band 6	43	1.14%	628	16.7%	48	1.3%
Band 5	47	1.25%	776	20.7%	149	4%
Band 4	8	0.2%	137	3.65%	8	0.2%
Band 3	29	0.8%	558	14.9%	54	1.43%
Band 2	17	0.45%	127	3.38%	12	0.3%
Band 1	1	0.03%	1	0.03%	1	0.03%
Under Band 1	0	0%	0	0%	0	0%
Other	3	0.08%	144	3.8%	7	0.18%
Total	176	4.74%	2921	78%	311	8.3%

Seniority	Disabled		Non-Disabled		Unknown	
Consultant	7	0.18%	200	5.3%	21	0.6%
Non-consultant Specialist	2	0.1%	84	2.2%	2	0.1%
Resident	0	0.0%	20	0.53%	8	0.2%

Out of the 3751 Clinical staff overall:

- Highest number of disabled staff are in Bands 5 and 6
- Highest number of nondisabled staff fall in Bands 3, 5, 6 and 7
- Staff disability of 311 staff members is unknown

In terms of Seniority

Of the senior membership:

- **only 9 members of staff are disabled,**
- **304 staff are Nondisabled and**
- **the disability of 31 staff is unknown.**

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Indicator 2

The relative likelihood of non-disabled applicants being appointed from shortlisting compared to Disabled applicants

	2023	2024	2025	Difference (2024 vs 2025)
Recruitment The relative likelihood of non-disabled applicants being appointed from shortlisting compared to Disabled applicants	1.54	1.09	0.95	0.14

In National Benchmarking report of 2023/2024 our Trust was ranked at 3% (where 0% indicates the best in the country to 100% indicating the worst in the country). This places our Trust in the upper quartile.

Action in conjunction with the POD/PIT / EDI manager

- Review local data and explore what evidence exists that indicates a need to address disparities in recruiting disabled staff
- Recruitment exercises show a proactive and positive transparency around meeting the needs of Disabled people and reviewing how reasonable adjustments are managed within the recruitment process
- Ensuring the social model of disability is integrated within Recruitment and Selection training
- Continue to work with local college to ensure proactive approaches are in place e.g. Project Choice

A figure less than 1.0 would suggest that disabled applicants are more likely to be appointed than non-disabled applicants.

Data collected shows that the likelihood of Non-Disabled applicants being appointed compared with Disabled applicants was 0.95; not significantly below "1.0" or equity.

Specifically:

- 468 out of 2582 **non-disabled** candidates were appointed from shortlisting (**18.1%**).
- Comparatively 38 out of 199 **Disabled** candidates were appointed (**19.09%**). While the figure for disabled candidate being appointed is slightly greater that Non-disabled, it is important to note that the total number of disabled applicants was comparatively very low
- The figure for **2023**, showed that applicants with a disability were **1.54 times less likely** to be appointed.
- The change can be seen in **2025**, where this figure shows an improved indicator for the likelihood of non- disabled applicants being appointed than disabled candidates (**0.95**)
- This figure is better than the appointment ratio in 2024

As a Disability Confident employer, the Trust is committed to creating an inclusive and supportive workplace for everyone. We want to ensure that all our employees have access to the tools, adjustments, and support they need to thrive in their roles from when they start working for the Trust.



Indicator 3

The relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff

Metric 3	2023	2024	2025	Difference (2023 vs 2024)
Capability	0	0	3.24 (4 members of staff)	3.24

Action

- With POD review the capability policy cross referenced to disability to provide assurance that all steps and reasonable adjustments are in place prior to the start of any capability process (ensuring there is transparency from any informal process to a formal one).
- Review the data collected and explore any disproportionate representation of disabled staff in formal capability processes.

This metric is based on data from a two- year rolling average of the current year and the previous year.

- The metric applies to capability on the **grounds of performance** and not ill health.
- Therefore, Staff entering the capability process for reasons of **both** performance and ill health **are not** included in this count.

The data shows that the *relative likelihood of disabled staff entering the formal capability process* compared to non-disabled staff is 3.24. The actual number has increased from **0** members of disabled staff in 2023/24 to **4** members of disabled staff.

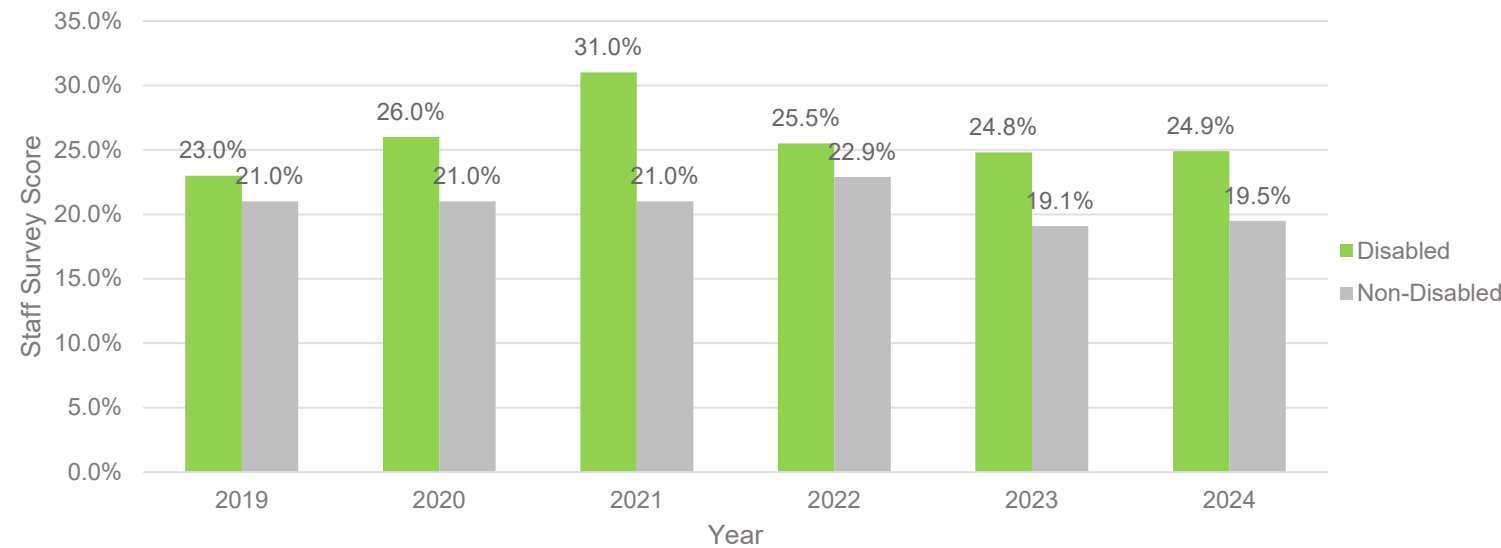
The Trust will ensure that all steps and reasonable adjustments are put in place for disabled individuals before any formal process starts.

In National Benchmarking report of 2023/2024 there was no ranking for our Trust.

Indicator 4a WDES Staff Survey Data 2024

In the last 12 months, percentage of staff experiencing harassment, bullying or abuse from patients / service users, their relatives or other members of the public

	2019	2020	2021	2022	2023	2024
Disabled	23.0%	26.0%	31.0%	25.5%	24.8%	24.9%
Non-Disabled	21.0%	21%	21.0%	22.9%	19.1%	19.5%



The percentage of staff who experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months:

- A higher proportion of Disabled staff experienced **harassment, bullying or abuse (25%)** than Non-disabled staff (**19.5%**)
- There has been a small Increase in both Disabled and Non-disabled staff experiencing **harassment, bullying or abuse** from 2023 to 2024 (**0.2%** and **1.4%** respectively). However, in the last year, comparatively Disabled staff have experienced more **harassment, bullying or abuse than Non-disabled staff (5.5%)**

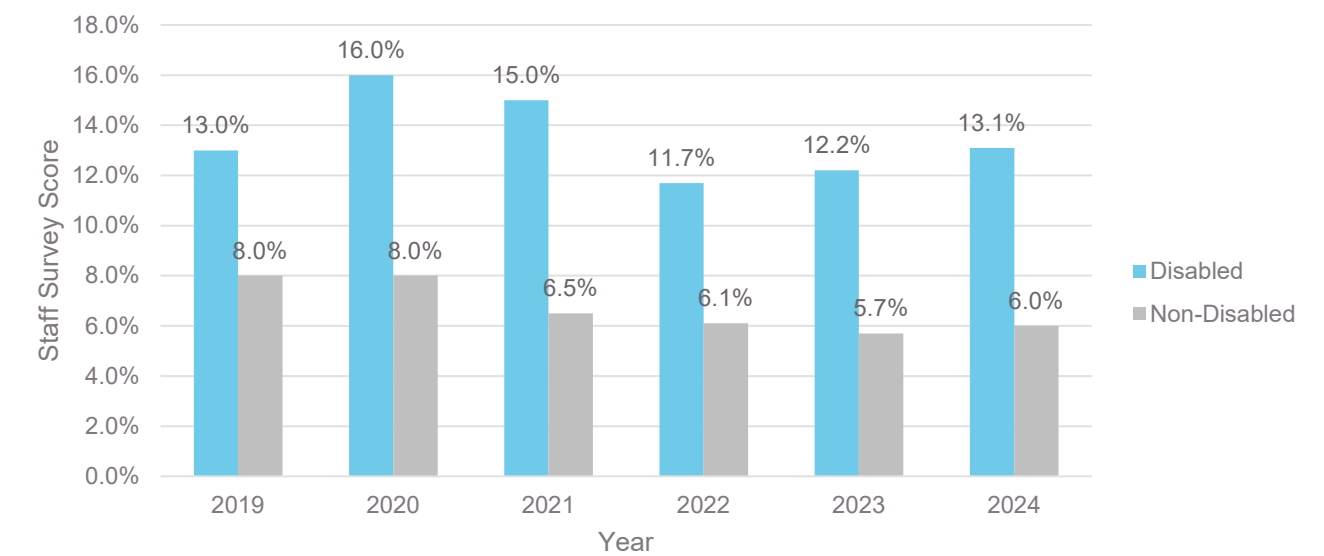
In National Benchmarking report of 2023/2024 our Trust was ranked at 10% for Disabled staff and 18% for Non-disabled staff (where 0% indicates the best in the country to 100% indicating the worst in the country).

Indicator 4b WDES Staff Survey Data 2024

In the last 12 months, percentage of staff experiencing harassment, bullying or abuse from managers



	2019	2020	2021	2022	2023	2024
Disabled	13.0%	16.0%	15.0%	11.7%	12.2%	13.1%
Non-Disabled	8.0%	8.0%	6.5%	6.1%	5.7%	6.0%



The percentage of staff who **experienced harassment, bullying or abuse from managers in the last 12 months:**

- The number of disabled staff experiencing harassment, bullying or abuse from managers in the last 12 months shows an increase of **0.9%** whereas for non - disabled staff the increase was **0.3%** .
- **In the last year the difference between Disabled and Non-disabled staff experiencing harassment, bullying or abuse from Managers is 7.1%.**
- Data collected also shows that disabled staff experiencing harassment, bullying or abuse from patients and managers has been relatively consistent and is higher than for Non-disabled staff.
- The number of disabled staff experiencing harassment bullying or abuse from their managers is more than twice as likely compared to Non-disabled staff

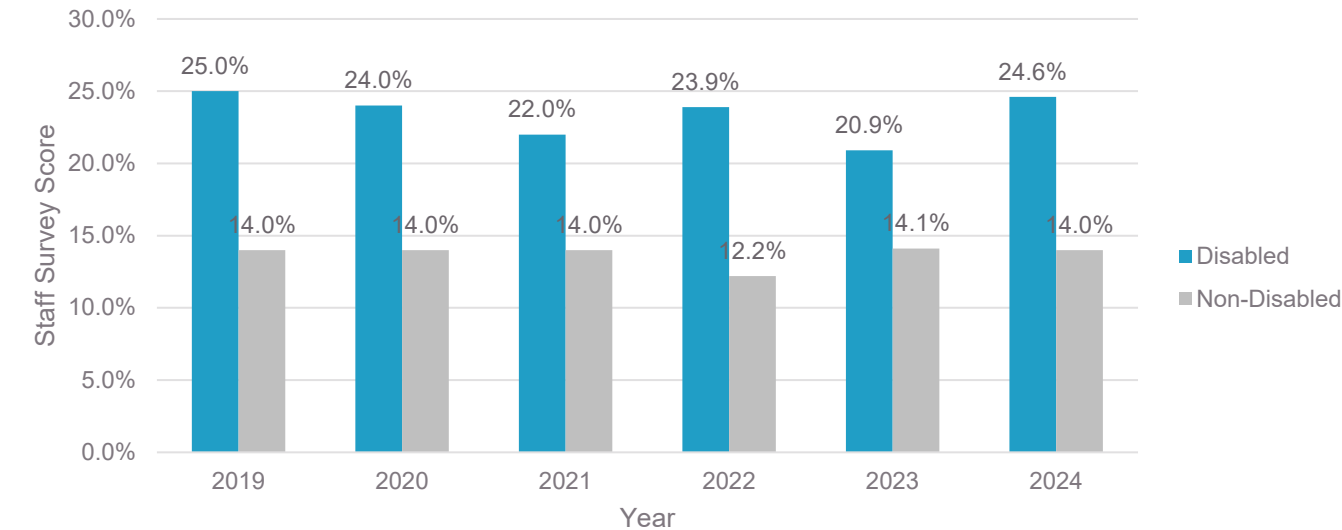
In respect of this metric specifically the National Benchmarking report of 2023/2024 our Trust was ranked at 24% for Disabled staff and 18% for Non-disabled staff (where 0% indicates the best in the country to 100% indicating the worst in the country).

Indicator 4c WDES Staff Survey Data 2024

In the last 12 months, percentage of staff experiencing harassment, bullying or abuse from colleagues



	2019	2020	2021	2022	2023	2024
Disabled	25.0%	24.0%	22.0%	23.9%	20.9%	24.6%
Non-Disabled	14.0%	14.0%	14.0%	12.2%	14.1%	14.0%



The percentage of staff who **experienced harassment, bullying or abuse from other colleagues in the last 12 months:**

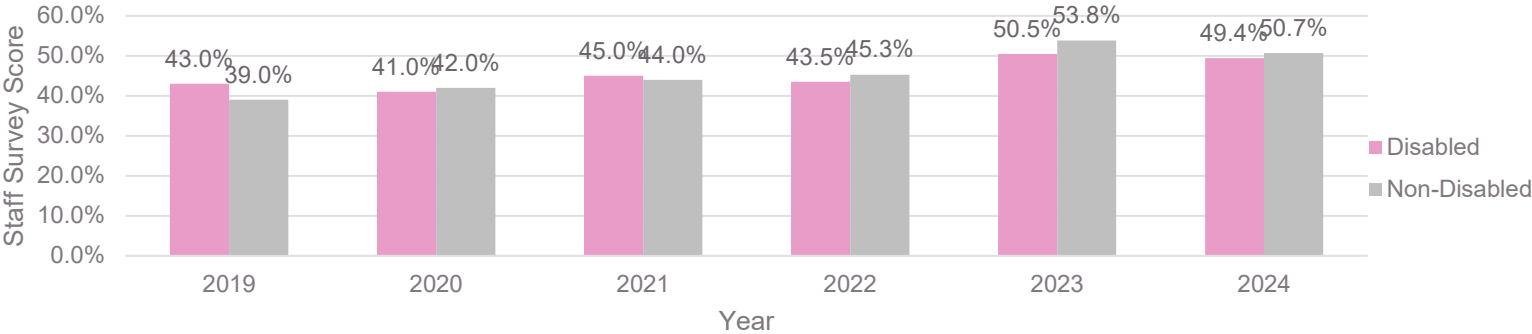
- was significantly higher for Disabled staff **24.6%**, than for non-disabled staff **14%** (**almost twice as much**)
- For non-disabled staff the percentages have remained mostly consistent at **14%** apart from a dip in 2022 (**12.2%**)
- Comparing the 2024 data, the difference between the percentages of staff **experiencing harassment, bullying or abuse from other colleagues in the last 12 months** shows a **fairly consistent differential** for Staff with disabilities compared to staff who do not have a disability - the 2024 data showing a difference of **10.6%**

In National Benchmarking report of 2023/2024 our Trust was ranked at 35% for Disabled staff and 35% for Non-disabled staff (where 0% indicates the best in the country to 100% indicating the worst in the country).

Indicator 4d WDES Staff Survey Data 2024

In the last 12 months, percentage of staff experiencing harassment, bullying or abuse they or their colleague reported it

	2019	2020	2021	2022	2023	2024
Disabled	43.0%	41.0%	45.0%	43.5%	50.5%	49.4%
Non-Disabled	39.0%	42.0%	44.0%	45.3%	53.8%	50.7%



The percentage of staff who indicated that they or a colleague reported an incident of harassment, bullying or abuse experienced at work was:

- Similar for Disabled staff, **49.4%**, and for non-disabled staff, **50.7%**
- For both groups there has been a slight drop in this metric in 2024
- Signing up to the Z tolerance, delivering Incivility Saves Lives, and the ongoing work around harassment and bullying may well account for the rise in reporting.
- While a poster campaign around Incivility has been produced, aspects pertaining specifically to addressing Disability equality will be actioned e.g. Recruitment, Inclusivity training.

In respect of this metric specifically the National Benchmarking report of 2023/2024 our Trust was ranked at **82% for Disabled staff and 88% for Non-disabled staff (where 0% indicates the best in the country to 100% indicating the worst in the country).**

Actions for this metric overall

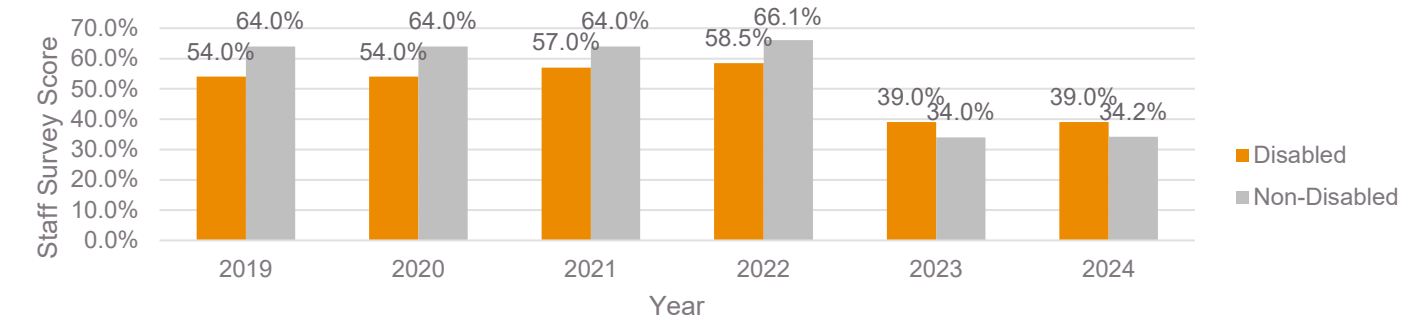
- Managers and the Executive Sponsor for D-ability to ensure messages on Incivility and Z tolerance are consistently updated and applied and training is provided as appropriate
- Managers to monitor staff relations and intervene with challenge and /or support as appropriate, integrated as part of the Appraisal process so that senior managers are aware and can take any action required.
- Ensure that all / any abuse is recorded on appropriate systems (e.g. Selinity) is compared on a quarterly basis and cross referenced to all protected characteristics to monitor trends and actions

WDES Indicator 5

The percentage of staff who believed that their organisation provided equal opportunities for career progression or promotion



	2019	2020	2021	2022	2023	2024
Disabled	54.0%	55.0%	57.0%	58.5%	39%	39.0%
Non-Disabled	64.0%	64.0%	64.0%	66.1%	34%	34.2%



Actions

- Work with the L and D team towards offering a developmental/ leadership model for disabled members of staff
- D-Ability Lead and Executive sponsor work with managers to ensure disabled staff are able to put themselves forward for career progression irrespective of the nature of their disability and be considered on an equal basis
- D-Ability Lead and Executive sponsor assess the potential for a mentoring programme to enable a better understanding of each others experiences and help in progression

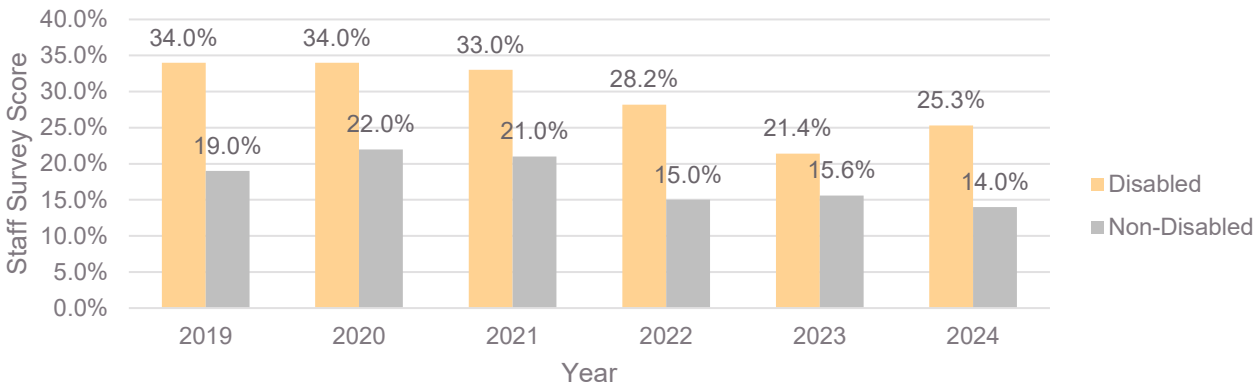
- Since 2019 to 2022, data collected showed that both **Disabled staff and Non-Disabled Staff held a stronger belief** that the Trust provided equal opportunities for career progression or promotion (**54% to 58.5% and 64% to 61.1%**)
 - However, since then both groups reflected a lower level of confidence in the Trust **providing equal opportunities for their career progression or promotion** (Disabled staff a drop of **19.5%** and for **Non –Disabled staff 32.1%**)
 - In comparison between both groups in 2024, there is a **4.8%** difference
- In the **National Benchmarking report of 2023/2024** our Trust was ranked at **9%** for Disabled staff and **91%** for Non-disabled staff (where **0%** indicates the best in the country to **100%** indicating the worst in the country).
- .

WDES Indicator 6

Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.



	2019	2020	2021	2022	2023	2024
Disabled	34.0%	34.0%	33.0%	28.2%	21.4%	25.3%
Non-Disabled	19.0%	22.0%	21.0%	15.0%	15.6%	14.0%



- Actions**
- The D-ability Network lead to work with the POD / EDI manager to review data and determine how appropriate reasonable adjustments can be made.
 - The D-ability Network lead to work with the POD / EDI manager to ensure discussions around Sickness leave are not integrated as part of an individual's disability and appropriate discretion is given when discussing absence/ sickness leave.

In the last year 2024 - the percentage of staff who felt pressure from their manager to come to work despite not feeling well enough to perform their duties:

- Shows an increase for staff who have a Disability by **3.9%**. (up from **21.4%** to **25.3%**)
- For non-disabled staff, this figure has dropped by **1.6%** to **14%**
- Previous indications around this indicator were linked to Covid, however, staff have reported that their personal health is often compromised due to the pressure to come to work. This is reflected within the latest data collected.
- Information from the staff network has also indicated disabled staff will come to work whilst not feeling well through fear of triggering sickness stages in the absence policy. Additionally, Managers may not take the individuals disability into account. However, the network has also indicated that for some colleagues the pressure to come to work may be self imposed and this needs to be explored further.

In the National Benchmarking report of 2023/2024 our Trust was ranked at **27% for Disabled staff and 32% for Non-disabled staff (where 0% indicates the best in the country to 100% indicating the worst in the country).**

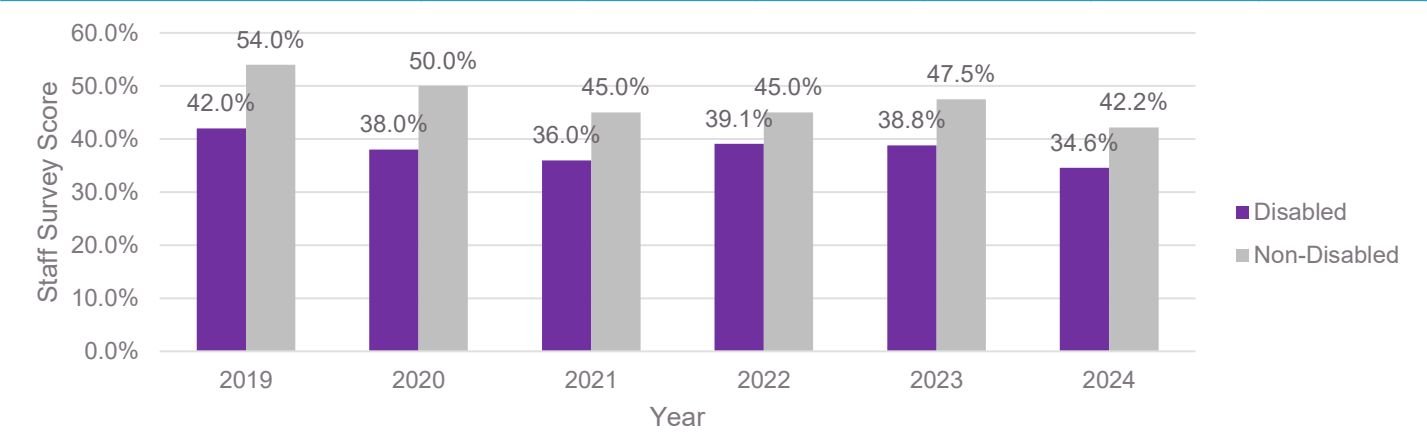
WDES Indicator 7

The percentage of staff who were satisfied with the extent to which their organisation values their work



Gateshead Health
NHS Foundation Trust

	2019	2020	2021	2022	2023	2024
Disabled	42.0%	38.0%	36.0%	39.1%	38.8%	34.6%
Non-Disabled	54.0%	50.0%	45.0%	45.0%	47.5%	42.2%



The percentage of staff who were satisfied with the extent to which their organisation values their work:

- Looking at the figures Disabled staff continue to feel that their work is less valuable to the organisation than Non Disabled staff, with a difference of **7.6%** between the two groups (2024).
- The difference between disabled and non-disabled staff suggests that there is a greater need to fully understand the experiences and improve the ways in which people feel valued and heard.

In the **National Benchmarking report of 2023/2024** our Trust was ranked at **44%** for Disabled staff and **64%** for Non-disabled staff (where 0% indicates the best in the country to 100% indicating the worst in the country).

Action

- The D-ability Network lead and Executive sponsor to work with the POD / EDI manager to engage management at all levels to work with disabled colleagues in raising the profile of disability so that the overall satisfaction of staff with a disability or long-term health condition becomes a priority, resulting in improved staff satisfaction in the workplace. .

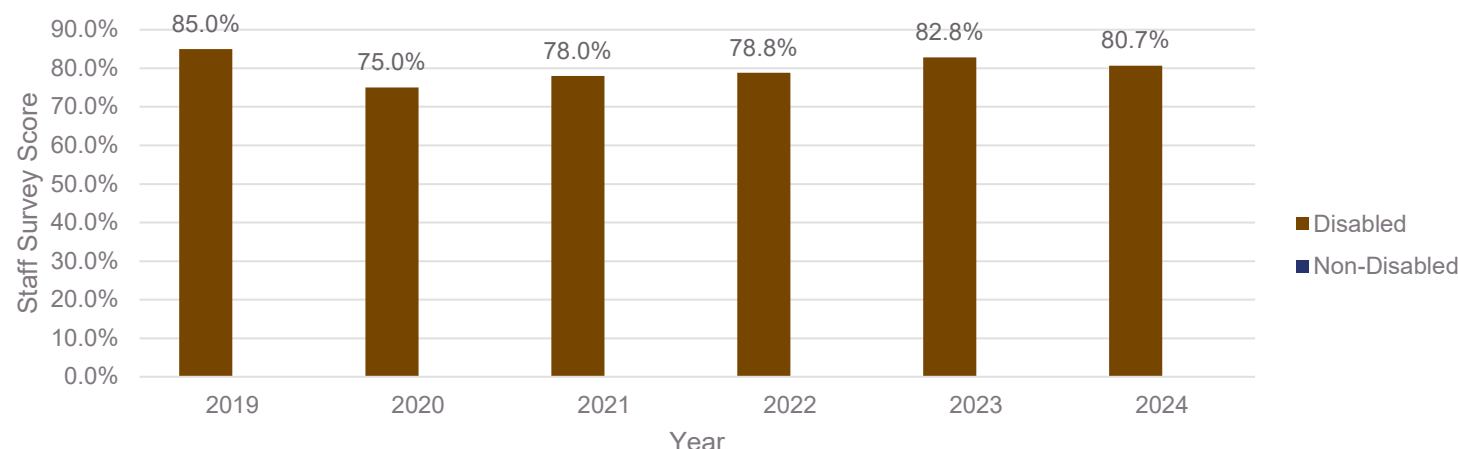
WDES Indicator 8

The percentage of Disabled staff whose employer had made reasonable adjustments to enable them to carry out their work



Gateshead Health
NHS Foundation Trust

	2019	2020	2021	2022	2023	2024
Disabled	85.0%	75.0%	78.0%	78.8%	82.8%	80.7%
Not-Disabled	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%



- 80.7% of staff with disabilities stated that the Trust had made adequate adjustments for them to carry out their work. This figure though, has decreased by **2.1%** from **82.8%** to **80.7%**. This suggests that nearly a 1/5 of disabled staff feel that the Trust has not made appropriate adjustment.
- It is worth noting that while there is a positive move in ensuring reasonable adjustments are in place there may still be some members of staff who have not declared their disability status.

In the National Benchmarking report of 2023/2024 our Trust was ranked at 9% for Disabled staff (where 0% indicates the best in the country to 100% indicating the worst in the country).

Action

- D-ability and the PIT team work towards ensuring disabled staff within the Trust are confident to self report their disability on ESR as well as discussing their disabilities with their Managers. This should enable reasonable adjustments are put in place as appropriate and individuals feel supported and valued.

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Indicator 4d

Indicator 5

Indicator 6

Indicator 7

Indicator 8

Indicator 9

Indicator 10

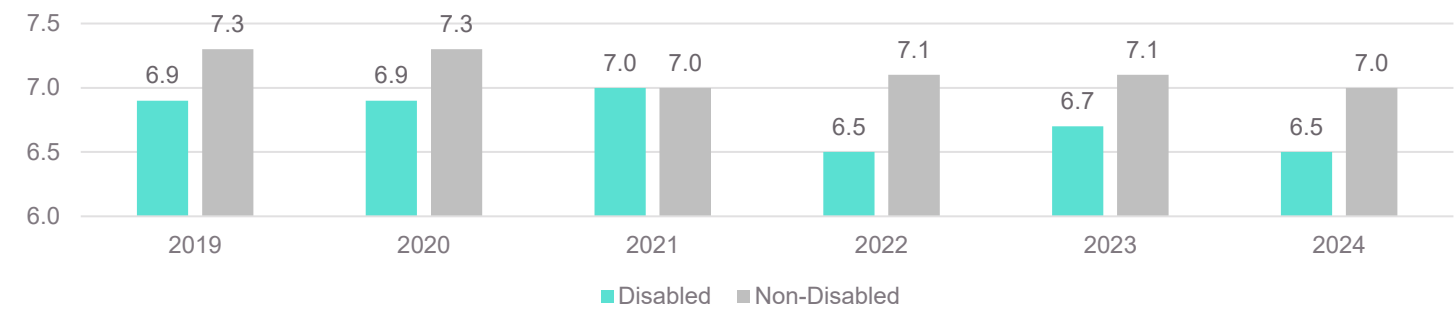
WDES Indicator 9

The NHS staff survey-based staff engagement score



Gateshead Health
NHS Foundation Trust

	Staff engagement score for disabled staff compared to non-disabled staff and the overall engagement for the organisation (out of 10).					
	2019	2020	2021	2022	2023	2024
Disabled	6.9	6.9	7.0	6.5	6.7	6.5
Non-Disabled	7.3	7.3	7.0	7.1	7.1	7.0



- This indicator shows that over the last six years the engagement score for Disabled groups have been consistently around the mid 6.5 mark, whilst for the non-disabled groups has stood at 7.
- The staff engagement score from 2024 for Disabled groups has dropped by 0.2% and Non-disabled staff has dropped by 0.1%
- The decrease suggests that work needs to be carried out to understand why disabled staff have worst experience at the Trust compared to other groups, to help us improve the ways in which staff feel valued, supported and heard.

In the National Benchmarking report of 2023/2024 our Trust was ranked at 41% for Disabled staff and 44% for Non-disabled staff (where 0% indicates the best in the country to 100% indicating the worst in the country).

Action

- Managers to consistently engage with the D-ability network members to determine what factors impact upon disabled staff, how they are / can better be supported and made to feel valued

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Indicator 1

Indicator 2

Indicator 3

Indicator 4a

Indicator 4b

Indicator 4c

Indicator 4d

Indicator 5

Indicator 6

Indicator 7

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Indicator 9

Indicator 10

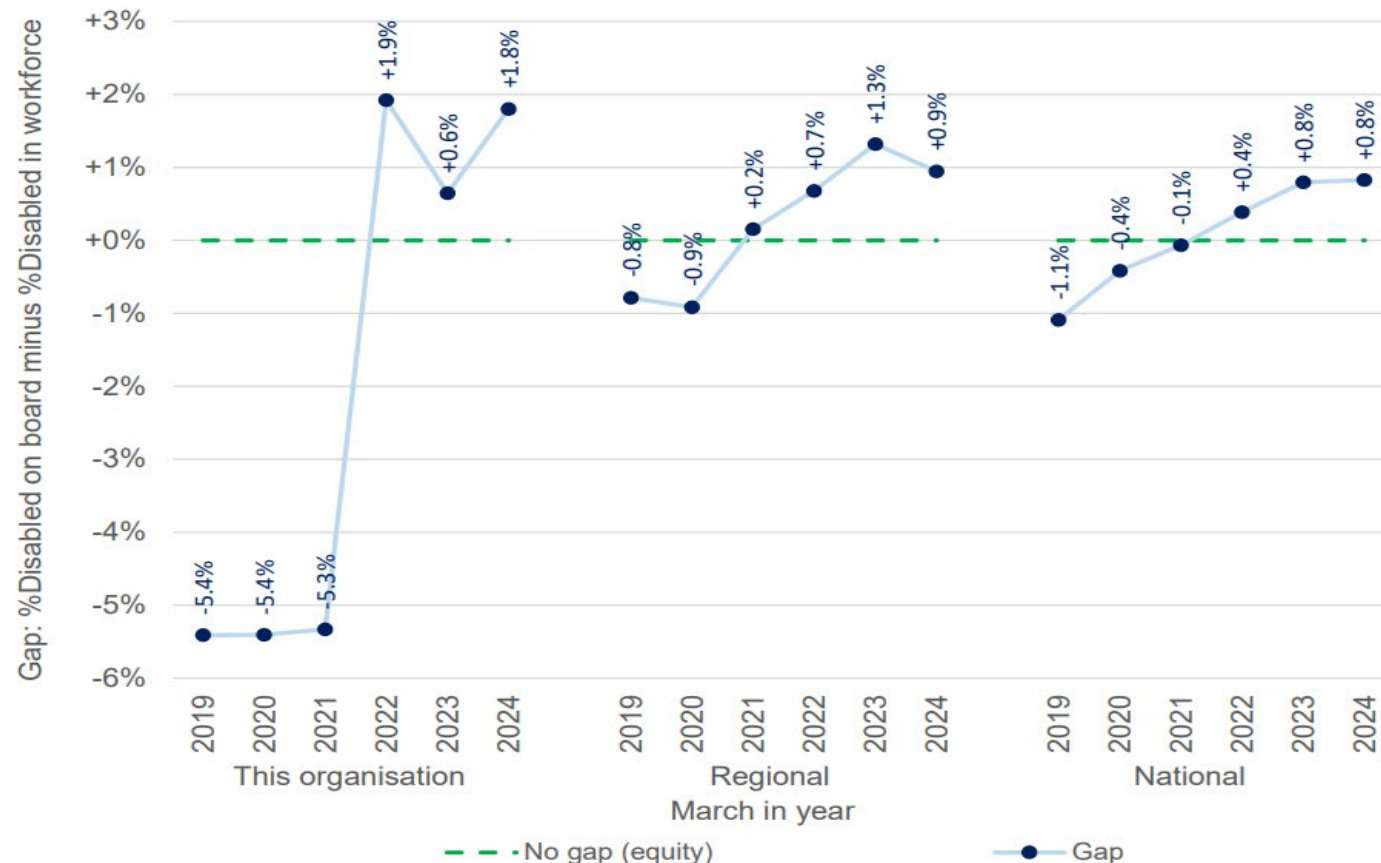
WDES Indicator 10

Overall board membership



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NHS Foundation Trust

Gap in Disabled representation at board level, overall



As at the end of March 2024:

- the difference between Disabled representation on the board and in the workforce was +1.8%.
- Disabled members were at least proportionately represented on the board in terms of a headcount.

In the National Benchmarking report of 2023/2024 our Trust was ranked at 36% overall
40% for Voting members
73% for Executive members (where 0% indicates the best in the country to 100% indicating the worst in the country).

Action

- Ensure that the EQIA process has been applied to guarantee that all external companies involved in Executive Search appointments have a proactive approach to engaging with Disabled groups and can show transparency and equality in their process of shortlisting
- Stakeholders and members of Trust are consistently included and involved in the initial discussions
- An external disability representative is present as part of the recruitment panel

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Indicator 1

Indicator 2

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Indicator 4a

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Indicator 10

WDES action plan 2025 - 26

Mitigation / Actions: Indicators 1 /2 /4	Risk	Lead	Time frame	WRES Metric
Review and develop guidance so that reasonable adjustments are in place for our staff and are fit for purpose. Refresh the Accessible Information Standard and Learning Passport for the Trust Recruitment will be value based , incorporates equity around disability and incorporates workforce planning, improve length of time to hire. Guarantee that our recruitment adverts have a diversity statement. Guarantee that our recruitment adverts are fully accessible by offering candidates the opportunity to request reasonable adjustments. Engaging with the D-ability network and POD / PIT and the EDI manager to improve disclosure rates on ESR Work with the D-ability group to promote the social model of disability and regularly promote positive messages relating to Disability and show a reduction in year-on-year data reported in Indicator 4 which relates to bullying, harassment and abuse	Disabled staff: - fail to experience any significant improvement in reasonable adjustments. - Disabled Candidates would not want to work in the Trust due to length of wait Staff Survey Indicators , 2/ 4 do not show an improvement	Head of People Services / FTSU/ POD Lead	November 2025 to November 2026	Indicator 2/ 4 and HIA 6
- Mitigation / Actions: Indicators 3 /6/8	Risk	Lead	Time frame	WRES Metric
Continue to capture diversity data for member of staff referred to any capability and performance management procedure, both formal and informal to provide assurance, that all steps and reasonable adjustments are in place prior to the start of any capability process (ensuring there is transparency from any informal process to a formal one). Review the data collected and explore any disproportionate representation of disabled staff in formal capability processes and take action as appropriate Work in collaboration with the FTSU Guardian, and the D-ability Network create and launch EDI feedback form specifically for staff to raise concerns Collect and analyse disability pay gap data Working with the Chair and Co-Chair of D-ability launch monthly webinars for all staff highlighting different aspects of disability.	Capability and Disciplinary processes are not transparent. Lack of reasonable adjustments within any process Disability Pay gap show a greater disparity with able bodied staff	Resourcing and EDI Manager and Head of People Services and L and D	October 2025 to October 2026	Indicator 3 /6/ 8 and HIA 6

WDES action plan 2025 - 26

Mitigation / Actions: Indicators 5/7	Risk	Lead	Time frame	WRES Metric
Further work to understand why there are large numbers of staff who have not declared their disability and agree a proactive approach to changing the data in this indicator. Investigate if the non declaring rates are also indicative of non reasonable adjustment and what if any appropriate actions are required. Promote leadership and career development opportunities, specifically tailored to disabled staff. Link in with regional and national Disability rights programme of work	Non-Declaration of disability is perceived to be better in career prospects. Career development opportunities are not seen as relevant for disabled staff	Head of People Services / FTSU/ POD Lead	November 2025 to November 2026	Indicator 5 /7
- Mitigation / Actions: Indicators 9 (Staff Engagement)	Risk	Lead	Time frame	WRES Metric
Creating multiple channels to allow staff to speak up and raise concern Facilitate conversations on lived experience Ensure appropriate training for all line managers to hold supportive conversations with disabled staff Exec. Sponsor to be proactive in inviting staff network to present at Board meetings Providing training sessions to raise awareness and discussion on such as neurodivergence	Employee criteria and marking is not transparent and choice of candidate may reflect unconscious bias as candidates responses do not reflect the requirement of the post	Resourcing and EDI Manager and Head of People Services Land D	October 2025 to October 2026	Indicator 9
- Mitigation / Actions: Indicators 9 (Staff Engagement)	Risk	Lead	Time frame	WRES Metric
All external companies involved in Executive Search appointments can show a proactive approach and transparency around engaging with Disabled groups and equity in their process of shortlisting The Disabled Network members are consistently included and involved in the initial discussions An external disabled representative is present as part of the recruitment panel	There is no improvement in representation of communities served and the Board representation remains the same		Ongoing	Indicator 2

Report Cover Sheet

Agenda Item: 24

Report Title:	Integrated Oversight Report August 2025			
Name of Meeting:	Trust Board			
Date of Meeting:	25 th September 2025			
Author:	Mrs Karen Parker Associate Director of Midwifery/SCBU			
Executive Sponsor:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Karen Parker			
Purpose of Report <i>Briefly describe why this report is being presented at this meeting</i>	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
	<i>This report presents an overview of maternity for August 2025</i>			
Proposed level of assurance – <u>to be completed by paper sponsor:</u>	Fully assured ☐ <i>No gaps in assurance</i>	Partially assured ☒ <i>Some gaps identified</i>	Not assured ☐ <i>Significant assurance gaps</i>	Not applicable ☐
Paper previously considered by: <i>State where this paper (or a version of it) has been considered prior to this point if applicable</i>	Obstetrics & Gynaecology Safecare 11/9/25 Division of Surgery, Women's Health and Children Operational Board 24/9/25			
Key issues: <i>Briefly outline what the top 3-5 key points are from the paper in bullet point format</i> <i>Consider key implications e.g.</i> • Finance • Patient outcomes / experience • Quality and safety • People and organisational development • Governance and legal • Equality, diversity and inclusion	• Maternity Dashboard 2025/26: • August 2025 data • Positive Highlights • Maternity dashboard exceptions • Exception reports: • Inphase's #20188 – Intrauterine death • PMRT (perinatal mortality report tool) Q1 summary • Maternity Incentive Scheme – update • North East & Yorkshire Maternity Service heatmap • NMPA update – published 11/9/25			
Trust Strategic Aims that the report relates to:	Aim 1 ☒	We will continuously improve the quality and safety of our services for our patients		
	Aim 2	We will be a great organisation with a highly engaged workforce		

	☐				
	Aim 3 ☐	We will enhance our productivity and efficiency to make the best use of resources			
	Aim 4 ☐	We will be an effective partner and be ambitious in our commitment to improving health outcomes			
	Aim 5 ☐	We will develop and expand our services within and beyond Gateshead			
Trust corporate objectives that the report relates to:					
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)					
Has a Quality and Equality Impact Assessment (QEIA) been completed?	Yes ☐	No ☐	Not applicable ☒		

Maternity Integrated Oversight Report

Maternity data from August 2025



Maternity IOR contents

- Maternity Dashboard 2025/26:
 - August 2025 data
- Maternity dashboard exceptions
- Exception reports:
 - 31+6 weeks IUD
- Items for information:
 - Q1 PMRT Update
 - Maternity Incentive Scheme
 - NEY Heatmap
 - NMPA report – published 11/9/25 with PPH outlier response

Maternity Oversight Report SPC Tool

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Births	Aug 25	166	-			161	126	196
Spontaneous vaginal deliveries	Aug 25	72	-			71	49	94
Assisted births	Aug 25	94	-			89	63	116
Induction of Labour	Aug 25	51	-			56	25	86
Maternity Readmissions	Aug 25	4	-			3	-1	7
Neonatal Readmissions	Aug 25	4	-			4	-1	10
Smoking at time of booking	Aug 25	4.93%	15.00%			6.60%	0.14%	13.07%
Smoking at time of delivery	Aug 25	2.41%	6.00%			4.77%	-0.76%	10.29%
In area CO at booking	Aug 25	99.30%	90.00%			94.07%	82.82%	105.31%
In area CO at 36 weeks	Aug 25	84.61%	80.00%			84.37%	74.15%	94.59%
Admitted directly to NNU (SCBU) (>37 weeks)	Aug 25	5	4			7	-1	15
Percentage Admitted directly to NNU (SCBU) (>37 weeks)	Aug 25	3.18%	6.00%			4.41%	-0.91%	9.73%
Preterm birth rate <=36+6 weeks at birth	Aug 25	4.85%	6.00%			5.17%	-0.78%	11.13%
Spontaneous Vaginal Births (%)	Aug 25	43.64%	-			44.56%	34.20%	54.93%
Induction Rate	Aug 25	30.72%	-			35.24%	20.14%	50.35%
Instrumental Delivery Rate	Aug 25	12.65%	-			12.38%	4.98%	19.78%
Elective C Section Rate	Aug 25	23.64%	-			19.44%	10.83%	28.06%
Emergency C Section Rate	Aug 25	20.00%	-			23.68%	13.77%	33.58%
C Section Rate	Aug 25	43.64%	-			43.12%	34.48%	51.76%
3rd or 4th degree tear (Total) Percentage	Aug 25	0.60%	3.00%			1.13%	-1.45%	3.70%
Massive PPH >=1.5L (All births)	Aug 25	7	2			7	-1	15
Breastfeeding: Percentage of Initiated Breastfeeding	Aug 25	78.79%	66.20%			79.33%	70.45%	88.20%
Breastfeeding: Breastfeeding at Discharge (Transfer to)	Aug 25	67.52%	56.20%			62.60%	49.49%	75.71%

Maternity



Gateshead Health
NHS Foundation Trust

Safe

Responsive

Maternity Dashboard 2025/2026

No new exceptions to report

2025/26		April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Number of perinatal losses		0	0	0	0	1							
Number of MNSI cases		0	0	0	0	0							
Number of incidents logged as moderate harm or above		0	0	1	0	0							
Minimum obstetric safe staffing on labour ward		100%	100%	100%	100%	100%							
Minimum midwifery safe staffing including labour ward (average fill rates)	Day shift	80.2%	80.1%	85.4%	82.1%	72.9%							
	Night shift	97.8%	99.1%	99.3%	99.5%	98.8%							
Service user feedback	FFT “Overall how was your experience of our service” – total score for very good and good responses	100%	100%	100%	100%								
	Complaints	2	2	2	1	2							
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust		0	0	0	0	0							
Coroner Reg 28 made directly to Trust		0	0	0	0	0							

PMRT Summary

Responsive
Safe
Maternity

Gateshead Health
 NHS Foundation Trust

Number of Completed Cases in this Quarter (see notes)	0	Number of meetings held	0	% of meetings external reviewer present	N/A	Number of external reviews attended	1 PSII 4 PMRT
Any issues with MIS compliance for reporting				No			
Number of Cases Graded C or D in Quarter				0	Number of these cases escalated to your Trust PS panel for discussion about level of investigation or previously referred / or under investigation or MNSI		N/A
Number of C & D Graded cases where issues associated with FGR Management Identified	Q1	Q2	Q3	Q4			
	N/A						
Number of C & D Graded cases where issues associated with RFM Management Identified	Q1	Q2	Q3	Q4			
	N/A						
Number of C&D graded intrapartum stillbirths, early neonatal deaths and severe brain injury where failures of intrapartum monitoring are identified as contributory factor.	Q1	Q2	Q3	Q4			
	N/A						
Number of C & D Graded cases where prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	Q1	Q2	Q3	Q4			
	N/A						
Other Themes and Actions from PMRT Cases: <i>Please also detail any specific themes/actions relating to socioeconomic deprivation and ethnicity.</i>					N/A		

Maternity Incentive Scheme progress

Responsive
Safe
Maternity

Gateshead Health
NHS Foundation Trust

Overview of progress on MIS year 7 safety action requirements

*Mandated Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	7	0	0	7
2	0	2	0	0	2
3	0	1	2	3	6
4	2	3	7	7	19
5	0	8	3	1	12
6	0	8	0	1	9
7	0	3	1	0	4
8	3	18	0	0	21
9	1	7	1	0	9
10	1	8	0	0	9
Total	7	65	14	12	98

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

*Non-mandated actions will not be included in this table.

Progress update since July 2025

- MNVP escalation to LMNS therefore SA7 compliant
- Obstetric safety champion in progress to meet compliance with SA9
- Non-compliance added to risk register – Risk ID #4778
- **Potential emerging concern – training compliance of 90% required by 30 November 2025 (SA8)**

NEY Maternity service heatmap

Responsive
Safe
Maternity

Gateshead Health
 NHS Foundation Trust

NENC Heatmap Metrics - LMNS Team Collection

12	Do you have any of the following leadership or specialist roles? Please select all that apply;	DoM or Associate DoM in every trust or Health Board?	HoM or Deputy DoM in every maternity unit within the organisation?	CD for Obstetrics or Obstetric Lead	Consultant Midwife	Lead Midwife for Education (LME)	Retention and Recruitment Lead	Professional Midwifery Advocate (PMA) Lead	Digital Midwife	Governance Lead	Bereavement Lead Midwife	Infant Feeding Lead Midwife	MNVP Chair	None of these roles in place
		Yes	N/A	No	No	Practice development midwife	Yes	Yes	Yes	Yes	Yes	In Public Health Midwife portfolio	Yes	N/A
13	If there are any gaps, what are your plans and timeframes to recruit to these posts?	Associate DoM in post, no plans for additional HOM/deputy HOM, CD for obstetrics vacant - awaiting new SLM in post to identify CD												
14	All Maternity Safety Champions in post? (Midwifery/Obstetric/Neonatal/Non-Executive Director/Ex Director)	Yes	Yes			No				No change since previous submission			N/A	
15	How many CQC Warning Notices (Section 29a) has the Trust received in relation to maternity services that are ongoing? (open action plan or in response phase?)	None												
	S29a warning notices no longer need counting once the ICB/LMNS has agreed via an appropriate governance process that all maternity service QI actions have been closed and expected improvements seen AND the CQC have carried out a follow up inspection or informed that the elements raised in the s29a have been met as all improvements have been made. PLEASE INCLUDE HERE ALL S29a NOTICES IN RELATION TO PERINATAL SERVICES ONLY REGARDLESS OF WHETHER THEY ARE IN THE PUBLIC DOMAIN OR NOT													
16	How many CQC Warning Notices (Section 29a) has the Trust received in response phase that are not yet in the public domain?	None												
	This information is captured to ensure that those CQC regulation notices that have not yet been shared in the public domain are excluded from the heatmap. INCLUDE HERE THE TOTAL NUMBER OF S29a NOTICES REPORTED IN Q15 THAT ARE NOT YET IN THE PUBLIC DOMAIN.													
17	Has the provider received any Regulation 28 Coroner Prevention of Future Death notices for maternity in the last 56 days?	Yes							No	No				
18	Are there any Regulation 28 Coroner Prevention of Future Death notices for maternity which have open action plans to address the issues raised?	Yes							No	No				
	Regulation 28 Coroner PFD notices no longer need counting once the ICB/LMNS has agreed via an appropriate governance process that all maternity service QI actions have been closed and expected improvements seen													
19	BirthRate+ completed in last 3 years.	Yes	Yes		No				In progress			No change since previous submission		N/A

Gateshead August 2025 submission, all other metrics taken from MSDS/other data sources already submitted

Please note the following slides are shared as an example only & some slides have been redacted as they contain data from another region.



Reading the Signals

Maternity and neonatal services in East Kent: 'Reading the signals' report

Key Action Area 1: Monitoring safe performance – finding signals among noise

There are huge benefits to the effective monitoring of outcomes. Clinicians can see where there is scope to improve effectiveness and address problems of service safety, and evidence from other specialties shows that – perhaps after a little early reluctance – they embrace this enthusiastically, with demonstrable improvement in outcomes and patient safety. Trusts can identify warning signs and take action where necessary, before problems and behaviour become embedded and perhaps intractable. Regulators, including NHS England (NHSE) and the Care Quality Commission (CQC), can identify units that are outliers and investigate appropriately before a trust descends into catastrophic failure. All parties can have a conversation based on relevant shared information about safety performance, rather than what otherwise might become a stand-off based on prejudice and refutation.



Purpose of the Maternity Heatmap

- Regional analytical tool that triangulates national and regional intelligence from a range of data sources.
- Enables regional monthly oversight of the triangulated data and then scores each element to read the signs of trusts that require additional early intervention and support.
- Enables systems to use the information to direct quality improvement work programmes and resources to the right areas.
- Aligns to the Perinatal Quality Oversight Model (PQOM) and 3-year Maternity Single Delivery Plan (3YSDP) to support delivery of the national priorities.
- Local intelligence is supplied through ICB Local Maternity and Neonatal Systems (LMNSs), key stakeholders and combined with national data intelligence.
- The heatmap has been developed into a visual Power BI dashboard and is shared widely across the regional team, systems and provider trusts.
- The heatmap has been used widely across the Midlands and North West since it was first published in August 2023, with a development update in November 2023.



Information Governance

As a statutory organisation NHS England is legally obliged to perform its functions and duties. We cannot perform them without a clear understanding of how the NHS is performing in relation to them. It is essential that we have information about all aspects of NHS services and its operating environment to achieve our Purpose. Much of the information included in the Regional Maternity Heatmap is publicly available and none of the information contains personal identifiable data.

Where information is not publicly available this comes directly from local Integrated Care Boards (ICBs) and is supplied with the direct purpose of consolidating and sharing the information within the Regional Maternity Heatmap to identify and support improvements in the safety and quality of maternity and neonatal care. All information collected would be disclosable under a Freedom of Information request. As a result, data sharing agreements or equivalent are not required.

We kindly ask that the data is not shared wider without the express permission of NHS England North East & Yorkshire Maternity Team and used only for the sole purpose it is intended.

Regional Maternity Heatmap

Trusts mapped to 22 quality and safety indicators

Aggregated indicator scores = heatmap score

Up to date - monthly for most indicators

Quality assurance process to confirm data accuracy

Aligns to national maternity policy

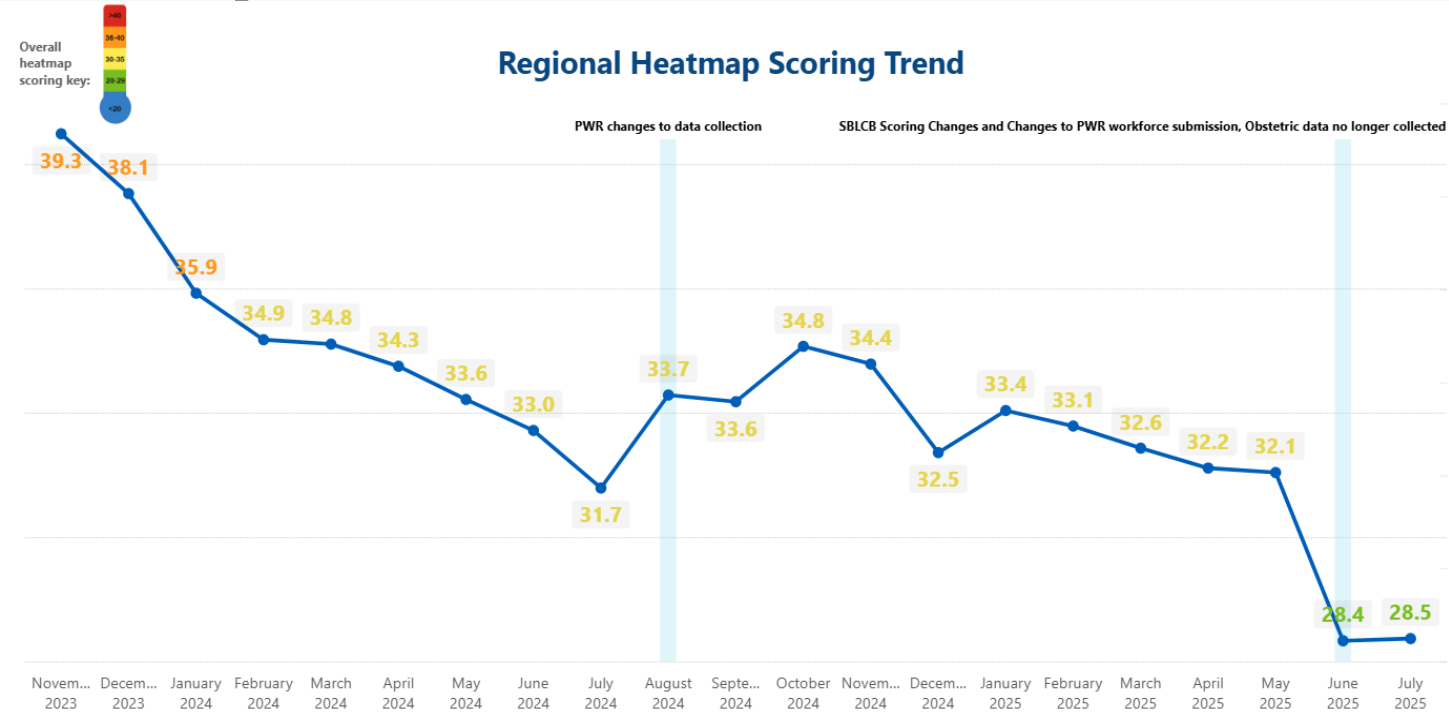
Higher score = greater quality and safety concerns

Indicator scores pinpoint areas for improvement

Local and regional intelligence feeds the heatmap

Widely accessible to region, ICBs & providers

Triangulates data from a range of sources in one place



Regional average heatmap score has improved significantly since its implementation

Regional Maternity Heatmap Scoring

Red rated organisations are showing significant areas of safety or quality concern and are receiving national oversight through the Maternity Services Safety Programme, or recommended to move onto the programme

Amber rated organisations are showing some areas of safety or quality concerns, or are demonstrating improvements from directed national, regional or system support having stepped down from a previous red rating

Trusts rated blue/green are organisations with the building blocks of a good service – there are limited, if any, regulatory or stakeholder concerns, with engaged and proactive ICBs and service user involvement

The scoring table is produced by provider and ICB and can be used to pinpoint the areas where there are safety or quality concerns and where resources and improvements are best focussed.



Regional Analysis - Heatmap

- Regional analysis gives useful comparative data oversight.



Trust Analysis - Heatmap

- Regional analysis gives useful comparative data oversight.

Regional Maternity Heatmap Scoring Methodology

- The scoring information breaks down the scoring measures and methodology.
- Not every item in the heatmap is scored.
- Scoring methodology has been mapped to national reporting or developed through consultation and PDSA cycles.

Measure	Data Source	Scoring
Achieved NHSR Maternity Incentive Scheme 10 Safety Actions	MIS	All 10 MIS Standards Met = 0 (Blue) 8-9 MIS Standards Met = 2 (Yellow) 6-7 MIS Standards Met = 3 (Amber) 4-5 MIS Standards Met = 4 (Red) 3 or less MIS Standards Met = 5 (Red)
Birthrate+ completed within last 3 years	LMNS submission	Yes (completed within last 3 years) = 0 (blue) In progress (More than 3 years since last review but in progress) = 1 (amber) No (More than 3 years since last review and no reassessment organised) = 3 (red)
CQC maternity rating	CQC ratings data	Outstanding = 0 (blue), Good = 1 (green), Requires Improvement = 3 (amber), Inadequate = 5 (red) Maternity services are rated at site level - for multi-site providers, take average of site level scores. Freestanding Midwifery Led Units and sites providing community maternity care are excluded from the scoring.
CQC Maternity Survey	CQC surveys	CQC published section scoring bands for the eight maternity survey sections are taken and assigned numeric values (much better = 0 -> much worse = 6). An average of these 8 values is then taken and is scored as follows: <2 = 0 (blue), <2.5 = 1 (green), <3 = 2 (yellow), <3.5 = 3 (amber), <4 = 4 (red), >=4 = 5 (red) If a section is not scored/banded by CQC it is ignored in this analysis.
CQC Section 31	Regional team	No = 0 (blue), Yes = 5 (red) Each "Yes" scores 5 points (e.g. 2 Yes answers = 10)
CQC Warning notice (Section 29a)	LMNS submission	No = 0 (blue), Yes = 5+ (red) Where there are multiple s29a notices for a given provider, score 5 for each
Ethnicity data quality	MSDS	>90% = 0 (blue), <90% = 3 (red)
External independent reviews (ongoing or in last 2 years)	Regional team	No = 0 (blue), Yes = 5 (red)
Maternity Safety Champions in post (x5 - Maternity, Obstetric, Neonatal, Exec, NED)	LMNS submission	Safety champions in post = 0 (blue), Not all safety champions in post = 3 (red)
Maternity safety oversight level	Regional team	Level 1 Oversight - No intervention/routine ICB oversight = 0 (blue) Level 2 Oversight - Enhanced ICB oversight = 2 (green) Level 3 Oversight - Enhanced ICB oversight with regional support = 3 (amber) Level 4 Oversight - National Maternity Services Support Programme (MSSP) = 5 (red)
MBRRACE Stillbirth rate, neonatal death rate, perinatal mortality rate	MBRRACE	Mortality is more than 15% lower than group average = 0 (Blue) Mortality is 5-15% lower than group average = 1 (Yellow) Mortality within 5% of group average = 3 (Amber) Mortality is over 5% higher than MBRRACE group average = 5 (Red)
Midwives, MSSW, obstetric vacancy rates	Regional workforce dashboard	Vacancy rate is 0% (no vacancies) = 0 (Blue) Vacancy rate is greater than 0% but less than 5% = 1 (Green) Vacancy rate is between 5% and less than 10% = 2 (Yellow) Vacancy rate is between 10% and less than 15% = 3 (Amber) Vacancy rate is between 15% and less than 20% = 4 (Red) Vacancy rate is 20% or higher = 5 (Red) Note: MSW's vacancy rate is calculated as a combined figure of Band 2, Band 3, and Band 4 vacancies.



Regional Maternity Heatmap Scoring Methodology

Measure	Data Source	Scoring
Number of leadership and specialist roles not in post	LMNS submission	All posts in place = 0 (blue), 1-2 posts not in place = 1 (green), 3-4 posts in place = 3 (amber), 5+ posts not in place = 5 (red). Does not include senior leadership roles (scored separately) or ISA role (currently in pilot phase).
Regulatory letters from coroner (Reg 28)	LMNS submission	No = 0 (blue), PFD received within last 56 days = 5 (red), PFD closed with coroner but with action plan open = 4 (amber)
Repayment of CNST (since introduction)	MIS	No = 0 (blue), Under review = 1 (amber), Yes = 3 (red)
Saving Babies Lives Care Bundle V3 implemetation level	LMNS submission	Pre Heatmap month of June 2025: Fully implemented - all elements 100% = 0 (green), Partially implemented (CNST yr 5 met) - Overall implementation 70%+ with no individual elements <50% = 3 (amber), Not on track to meet CNST yr 5 - Overall implementation <70% or any individual element <50% = 5 (red) From Heatmap month of June 2025 Overall implementation >=95% + No individual element <=90% = 0 Overall implementation >=95% + Any individual elements <80% = 1 Overall implementation >=90% + No individual element <=80% = 2 Overall implementation >=90% +/or An individual element <=50% = 3 Overall Implementation 80-89% +/or An Individual element <50% = 4 Overall Implementation <79% + Any Individual element <50% = 5
Senior leadership in post	LMNS submission	No senior leadership roles vacant = 0 (blue), Any of DOM/Assoc DOM, HOM/Deputy DOM, Clinical director for Obstetrics/Obs lead not in post = 5 (red)
Total number of stakeholder concerns	Regional team	For each stakeholder add 1 to the score

Report Cover Sheet

Agenda Item: 24i

Report Title:	Maternity Safety Champion Report			
Name of Meeting:	Board of Directors			
Date of Meeting:	25 September 2025			
Author:	Dr Gerry Morrow, Maternity Safety Champion and Non-Executive Director			
Sponsor:	Dr Gerry Morrow, Maternity Safety Champion and Non-Executive Director			
Report presented by:	Dr Gerry Morrow, Maternity Safety Champion and Non-Executive Director			
Purpose of Report <i>Briefly describe why this report is being presented at this meeting</i>	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
	To provide additional assurance to support the Maternity Integrated Oversight Report based on regular discussion with our people, patients and maternal and neonatal voices partnership (MNVP) service users			
Proposed level of assurance <i>– to be completed by paper sponsor:</i>	Fully assured ☐ <i>No gaps in assurance</i>	Partially assured ☒ <i>Some gaps identified</i>	Not assured ☐ <i>Significant assurance gaps</i>	Not applicable ☐
Paper previously considered by: <i>State where this paper (or a version of it) has been considered prior to this point if applicable</i>	-			
Key issues: <i>Briefly outline what the top 3-5 key points are from the paper in bullet point format</i> <i>Consider key implications e.g.</i> • Finance • Patient outcomes / experience • Quality and safety • People and organisational development • Governance and legal • Equality, diversity and inclusion	• This new report seeks to support the triangulation of information and intelligence from a variety of sources, providing a voice for our people and patients at Board through the Maternity Safety Champion. • This is a new report and will continue to develop. • Key issues will be presented and progress on these issues will be described in each report, which will be provided six times a year.			
Recommended actions for this meeting:	Board Members are requested to review the content of this report for assurance in conjunction with the Maternity			

Outline what the meeting is expected to do with this paper	Integrated Oversight Report, noting that updates on the key issues will be provided in the next report.				
Trust strategic priorities that the report relates to:	☒	Excellent patient care			
	☒	Great place to work			
	☐	Working together for healthier communities			
	☐	Fit for the future			
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	1) We will be a clinically-led organisation focused on delivering safe, high-quality care and improving health outcomes for our patients 2) We will ensure our patients experience the best possible compassionate care and make every contact count 3) We will continually improve our services creating a restorative culture where learning, innovation and research can flourish				
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):	3107 - Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings (15) 2341 - There is a risk to ongoing business continuity of service provision due to ageing trust estate (16) 4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (20) 4713 - The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis (16)				
Has an Equality and Quality Impact Assessment (EQIA) been completed?	Yes ☐		No ☐		Not applicable ☒

Maternity Non-Executive Director Safety Champion Report September 2025

1. Introduction

- 1.1. This is a narrative report which will complement the Integrated Oversight Report (IOR) report covering national metrics of maternal and neonatal safety.
- 1.2. I am mindful that there are many obstetric and neonatal safety metrics and that there is a current national review and update ongoing.
- 1.3. This report seeks to provide an additional level of narrative assurance to board. It is based on my regular discussions with staff, patients, and maternal and neonatal voices partnership (MNVP) service users. It is not designed to be exhaustive but if board members would like more detail on any of the themes I would be happy to discuss further or provide more detail.
- 1.4. The principles employed cover the Royal College of Obstetricians (RCOG) methodology for maternity safety work and include.
 1. Safe staffing
 2. Multi-disciplinary team working
 3. Staff wellbeing
 4. Leadership
 5. Personalised care
 6. Compassionate care and listening to women
 7. Technical skills and knowledge
 8. Addressing inequalities
- 1.5. In essence, I am trying to be problem-sensitive and in doing so provide a voice for patients and staff to improve both care and safety.
- 1.6. Key issues will be presented and progress on these issues will be described in each report, which will be provided six times a year.

2. Key issues

- 2.1. High quality of care provided continues despite challenges.

- 2.2. New recurrent funding of £100k will be provided by ICB for perinatal mental health service, this will be developed in collaboration with Newcastle-upon-Tyne Hospitals NHS Foundation Trust (NUTH) who have £200k funding.
 - Focus is likely to be on provision of services to women with birth trauma, loss, or tokophobia (fear of pregnancy and childbirth) by expanding birth reflections service. More detail to follow as discussions progress.
- 2.3. NEWTT2 updates (newborn early warning and trigger).
 - This revised national scoring system alerts clinicians about deteriorating neonates will be updated in the Badger system in November. This will be discussed regionally and a consistent approach made to the clinical escalation processes at the trust following this consensus.
 - We discussed the use of the RCOG escalation tool AID = advise, inform, do. This has been implemented but auditing its use in practice is challenging, as explicit usage is not always recorded and the range of note taking systems at the trust is also varied. This is also part of a regional QI project.

3. Progress on issues

- 3.1. Concern about gap of obstetric clinical lead. I had a meeting with Dr Fiaz Ahmad, Associate Medical Director, to discuss this issue. Progress may be possible after the appointment of a substantive Service Line Manager (SLM) in November.
- 3.2. Challenges continue in the Women's Health Clinic mainly relating to staff levels and patient flow. A paper has been submitted to Gateshead Health Leadership Group (GHLG) by the senior matron to outline possible routes for improvement. More details to follow once this group has discussed the paper.
- 3.3. There are still vacancies in the Advanced Neonatal Nurse Practitioner (ANNP) team, but approval has been given to use bank recruitment whilst members of the team undertake additional training to gain the ANNP qualification.
- 3.4. The Maternity Incentive Scheme (MIS) has a variety of actions which need to be satisfied. There are currently concerns about Safety Action 7 which requires that MNVP service users be involved in a variety of meetings at the trust. The number and scope of these meetings have been recognised as very challenging for our MNVP representatives. Other trusts have also recognised similar challenges and there is a national conversation about revising these requirements. This has been placed on the trust risk register and escalated to

the ICB. This will enable the trust to be compliant as the challenge then lies with the ICB to ensure appropriate commissioning and funding arrangements are in place. Further details will be provided when these are available.

- 3.5. Antenatal clinic booking and capacity. Dr Jill Sturt, consultant obstetrician and gynaecologist, outlined the current difficulties of capacity in the antenatal clinic. This is especially problematic given the complexity of the clinical caseload and the need for longer appointments (particularly for those women with previous caesarian sections). I discussed this with Fiaz who explained that the initial approach will be to implement improvements in the Women's Health Clinic to address flow and staffing issues. The situation will be reviewed following these improvements.

4. Summary

- 4.1. Board Members are requested to review the content of this report for assurance in conjunction with the Maternity Integrated Oversight Report, noting that updates on the key issues will be provided in the next report.

Report Cover Sheet

Agenda Item: 25

Report Title:	Midwifery staffing report Q1 2025/26			
Name of Meeting:	Trust Board			
Date of Meeting:	25 th September 2025			
Author:	Karen Parker Associate Director of Midwifery and SCBU			
Executive Sponsor:	Gill Findley			
Report presented by:	Karen Parker			
Purpose of Report <i>Briefly describe why this report is being presented at this meeting</i>	Decision: ☐	Discussion: ☒	Assurance: ☒	Information: ☒
	This report demonstrates compliance with the Maternity Incentive Scheme Year 7 Safety Action 5 (midwifery workforce)			
Proposed level of assurance – to be completed by paper sponsor:	Fully assured ☐ <i>No gaps in assurance</i>	Partially assured ☐ <i>Some gaps identified</i>	Not assured ☐ <i>Significant assurance gaps</i>	Not applicable ☐
Paper previously considered by: <i>State where this paper (or a version of it) has been considered prior to this point if applicable</i>	Obstetric Safecare 15/10/2025 Division of Surgery, Women's Health and Children Operational Board 24/9/2025 Nursing and Midwifery Workforce Group 19/9/2025			
Key issues: <i>Briefly outline what the top 3-5 key points are from the paper in bullet point format</i> <i>Consider key implications e.g.</i> • Finance • Patient outcomes / experience • Quality and safety • People and organisational development • Governance and legal • Equality, diversity and inclusion	Midwifery workforce should be compliant with Birthrate+ three-yearly assessment and a bi-annual report submitted to Trust board - this is required to meet Safety Action 5 of the Maternity Incentive Scheme. Year 7 MIS compliance covers the reporting period of 2 April 2025 – 30 November 2025.			
Recommended actions for this meeting: <i>Outline what the meeting is expected to do with this paper</i>	Accept this report as evidence of compliance with Safety Action 5 Midwifery 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 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 ☒		

Midwifery Staffing Review

Midwifery workforce report – Q1 2025/26

September 2025

Introduction

The purpose of this report is to provide the Board with an overview of midwifery staffing and give assurance that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels

The report covers the period of Q1 2025/26.

This report will in part fulfil the aims of the Maternity Incentive Scheme (MIS) (Year 7, NHS Resolution, 2025) and the Three Year Delivery Plan for Maternity and Neonatal Services (NHS England, 2023). This is also aligned to the Trust Strategic Objectives for 2024/25 which note compliance with MIS and Ockenden recommendations, and the 2025/26 Strategic Objective to comply with the Three-year delivery plan.

Safety Action 5 of the Maternity Incentive Scheme requires:

a	A systematic, evidence-based process to calculate Midwifery staffing establishment has been completed within the last three years.
b	Trust Board to evidence Midwifery staffing budget reflects establishment as calculated above
c	The Midwifery Coordinator in charge of Labour Ward must have supernumerary status <i>at the start of every shift</i> . An escalation plan should be available and must include the process for providing a substitute co-ordinator where there is no co-ordinator available at the start of a shift.
d	All women in active labour receive one-to-one Midwifery care
e	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Trust Board every six months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year six and seven reporting periods.

Gateshead Maternity service completed its three-yearly Birthrate+ midwifery workforce assessment in 2023/24 and a paper describing the recommendations was presented to the Trust board in June 2024. Funded midwifery establishment was increased to meet the recommendations in October 2024.

The 2024 Birthrate+ assessment recommended the following staffing establishments:

2024 Birth Rate BR Recommended wte	98.76wte
Specialist roles	11.85wte
Total wte	110.61wte

Monthly Fill Rates

Midwifery fill rates are reported in the monthly Maternity Integrated Oversight Report (IOR) which is presented at a number of governance meetings within the service, division and to Trust board. Overall fill varies depending on vacancies, gaps in rosters and number of patients. Between April 2024 and July 2025, Gateshead Health midwifery fill rates have continued to follow a steady decline. Staffing on night shifts is prioritised to ensure safety out of hours and day shift fill rates are now reported at an average of 81.9% for Q1, which is an improvement on Q4 2024/25, with safety continuing to be maintained by the use of escalation processes (contained within the red flag section of this report).

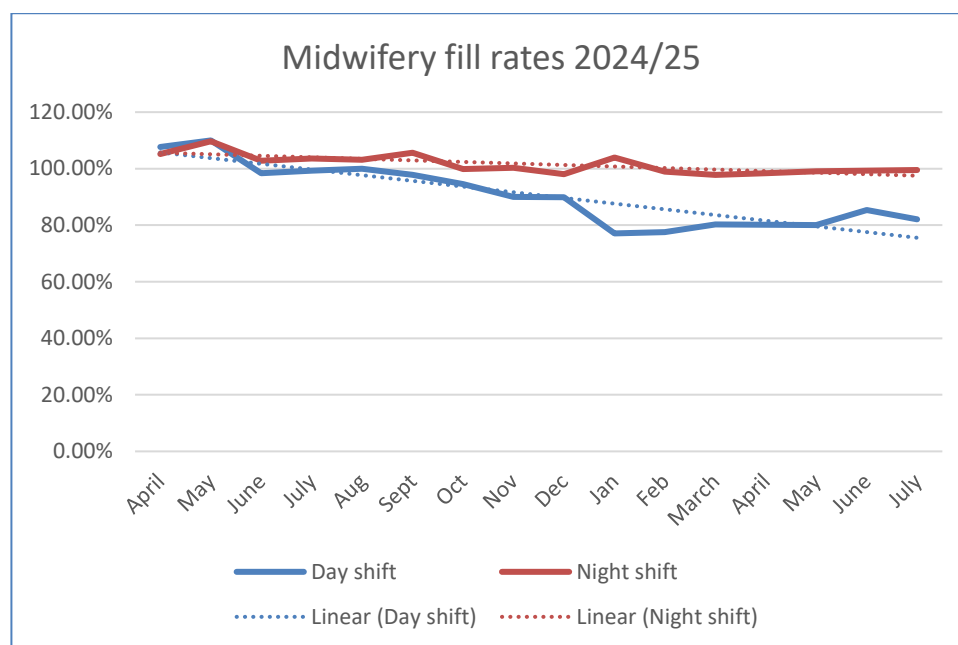


Figure 1: Monthly Midwifery fill rate

Labour ward acuity

Labour ward coordinators complete the labour ward Birthrate+ acuity tool every four hours. If staffing and or patient demand/acuity changes, additional reports can be submitted to the tool to reflect changes in safe staffing and any actions required. Accurate oversight of staffing and acuity challenges for our unit require complete and accurate data input into the tool. Birthrate advise an overall compliance of 85% to obtain accurate data.

24/25	Compliance percentage	25/25	Compliance percentage
Q1	75.6%	Q1	85.16%
Q2	71.56%	Q2	
Q3	72.64%	Q3	
Q4	83%	Q4	

Table 1: Compliance with four-hourly data submission to acuity tool

The service procured bespoke training in January 2025 for Labour Ward Coordinators and Matrons to increase compliance with the tool and standardisation with other Maternity units using the same tool, thus providing robust and accurate data. We have seen an increase in compliance following the refresh training and we will continue to monitor this to ensure improved data quality.

The acuity tool captures workload on labour ward, including the level of care required for each patient based on how complex their care is (acuity) and matches this against the midwifery staffing on the labour ward every 4 hours. The data is inputted into the tool which then calculates this workload and produces a flag based on the staffing levels, this follows a RAG rating system – see below.

Green = Staffing levels meet the acuity of the workload on the labour ward at that time.

Amber = The staffing levels are up to 1 WTE midwife short, based on the workload.

Red = The staffing is greater than 1 WTE midwife short

Ongoing total acuity

2024/25	Q1	Q2	Q3	Q4
Staffing meets acuity	83.3%	65% ↓	72% ↑	78% ↑
Short by up to 1 midwife	11.2%	22% ↑	13% ↓	14% ↑
More than 1 midwife short	5.5%	13% ↑	15% ↑	8% ↓

2025/26	Q1	Q2	Q3	Q4
Staffing meets acuity	86% ↑			
Short by up to 1 midwife	8% ↓			
More than 1 midwife short	6% ↓			

Table 2: 2024/25 & 2025/26 overall quarterly labour ward midwifery staffing acuity*

*Acuity is measured once any clinical or management actions have been taken such as redeployment of specialist staff

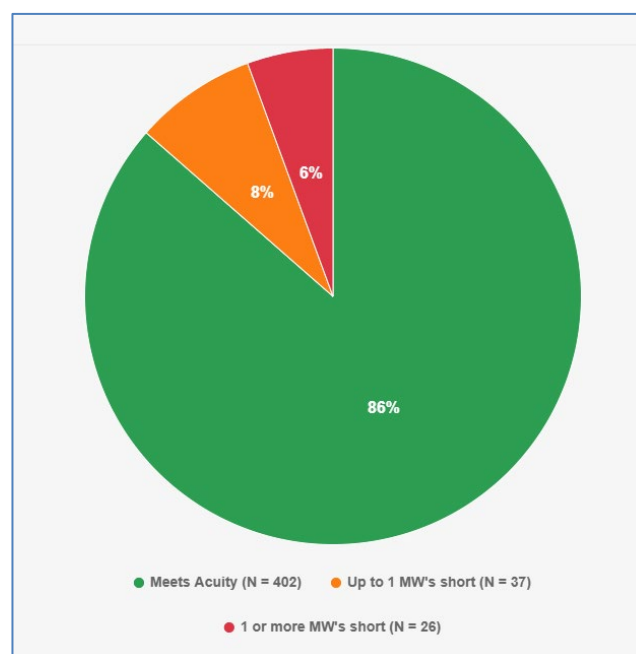


Figure 2: Q1 2025/26 labour ward midwifery staffing acuity

Red Flag Incidents

Red flags are used by staff when staffing levels have been identified as impacting safety on the ward either by reduced staff numbers, skill shortfall or delay to care. Midwifery red flag events are a warning sign that something may be wrong with midwifery staffing and actions are required to maintain safety on the unit (NICE 2015).

Red flags are collected through the Birth Rate Plus acuity tool and reviewed by the Matrons.

The Red Flags included in the chart below are recommended by BR+, MIS and NICE (2015) to identify and escalate safer staffing concerns. The main key themes recorded over the past 12 months are:

- Delays to commence induction of labour
- Coordinator unable to retain supernumerary status

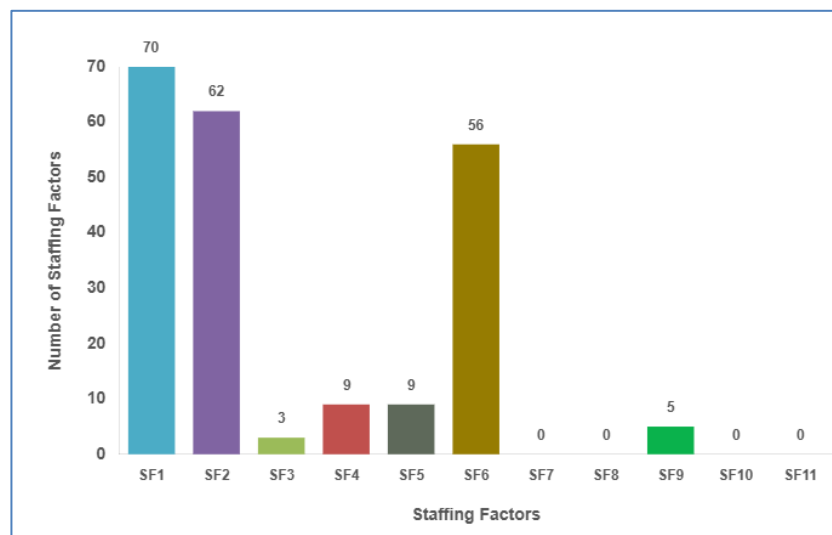
It is important to note that whilst red flag reporting is evident, low reporting is likely linked to staff being too busy to raise a red flag. Matrons continue to support red flag reporting to ensure accurate documentation.

Red Flags	Breakdown of Red Flags	Times occurred	Percentage
 RF1	Delayed or cancelled time critical activity	4	10%
 RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	1	3%
 RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
 RF4	Delay in providing pain relief	0	0%
 RF5	Delay between presentation and triage	0	0%
 RF6	Full clinical examination not carried out when presenting in labour	0	0%
 RF7	Delay between admission for induction and beginning of process	4	10%
 RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
 RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
 RF10	Coordinator unable to maintain supernumerary status	10	25%
 RF11	Co-ordinator unable to maintain supernumerary status: NOT providing 1:1 care	21	53%
TOTAL		40	

*The % is rounded to nearest whole number

Table 3: Red Flags events on labour ward Q1 2025/26

Factors impacting safe staffing on Labour Ward



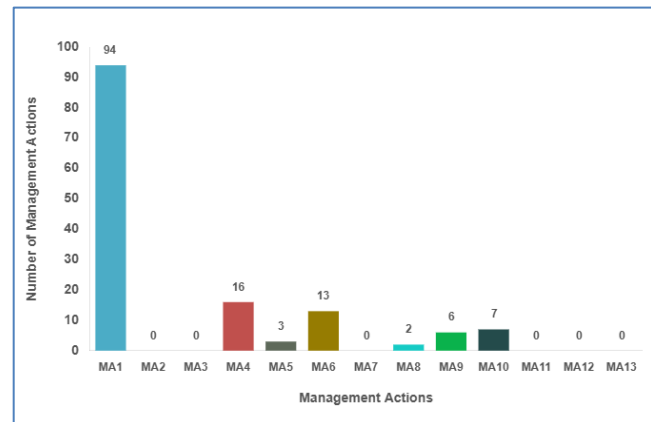
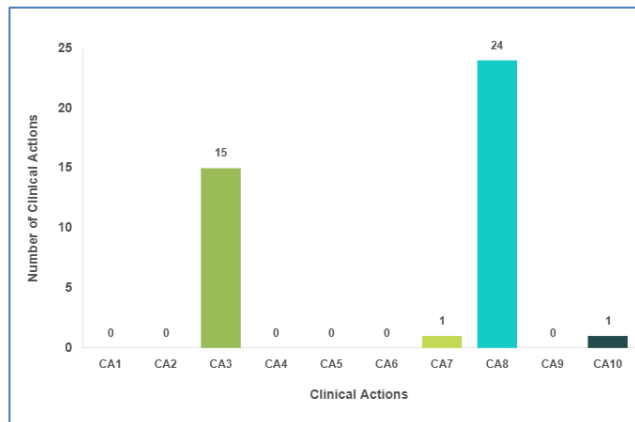
Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected Midwife absence/sickness	70	33%
SF2	Unable to fill vacant shift	62	29%
SF3	Midwife on transfer duties	3	1%
SF4	MW redeployed to other area	9	4%
SF5	Support staff less than rostered numbers	9	4%
SF6	Midwife scrubbed in theatre	56	26%
SF7	DO NOT USE -Continuity team Midwife present	0	0%
SF8	DO NOT USE -Continuity team Midwife not available	0	0%
SF9	2 or more Band 5 Midwives on duty	5	2%
SF10	No MW available to provide fresh eyes (missed fresh eyes or >30 minute delay)	0	0%
SF11	Unable to provide a 2nd MW for emergency theatre case (trial in theatre or category 1/2/3 Emergency LSCS)	0	0%
TOTAL		214	

*The % is rounded to nearest whole number

The top three main factors affecting midwife staffing on labour ward remain:

- Unexpected absence
- Unable to fill vacant shift
- Midwife scrubbed in theatre

Actions taken in response to staffing deficits are reported under two categories; clinical actions and management actions.



Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Decline in utero transfer	0	0%
CA2	Delay in accepting transfers	0	0%
CA3	Delay in commencing IOL (as per Trust guidelines)	15	37%
CA4	Delay /cancel planned procedures e.g.ECV,Cervical suture	0	0%
CA5	Delay in transfer of cases to theatre e.g. perineal repair, MROP	0	0%
CA6	Delay EI. LSCS >24hrs	0	0%
CA7	2nd theatre in use	1	2%
CA8	Delay in ongoing IOL/ ARM or augmentation	24	59%
CA9	Delay in admission for IOL from home	0	0%
CA10	Unable to perform ward round due to Acuity	1	2%
TOTAL		41	

*The % is rounded to nearest whole number

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	94	67%
MA2	Redeploy staff from community	0	0%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	16	11%
MA5	Staff stayed beyond rostered hours	3	2%
MA6	Specialist Midwife working clinically	13	9%
MA7	Manager/Matron working clinically	0	0%
MA8	Staff sourced from bank/agency	2	1%
MA9	Utilise on call Midwife	6	4%
MA10	Escalate to Manager on call	7	5%
MA11	Maternity Unit on Divert	0	0%
MA12	Home Birth Service Suspended	0	0%
MA13	Requested mutual aid	0	0%
TOTAL		141	

*The % is rounded to nearest whole number

The main clinical actions taken to maintain safe staffing are delays to commence or continue Induction of Labour.

The main management actions taken to maintain safe staffing are to redeploy staff internally, staff unable to take breaks and specialist midwives working clinically via the escalation process.

The Maternity unit was placed on external divert on 0 occasions in Q1.

Recruitment and retention

Recruitment and retention remain a key priority for Gateshead Health. The maternity service currently has an overall midwifery vacancy rate of 7% (June 2025). This is within the Organisational target of 8%. The service employs 1wte Band 7 Retention and Recruitment Midwife which is funded on a recurrent basis by the Local Maternity and Neonatal Service following the recommendation in the Three-year delivery plan for Maternity and Neonatal Services (NHS England, 2023). The post supports new recruitment into the service with a robust preceptorship programme for newly qualified midwives.

Midwifery Turnover

Midwifery turnover continues to be at a higher rate than previous years within the service at 11%, above the Trust target of <9.7%. Recruitment is ongoing and new starters have been welcomed into the service. We offer a comprehensive preceptorship package and receive large numbers of applications for any advertised posts. All of our own student midwives have secured employment on qualification, with several choosing to stay at Gateshead.

Recent developmental and promotional vacancies have been recruited to internally, enabling career growth opportunities to Gateshead midwives.

Unavailability

Sickness/staff absence

Sickness absence levels within the midwifery teams remain high and above the NHS target of 5% but community sickness levels have shown improvement since the last staffing report. Currently sickness absence is 6.6% in community midwifery teams and 10.4% in acute teams (Q1 2025/26). Work continues with POD to review sickness and absence reasons and work with staff to support them to return to work safely.

Maternity leave

The demographic of the midwifery workforce is predominantly female and therefore has traditionally incurred higher levels of maternity and parental leave. Current levels (Q1 2025/26) are 6.5% in community teams and 6.8% in the acute service. The service has had approval for some temporary recruitment to cover the current high levels of maternity leave and this has been supported by one-off funding from the NHS England commitment to employment offers for newly qualified midwives.

Right skills

Mandatory Maternity Training:

Gateshead Health Maternity Service have again been key partners in the development of the 2025/26 North East and North Cumbria Maternity Training Faculty. Multi-disciplinary training is widely recognised as an essential component of a safe Maternity Service and as such, all Trusts in NENC have adopted the agreed 3-day syllabus with standardised content and competency assessment in line with the Core Competencies Framework and enabling compliance with Safety Action 8 of Year 7 of the Maternity Incentive Scheme. The service is on track for full compliance with >90% attendance with the relevant midwifery training requirements for the Year 7 MIS scheme.

Leadership:

The acute maternity matron returned to the service following an external secondment. Midwifery ward managers are allocated 1-2 days/week for management duties where possible but have been utilised frequently in Q1 to support the clinical workload in times of escalation. Leadership training has been provided via RCM opportunities and all Labour Ward Coordinators have attended the bespoke programme at Teesside University as recommended in the Ockenden report. The service has recently undergone successful expansion of core teams in all areas via expressions of interest. This will support succession planning and specialist knowledge in all teams, and support for new staff joining the service.

Healthcare Assistants (HCA) and Maternity Support Workers (MSW):

Birthrate+ does not mandate numbers for support staff however there is a recommendation included in the workforce report. They are a vital part of the workforce providing key safety critical roles in Maternity Theatre, support of a Transitional Care service and in outpatient/antenatal care pathways.

Approval has been given to offer additional cover for maternity theatres to ensure two HCA staff present in theatre to protect the safety critical count role. Available bank shifts are on Healthroster but

appropriately, skilled staff are currently unable to fill all the shifts required. A review of band 3 staff establishment and requirements is underway.

Ward area	BR+	Budgeted establishment
Delivery suite & Maternity Theatre	10.84wte	19.44wte
Ante/Postnatal ward	10.84wte	
PAU	1.81wte	
Antenatal clinic	4.07wte	4.70wte
Community	*community MSWs included in midwifery establishment	*3.17wte
Total	29.58wte	27.31wte

Table 4: Additional support staff wte (Gateshead Health Birthrate+ Report 2023/24)

Right place, right time

Headroom:

Gateshead Health headroom is currently calculated at 21%, which is broken down by annual leave 13%, Study leave & training 4% and Sickness absence 4%. There is a wide variance in the headroom reported by regional and national maternity teams to reflect the time requirements of mandatory maternity safety training (from 21% up to 25% or more). It is understood that discussions are underway to review whether a national steer would be helpful for Trusts in ensuring appropriate time is factored into staffing establishments to enable national training requirements to be met.

Bank/agency use:

The service does not use agency staff to support midwifery or support staff vacant shifts. Bank usage is relatively stable around 3.5% in Q1 but is showing early signs of increasing in Q2.

Use of on-call midwife (out of hours):

The on-call midwife was utilized on two occasions for a total of 6 hours and 13 minutes during Q1.

Recommendations:

This report should be accepted as the bi-annual midwifery staffing update which will be used as evidence towards compliance with the MIS Year 7 Safety Action 6 requirements.

The Q2 2025/25 midwifery staffing reports will be presented in November 2025.

Continuing POD support for management of sickness absence in line with Trust policy.

Separate work and proposal around safe staffing in Women's Health Clinic and as part of Theatre Roadmap is ongoing. Band 3 workforce review underway for the acute maternity service including SCBU.

Report Cover Sheet

Agenda Item: 26

Report Title:	Nursing Staffing Exception Report			
Name of Meeting:	Board of Directors			
Date of Meeting:	24 th September 2025			
Author:	Helen Larkin, Clinical Lead for E-Rostering			
Executive Sponsor:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs.			
Purpose of Report	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☒
	This report is to provide assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis to provide adequate staffing levels.			
Proposed level of assurance – to be completed by paper sponsor:	Fully assured ☐ <i>No gaps in assurance</i>	Partially assured ☒ <i>Some gaps identified</i>	Not assured ☐ <i>Significant assurance gaps</i>	Not applicable ☐
Paper previously considered by:				
Key issues:	- Staffing challenges in August were driven by sickness absence, maternity leave, and vacancies in specific areas. - Wards below 75% funded establishment included: Critical Care, SCBU, Maternity, Ward 14, Ward 28, Craggside Court and others as detailed in the report. 14 nurse staffing incidents were reported through InPhase (8 on Ward 25). Harm levels were low (4 incidents of low physical/psychological harm). 90 Nursing Red Flags were raised in August (an increase from 75 in July), with all escalated to matrons for review. - Escalation beds remain open across several wards, continuing to impact staffing capacity. - The permanent closure of Ward 23 on 20 August released some staffing resource for redeployment.			

Recommended actions for this meeting:	The Board is asked to: • Receive the report for assurance. • Note the ongoing work to address shortfalls, including targeted recruitment, redeployment, and staff attendance management. • Acknowledge the partial assurance position due to sickness absence and vacancy pressures, while recognising the mitigations in place and the absence of serious harm events.				
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)	• Ongoing staffing pressures create risk to patient safety and quality of care. • Recruitment and retention initiatives remain critical to mitigating risk. • No incidents of moderate or severe harm were reported in August.				
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
August 2025

Introduction

This report sets out the nursing and midwifery staffing exceptions at Gateshead Health NHS Foundation Trust for August 2025. Establishments are determined using nationally recognised evidence-based tools: the Safer Nursing Care Tool (SNCT) for acute medical and surgical wards, the Mental Health Optimal Staffing Tool (MHOST) for mental health services, and Birthrate Plus for maternity. Data from these tools is triangulated with patient acuity, professional judgement and key quality indicators. Mental health and maternity staffing are reported separately to the Quality Governance Committee and the Trust Board.

Staffing

Table 1 shows the average ward staffing levels in August 2025 compared with funded establishments. A full ward-by-ward breakdown is provided in Appendix 1. The Trust also submits monthly Care Hours Per Patient Day (CHPPD) to NHS Digital as part of the national reporting requirement.

Table 1: Whole Trust wards staffing August 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 (%)
84.1%	75.4%	100.0%	101.0%

These figures represent overall averages across the Trust. They do not capture daily variation or the operational pressures required to maintain safe staffing levels, which are managed through redeployment, escalation processes, and matron oversight.

Exceptions:

National guidance requires the Board to be advised where ward staffing capacity or capability falls significantly below plan, with explanation of the reasons, the impact on quality, and the actions taken. At Gateshead Health, exception reporting is triggered if planned staffing in any ward falls below 75%.

The Safer Nursing Care Tool (SNCT) is used to set establishments for acute wards, with data collected every six months (January and July). This data is triangulated with professional judgement and quality indicators, in line with *Developing Workforce Safeguards* and NHSI's *Safe Staffing Recommendations (2018)*. The revised SNCT, now in use, takes account of enhanced care requirements and side room dependency. The most recent Trust-wide data collection was completed in July 2025.

Contextual information and actions taken

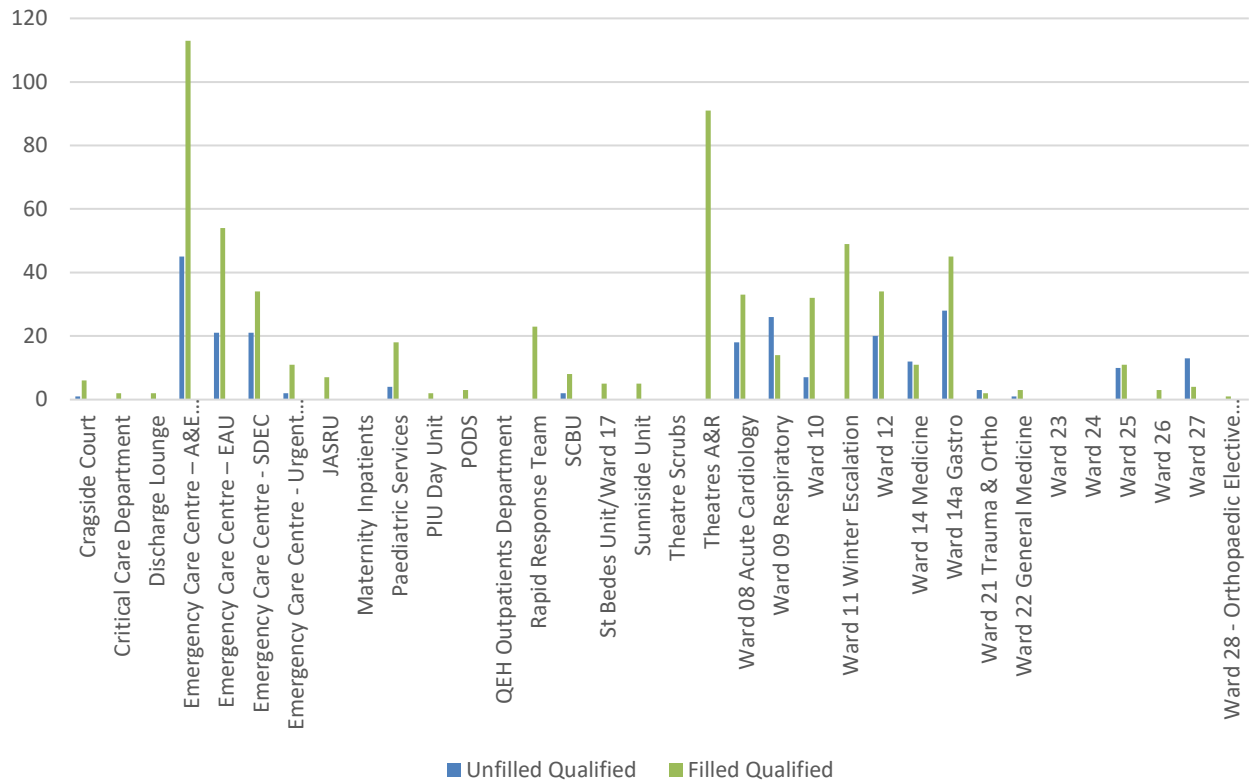
Several wards and departments reported staffing fill rates below 75% during August. The main drivers were vacancies, maternity leave, and sickness absence. Key areas are summarised below, with actions and mitigations.

- **Critical Care** – Registered nurse day fill rates were 73.8% due to 4.04 WTE vacancies and maternity leave. Two staff are due to return from secondment and career break. Unregistered day fill rates were also below threshold (72.8%). Sickness absence was 4.8%.
- **JASRU** – Unregistered day fill rates fell to 62.6% with HCSW sickness absence at 12.8%. Two Red Flags were raised but no incidents reported.
- **SCBU and Maternity** – SCBU registered nurse day fill rate was 73.1% (sickness absence 11.5% and maternity leave). Maternity midwife fill rate was 72.9%, linked to vacancies and long-term sickness. Recruitment is ongoing and escalation processes maintained safe cover. No incidents reported.
- **Ward 8** – Unregistered day fill rate 75% (sickness 4.1%). Bank shifts were requested but many unfilled.
- **Ward 9** – Unregistered day fill rate 64.3%, impacted by 13.7% sickness, vacancies, and maternity leave.
- **Ward 14 (Medicine)** – Registered nurse fill rates were below threshold both days (71.4%) and nights (72.6%), with high long-term sickness. The ward has historically rostered three RNs at night, which was not always achievable in August despite bank requests.
- **Ward 28** – HCA fill rates remained low across days and nights. The ward manager has confirmed staffing is safe for the reduced occupancy and acuity. Staff continued to be redeployed to support other areas.
- **Cragside Court and Sunnyside** – Cragside reported 67.8% RN fill at night. Both units had one RN per night but no cross-cover, which reduced fill rates. High HCA sickness increased demand for constant observation, reflected in elevated HCA night fill rates (Cragside 201.4%, Sunnyside 130.2%). Redeployment from Ward 23 helped mitigate risks. No incidents or Red Flags reported.
- **Wards 21–27** – Several areas reported reduced HCA hours due to vacancies. Work is underway to confirm the establishment requirements following redeployment from Ward 23.
- **Ward 23** – Activity and bed base reduced throughout August before permanent closure on 20 August. Reduced fill rates reflect this planned closure.

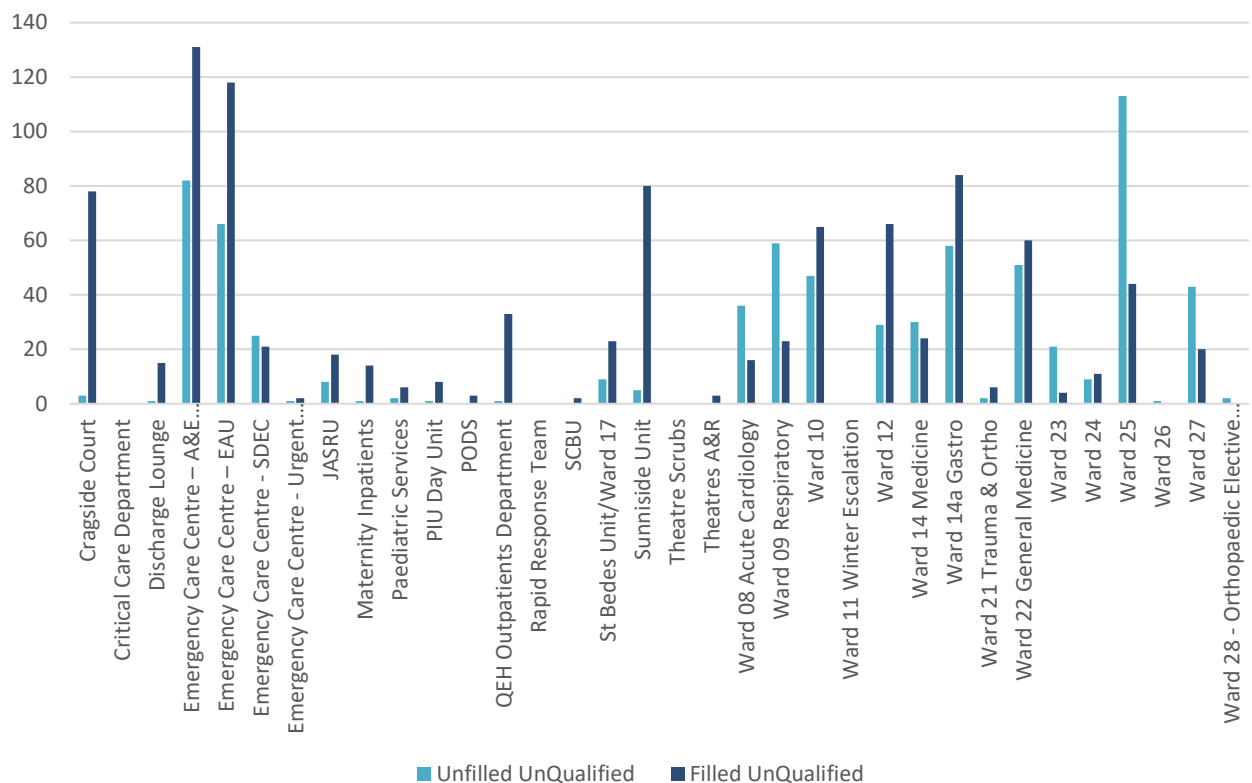
Commentary Summary

- Main hotspots: Critical Care, Maternity, SCBU, Ward 14, and HCA workforce across multiple wards.
- Drivers: vacancies, long-term sickness absence, maternity leave, and high HCA turnover.
- Mitigations: daily redeployment, escalation to matrons, POD support for sickness management, and recruitment to vacant posts.
- Patient safety: Red Flags were raised appropriately and managed; no staffing-related incidents causing moderate or severe harm were reported.

Registered Nurse Bank Shifts Filled Vs Unfilled



HCSW Bank Shifts Filled Vs Unfilled



The exceptions to report August are as below:

August 2025	
Registered Nurse Days	%
Critical Care Dept	73.8
Maternity	72.9
SCBU	73.1
Ward 14 Medicine	71.4
Ward 28 – Orthopaedic Elective Ward	71.4
Ward 23	53.1
Registered Nurse Nights	%
Craggside court	67.8
Ward 14 Medicine	72.6
Ward 23	68.7
Healthcare Assistant Days	%
Critical Care Dept	72.8
JASRU	62.6
Ward 08 Cardiology	75
Sunnyside Unit	152.7
Ward 09 Respiratory	64.3
Ward 21 Trauma & Ortho	74.1
Ward 28 – Orthopaedic Elective Ward	26.7
Ward 22	72.7
Ward 23	26.6
Ward 24	61.7
Ward 25	70.8
Ward 26 Gynae	73.6
Ward 27 Treat/Centre	63.8
Healthcare Assistant Nights	%
Craggside court	201.4
Sunnyside Unit	130.2
Ward 28 – Orthopaedic Elective Ward	19.4
Ward 23	27

Operational Model and Mitigations

In August, the Trust worked to the agreed clinical operational model. This meant that where some wards had lower patient occupancy, staff were redeployed to areas of greatest clinical need. Deficits were escalated in line with the staffing policy, and matrons applied professional judgement to balance acuity and demand. Key mitigations included:

- Redeployment of registered nurses and healthcare assistants, sometimes on an hourly basis, between wards.
- Targeted support from matrons and the People and Organisational Development (POD) team to manage sickness absence and progress recruitment to vacant posts

Care Hours Per Patient Day (CHPPD)

CHPPD provides a consistent way of reporting staffing deployment on inpatient wards. It is calculated by combining registered nurse and support worker hours, divided by the total inpatient admissions over 24 hours.

For August, Trust-wide CHPPD was **7.7**, which benchmarks favourably with peer organisations. Month-on-month variation is influenced by:

- Patient acuity and dependency,
- Requirement for enhanced care, and
- Bed occupancy levels.

Ward-level CHPPD data is provided in Appendix 1.

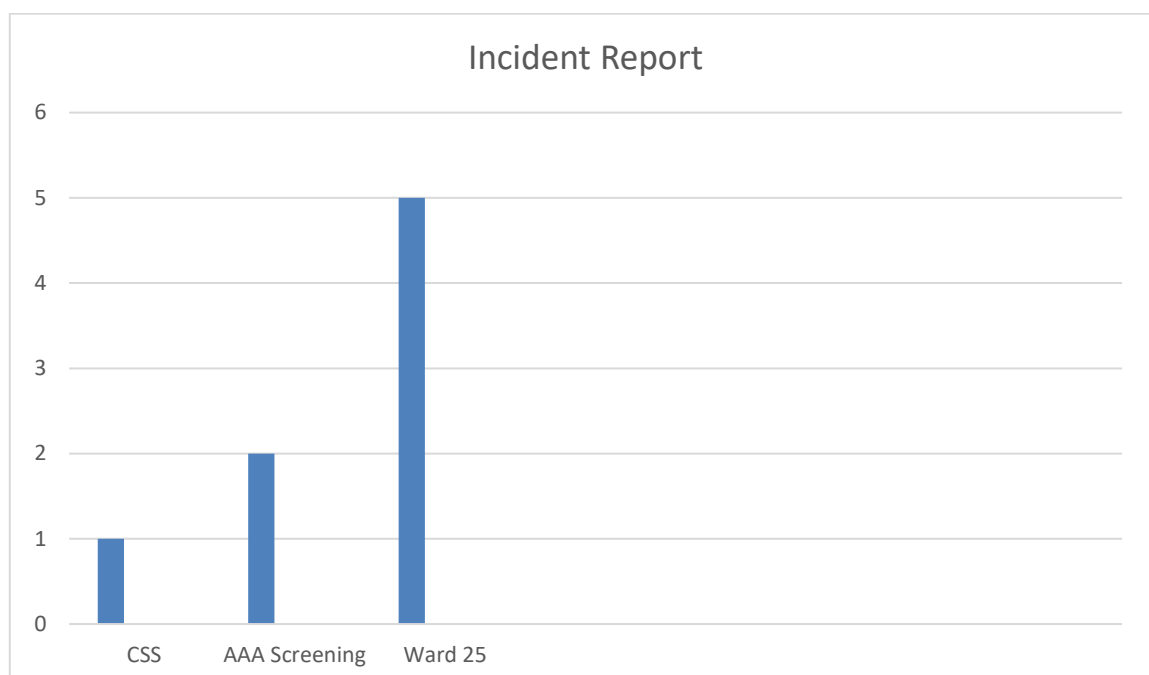
Monitoring via Incident Reporting

The Trust has an established escalation process to address staffing shortages. Work is underway to:

- Define clear thresholds for when a staffing-related incident should be formally reported, to ensure consistency.
- Improve subcategories in the incident reporting system, allowing more precise analysis of root causes (e.g., short-notice sickness, redeployment, unfilled rota gaps).
- Triangulate fill rates and CHPPD with incident data and patient safety outcomes to strengthen assurance.

Summary:

- CHPPD remains stable at 7.7 and compares well with peers.
- Staffing deficits are actively managed through redeployment and escalation.
- No evidence of significant impact on patient safety, though incident reporting categories are being refined to give clearer insight into underlying causes.



Nursing Red Flags

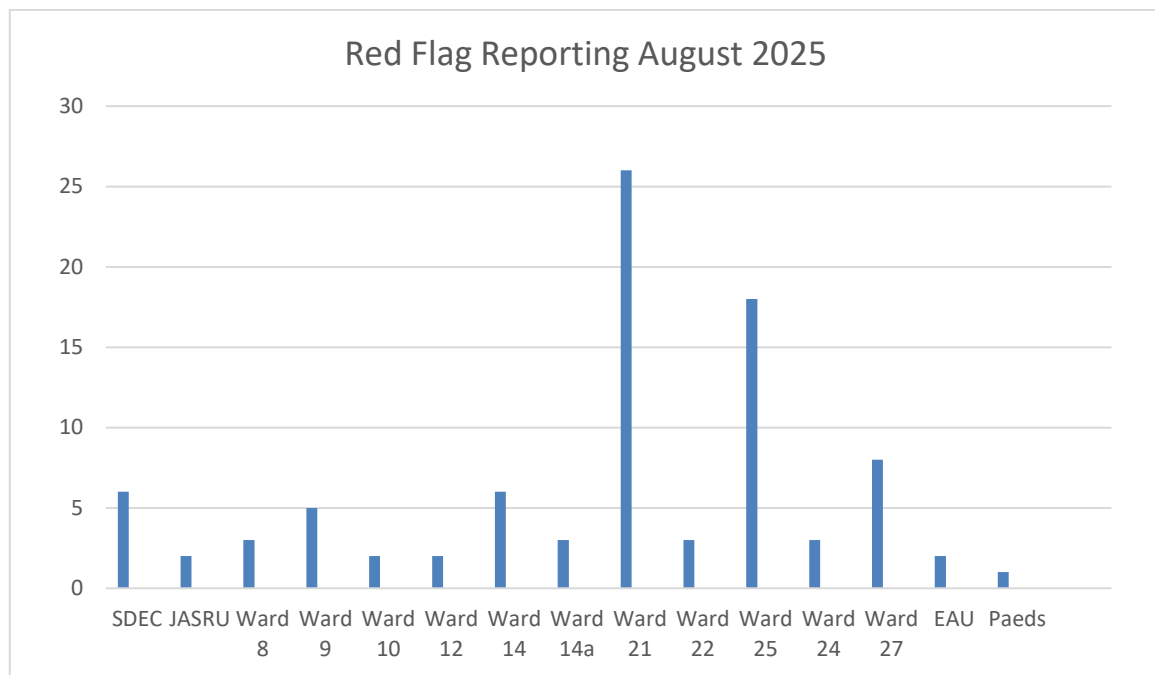
National guidance (NICE, 2014) requires the use of nursing Red Flag reporting to highlight potential risks to safe staffing. A Red Flag can be triggered either through the roster system or by the nurse in charge if they identify a shortfall.

In August, **90 Red Flags were reported**, an increase from **75 in July**. Each was escalated in real time to the Matron or senior nurse for review and action.

A breakdown by department is shown in the graph below.

Summary:

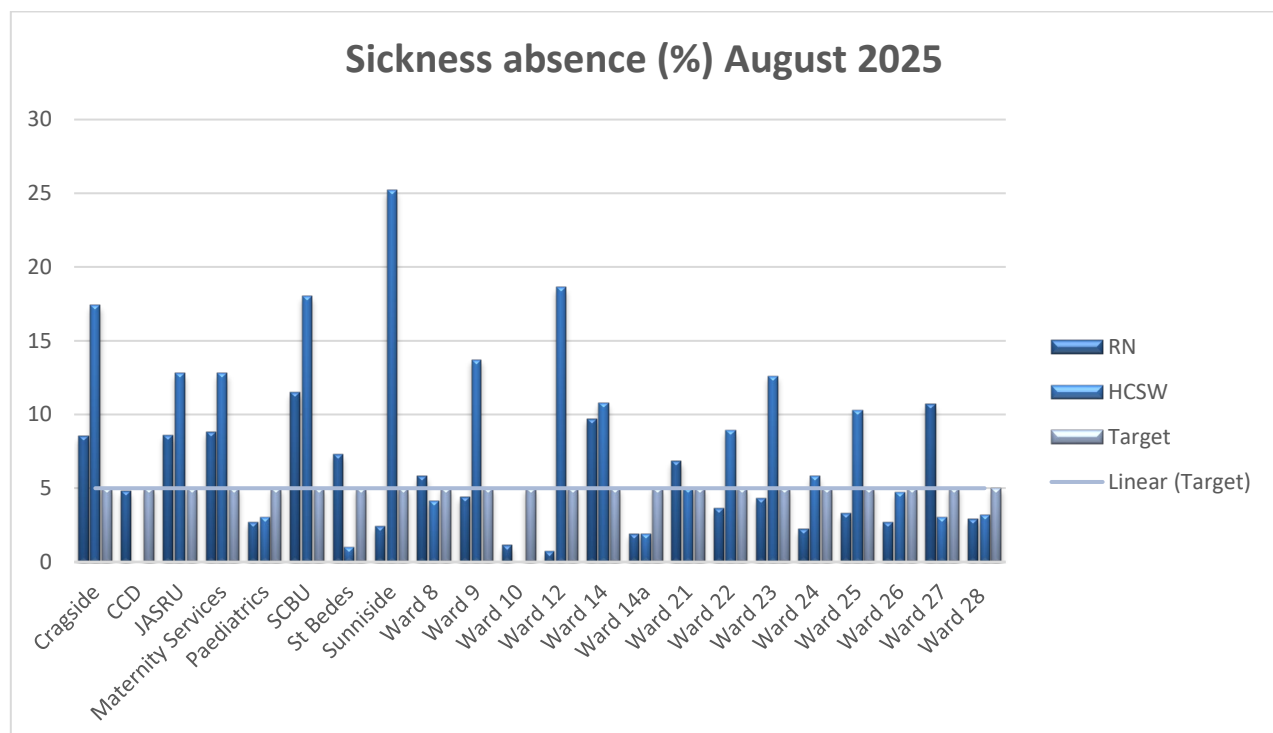
- Increase in Red Flags from July to August reflects ongoing staffing pressures, particularly linked to vacancies and sickness absence.
- All Red Flags were escalated and addressed in line with policy.
- No serious patient safety incidents were linked to Red Flag events.
- The rise in reporting may also indicate improving staff confidence in using the Red Flag system appropriately.



Attendance

The below table displays the percentage of sickness absence per staff group for August.

Data extracted from Health Roster.



Governance

Staffing levels are monitored in real time through the SafeCare Live system, which records actual staff on duty against planned establishments on every shift. Twice-daily updates of patient acuity and dependency support robust risk assessments and inform decisions on redeployment across wards.

Conclusion

This report provides the Board with an overview of nursing and midwifery staffing exceptions for August 2025. While pressures remain in specific areas, mitigations are in place and there is no evidence of significant patient safety impact. Focus now is on recruitment and retention to secure sustainable improvement. Work continues to strengthen assurance through a monthly dashboard that triangulates staffing data (vacancies, sickness absence, bank and agency use) with quality measures and patient safety indicators.

3. Recommendations

The Board is asked to:

- Receive this report for assurance.
- Note the areas of staffing pressure and the actions being taken to mitigate risk.
- Support the development of the monthly staffing and quality dashboard to enhance future reporting.

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

Appendix 1- Table 3: Ward by Ward staffing August 2025

 Decrease from previous month
  Increase from previous month

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative patient count over the month	Registered midwives / nurses	Care Staff	Overall
Cragside Court	 85.6%	 96.7%	 67.8%	 201.4%	 199	 8.0	 14.3	 22.3
Critical Care Dept	 73.8%	 72.8%	 97.3%	 80.4%	 234	 33.6	 3.6	 37.1
Emergency Care Centre - EAU	 82.7%	 87.4%	 97.4%	 88.0%	 1332	 5.8	 4.0	 9.7
JASRU	 105.9%	 62.6%	 105.9%	 107.0%	 599	 4.0	 3.3	 7.3
Maternity Unit	 72.9%	 107.0%	 99.8%	 92.6%	 583	 13.0	 4.5	 17.5
Special Care Baby Unit	 73.1%	 75.2%	 105.8%	 80.6%	 112	 16.7	 3.4	20.1
St. Bedes	 82.5%	 86.8%	 102.8%	 123.8%	 290	 5.2	 3.9	 9.1
Sunniside Unit	 97.4%	 152.7%	 77.6%	 130.2%	 256	 6.5	 6.4	 12.9
Ward 08	 96.0%	 75.0%	 98.2%	 114.8%	 609	 4.5	 2.8	 7.3
Ward 09	 93.1%	 64.3%	 100.9%	 100.2%	 802	 2.7	 1.8	 4.5
Ward 10	 89.3%	 88.2%	 104.1%	 119.1%	 716	 3.0	 2.6	 5.6

	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	84.5%	87.3%	105.1%	100.5%	789	2.6	2.2	4.8
Ward 14 Medicine	71.4%	87.9%	72.6%	103.1%	778	2.8	2.3	5.1
Ward 14a Gastro	109.9%	105.1%	87.6%	117.3%	788	2.9	2.7	5.6
Ward 21 T&O	104.6%	74.1%	99.6%	100.3%	974	3.5	2.9	6.4
Ward 22	81.1%	72.7%	150.9%	102.2%	920	2.7	2.3	5.0
Ward 23	53.1%	26.6%	68.7%	27%	233	5.2	2.6	7.7
Ward 24	100.2%	61.7%	149.5%	97.5%	921	3.1	2.0	5.1
Ward 25	89.5%	70.8%	155.0%	97.6%	929	2.9	2.2	5.1
Ward 26	97.7%	73.6%	98.6%	98.6%	718	3.5	2.6	6.1
Ward 27	102.4%	63.8%	92.7%	113.0%	835	3.0	2.2	5.2
Ward 28	71.4%	26.7%	100.4%	19.4%	157	10.0	2.9	12.9
QUEEN ELIZABETH HOSPITAL - RR7EN	84.1%	75.4%	100.0%	101.0%	13594	4.7	3.0	7.7

Report Cover Sheet

Agenda Item: 27

Report Title:	Register of Official Seal			
Name of Meeting:	Board of Directors			
Date of Meeting:	25 th September 2025			
Author:	Diane Waites, Corporate Services Assistant			
Executive Sponsor:	Sean Fenwick, Acting Chief Executive			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report <i>Briefly describe why this report is being presented at this meeting</i>	Decision: ☐	Discussion: ☐	Assurance: ☒	Information: ☐
	To receive details of the use of the Trust's official seal between 1 September 2024 and 31 August 2025.			
Proposed level of assurance – to be completed by paper sponsor:	Fully assured ☒ <i>No gaps in assurance</i>	Partially assured ☐ <i>Some gaps identified</i>	Not assured ☐ <i>Significant assurance gaps</i>	Not applicable ☐
Paper previously considered by: <i>State where this paper (or a version of it) has been considered prior to this point if applicable</i>	-			
Key issues: <i>Briefly outline what the top 3-5 key points are from the paper in bullet point format</i> <i>Consider key implications e.g.</i> • Finance • Patient outcomes / experience • Quality and safety • People and organisational development • Governance and legal • Equality, diversity and inclusion	In accordance with the Board's Standing Orders paragraph 25.5 the Board must receive an annual report documenting when the official Trust seal has been used throughout the year. This report is presented to the Board each September in accordance with the cycle of business and formally documents the use of the official seal in accordance with Standing Order paragraph 25.5.			
Recommended actions for this meeting: <i>Outline what the meeting is expected to do with this paper</i>	The Board is asked to formally note the use of the official seal during this current year (September 2024-2025).			

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

Gateshead Health NHS Foundation Trust
Register of Official Seal
1 September 2024 – 31 August 2025

Seal No	Date	Description	Signed	Witness
321	03.03.2025	Sale Purchase Agreement for sale and purchase of certain shares of Healthcall Solutions Limited	Mrs T Davies Mrs A Marshall	Mrs K Curry
322	03.03.2025	Shareholders Agreement relating to Healthcall Solutions Limited	Mrs T Davies Mrs A Marshall	Mrs K Curry

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			√				
Winter Plan	Chief Operating Officer	Item for Assurance	Part 1				√			
Responsible Officer Report	Medical Director	Item for Decision	Part 1				√			
Board Committee Annual Reviews of Effectiveness and Terms of Reference Update	Company Secretary	Item for Decision	Part 1							√
Green Plan	QEF Managing Director	Item for Decision	Part 1	deferred		deferred	√			
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	deferred		deferred	√			
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	deferred		√		√		
Learning from Deaths (quarterly report)	Group Medical Director	Item for Assurance	Part 1	deferred		√	deferred	√		√
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						√	
Freedom to Speak Up Guardian Report	Group Director of People & OD	Item for Assurance	Part 1				deferred	√	√	
WRES and WDES Report	Group Director of People & OD	Item for Assurance	Part 1				√			
Board Walkabout Feedback	Chief Nurse	Item for Assurance	Part 1	√		none	none	√	√	√
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				?			
Premises Assurance Model	QEF Managing Director	Item for Decision	Part 1				√			
Charitable Funds Audited Financial Performance	Group Director of Finance	Item for Board of Trustees	Part 1						√	