Board of Directors (Part 1 – Public)

A meeting of the Board of Directors (Part 1 – Public) will be held at 09:30am on 21st May 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 26 March 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 – Frailty Virtual Ward	Assurance		Presentation
ITEMS FOR ASSURANCE					
8.	10:00	Chair's Report	Assurance	Chair	Paper
9.	10:10	Chief Executive's Report	Assurance	Chief Executive	Paper
10.	10:20	Governance Reports:			
		i) Board Assurance Framework update	Assurance	Company Secretary	Paper
		ii) Organisational Risk Register	Assurance	Chief Nurse	Paper
11.	10:35	Assurance from Board Committees:			
		i) Finance and Performance Committee – April and May 2025	Assurance	Chair of the Committee	Paper
		ii) Quality Governance Committee – May 2025	Assurance	Chair of the Committee	Paper
		iii) People and Organisational Development Committee – May 2025	Assurance	Chair of the Committee	Paper
		iv) Digital Committee – April 2025	Assurance	Chair of the Committee	Paper
12.	10:55	Board Walkabout Feedback	Assurance	Chief Nurse	Paper
13.	11:05	Finance Report	Assurance	Group Director of Finance	Paper
14.	11:15	Strategic Objectives and Constitutional Standards Report	Assurance	Group Director of Finance	Paper
15.	11:25	Maternity Integrated Oversight Report	Assurance	Head of Midwifery	Paper
16.	11:35	Nurse Staff Exception Report	Assurance	Chief Nurse	Paper
ITEMS FOR INFORMATION / MEETING GOVERNANCE					
17.	11:45	Cycle of Business 2025/26	Information	Company Secretary	Paper
18.	11:50	Questions from Governors in Attendance	Discussion	Chair	Verbal

No	Start time	Item	Purpose	Lead	Paper / Verbal
19.	12:00	Any Other Business	Discussion	Chair	Verbal
20.	12:05	Date and Time of Next Meeting – 9:30am on Wednesday 30 July 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 26th March 2025 in Room 3, Education Centre, Queen Elizabeth Hospital and via MS Teams.

Name	Position
Members present	
Mrs Alison Marshall	Chair
Mr Adam Crampsie	Non-Executive Director
Mrs Trudie Davies	Group Chief Executive
Mr Gavin Evans	Managing Director for QE Facilities
Mrs Jane Fay	Acting Group Director of Finance
Dr Gill Findley	Deputy Chief Executive / Chief Nurse
Mr Neil Halford	Medical Director of Strategic Relations
Mrs Joanne Halliwell	Group Chief Operating Officer
Mr Martin Hedley	Non-Executive Director / Senior Independent Director
Dr Carmen Howey	Group Medical Director
Dr Gerry Morrow	Non-Executive Director
Mrs Hilary Parker	Non-Executive Director
Mrs Maggie Pavlou	Deputy Chair / Non-Executive Director
Mr Mike Robson	Non-Executive Director
Mrs Amanda Venner	Group Director of People & Organisational Development
Attendees present	
Ms Lucy Blackwell	Clinical Trials Officer (Agenda Item 25/03/07)
Mrs Jennifer Boyle	Company Secretary
Ms Nicola Bruce	Director of Strategy and Partnerships (Agenda Item 25/03/13)
Mrs Alison Harvey	Head of Research and Development (Agenda Item 25/03/07)
Ms Tracy Healy	Freedom to Speak Up Guardian (Agenda Item 25/03/17)
Dr Simon Lowes	Consultant Breast Radiologist/Vice Chair Research and Development Group (Agenda Item 25/03/07)
Mrs Karen Parker	Head of Midwifery (Agenda Item 25/03/22)
Ms Diane Waites	Corporate Services Assistant
Governors and Observers	
Cllr Dorothy Burnett	Appointed Governor
Mr Steve Connolly	Lead Governor
Mr Mark Learmouth	Public Governor – Central and Eastern Gateshead
Mr Michael Loome	Public Governor – Central and Eastern Gateshead
Mrs Janet Thompson	Staff Governor
Apologies	
Mrs Kris Mackenzie	Group Director of Finance
Mr Andrew Moffat	Non-Executive Director

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25/03/01	**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	

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	accordance with the Trust's Constitution and Standing Orders. She welcomed those present including the Trust Governors and observers. Mrs Marshall highlighted that there were a number of items on the agenda for this meeting and asked presenters to take reports as read.	
25/03/02	**Declarations of Interest:** Mrs Marshall requested that Board members present report any revisions to their declared interests or any additional declaration of interest in any of the items on the agenda.	
25/03/03	**Apologies for Absence:** There were apologies received from Mrs K Mackenzie and Mr A Moffat.	
25/03/04	**Minutes of the Previous Meeting:** The minutes of the meeting of the Board of Directors held on Wednesday 27th November 2024 were approved as a correct record following a minor amendment: **25/01/13 Board Walkabout Feedback (page 10)** *Following a query from Mrs Marshall in relation to timescales relating to the review of the operating model*	
25/03/05	**Matters Arising from the Minutes:** The Board reviewed the action tracker as below: • Action 24/11/17 relating to providing further information in relation to maternity bookings and review of quality impact assessment within the Maternity Integrated Oversight Report. It was last reported that the impact on safety will be considered further in the February Equality and Quality Impact Assessment (EQIA) panel and Dr G Findley, Chief Nurse and Deputy Chief Executive, confirmed that this has now taken place and it was recommended that the cap remains in place. Further review will take place via the Finance and Performance Committee therefore action was agreed for closure. • Action 25/01/06 relating to the approach to complaints being discussed via the Executive Management Team and Gateshead Health Leadership Group. This has taken place and it was confirmed that all complaints now receive a telephone call contact from the team. Action agreed for closure.	

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	• Action 25/01/13 relating to developing some options around balance of Board walkabout visits. It was reported that time has been protected in the diaries as part of the refresh and the commitment to Board walkabouts and is documented in the Board Walkabout paper on the agenda (Item 18). Action agreed for closure. The Board reviewed the actions closed at the last meeting which ensures actions have been closed in line with expectations and the agreements made at the previous Board meeting. Mrs J Boyle, Company Secretary, highlighted that Action 24/09/08 relating to updating the Standing Orders and Scheme of Delegation to reflect changes to Terms of Reference was closed at the November 2024 meeting as they were scheduled to be presented at the January and March meeting however these will now be presented at the July Board meeting to allow review by the Audit Committee.	Cycle of business
25/03/06	**Top 4 Organisational Risks:** The Top 4 organisational risks were noted as follows: • Risk 4417 (People and Organisational Development) 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 2969 (Medicine) Risk of patient harm due to length of stay in the Emergency Department resulting in potential regulatory action and poor patient experience. (Risk Score 20) • Risk 4694 (Finance) Risk that the Trust will not achieve a break-even revenue plan for 2025-26 and a deterioration from the 2024-25 planned deficit, resulting in a deterioration to Trust's NHS Oversight Framework rating. (Risk Score 20) • Risk 4705 (Digital) Risk of considerable clinical and operational impact to patient care due to instability of Picture Archiving and Communication System (PACS) environment. This is resulting in delayed diagnosis and treatment plans across services, as well as delayed discharges, resulting in significant disruption to patient pathways throughout the organisation. (Risk Score 20) Mrs J Halliwell highlighted that Risk 2969 is likely to reduce at the next Executive Risk Management Group as work has been completed to update monitoring relating to performance metrics and operational mechanisms.	

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25/01/07	**Staff Story – Northern Centre for Breast Research:** The Board welcomed Dr Simon Lowes, Consultant Breast Radiologist and Vice Chair for the Research and Development Group, Mrs Alison Harvey, Head of Research and Development, and Ms Lucy Blackwell, Clinical Trials Officer, who shared their work around the Northern Centre for Breast Research and the planned launch in May 2025. Dr Lowes highlighted the importance of research delivery which leads to improved quality of patient care and highlighted the role of staff members leading research in a variety of regional and national organisations, including contributing to national guidelines and national research studies. The research centre is due to launch on 21st May 2025 as part of the International Clinical Trials Day and will be run within existing space within the Breast Unit. Mrs Marshall highlighted that research and innovation is a priority area within the Alliance work and following a query from Mr A Crampsie, Non-Executive Director, in relation to ensuring active involvement, Dr Lowes explained that work is being undertaken around education and promotion however there are still some challenges around embedding research into clinical practice due to current pressures. Dr G Morrow, Non-Executive Director, queried whether the Board could support in reducing some of the barriers and Mrs Harvey explained that some education opportunities are in place around junior doctor induction however it was important to ensure that all clinical staff were aware of the importance of research and funding benefits to maximise opportunities. Mrs J Fay, Acting Group Director of Finance, felt that further discussion could take place to support this and will be picked up outside of the meeting. Mr M Robson, Non-Executive Director, felt that it would be beneficial to involve the Trust Charity and Mrs N Bruce, Director of Strategy and Partnerships, highlighted that this will be looked at as part of the alignment to the Trust strategy work going forward. Mrs Marshall thanked Dr Lowes, Mrs Harvey and Ms Blackwell for sharing the development of the research centre and wished to express the thanks of the Board to whole team. Dr Lowes, Mrs Harvey and Ms Blackwell left the meeting.	
25/03/08	**Annual Declarations of Interest:** Mrs J Boyle, Company Secretary, the latest Board of Directors' Register of Interests which have been declared in accordance with local and national policy and in accordance with the Trust's governance documents.	

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	She confirmed that all Board members have completed the declarations and are included on the register and is appended to the report. Mr M Robson, Non-Executive Director, felt that the declaration in relation to Mr A Crampsie indicated that Everyturn was a provider to the Trust therefore it was suggested that this is amended to highlight that this is an Integrated Care Board funded organisation which works alongside the Trust. After consideration, it was: **RESOLVED:** to formally approve the annual register of interests for the Board of Directors following the above amendment, ensuring it is publicly accessible through the Board papers.	JB
25/03/09	**Quality Governance Committee Terms of Reference:** Mrs J Boyle, Company Secretary, presented the revised Terms of Reference for the Quality Governance Committee. She highlighted that this is an interim update to the terms of reference for Quality Governance Committee to align with the changes made to the governance structure and has been approved by the Committee. After consideration, it was: **RESOLVED:** to review and ratify the revised terms of reference on the recommendation of the Quality Governance Committee	
25/03/10	**Care Quality Commission (CQC) Statement of Purpose and Registration:** Dr G Findley, Chief Nurse and Deputy Chief Executive, presented the Statement of Purpose which is a CQC registration requirement document that must be regularly reviewed and updated to reflect any changes in the organisation and the description and location of services. She highlighted that updates include the addition of two community hubs where Maternity Community Midwives consult with patients and the inclusion of Mrs Jo Halliwell as a Registered Manager for surgical procedures and diagnostic and screening procedures. Dr C Howey, Group Medical Director, highlighted that services were no longer provided from Chowdene Children's Centre therefore this will be reviewed and amended. Following consideration, it was:	GF

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	RESOLVED: to approve the CQC Statement of Purpose and Registration subject to the above amendment.	
25/03/11	**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 highlighted that Mr Andrew Moffat, Non-Executive Director Chair of the Group Audit Committee and Digital Committee, has announced his intention to leave the Board on 30th June 2025 therefore work will be taking place with the Trust Governors to commence Non-Executive Director recruitment for two positions which includes the Finance NED role as Mr Mike Robson will reach the end of his term on the same date. The recruitment process for the shared Chair across the Alliance (Gateshead, Newcastle and Northumbria) is now underway with applications closing on 7th April 2025. Mrs Marshall drew attention to the Star of the Month nominations for January and February 2025 and congratulated Michelle Thomas who was the winner for January 2025 which recognised her work within Pea Pod around supporting staff and family following a difficult situation. After consideration, it was: **RESOLVED:** to receive the report for assurance.	
25/03/12	**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 Strategic Aims. Mrs Davies drew attention to Strategic Aim 1: *We will continuously improve the quality and safety of our services for our patients* – she highlighted that a review of the Trust's model of care is taking place with the aim of reducing long waits for our patients and improving patient flow through the hospital and illustrates that positive action and outcomes have taken place. In relation to Strategic Aim 2: *We will be a great organisation with a highly engaged workforce* – this highlights the challenges associated with the 2025/26 planning round particularly around maintaining the size of our workforce given the significant financial pressures across the whole NHS. This links with the national announcements earlier this month regarding the level of change and challenge facing the NHS, including NHS England and Integrated Care Boards. In particular workforce and	

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	corporate services are areas all NHS organisations are being asked to look at and it is recognised that this will be a particularly unsettling time for colleagues, A dedicated question and answer session was held recently which was well attended and a comprehensive vacancy control process is already in place within the Trust. In relation to Strategic Aim 2: *We will enhance our productivity and efficiency to make the best use of resources* – Mrs Davies highlighted that work has continued to develop the annual plan for the Trust particularly around improving productivity and the consideration of difficult decisions which will be required to deliver the plan. In relation to Strategic Aim 3: *We will enhance our productivity and efficiency to make the best use of resources* – Mrs Davies drew attention to the unexpected loss of the Picture Archiving and Communication System (PACS) and explained that a longer-term solution is being worked on to minimise the risks of the problem reoccurring. Assurance was provided that there were no incidences of patient harm and thanked colleagues who worked hard to resolve the issues. In relation to Strategic Aim 4: *We will be an effective partner and be ambitious in our commitment to improving health outcomes* – A celebratory event took place for International Women's Day which provided an opportunity to showcase how the Trust is supporting women's health in Gateshead and beyond as part of our centre of excellence for women's health ambition. Cllr Burnett highlighted that a Women and Girls Committee is being established by the local authority and Ms N Bruce, Director of Strategy and Partnerships and Mrs J Halliwell, Group Chief Operating Officer will link with this. Mrs Davies highlighted that Dr Carmen Howey, Group Medical Director, and Dr Nithya Ratnavelu, Associate Medical Director for Cancer, were recognised as inspiring women at the event. Strategic Aim 5: *We will develop and expand our services within and beyond Gateshead* – highlights the engagement work which has continued to take place in relation to the development of the 5 year strategy and this will also ensure alignment to the annual plan. After further discussion, it was: **RESOLVED:** to receive the report for assurance.	
25/03/13	**Great North Healthcare Alliance Progress Report:** Ms N Bruce, Director of Strategy and Partnerships, provided an update on the progress made in respect of the Great North Healthcare Alliance. She reminded the Board of the fundamental principles and drew attention to some of the progress against the objectives and vision which includes	

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	a reduction in waiting times and occupied bed days within cardiology and positive progress within urology which has seen the elimination of over 52 week waits for the Trust. A longer term plan has been agreed to deliver an interoperable set of digital services to enable information and data to exchange across the Alliance to effectively support patients and frontline services and a shared Digital Director has been appointed to coordinate this work across Newcastle, Gateshead and Northumbria, working closely with North Cumbria. Ms Bruce also drew attention to the work taking place around research and innovation and an Alliance wide session has been held to agree priority areas. She concluded that progress across the Alliance has been good during the first year and there continues to be enthusiasm for working together across the organisations and a number of tangible benefits have already been delivered with support for greater collaboration in the future. Mr M Hedley, Non-Executive Director, felt that it would be beneficial to publish some of the progress to staff and Ms Bruce explained that this will be looked at. Dr G Morrow, Non-Executive Director, queried whether any progress had been made in relation to the aim to deliver improved services within oral and maxillofacial surgery, and Ms Bruce explained that some discussions have taken place with primary care however Dr Morrow felt that this may need to be further clarified in relation to dentistry services. Mr A Crampsie, felt that there may be further opportunities within the Alliance in relation to the present risks surrounding the NHS and Mrs T Davies, Group Chief Executive, highlighted that discussions have been taking place with the Provider Collaborative and Integrated Care Board to support the changing infrastructure and further service opportunities however this requires further work to assess the impact. Dr C Howey, Group Medical Director, felt that it was important to share some of the positive outcomes to ensure a wider understanding of the work being undertaken to demonstrate the opportunities to reconfigure services for the benefit of patients not just for financial benefits therefore some external marketing may need to be considered. Following further discussion, it was: **RESOLVED:** to receive the report for assurance and note the progress being made across the Alliance.	
25/03/14	**Governance Reports:** **Organisational Risk Register (ORR):** Dr G Findley, Chief Nurse and Deputy Chief Executive, presented the updated ORR to the Board which shows the risk profile of the Trust, including a full register, and provides details of reviewed compliance and	

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	risk movements. This report covers the period 19th January 2025 to 19th March 2025. She reported that there are currently 19 risks on the ORR and 5 risks have been added following the Executive Risk Management Group meetings in February and March 2025. These included some of the financial risks regarding the considerable challenges forecast for the forthcoming year 2025/26 however these have replaced the financial risks for 2024/25. Another risk added related to the recent significant clinical impact of PACS (Picture Archiving and Communication System) downtime however a resolution plan is in place which is currently being implemented. Compliance of reviews remains static at 89% for risks and has achieved 100% for associated actions. The report also provides trends of risk movement in the last six months however discussion took place around whether this was beneficial to the Board and it was felt that further narrative may be required to provide additional assurances. Dr Findley agreed to review this however Mr A Crampsie, Non-Executive Director, felt that it was also important for the Board Committees to review relevant risks on a regular basis and this level of detail would be considered at Committee level. After consideration, it was: **RESOLVED:** to receive the report for assurance.	GF
25/03/15	**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:** Mr M Robson, Committee Chair, provided a brief verbal overview to accompany the narrative reports following the February 2025 meeting and drew attention to the most recent meeting which took place on 25th March 2025. Mr Robson highlighted that there were four issues identified as requiring alert to the Board, the first of which relates to the 2025/26 Annual Plan submission. Some amendments have been recommended by the Committee for the Board to consider later in the meeting prior to submission on Friday. The Committee also received an update in relation to the Sister Winifred Laver Promoting Independence Centre which has closed to new admissions in response to the recent Care Quality Commission report. The Committee noted the possible risk to the organisation in relation to patient flow. A six month review is taking place in relation to the Community Diagnostic Centre to evaluate against the delivery model and this will be reported back to the Committee in May	

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	2025. Some concerns were raised in relation to the Order Communications business case particularly around governance arrangements however will be discussed further later in the meeting. There are some areas subject to ongoing monitoring which includes: • The Committee approved the 2025/26 budget plans which will be discussed later in the meeting however recommend adopting the approach. • The Committee noted that there were significant challenges achieving performance targets particularly around diagnostics. The Committee received positive assurance in relation to the following areas: • The delivery of the capital programme is on track. Some further schemes will be brought back to the Board in May 2025 for consideration. Retrospective business cases relating to colposcopy and paediatrics were supported and are recommended for approval by the Board later in the meeting. • The Committee noted the improvements to quality standards in relation to maternity and screening programmes and wished to congratulate the teams. **Quality Governance Committee:** Mr A Crampsie, Committee Chair, provided a brief verbal overview to accompany the narrative report following the February 2025 meeting. He reported that there were two issues identified as requiring escalation to the Board for further action which relates to the PACS ongoing incident that was reported on earlier in the meeting and has been recognised as one of the top organisational risks. The other relates to concerns raised in relation to the number of key assurance meetings being stood down including the Health and Safety Group and Mortality Council which has resulted in the lack of Executive oversight and sufficient assurance levels. Dr G Findley, Chief Nurse and Deputy Chief Executive, reported that these meetings have now been reinstated however Mrs T Davies, Group Chief Executive, felt that it was important to ensure processes are in place to provide further mitigation and assurance. There are some areas subject to ongoing monitoring which includes: • There has still been no response from the Integrated Care Board in relation to the additional funding required for Children in Care however Dr Findley highlighted that the Trust is working with the Local Authority to ensure that local mitigations 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 March 2025 meeting.	Cycle of business

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	She reported that there were one issue requiring escalation to the Board relating to continued concerns around sickness absence rates particularly in relation to anxiety/stress/depression and the Committee were not assured of the plan to address this however this will continue to be reviewed. Mrs A Venner, Group Director of People and Organisational Development highlighted that a dedicated absence taskforce is being launched, and work continues across the Alliance and Provider Collaborative. There are some areas subject to ongoing monitoring which includes: • Gender pay gap - an overarching report to be developed to highlight the Group position and provide an overall Group figure for the year. • The Committee were advised of the decision to pause the three nurse apprenticeship programmes for the 2025-26 financial year and demonstrates that difficult decisions are being made. • Work is taking place around the alignment of the 10 year People Plan and required in-year cost reductions The Committee received positive assurance in relation to the following areas: • Review of the Board Assurance Framework and delivery against the strategic aims. This has resulted in the Provider Collaborative workforce risk rating being reduced to 6 given the successful role of Gateshead in influencing the direction of travel, including the role of the Chief Executive as chair of the regional workforce group. • Assurance was provided in relation to the reporting and processes mechanisms relating to employee relations and workforce planning. **Digital Committee:** Mr M Hedley, Non-Executive Director, provided a brief verbal overview to accompany the narrative report following the February 2025 meeting. He reported that there was one issue requiring escalation to the Board relating to ensuring that the work around Artificial Intelligence (AI) is properly aligned and a further report on this has been requested by the Committee. There are some areas subject to ongoing monitoring which includes: • The Committee has requested further discussion in relation to the use of the free licenses for the Co-Pilot AI software. • At the time of the Committee meeting, it was reported that the Outline Business Case for the Electronic Patient Record was on track to deliver timescales however a report on progress will be provided later in the meeting.	

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	Mrs J Halliwell, Group Chief Operating Officer, commented that further detail within the assurance report around specific topics would be useful and this was noted. **Audit Committee** Mrs H Parker, Non-Executive Director, provided a brief verbal overview to accompany the narrative report following the March 2025 meeting. She reported that there were no issues requiring escalation to the Board however highlighted that there are some areas subject to ongoing monitoring which includes: • The Committee discussed compliance of the Standing Financial Instructions (SFIs) and it was felt that further work is required to determine whether it would be feasible to include an assurance guide / map in the next iteration. Mrs J Fay, Acting Group Director of Finance explained that an assurance table will be added to each section. **Group Remuneration Committee:** Mr M Hedley, Committee Chair, provided a brief verbal overview to accompany the narrative report following the January 2025 meeting. There were no issues requiring escalation to the Board however Mr Hedley highlighted that the Committee approved the proposed temporary acting arrangement for the Group Director of Finance post and approved an update to the Group Remuneration policy to reflect the application of NHS England's 2024/25 very senior manager remuneration recommendations. Mrs Marshall thanked the Committee Chairs for their reports. After consideration, it was: **RESOLVED**: to receive the reports for assurance	
25/03/16	**Annual Staff Survey Results:** Mrs A Venner, Group Director of People and Organisational Development, presented the 2024 Annual Staff Survey results which also includes the National Quarterly People Pulse Update. Mrs Venner highlighted that the results show that there has been the highest ever completion rate which indicates a higher level of staff willingness to provide honest feedback. The results have been widely discussed and disseminated across the organisation, and she drew attention to the two broad recommendations and key messages around stopping incivility and promoting and taking positive action on engagement. It is planned that discussions will now take place with the	

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	divisional and corporate teams and action plans are being developed for monitoring via the People and Organisational Development Committee. Following discussion, it was: **RESOLVED:** to receive the report for assurance.	
25/03/17	**Freedom To Speak Up Guardian Report:** Ms T Healy, Freedom to Speak Up (FTSU) Guardian, provided an update on of FTSU activity. Ms Healy reported that during 2023/24 59 concerns were raised and for 2024/25 so far there have been 64 concerns raised. She highlighted that the current data demonstrates that there has been an increase in staff concerns and further analysis against national reporting will be undertaken when data is available however following discussions with colleagues from the Great North Healthcare Alliance, FTSU services are reporting similar percentages. Ms Healy provided assurance that staff concerns are managed in a variety of ways, initially being RAG rated for current risk and safety for patients and/or staff and any cases rated high risk to patient or staff safety are escalated immediately to the Chief Nurse and Deputy Chief Executive, and Group Director of People and Organisational Development. The Trust has increased the network of FTSU champions from 8 to 30 and all Board members have completed the three levels of FTSU training resulting in 100% compliance. Ms Healy highlighted that the FTSU policy has been implemented in line with the National Guardian Office guidance and a standard operating procedure is being completed which is due to be approved by the Gateshead Health Leadership Group. The report also highlights the national update on current statutory requirements which will require a self-assessment to be undertaken and development of Trust action plan with the Executive Management Team to provide monitoring of compliance. A FTSU strategy will also be developed in line with the Trust Strategy work and a key stakeholder event will be taking place. Mrs H Parker, Non-Executive Director and FTSU NED representative, thanked Ms Healy for providing a comprehensive report which provides the Board with good assurance however felt that the organisational risk may need to be reworded to provide further encouragement to staff to speak up therefore it was agreed that this will be looked at further. Mr A Crampsie, Non-Executive Director, felt that further system support may be required around the FTSU service particularly around complex employment cases and Mrs Healy explained that plans are being reviewed via the strategy development work however Mrs T Davies,	GF / AV

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	Group Chief Executive, felt that it may be beneficial to discuss this further via a future Board Development Day. Following a query from Mrs A Venner, Group Director of People and Organisational Development, in relation to work around themes and trends within divisions, Ms Healy explained that listening exercises have taken place which has resulted in a lot of positive information and further work will be taking place to provide support within the divisions. Following a query from Mrs M Pavlou, Non-Executive Director, in relation to the road map and routes of escalation, Ms Healy explained that this had been developed following the staff survey. Mrs Davies reported that a lot of work has already taken place around the organisational review work and specific actions have been identified to ensure that the correct routes are taken and Ms Healy highlighted that the standard operating procedure will also be used alongside this. After further discussion, it was: **RESOLVED:** to receive the report for assurance. Ms Healy left the meeting.	JB
25/03/18	**Board Walkabout Feedback:** Dr G Findley, Chief Nurse and Deputy Chief Executive, provided the Board with an overview of observations and reflections from Board walkabouts, supporting triangulation with other sources of information and assurance. The report covers two visits including maternity and cardiology and it was noted that feedback from patients who were being surveyed by the Patient Experience team was very positive, which is recognition of the hard work of the teams. Following discussion at the last Board meeting, Dr Findley explained that the process for planning Board walkabouts has been revised to ensure that time is protected in the diaries for this important activity. There will be an identified slot in the week when Directors will go out to meet the various teams across all sites including corporate teams and Dr Findley highlighted that this is also open to any Non-Executive Directors who wish to take part. After consideration, it was **RESOLVED**: to receive the report for assurance	

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25/03/19	**Finance Report:** Mrs J Fay, Acting Group Director of Finance, provided the Board with a summary of financial performance for April 2024 to February 2025 (Month 11) for the Group (inclusive of the Trust and QE Facilities, excluding Charitable Funds). Mrs Fay highlighted some of the key points and reported that previously the Trust had been planning to achieve a revised planned deficit of £7.333m however this has reduced to £2.192m following the allocation of non-recurring deficit support funding to North East and North Cumbria Integrated Care System to deliver breakeven across the System. Mrs Fay reported that the Trust continues to experience financial pressures and capital spend has been less than planned however plans are in place for this to be achieved. Cash balances are healthy which is informed by the delivery of the forecast deficit and capital programme. After consideration, it was: **RESOLVED:** to receive the Month 11 financial position and note partial assurance for the achievement of the forecast 2024/25 planned deficit as a direct consequence of the reported year to date position and financial risks.	
25/03/20	**Strategic Objectives and Constitutional Standards Report:** Mrs J Halliwell, Group Chief Operating Officer, presented the progress, risks and assurance in relation to the Trust's Strategic Objectives for Month 11 2024/25. Mrs Halliwell explained that detailed discussions took place at the Finance and Performance Committee however the improvements around urgent and emergency care performance were noted. There are some areas requiring additional support including diagnostic compliance and echo-cardiology however this is similar within other organisations and recovery plans are being managed via the weekly performance meetings. Focus remains on achieving zero over 52 weeks and reducing outpatient waiting times. Mrs Halliwell highlighted that the report states that the Trust has been highlighted nationally as one of the Top 20 Trusts for RTT (referral to treatment) performance and selected for the Going Further Faster Programme however this has not yet been confirmed and has been changed to a pioneer programme. Following consideration, it was:	

Agenda Item No		Action Owner
	RESOLVED: to receive the report for assurance and note the key areas of improvement and challenge.	
25/03/21	**Learning from Deaths Quarterly Report:** Dr C Howey, Group Medical Director, provided an overview of the organisational learning from deaths for Quarter 3. It should be read together with the Mortality Data report, the Medical Examiner report and Response from the Medical Director to ensure an understanding of the context and an overview of the mortality related activity within the Trust. Dr Howey highlighted that there have been recent difficulties with the scheduling of the Mortality Council meetings meaning that review of deaths in that forum has been delayed however good progress has been made in the review of the deaths of patients with Learning Disability. There also remains a significant number of deaths for patients with Serious Mental Health Illness (SMI) which require review however plans are in place for these to be scrutinised at the Mortality Council. Following a query from Mrs T Davies, Group Chief Executive, in relation to the timeframes surrounding the learning disability deaths and whether any learning may have been missed, Dr Howey explained that it will take several months to review the deaths via the Mortality Council and Dr G Findley, Chief Nurse and Deputy Chief Executive, explained that a process is being reviewed with the Integrated Care Board in relation to the accessibility of notes for review. It was felt that this may require further support therefore Dr Howey will discuss further with colleagues at Cumbria, Northumberland and Tyne and Wear NHS Foundation Trust. Mr A Crampsie, Non-Executive Director, highlighted that detailed discussion has also taken place via the Quality Governance Committee and the Committee were assured by the update. Dr Howey will ensure this is noted on future reports. The Board reviewed the Mortality Data Report and Dr Howey highlighted that there were no areas of concern. She drew attention to the Medical Examiner's Report and Response from the Medical Director in relation to some concerns raised however it was felt that the Mortality Data report does not give any indication that the Trust is an outlier with regard to its mortality data and does not raise any specific issues of concern. In response to the concern raised in relation to the Medical Examiner having independence, a risk has been added to the risk register to reflect this. After further discussion, it was: **RESOLVED:** to receive the report for assurance however it was noted that partial assurance is received in relation to internal processes due to the limited number of deaths which	

Agenda Item No		Action Owner
	have been reviewed through Mortality Council and the number of outstanding SMI deaths which still require specialist review.	
25/03/22	**Maternity Integrated Oversight Report:** Ms K Parker, Head of Midwifery, presented a summary of the maternity indicators for the Trust for February 2025. She drew attention to the key performance indicators within the Maternity Dashboard and highlighted that there has been a slight increase in the overall caesarean section rate with a reduction in instrumental delivery rate and a deep dive exercise is taking place with feedback being provided to the Quality Governance Committee. The report highlights good breastfeeding rates and a vulnerable babies breast milk initiative is in place. Following a query from Mr A Crampsie, Non-Executive Director, in relation to only 8% of babies being fed within 60 minutes of birth, Ms Parker explained that has been identified as low however improvements around reporting are being reviewed. Ms Parker drew attention to the current pressures on workforce in relation to the Birth Reflections Service and highlighted that new referrals have been paused whilst the backlog is addressed. A risk has been raised in relation to there being no system administrator for Badger Neonatal Electronic Patient Record (EPR) from 1st April 2025 however Dr G Findley, Chief Nurse and Deputy Chief Executive, highlighted that this has been discussed at the Digital Committee and has been resolved. Mr A Crampsie noted that there had been rise in complaints and queried whether any concerns needed to be addressed. Ms Parker explained that there were no current themes however this demonstrates the current pressures on workforce and Dr Findley agreed that this should be reviewed via the Quality Governance Committee. Following discussion, it was: **RESOLVED:** to receive the report for assurance.	
25/03/23	**Nurse Staffing Exception Report:** Dr G Findley, Chief Nurse and Deputy Chief Executive, presented the report for February 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 this demonstrates some areas with staffing challenges which relates to sickness absence and enhanced care requirements. The Trust has also continued to experience periods of	

Agenda Item No		Action Owner
	increased patient activity with surge pressure resulting in escalation areas open in Ward 11. The Board noted the red flag incidents and Dr Findley explained that there had been some gaps for Health Care Assistants however further recruitment and training has taken place which should resolve this. Following discussion, it was: **RESOLVED:** to receive the report for information and assurance.	
25/03/24	**Cycle of Business 2025/26:** Mrs J Boyle presented the new 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 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 new financial year 2025/26.	
25/03/25	**Questions from Governors in Attendance:** There were no questions received from Governors.	
25/01/26	**Any Other Business:** There was no other business discussed.	
25/01/27	**Date and Time of Next Meeting:** The next meeting of the Board of Directors will be held at 9.30am on Wednesday 21st May 2025.	
Exclusion of the Press and Public: Resolved to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed.		

PUBLIC BOARD ACTION TRACKER

Gateshead Health NHS Foundation Trust

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

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
24/09/08	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	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.**	
24/09/09	24/09/2024	National Pay Award	To review and update the wording in the SFIs and Scheme of Delegation relating to Board approval of national pay awards.	~~27/11/2024~~ 30/07/2025	Kmac	Nov 24 - links to action 24/09/08 therefore action agreed for closure as above Jan 25 – as above **Feb 25 – recommendation to reopen the action until updates are made – expected at July Board meeting to allow review by the Audit Committee**	
25/03/08	26/03/2025	Annual declaration of interest	To amend the register of interests to clarify that the Trust does not directly commission services from Everyturn (Adam Crampsie's declaration)	21/05/2025	JB	May 25 – Board register of interest updated accordingly. **Action recommended for closure.**	

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
25/03/10	26/03/2025	CQC Statement of Purpose and Registration	To remove Chowdene Children's Centre as a location for the delivery of services	21/05/2025	GF	Completed – **action recommended for closure**	
25/03/14	26/03/2025	Organisation Risk Register	To review report particularly around trends of risk movement and whether further narrative required to provide additional assurances	21/05/2025	GF	Completed – trends to be presented as one table. **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. **Action recommended for closure.**	

Closed Actions from last meeting

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

Top Organisational Risks – May 2025

The top 3 organisational risks as agreed by the Executive Risk Management Group on 6 May 2025 are as follows:

Top 3 Organisational Risks:

Risk Id	Division	Description	Initial Risk Grade	Grade	Target Grade
4417	People & OD	There is a risk that promoting an environment that encourages speaking out and creating a psychologically safe culture has led to increased reports of poor behaviour. This could have a negative impact on staff and require additional time and capacity to appropriately address the concerns. This could result in further health and well being concerns and staff absence.	15	15	6
4694	Finance	Risk that the Trust will not achieve 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
4734	Medical Services	Risk of patient harm due to inability to meet 4 hour ED Emergency Care standard. Resulting in potential regulatory action and poor patient experience.	20	16	8

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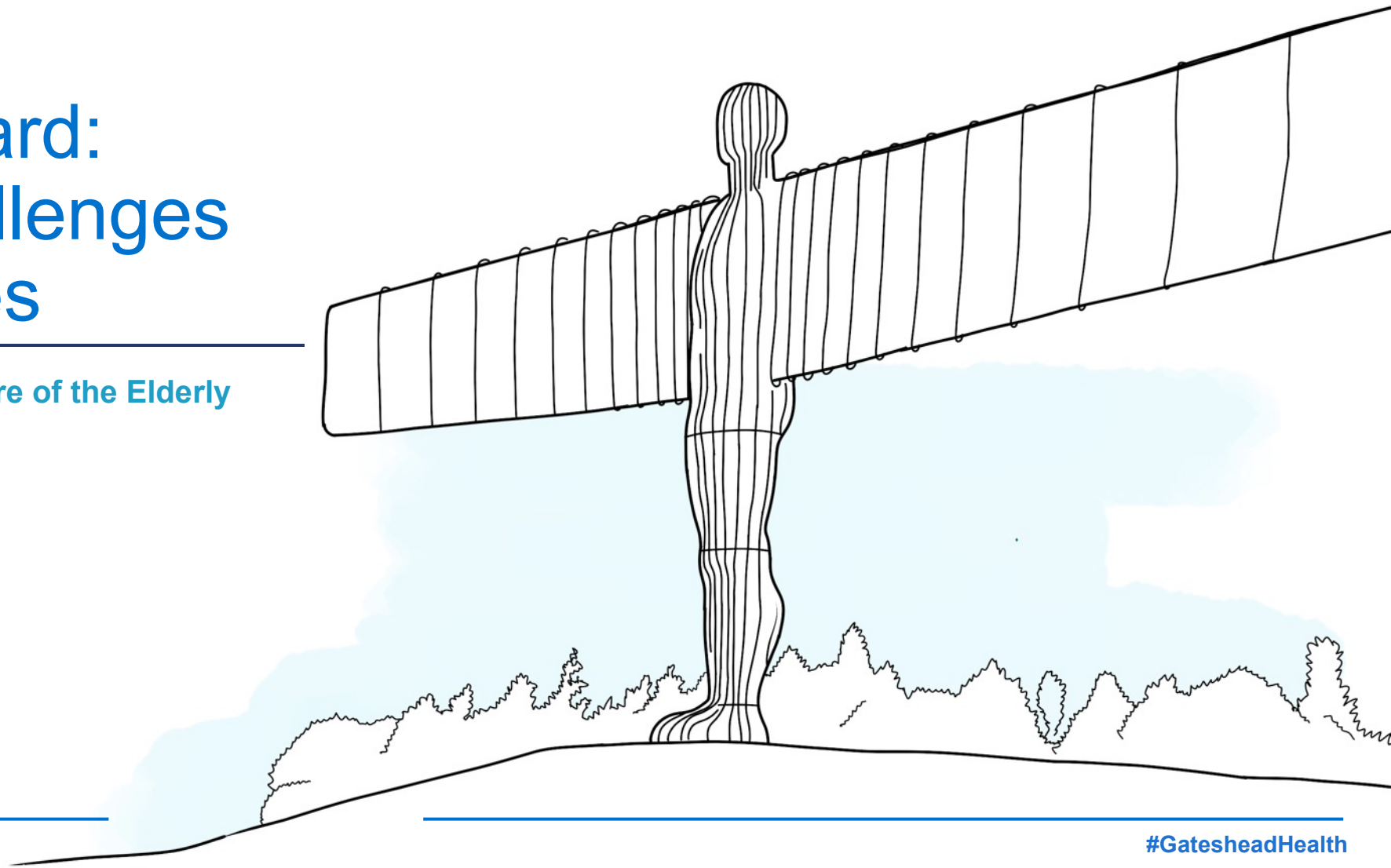
Frailty Virtual Ward: Successes, Challenges and Opportunities

Dr Peter Brock – Clinical Lead for Care of the Elderly

21st May 2025



NHSE Virtual Wards Operational Framework 2024

Gateshead Health NHS Foundation Trust

A virtual ward is defined by:

- effective governance and clinical leadership, with consultant physician/consultant practitioner/GP oversight
- operating hours (8am–8pm, 7 days a week at a minimum) and out-of-hours provision
- clear admission criteria and assessment processes
- personalised care and support planning and shared decision-making
- daily board rounds involving a senior clinical decision-maker, medical input and the wider MDT
- hospital-level diagnostics
- hospital-level interventions/treatment
- technology-enabled care, including remote monitoring
- pharmacy, medicine reconciliation and optimisation
- clear discharge processes, including monitoring of length of stay

Gateshead Frailty Virtual Ward

Gateshead Health NHS Foundation Trust

WHERE ARE WE NOW?

Gateshead Frailty Virtual Ward

Gateshead Health NHS Foundation Trust

WHERE ARE WE GOING TO?

Gateshead Frailty Virtual Ward - Successes

Gateshead Health NHS Foundation Trust

A REAL LIFE EXAMPLE

Gateshead Frailty Virtual Ward - Successes

- Rapid admission and discharge of patients
- Consultant led Multi-Disciplinary Team work
- Hospital quality care – IV antibiotics, palliative oxygen, SC fluid, investigations through SDEC, long term care planning
- Rapid carer support through Prime
- Increasing step ups with links to Primary Care, NEAS, CPNs, Community Nurses, Rapid Response
- Joined up care for older people throughout Gateshead Health NHS Foundation Trust

Gateshead Frailty Virtual Ward - Successes

- The patient's perspective:

"My mother in law who is a very frail lady suffering with end stages of dementia and gets disoriented and frightened being taken out of her own environment. This service meant we were able to get her home on the same day. The staff helped us get everything into place and were so caring and professional with all of us and as a family who had been struggling for some time to try and get people to understand how much my mother in laws dementia was progressing we will be forever grateful and for the first time in a long time felt we were not on our own. I feel this service is a real necessity once again many thanks"

"So she was referred to a "virtual ward" I think it's called and OMG what a brilliant service this is every day the nurse came and brought a doctor with her at one point.

Mam is feeling somewhat better but she is happier in her home and that makes such a difference

She is being discharged today from that virtual service but I am so glad that in Gateshead we have that service and the great staff within it"

Gateshead Frailty Virtual Ward - Successes

Gateshead Health NHS Foundation Trust

BUILT FROM THE GROUND UP

Gateshead Frailty Virtual Ward - Challenges

Gateshead Health NHS Foundation Trust

BUILT FROM THE GROUND UP

Gateshead Frailty Virtual Ward - Challenges

Gateshead Health NHS Foundation Trust

- Failure to have joined up digital resources between hospital and community
- Prescribing in community contexts
- Lack of overnight care provision
- Inefficiencies of small services
- Buy in from other hospital departments

Gateshead Frailty Virtual Ward - Opportunities

Gateshead Health NHS Foundation Trust

- Expansion of this model of to care for more people
- Applications of principles to other specialties – respiratory, cardiology, therapy, surgery
- Reduction in use of all stages of hospital care
- A true move from hospital to community

Gateshead Health NHS Foundation Trust

Questions?

- Clinical Lead for Frailty Virtual Ward:
  - Dr Helena Maddock (helena.maddock@nhs.net)
- Clinical Lead for Care of the Elderly:
  - Dr Peter Brock (peter.brock@nhs.net)
- Service Line Manager for Care of the Elderly:
  - Sarah Urwin (sarah.urwin@nhs.net)

Gateshead Health
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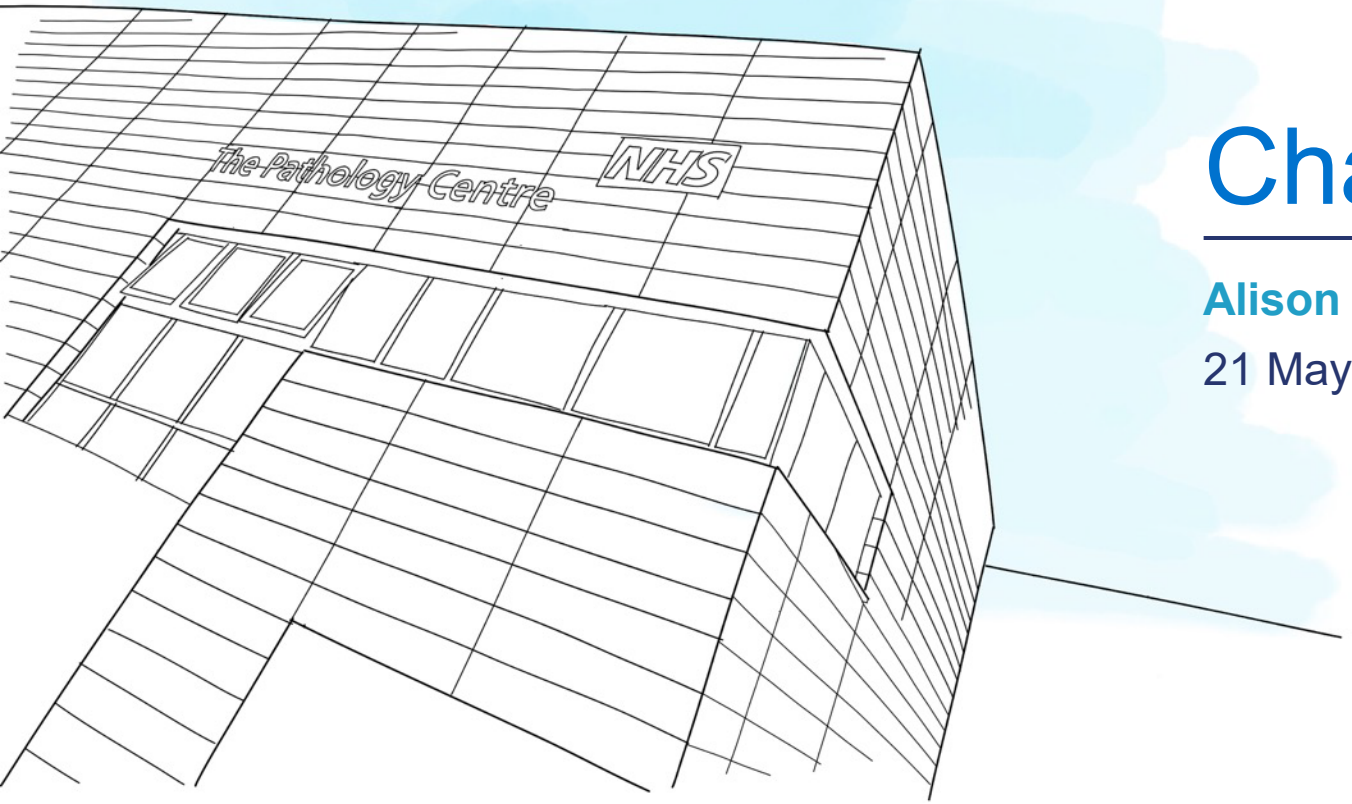

Chair's Report

Alison Marshall, Chair of the Board of Directors

21 May 2025

Board updates and engagement

Gateshead Health NHS Foundation Trust

Board of Directors

- This Board meeting marks the last public Board meeting for Mike Robson and Andrew Moffat, Non-Executive Directors.
- Mike Robson has served on the Board for 7 years and Andrew Moffat has been on the Board for 5 years.
- We would like to formally record our sincere gratitude for the commitment and contributions that Mike and Andrew have provided to the Trust during the tenure.
- The recruitment process to appoint 2 Non-Executive Directors to replace Mike and Andrew and chair our Group Audit Committee and Digital Committee has been conducted since the last Board meeting. The process has been led by our Governor Remuneration Committee with stakeholder presentations and interviews held on 12 and 13 May.
- The Council of Governors met on 14 May to consider the recommendations from the interview panel and ratified the proposed appointments to both positions. We look forward to welcoming our new Non-Executive Director colleagues in July 2025.
- An announcement will be made regarding the successful candidates once pre-employment checks are completed.

Engagement

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

- Chaired Great North Healthcare Alliance Committees in Common and Joint Committee meetings
- Chaired the first Great North Healthcare Alliance event for Governors across all four Alliance partner Trusts
- Meeting with the Leader and Chief Executive of Gateshead Council
- Chaired Board Development day with a focus on the Insightful Board and the development of the 5-year strategy
- Chaired Consultant interviews panels
- Non-Executive Director interviews
- Attended ICB Chair and FT Chairs forum

Great North Healthcare Alliance

- The first Great North Healthcare Alliance Governor workshop was held on 8 April, bringing together Governors from across all 4 Alliance Trusts.
- 51 Governors attended the event and the feedback from Governors following this was positive with an overall satisfaction rating of 8.6 out of 10.
- Governors heard short presentations from Chief Executives and Chairs across the 4 Trusts.
- This was followed by an opportunity to discuss three key areas (the role of the Governors, communication and information in the context of the Alliance) in mixed tables. This provided time for building relationships and learning more about the other Trusts in the Alliance.
- A number of proposed next steps following the event were discussed at the Committee in Common with an agreement that it would be beneficial for Lead and Deputy Lead Governors to collectively meet with the Chairs to consider these.
- There is a commitment to hold a follow-up event later in the year.

Governor and Member Updates

Gateshead Health NHS Foundation Trust

- We held a **Council of Governors** meeting on 14 May where a number of key decisions were made and assurances received, including:
  - Formally ratifying the appointment of the Lead and Deputy Lead Governors. Steve Connolly has been re-elected as Lead Governor and Michael Loome has been re-elected as Deputy Lead Governor – congratulations to both Steve and Michael!
  - Presentations from the Non-Executive Director chairs of the Quality and Group Audit Committees;
  - Receiving the outcomes of the recent by-election;
  - Receiving updates on the development of the Trust's 5-year strategy and the outcome of the annual planning process;
  - Receiving an update on Equality, Diversity and Inclusion; and
  - Receiving an informative presentation on development of the Northern Centre for Breast Research.
- A **by-election** was recently held in the newly merged Central and Eastern constituency. This was a contested election with four candidates for three seats. Congratulations to Paul Johnson and Sheena Sykes who will join the Council for the first time for a term of 2.5 years. Congratulations to John Bedlington MBE who will return to the Council for a term of 1.5 years. We look forward to Paul, Sheena and John formally joining the Council on 1 June 2025.
- Our **Joint Nomination Committee (JNC)** members have been working with counterparts at Newcastle and Northumbria Foundation Trusts to deliver the recruitment process for the Shared Chair across all three Trusts. The stakeholder presentations and interviews will be held on 19 and 20 May, with consideration of the recommendations for appointment by each Council of Governors later in the week.

Star of the Month Nominations

March

- Anna Richardson
- Caitlin Robinson
- Jade Lambert
- Lisa Atkinson
- Rachael Duffy
- Kelly Taylor
- Claire Bell
- Jessica Robinson

April

- Tamsin Imber
- Olivia Simpson (2 nominations)
- Kira Fairclouth
- Holly Ridley
- Samuel Oshagbami
- Hannah Brown
- Michelle Lewins
- Claire Vesey

Ammar Rabeh

You're a Star Winner

Anita Tilley

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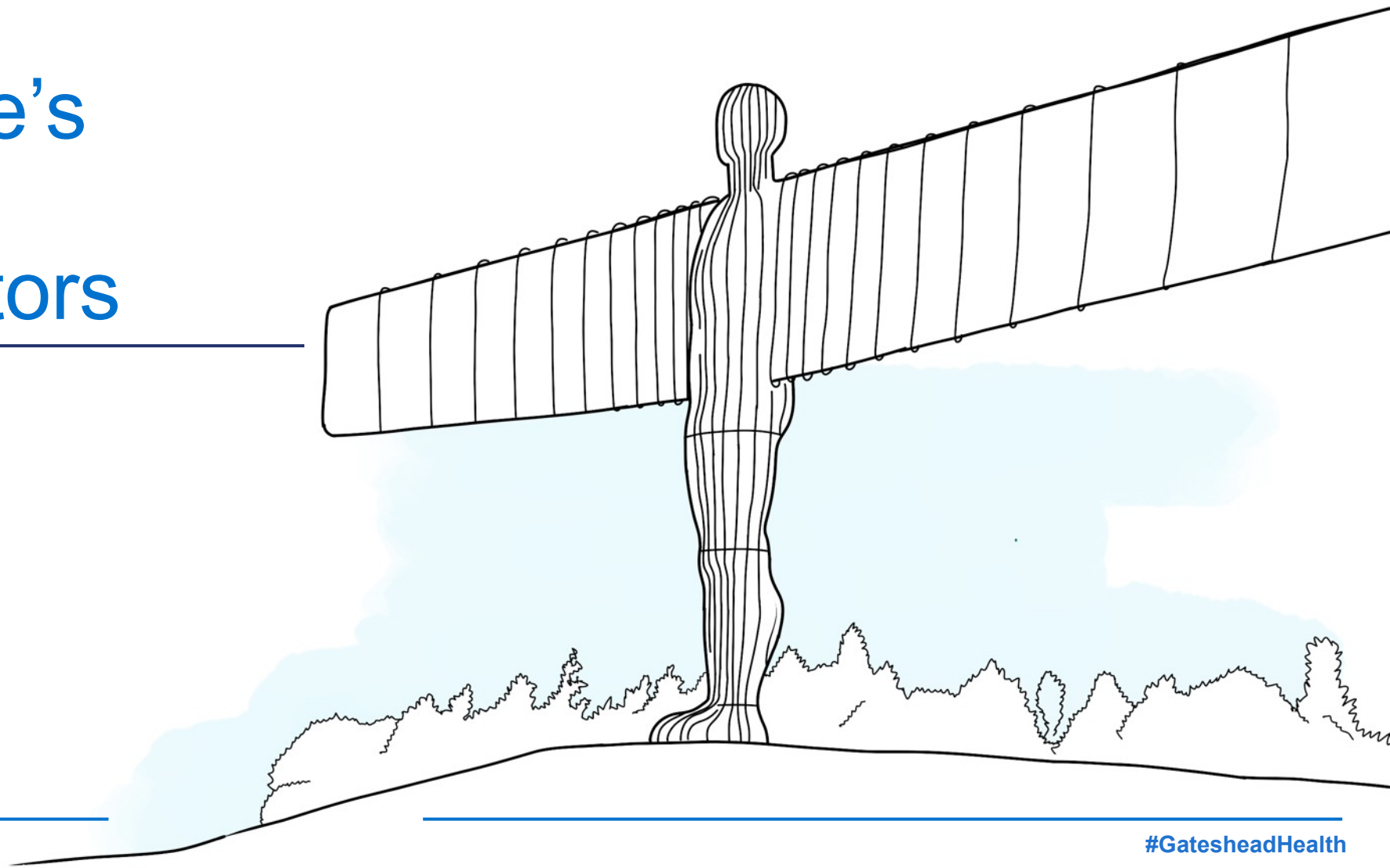
Chief Executive's Update to the Board of Directors



Trudie Davies, Chief Executive

14 May 2025

National statistics and context

Gateshead Health NHS Foundation Trust

National policy, context and operating models

Period of significant change in structure and form for the NHS with national, regional and local implications

Work is being undertaken on a high-level plan for merging NHS England (NHSE) into the Department of Health and Social Care (DHSC). The full details are yet to be published.

All 42 Integrated Care Systems (ICS) must reduce running costs by 50%. For the North East and North Cumbria ICS this equates to a reduction of £34.5m.

ICB Blueprint now published which provides more details around where key functions will sit

All NHS providers requested to reduce corporate cost growth by 50% during Quarter 3 2025/26.

Expectation that nationally there will be a requirement for Trusts to produce a three year financial plan later this year

National shift to more of a devolved, rules-based system built on strong Board accountability, greater openness and transparency

New NHS performance assessment framework to be launched by NHSE at the end of Q1. Metrics will be aligned to the planning guidance with additional measures e.g. collaboration. Any trust in deficit will be restricted to max segment 3

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

Gateshead Health NHS Foundation Trust

- A recent **inquest** into the sad death of a patient, Mr Johnson, from lung cancer in 2023 identified that an opportunity to review a suspicious legion on his chest x-ray in 2022 had been missed. The Coroner deemed there to have been a failing within his healthcare whilst under the Trust's care. The Trust has undertaken a full investigation and expressed sincere apologies to the family during the investigations and the coronial process. We have taken a number of actions to improve our systems and processes and make our systems as safe as possible, overseen by a dedicated task and finish group. This has included the immediate deployment of fail-safe mechanisms for communicating 'red flags' and new policies and procedures to govern the processes around test results.
- The Trust has reported 6 deep **surgical site infections** since October 2024. This is a significant increase and nearly double the expected rate of infections. Each case is being investigated and there are detailed action plans associated with each case. There is also a task and finish group chaired by the Director of Infection, Prevention and Control who, with the surgical division, will oversee the overarching actions that need to be taken in relation to theatre cleanliness, monitoring and management of the environment. This is a multifaceted issue and there are no clear themes identified at this point. External agencies (CQC and ICB) have been notified.
- During 2024/25 there were 48 cases of **C-difficile** against our threshold of 37. A ten-point C-diff reduction plan is in place with a drive to 'back to basics' for clinical areas, particularly focussing on hand hygiene. Community prevalence is at higher than normal levels, reflecting national and local trends.
- We reported 100% compliance with the recommendations from the **Ockenden** national maternity review and 100% compliance with the **Maternity Incentive Scheme** recommendations at year-end. This provides good assurance regarding our maternity services.
- **Falls** continues to be an area of focus with a slight increase in no / low harm falls with the harms falls rate per 1000 bed days at 4.82 compared to the threshold of 3.2 (March 2025 figures). Operational challenges have restricted falls work progression although the falls prevention group is being re-established with a focus on prevention.
- Following a successful capital bid in 2024/25 we have been able to **upgrade our flagship laparoscopic theatres**. Theatres 7 and 8 are now fully upgraded with the latest equipment which allows laparoscopic surgery to be performed more efficiently. This type of surgery is minimally invasive and typically results in a shorter length of stay, ultimately leading to an improved patient experience.

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

- Following announcements regarding the **level of change and challenge facing the NHS**, including NHS England and Integrated Care Boards, we have been engaging with our colleagues to provide support and share as much information as we have available to us. We recognise that this an unsettling time for people and that uncertainty and change brings anxiety. Workforce and corporate services in particular are areas that all NHS organisations are being asked to look at given the scale of the financial challenges ahead. We are holding corporate question and answer sessions and seeking to support colleagues during what we know is a particularly stressful and uncertain time for many. On 19 May we will be launching a voluntary severance scheme (VSS), consistent with many other providers in the region.
- We are committed to **creating an environment where staff feel heard and supported**. Our executive team regularly visit departments to speak with colleagues, listen to feedback, answer questions and gain insights into the challenges and successes of each department. This includes the new Walkabout Wednesdays initiative with a commitment to use this time to visit teams. In recent weeks directors have visited the orthotics department and St Bedes.
- On 16 April the UK Supreme Court unanimously ruled that a woman is defined by biological sex under the **Equality Act 2010**. Like all other NHS trusts we are now waiting for the Equality and Human Rights Commission to provide further guidance on how any gender-related policies and practices within health and social care may be impacted. We recognise the impact of this ruling and the uncertainty it may have on our trans and non-binary colleagues, patients and carers whilst we await further guidance. We are proud of our diversity and maintain our zero tolerance approach to any form of discrimination.
- During May we will be undertaking a **number of staff celebrations.** We celebrated International Day of the Midwife on 5 May, International Nurses Day on 12 May and Operating Department Practitioners Day on 14 May.
- We are pleased to share that we have successfully recruited Tim Key, an **anaesthetic consultant**, to join the anaesthetic team. We are also pleased to announce that Noel Renton has been appointed as the new **Clinical Lead for the Emergency Department and Urgent Treatment Centre**.
- **Sickness absence** continues to be a challenging area with the rolling 12 month figure for March 2025 being 5.7% against a target of 4.9%. A Managing Absence and Wellbeing Taskforce was established at the beginning of April to target areas of high absence and ensure proactive support is in place.

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

- In April we declared a **critical incident** following significant disruption to our diagnostic imaging system, **PACS** (Picture Archiving Communication System). PACS is used throughout the Trust to review diagnostic images such as x-rays, CT scans and MRI scans. During the incident we made the difficult decision to pause breast screening services for some of our appointments. As part of the critical incident response we sought support from partners (particularly those in the Great North Healthcare Alliance) to seek to minimise the impact on patients. Teams worked tirelessly to restore the PACS system and the critical incident was stood down on 17 April. Work has continued since this time to improve PACS resilience and performance by conducting a period of system maintenance.
- Our **annual plan** was submitted in line with regional and national timescales. As previously communicated and illustrated through the national context slides we expect this to be a challenging year and we are focussing on the actions we need to take to deliver our financial plan, which will involve a series of difficult decisions. We have been provided with information on our corporate infrastructure costs and associated cost reduction expectations. We are working through this with our Gateshead Health Leadership Group colleagues to review corporate budgets, services and functions with a focus on being able to demonstrate effectiveness and efficiency. The next steps are meeting with corporate teams locally to discuss. As outlined under Strategic Aim 2 we are holding regular team briefings and Q&A sessions to ensure that we are transparent and open with colleagues and provide opportunities for questions and feedback.
- We have been reviewing **productivity metrics** through national benchmarking to identify where our greatest opportunities exist in relation to delivering efficient and responsive services for our people and patients. Our productivity and quality metrics improved during 2023/24 and into 2024/25 which provides a good indicator for the future. We are engaging with our clinical colleagues at Clinical Strategy Group to review the benchmarking and shape future plans.
- Given our projected deficit position for 2025/26 we are receiving **external financial oversight** from NHS England / the Integrated Care Board. Tim Savage has joined the Trust to provide financial support for 2 days each week. We have also been asked to submit financial information to NHS England to ensure that our plans are as robust as they can be.

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

- We were delighted that one of our most dedicated fundraisers, Pat Stephenson, was featured in a recent Chronicle article. Pat raised over £700 from her hospital bed, organising the fundraiser remotely from Ward 8. Pat wanted to thank Ward 8 staff for being able to spend Easter Sunday with her family. A huge thank you and well done to Pat for all her support!
- Our **paediatrics department** recently conducted a walk-through with patient Orin Milor and his mother, Jen. This exercise to look at a child's surgical journey through our hospital and provided us with valuable insights to help to ensure that young patients and their families have a positive hospital experience.
- Our **Abdominal Aortic Aneurysm (AAA) screening programme** team has produced a set of informative videos to raise awareness about AAA screening and its life saving benefits. The NHS offers screening to men aged 65, who are six times more likely to develop an AAA than women. The videos aim to help males 65 or older understand what AAA screening involves, why it is important, and how to access the service. The videos can be accessed here.

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

NHS Gateshead Health NHS Foundation Trust

- The recruitment to the **Shared Chair** position for Newcastle, Northumbria and Gateshead is progressing well. The Joint Nominations Committee completed the shortlisting process in early May and the interviews are scheduled for 20 May. An extraordinary Council of Governors meeting will be held to ratify the appointment (should a recommendation for appointment be made by the Joint Nominations Committee).
- As detailed in the separate Great North Healthcare Alliance update on the agenda, we were delighted to hold our **first Alliance event for Governors** of all 4 Alliance Trusts in April. This was an excellent opportunity to network, build connections and share thoughts and suggestions about the Alliance from a Governor perspective. We look forward to holding another event later in 2025.
- Work has continued on the development of our **5 year strategy**. A number of engagement events have taken place with colleagues from within and outwith the Trust, including at a recent Governor workshop. These engagement events will shape the first draft of the strategy which will be tested out with colleagues in the coming weeks prior to formally signing this off at Board in June 2025.
- On 8th May, our CEO joined other CEOs from provider organisations and Local Authorities in the North East to understand and work through the implications of the new “Model ICB” document. These are important conversations to help us to influence and understand how we might work better together in the future and avoid loss of key functions and skills amongst national changes taking place.

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 10i

Report Title:	**Board Assurance Framework (BAF) 2024-25**			
Name of Meeting:	Board of Directors			
Date of Meeting:	21 May 2025			
Author:	Jennifer Boyle, Company Secretary Executive Directors			
Executive Sponsor:	Dr Gill Findley, Chief Nurse			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To review the current Board Assurance Framework position, triangulating its content against the items discussed on the agenda.			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Board of Directors – January 2025 Board committees between January 2025 and May 2025			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• The latest updates agreed at each committee meeting are shown in red text in enable the changes to the BAF to be tracked. • The updates to the BAF demonstrate that there has been active review and update of the controls and assurances for each strategic risk area. • The summary risk scores linked to the following strategic objective areas have been reduced down to their target levels: ➢ Maternity compliance ➢ Electronic patient record strategic plan ➢ Estates strategy ➢ Provider Collaborative workforce workstream ➢ Business growth • For a number of risks the current score has remained static all year, although there have been actions taken to improve the control and assurance environments.			

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A summary of progress is appended to this cover sheet to provide the Board with a more detailed overview of Committee decisions regarding the consideration of current risk scores.
As agreed at the Board in January 2025 the 2024/25 BAF has continued into 2025/26 until the new strategic objectives are agreed (at which point the summary risks associated with them will be considered and the BAF developed on this basis).
The BAF key is as follows:

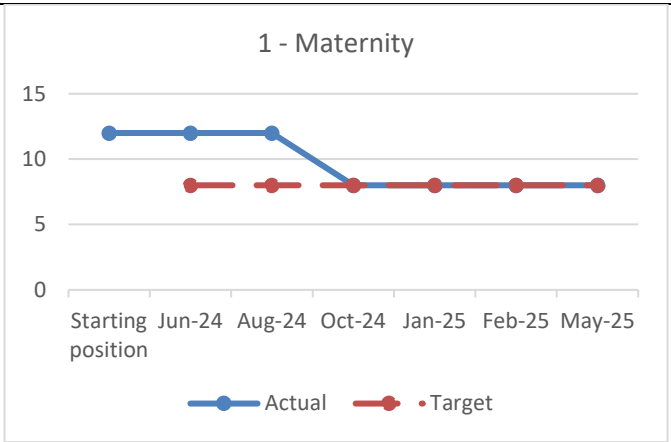
<table>
<tr><th>Key</th><th>Description</th></tr>
<tr><td></td><td>Not yet started</td></tr>
<tr><td></td><td>Started and on track no risks to delivery</td></tr>
<tr><td></td><td>Plan in place with some risks to delivery</td></tr>
<tr><td></td><td>Off track, risks to delivery and or no plan/timescales and or objective not achievable</td></tr>
<tr><td></td><td>Complete</td></tr>
</table>
</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="2">To review the BAF for completeness, accuracy and triangulation against the assurances and risks discussed as part of the Board meeting.

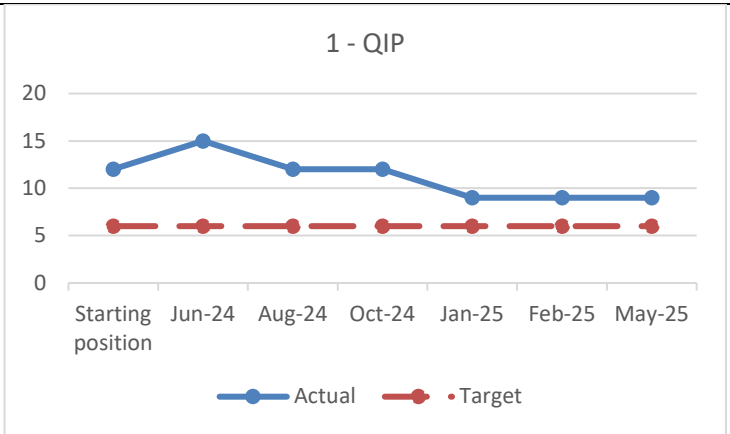
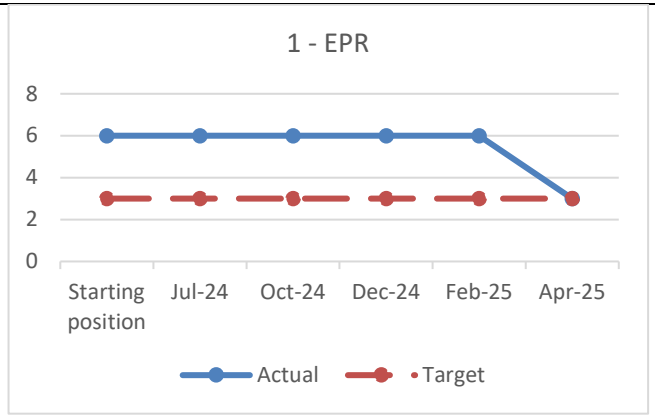
The Board is asked to specifically review whether based on the assurances and risks identified through the meeting the current risks scores continue to reflect the current operating environment.

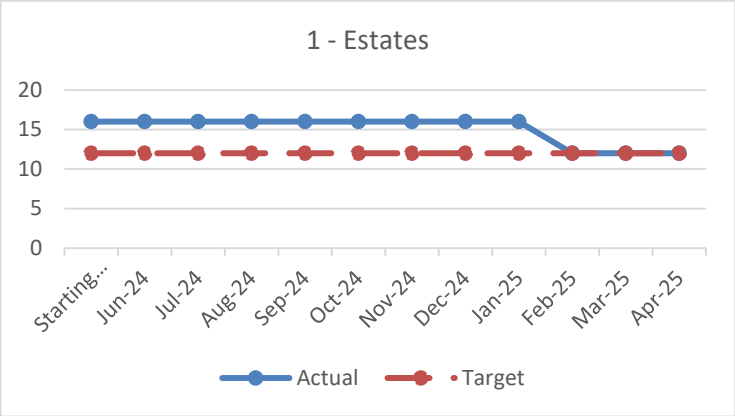
As the Alliance BAF extract is monitored directly at Board, it is for the Board to consider whether the current risk score can be reduced based on the progress made to-date in managing the risk.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1 ☒</td><td>We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2 ☒</td><td>We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3 ☒</td><td>We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4 ☒</td><td>We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5 ☒</td><td>We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust strategic objectives that the report relates to:</td><td colspan="2">As outlined on the BAF itself</td></tr>
</table>

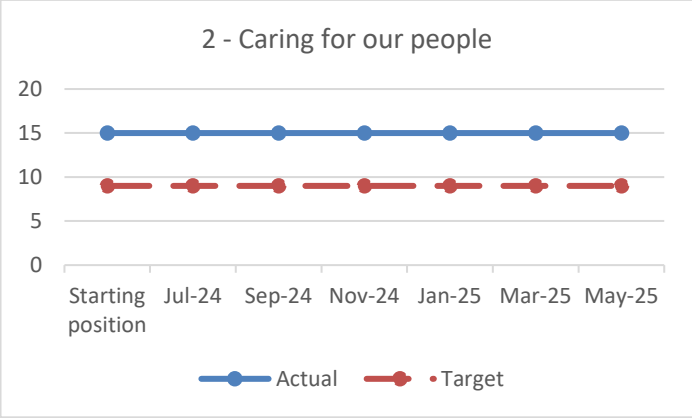
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	Risks identified on the BAF				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

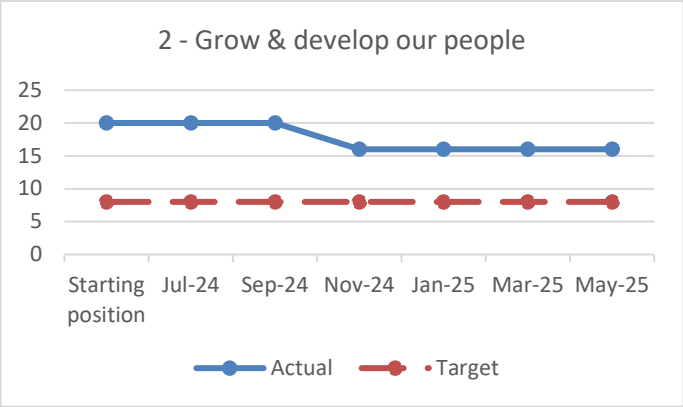
Board Assurance Framework 2024/25 – May 2025 - Summary

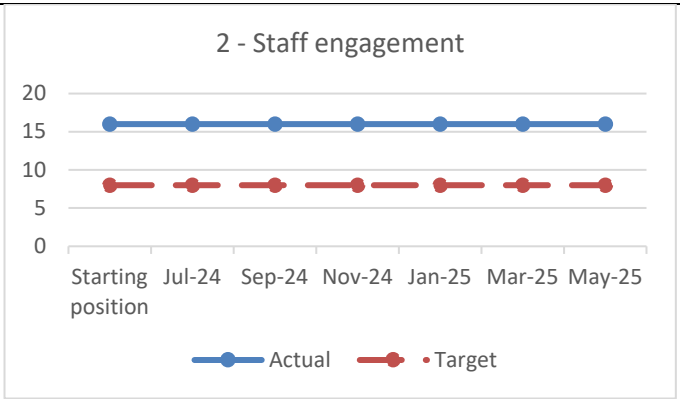
Strategic Objective	Summary risk	Risk scores	Overview
Evidence full compliance with the Maternity Incentive Scheme (MIS) and the Ockenden actions	There is a risk that the Trust is not able to comply with the MIS and Ockenden actions, caused by pressures on resources (finance, workforce, estates and demand), resulting in a negative impact upon the quality of maternity services and a decline in performance against the maternity metrics and patient outcomes.		Target risk score of 8 achieved in October 2024. The Quality Governance Committee (QGC) felt assured that the summary risk had been mitigated down to the target level given the evidence available to support compliance. This included maternity assurance visits and the CQC maternity patient survey outcome. QGC queried whether the target score had been set too high and would reflect on this as part of the setting of target scores for 25/26. Positive assurance continued to be received including completion of the Ockenden actions and 100% compliance with the Maternity Incentive Scheme and therefore the Committee confirmed in May 2025 that the current score remained at target level.

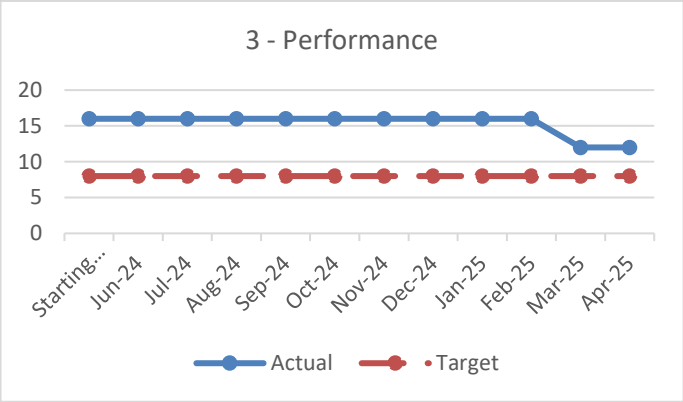
Strategic Objective	Summary risk	Risk scores	Overview
Full delivery of the actions within the Quality Improvement Plan leading to improved outcomes and patient experience with particular focus on improvements relating to mental health, learning disabilities and cancer.	There is a risk that the quality improvement plan is not delivered, caused by resourcing pressures (finance, people, demand and external influences) resulting in no improvement in patient outcomes and experience and a potential lack of compliance with regulatory standards and requirements.		Since June 2024 the current score for this risk has been gradually reducing down towards the target score. The target score of 6 has not yet been reached, with the current score being 9 following a reduction in the likelihood to 3 in January 2025. The score of 9 was retained at the May meeting, which reflected that there remains some areas of work to reduce risk in relation to aspects of the quality improvement plan - for example falls.
Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.	There is a risk that the Trust does not develop an effective EPR system delivery plan, caused by a lack of resource (financial, digital team capacity, lack of strategic clarity) or lack of a robust process for identifying the most appropriate		At its April 25 meeting the Digital Committee agreed to reduce the summary risk score from 6 to 3. This reflected the fact that there is now a strategic plan in place regarding EPR, which was the focus of the objective for the year. A position statement was presented to the Board in March 2025 with the outline business case due to be presented in May 2025.

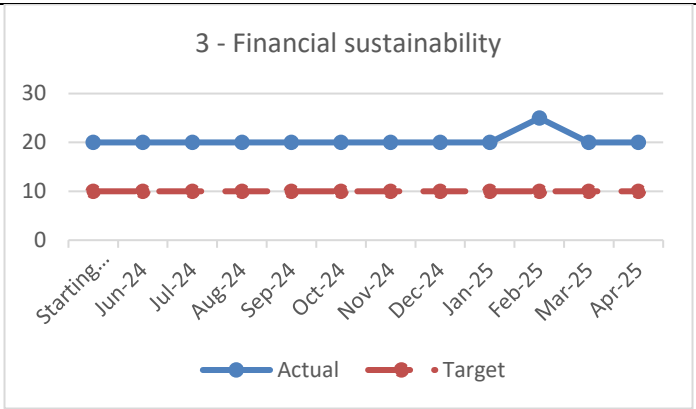
Strategic Objective	Summary risk	Risk scores	Overview
	EPR system. This may result in clinical disengagement, continued clinical risk presented by the current system (i.e.. lack of joined-up system containing all patient records) and a reduced ability to deliver future efficiencies and productivity gains.		
Development and implementation of an Estates strategy that provides a 3 year capital plan to address the key critical infrastructure and estates functional risks across the organisation by March 2025	There is a risk that the Trust is unable to deliver services in line with its operational plan and strategic ambition due to estates-related issues. This is caused by a lack of available capital and / or inappropriate prioritisation of capital investment in the estates strategy. This may		The current risk score met the target score of 12 in February 2025. The score of 12 was maintained at the March and April 2025 F&P meetings. The Committee reflected that the capital prioritisation scheme had addressed some of the risk and the work across the Alliance may reduce the risk further. The Committee concluded that the work on capital planning had progressed as far as possible during 2024/25.

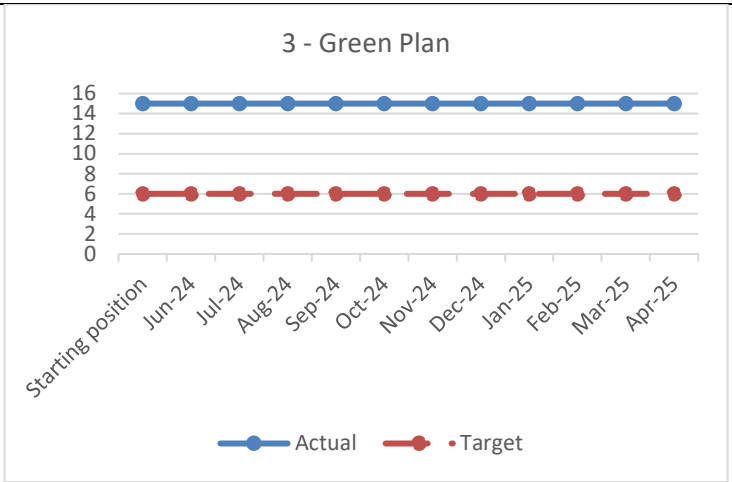
Strategic Objective	Summary risk	Risk scores	Overview
	result in a negative impact on operational delivery, patient outcomes and staff experience (including recruitment and retention)		
Caring for our people in order to achieve the sickness absence and turnover standards by March 2025	There is a risk that our people may be absent from work or leave the Trust. This may be caused by a range of internal factors and / or external factors (i.e. those factors not directly within the control of the Trust). This may result in increased vacancies, reductions in morale, poor reputation as an employer and ultimately impact negatively on our ability to deliver		The current risk score has remained at 15 and has not reduced towards the target score of 9. At the March 2025 meeting the People and OD (POD) Committee noted that work is ongoing in relation to reducing sickness absence and improving adherence to the policy, but the impact of this work had not yet been seen. The importance of understanding the themes and trends from the free text comments in the staff survey in relation to the *caring for our people* objective was noted. The Committee acknowledged that this remained an area of significant risk. As such the Committee agreed to maintain the current score of 15, but did reflect the additional of enhanced controls such as the Absence Taskforce and the focus on triangulation (May 2025 meeting).

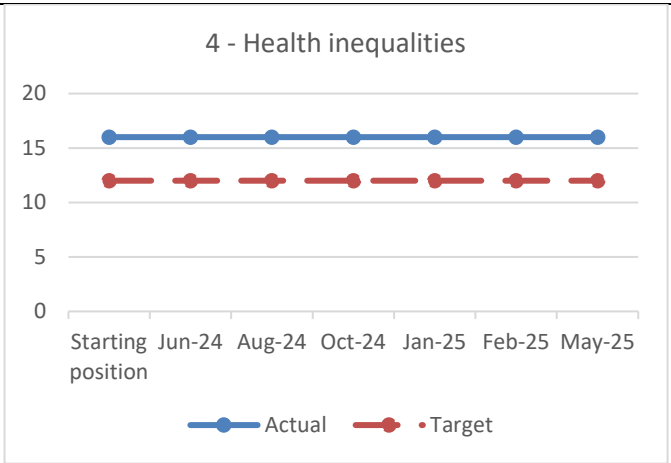
Strategic Objective	Summary risk	Risk scores	Overview
	high quality care to our patients		
Growing and developing our people in order to improve patient outcomes, reduce reliance on temporary staff and deliver the 24-25 workforce plan	There is a risk that the composition of our workforce does not align with our strategic intent and plans, caused by incremental historic growth without reference to the ambition of the Trust. This results in a risk that operational plans and the strategic ambition of the Trust is not achieved, impacting on patient outcomes, our reputation and financial challenges should this result in the use of agency staff.		The current score of 16 was retained by the Committee at the last meeting in March 2025. The Committee noted that the current national ask to reduce workforce costs does not align with the 10 year strategic plan for workforce and therefore the implications in the longer term are not clear. The link to transformation was discussed – i.e. to deliver services differently given the need to reduce workforce costs. The Committee noted that management and leadership development offerings in the Trust were being reviewed, alongside the implementation of the servant leadership model. The Committee agreed to maintain the current score of 16 given the challenging asks regarding the reduction in workforce costs and the work being undertaken internally in respect of this. In May 2025 the Committee received an update on voluntary severance scheme plans. It was noted that further detailed plans in relation to workforce cost reduction would be presented at the next meeting.

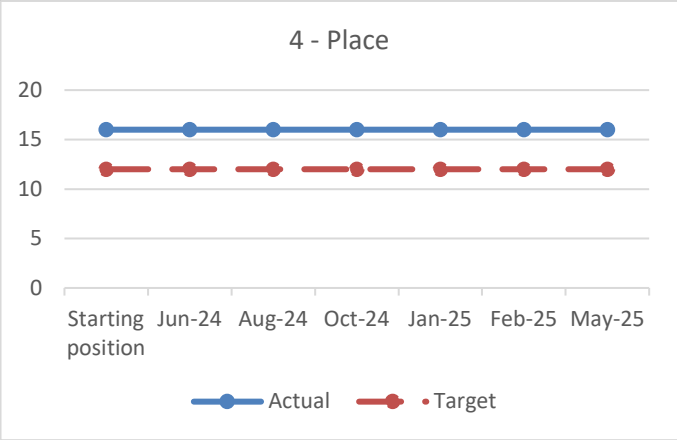
Strategic Objective	Summary risk	Risk scores	Overview
Evidence an improvement in the staff survey outcomes and increase staff engagement score to 7.3 in the 2025 survey	There is a risk that the Trust's culture does not reflect the organisational values. This may be caused by pockets of poor behaviour which is not appropriately addressed and / or resourcing pressures which impact on the ability of our people to work to the best of their ability. The result is that our people may feel disengaged, disempowered or discriminated against, leading to reduced retention rates, loss of reputation and poor staff survey results - ultimately impacting on our ability to be a good employer delivering excellent		In March 2025 the Committee agreed to retain the current score of 16. The score remains static to reflect the level of work emerging from the reviews and speaks ups, as well as the latest staff survey results. The Committee reflected that given difficult messages and decisions which will need to be made to deliver sustainability the risks and challenges would continue in this area for some time. The impact of these challenges and changes influenced the Committee's decision to maintain the risk at 16 in May 2025.

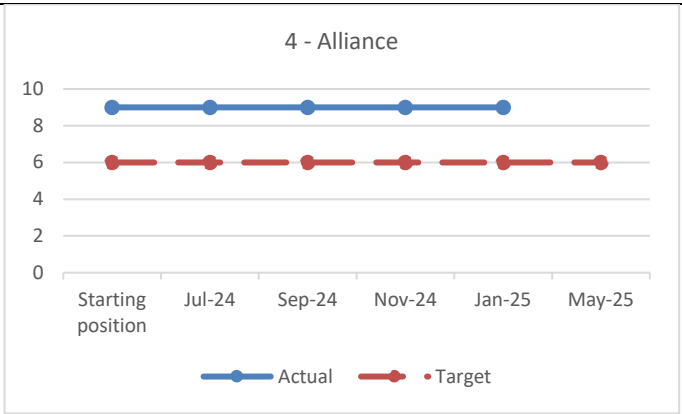
Strategic Objective	Summary risk	Risk scores	Overview
	care to our patients.		
Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025.	There is a risk that the Trust is unable to meet the locally agreed stretch standards as described in the Leading & Breakthrough Indicators, due to resource pressures (such as demand and capacity imbalances) or external factors (for example reliance on other providers, impact of Industrial Action or regulatory requirements). This may result in reduced responsiveness for patients, reputational damage and loss of confidence in the organisation		In March 2025 F&P Committee agreed to reduce the current score to 12 (by reducing the likelihood to 3). This lowered the current score for the first time during 2024/25. The score reduction is due to evidenced improvement against KPIs and the assurance the Committee has received in relation to this. The Committee noted that the size of the waiting list remains an issue, and therefore the target score of 8 has not yet been achieved. The Committee noted that the objective would be refreshed in the context of the new strategy, the year-end outturn and the 2025/26 annual plan. The Committee agreed to retain the score of 12 in April 2025.

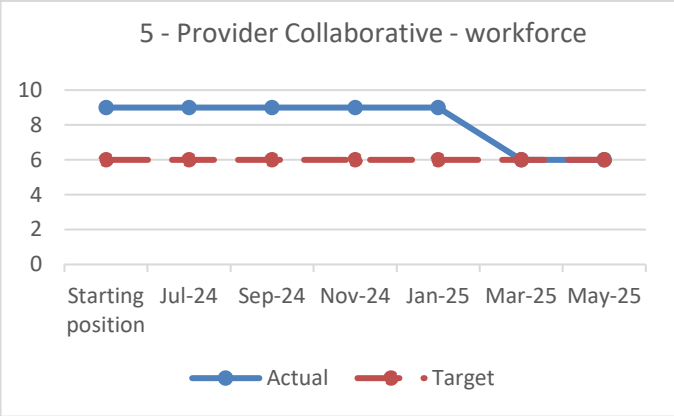
Strategic Objective	Summary risk	Risk scores	Overview
Evidence of reduction in cost base and an increase in patient care related income by the end of March 2025 leading to a balanced financial plan for 2025-26.	There is a risk that the Trust does not achieve its activity, efficiency and income generation plans by March 2025. This may be caused by a lack of grip and control on spending and / or the inability to meet planned activity and growth targets due to demand and resource pressures. This will result in significant challenges in returning to financial balance by 25/26, further regulatory intervention and may result in an inability to invest in our services and people		In February 2025 the Committee reflected on the summary risk which referred to the need to achieve financial balance in 2025/26. The Committee reflected that as the ultimate risk of not delivering sufficient income and efficiency savings in 2024/25 to support the achievement of a balanced plan in 2025/26 was almost certain, then the likelihood score should increase to 5. This increased the overall score to 25. In March 2025 the Committee discussed the score and agreed to reduce this back down to 20 to reflect the achievement of the 24/25 outturn. It was noted that if the objective and summary risk had focussed solely on 24/25 then the target risk would have been achieved, but the underlying position for 25/26 remains high risk and therefore drives the risk score to remain at 20. The score of 20 was retained in April 2025.

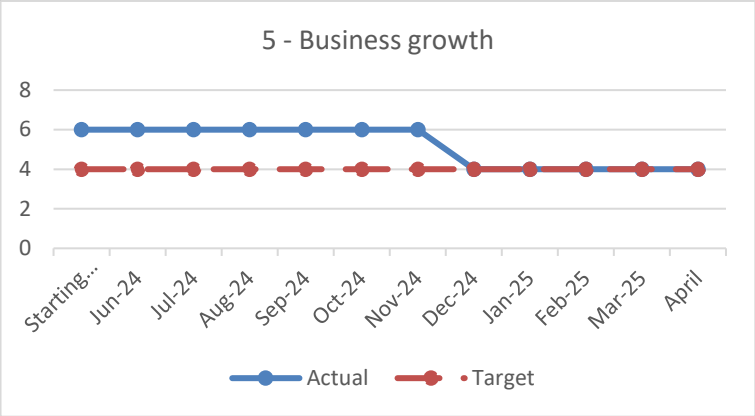
Strategic Objective	Summary risk	Risk scores	Overview
Review and revise the 22-25 Green Plan and align with the group structure by the end of Q2	There is a risk that the Group cannot articulate or fully understand the Green Plan. This may be caused by a lack of visibility on the Green Plan and its delivery through the governance structure and therefore a lack of strategic leadership and prioritisation of resources at a senior level. This may result in the Trust not meeting its environmental sustainability targets (locally and nationally). This impacts on the reputation of the Trust and its ability to demonstrate that it is well-led and socially responsible.		The risk in relation to the Green Plan has remained at 15. This reflects that progress has been constrained by vacancies, although F&P Committee note that a new Safety, Health, Environment and Quality manager (SHEQ) has now been recruited. A peer review of environmental sustainability which is being conducted by Newcastle and Northumbria counter-parts will support the revision of the Green Plan and sustainability arrangements. The Committee agreed to maintain the risk at 15 in March 2025 until the governance arrangements for the green plan / sustainability are clearer. It was noted that there have been some national delays in rolling out central reporting for some metrics. In April 2025 the governance arrangements for the Green Plan reporting and assurance were confirmed. The Board will sign off the Green Plan annually, with twice a year reporting through the Finance and Performance Committee. The first report will be received in July 2025.

Strategic Objective	Summary risk	Risk scores	Overview
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	There is a risk that the Trust does not deliver its services in a manner which supports the reduction in health inequalities. This is caused by a lack of access to key data (which enables health inequalities to be identified sufficient early and patient outcomes to be tracked) plus a lack of resource and focus on tackling health inequalities. This results in poor patient outcomes and also an inability to deliver on our strategic intent to be a women's health centre of excellence and an outstanding district general hospital, therefore		The health inequalities summary risk has remained at 16. Recent work has been undertaken to review health inequalities arrangements within the Trust. This was reported to QGC in October 2024. It identified the need to raise the profile of health inequalities across the Trust, embed this as a responsibility for colleagues to address and refresh the strategy. In January 2025 QGC agreed to maintain the risk at 16 until the impact of the review recommendations can be demonstrated. In February 2025 QGC agreed to maintain the current score for the reasons articulated in January. In May 2025 the Committee received a report on the early delivery plan for assurance.

Strategic Objective	Summary risk	Risk scores	Overview
	impacting upon our reputation		
Work collaboratively as part of the Gateshead system to improve health and care outcomes to the Gateshead population	There is a risk that the health and care outcomes for the Gateshead population are not improved. This may be caused by the lack of appropriate engagement and involvement in collaborative working at place-level and the lack of effective use of funds and resources across Gateshead place. This may result in poor patient outcomes and an inability to deliver place-based plans.		The summary risk in relation to place-based working remained at 15. When discussed at the January 2025 QGC meeting it was agreed that further narrative would need to be evidenced to justify a reduction in the risk level. It was noted that this was more in relation to being able to articulate the progress made, rather than being indicative of concerns regarding addressing place-related risks. In February 2025 QGC agreed to maintain the current score for the reasons articulated in January. In May 2025 the Committee received a dedicated Gateshead place update. It was noted that the future ICB model will help provide a greater understanding of the future of commissioning with potential opportunities for closer working and greater partnership.

Strategic Objective	Summary risk	Risk scores	Overview
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'	There is a risk that the Trust is unable to sufficiently influence key directions of travel re delivery of system performance metrics, financial frameworks (incl system medium term financial plan), workforce development and clinical strategy locally and across the system and Alliance footprint. This may be caused by a lack of appropriate engagement and involvement in key Alliance discussions and meetings. This may result in poorer patient outcomes and an inability to meet performance and finance targets,		The summary risk in relation to Alliance working has remained at 9, which is above the target risk of 6. Regular Alliance updates have been provided at Board. A number of additional controls are in place, including the agreed processes around the Shared Chair recruitment, the continued embedding of the Joint Committee arrangements and the recent Governor workshop for all four trusts. **As this BAF extract is monitored directly at Board, it is for the Board to consider whether the current risk score can be reduced based on the progress made to-date in managing the risk.**

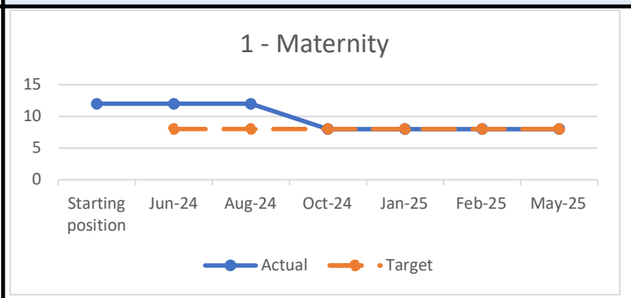
Strategic Objective	Summary risk	Risk scores	Overview
	impacting upon sustainability		
Contribute effectively as part of the Provider Collaborative to maximise the opportunities presented through the regional workforce programme	There is a risk that the Trust is unable to sufficiently influence key directions of travel re delivery of system performance metrics, financial frameworks (incl system medium term financial plan), workforce development and clinical strategy locally and across the regional system. This may be caused by a lack of appropriate engagement and involvement in key regional discussions and meetings. This may result in poorer patient outcomes and an inability to meet performance and finance targets,		The summary risk in relation to the contribution to the Provider Collaborative regional workforce programme reduced to 6 at the March Committee meeting. This reflected the contribution that the Trust has made to the Provider Collaborative workforce agenda. The CEO is the regional workforce lead for this area and the Committee was assured that the Trust had had a positive influence on the direction of travel and been a key voice in workforce forums. The Committee felt that the influence of the Trust was sufficient to reduce the score down to its target level of 6 in March 2025. The score of 6 was maintained in May 2025, noting the progress made in agreeing a regional approach to the voluntary severance scheme.

Strategic Objective	Summary risk	Risk scores	Overview
	impacting upon sustainability		
Evidenced business growth by March 2025 with a specific focus on Diagnostics, Women's health and commercial opportunities	There is a risk that the Group will miss opportunities to utilise skills and expertise to generate income for reinvestment in patient care and staff wellbeing. This may be caused by a lack of focus on innovation and emerging opportunities, resulting in increased pressures on existing funding and an inability to deliver our ambitions regarding being a centre of excellence for diagnostics and women's health		The current score was reduced to 4 at the December 2024 F&P Committee, which means the target score has been achieved. The control environment has been strengthened by the appointment of a Commercial Director at QE Facilities. In January 2025 the Committee recognised the over-achievement against the business growth target, although noted that this was not necessarily through the delivery of a fully developed commercial plan. The Committee agreed to maintain the risk at 4 in March 2025 and April 2025.

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

Strategic objective:	Evidence full compliance with the Maternity Incentive Scheme (MIS) and the Ockenden actions
Executive Owner:	Chief Nurse
Board Committee Oversight:	Quality Governance Committee
Date of Last Review:	May-25
Summary risk	

There is a risk that the Trust is not able to comply with the MIS and Ockenden actions, caused by pressures on resources (finance, workforce, estates and demand), resulting in a negative impact upon the quality of maternity services and a decline in performance against the maternity metrics and patient outcomes.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
2	**4**	**8**	**2**	**4**	**8**

Links to risks on the ORR:

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

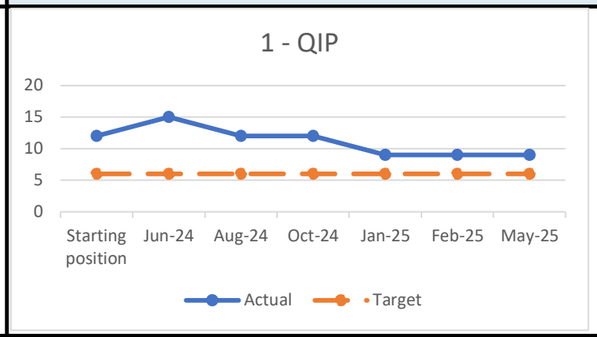
~~2438 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures – 8~~. Risk removed from ORR as a result of the positive impact of the discharge liaison team in facilitating timely discharges

2341 - There is a risk to ongoing business continuity of service provision due to ageing Trust estate – 16

4714 - 2025/26 planned activity is not achieved resulting in the Trust not achieving planned income - 12

Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Core maternity roles substantively filled	Increased birth rates and increasing acuity / interventions observed over 2023/24. Working being undertaken to formulate recommendations on midwifery workforce requirements	Head of Midwifery	TBC	Oct 24 - work being undertaken with other local trusts and the ICB re: managing demand from out of area patients. Dec 24 - actions have been taken manage out of area bookings in order to effectively manage demand and maintain patient safety and experience. Communicated to key stakeholders and performance information to be shared as part of maternity reporting to monitor impact. **Action recommended for closure**	
Six monthly reviews of maternity staffing conducted	Estates strategy currently being refreshed – next report to Board due in ~~July 2024~~ April 2025.	QEF Managing Director	~~July 2024~~ April 2025	Sept - update provided to Board in July. Oct 24 - The refresh of the Estates Strategy has been set as one of the Objectives for QEF in 2024/25 and is expected back at board in April 2025. The tender process to identify a specialist contract to support this has now been completed however a review of the proposal is required to account for the potential impact of the Great North Healthcare Alliance and the “Big Build”	

Maternity Safety Champion role in place and active		Pest control issues identified linked to the age of the estate. Corrective actions being taken to mitigate any risks to patients and staff and minimise the issue within the parameters of what is possible given the aged estate.	QEF Managing Director	Jul-24	Immediate actions taken by the teams with support of external pest control company. Sept 24 - All outstanding actions have now been completed with no further reports of pest activity, as such **action recommended for closure.**	
Neonatal Badger system in place						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Performance is monitored within the department at governance meetings		Increased C section rate since March 2024 - deep dive review underway to understand the drivers	Chief Nurse	May-25	May 25 - deep dive reported presented at May Committee with overview of drivers. No additional actions identified by the Committee. Action recommended for closure	
Divisional Safecare meetings in place						
Twice daily safety huddles in place in maternity						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Maternity staffing report presented to Board and Quality Governance Committee biannually						
Maternity IOR presented to every QG Committee and Board meeting						
Maternity Incentive Scheme Year 6 Assurance Framework reviewed at Quality Governance Committee						
Quality Governance Committee assured over achievement of the Ockenden strategic objective						
100% compliance achieved for MIS Year 6 - confirmed position - reported to Board and Quality Governance Committee						
Assurance (Level 3 – external)						
MIS audit from AuditOne provided reasonable assurance – actions taken to enhance compliance and achieve MIS						
Maternity services rated ‘good’ by CQC in 2023						
CQC patient survey ranked GH maternity as the best in the country for 2024						
NENC LMNS Perinatal Quality Surveillance Annual Assurance Peer Review Visit Report - provides external validation						
Maternity Assurance Visit						

Strategic Aim 1: we will continuously improve the quality and safety of our services for our patients									
Strategic objective:	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.								
Executive Owner:	Chief Nurse								
Board Committee Oversight:	Quality Governance Committee								
Date of Last Review:	May-25								
Summary risk									
There is a risk that the quality improvement plan is not delivered, caused by resourcing pressures (finance, people, demand and external influences) resulting in no improvement in patient outcomes and experience and a potential lack of compliance with regulatory standards and requirements.		**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		3	**3**	**9**	**2**	**3**	**6**
Links to risks on the ORR:	3107 - Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings – 15 ~~2438 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures – 8~~. Risk removed from ORR as a result of the positive impact of the discharge liaison team in facilitating timely discharges 2341 - There is a risk to ongoing business continuity of service provision due to ageing Trust estate – 16 4714 - 2025/26 planned activity is not achieved resulting in the Trust not achieving planned income - 12 ~~2969 - Risk of patient harm due to length of stay in ED - 20~~. Risk replaced by 4734 - risk of patient harm due to inability to meet 4 hour ED emergency care standard - 16								

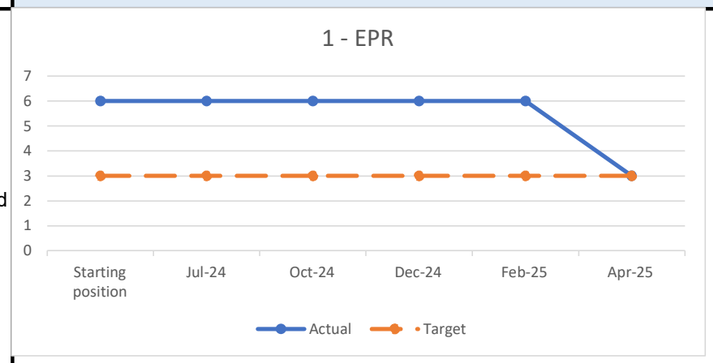
Controls		**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
CQC compliance manager in place		New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24	Sept - tier 2 meetings now in place alongside GHLG. Effectiveness to be assessed within 6 months. **Action to be considered for closure**	
Clinical audit programme in place		Quality Improvement Plan not yet reviewed by the Committee	Chief Nurse	Aug-24	Aug - this has now been reviewed by the Committee and gap agreed as closed.	
Transformation team in place to support quality improvements						
Quality Strategy approved in 2023						
PSIRF policy in place and training has been delivered						
New governance structure simplifies and streamlines quality oversight and reporting						
Quality Improvement Plan in place						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**

Safecare meetings in place at corporate and divisional level		Further assurance required regarding the complaints re: pace of progress	Chief Nurse	Aug-24	Aug 24 - information provided and Committee agreed gap has been closed.	
Quality improvement plan is reviewed at the Group Leadership Meeting		Further assurance required regarding falls given the increase - action to provide a regular report on this	Chief Nurse	Aug-24	Aug 24 - information provided and Committee agreed gap has been closed.	
		Falls Prevention Group not having the desired impact. Review of terms of reference and membership is being undertaken	Chief Nurse	May-25	May 25 - falls rate continues to increase. Committee agreed to add as a standing agenda item going forwards to ensure continuous scrutiny	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Leading indicator report reviewed at Quality Governance Committee and Board						
Patient / staff story presented to every Board and Council of Governors' meeting						
Safe staffing reports presented to Board and Quality Governance Committee						
Clinical audit outcomes reported to Quality Governance Committee						
Quality and safety reporting on QEF non-core contract now in place						
Assurance deep dives reports into complaints and falls reviewed by QGC						
Falls update report to QGC - Feb 25						
Quality Account						
Assurance (Level 3 – external)						
Awarded National Joint Registry (NJR) Quality Data Provider – reflects high standards of patient safety						
Awarded Gold Standard for Autism Acceptance by the North East Autism Society.						
External accreditations						
7 external assurance visits to CSS including NHSE Paediatric Audiology, UKAS Assessment HSE visit, SQAS Bowel Cancer Screening, Regional Endoscopy training review, HTA inspection, aseptic unit accreditation						
ICB inpatient review visit and RcPsych Psychiatric Liaison Accreditation Review for Older Persons Mental Health Services						
CQC Mental Health Act Monitoring Visits to Cragside and Sunniside						
ADQM assessment						
Annual CBRN audit						
Cancer Patient Experience Report provides good assurance						

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

Strategic objective:	Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.
Executive Owner:	Group Director of Finance and Digital
Board Committee Oversight:	Digital Committee
Date of Last Review:	Apr-25
Summary risk	

There is a risk that the Trust does not develop an effective EPR system delivery plan, caused by a lack of resource (financial, digital team capacity, lack of strategic clarity) or lack of a robust process for identifying the most appropriate EPR system. This may result in clinical disengagement, continued clinical risk presented by the current system (i.e.. lack of joined-up system containing all patient records) and a reduced ability to deliver future efficiencies and productivity gains.

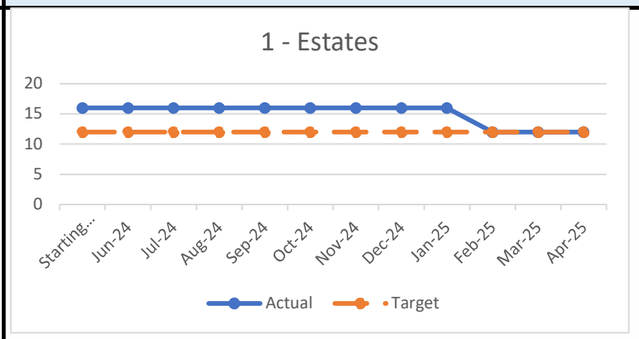


CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
Was 2 now 1	3	3	1	3	3

Links to risks on the ORR:	4405 - Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure - 8 4402 - Inability to support legislation and best practice associated with records management - 16 4713 - the 25/26 cost reduction programme is not achieved both in year and on a recurring basis - 16 4705 - risk of considerable clinical and operational impact to patient care due to instability of PACS environment - 20

Controls		Gap in controls and corrective action	Owner	Timescale	Update	Action status
EPR engagement event held in December 2023		The EPR business case has not yet been completed	Group Director of Finance & Digital	Mar-25	Oct 24 - business case to be presented at Board in January 25 Dec 24 - progressing in line with timescales Jan 25 - business case not ready for Board in Jan. Update paper to be presented to Board March 25 - extraordinary Digital Co held in Feb to discuss. Position statement shared at March Board and supported. OBC to be presented to Board in May setting out options April 25 - Plan in place. EPR position paper presented to Board with outline business case being presented in May 25	

Gap analysis completed which supports the implementation of an EPR	[redacted]	Chief Digital Information Officer position is vacant with cover arrangements in place from existing team. Role to be recruited to provide strategic leadership and increase capacity	Group Director of Finance & Digital	TBC	Oct 24 - job description has been shared with colleagues in the Alliance Dec 24 - post remains vacant with cover being provided from within the team. Discussions being held via the Alliance March 25 - Chief Digital Officer appointment made across Alliance and commencing in post in April 25. **Action to be considered for closure**	
Digital strategy in place		New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24	Sept - tier 2 meetings now in place alongside GHLG. Effectiveness to be assessed within 6 months. Action to be considered for closure Oct 24 - Committee agreed to keep action open and consider for closure at the next meeting March 25 - action to be considered for closure	
Chief Digital Officer appointment made for Alliance						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Digital delivery plan reviewed at every Digital Committee						
EPR position statement received at Board - March 2025						
Assurance (Level 3 – external)						

Strategic Aim 1: we will continuously improve the quality and safety of our services for our patients										
Strategic objective:	Development and implementation of an Estates strategy that provides a 3 year capital plan to address the key critical infrastructure and estates functional risks across the organisation by March 2025									
Executive Owner:	Managing Director, QE Facilities									
Board Committee Oversight:	Finance and Performance Committee									
Date of Last Review:	Apr-25									
Summary risk										
There is a risk that the Trust is unable to deliver services in line with its operational plan and strategic ambition due to estates-related issues. This is caused by a lack of available capital and / or inappropriate prioritisation of capital investment in the estates strategy. This may result in a negative impact on operational delivery, patient outcomes and staff experience (including recruitment and retention)		**CURRENT RISK SCORE**			**TARGET RISK SCORE**					
		Likelihood	Impact	Score	Likelihood	Impact	Score			
		3	**4**	**12**	**4**	**3**	**12**			
Links to risks on the ORR:	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**
Asset condition survey carried out by external specialists resulting in risk based condition scoring of all fixed assets.		The current Estates Strategy 2023-2028 has not been agreed by Board and no longer reflects the Organisation's priorities - A revised strategy is to be submitted to the Group Board.	QEF Managing Director	Mar-25	Oct 24 - work paused on individual estates strategy pending discussions on an Alliance estates strategy Feb 25 - development of the strategy has been paused pending the Alliance discussions - decision made not to progress with the development of an individual estates strategy. May 25 - On track status retained as action has changed and Alliance work is progressing	
Board Approved Estates Strategy including a 3 year Capital Programme.		Capital plan for 24/25 not yet approved by Board. - Capital plan to be presented for approval in June 24.	QEF Managing Director	Jun-24	25/06 - Committee noted that the capital plan was approved by Board in June 2024 and therefore this gap has been addressed and closed.	

Clinically led Capital planning process.	There is no agreed Capital Planning process. - A process for the prioritisation, review and agreement of the Capital Programme is to be developed.	QEF Managing Director	~~August 24~~ Nov 24	Oct 24 - The existing CAT D & E Capital Works request processes are still in place however as presented at CSG on the 9th October work is ongoing with the Trust Corporate Services Team to define a revised process that we hope to submit back to the CSG at the November meeting. Dec 24 - capital planning process is now in place and work continues with the Alliance in support of the Big Build project. Action agreed as closed.	
Regular review of Capital delivery by the Finance & Performance Committee.	New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24	Sept - tier 2 meetings now in place alongside GHLG. Effectiveness to be assessed within 6 months. Dec 24 - action agreed as closed.	
Capital plan for 2024/25 in place following Board approval					
New governance structure implemented which strengths the controls environment in relation to the process for reporting and escalating estates related issues, risks and assurances					
Capital prioritisation process now in place					
Collaborative work across the Alliance and ICB to review estates related issues across the patch with a view to developing collaborative strategic approaches					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Monthly review of the Capital Delivery by the Capital Steering Group.	The Capital Programme for 2024/25 is still to be agreed. - Capital Programme for 2024 / 25 to be submitted to the Group Board for approval.	QEF Managing Director	Jun-24	25/06 - Committee noted that the capital plan was approved by Board in June 2024 and therefore this gap has been addressed and closed.	
	The format for Capital reporting is still to be developed. - A monthly Capital report summary to be agreed.	QEF Managing Director	Jul-24	Oct 24 - A Monthly Capital Update Report has now been produced with the first draft submitted to the Gateshead Leadership Group at the 26th Sept 24 meeting. Dec 24 - action agreed as closed with reporting process now embedded	

		The reporting route for Capital delivery is still to be agreed as part of the review of the Organisations Governance Structure.	QEF Managing Director	~~Aug 24~~ Nov 24	Oct 24 - The reporting route is currently in discussion with a proposal submitted to the Group Finance Director and Chief Operating Officer. Jan 25 - reporting route now agreed and streamlined under the structure. **Action recommended for closure**	
		The reporting route to Board is to be agreed. - The reporting requirements for Capital Delivery are to be agreed and detailed in the Finance and Performance Committee Terms of Reference.	QEF Managing Director	~~Aug 24~~ Nov 24	Oct 24 - To be decided dependent on the outcome of the conversation detailed above.	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Regular reports to Trust Board on estates prioritisation and strategy development						
Regular reporting in place to Gateshead Health Leadership Group						
Capital reporting to F&P Committee provides assurance over the spend against the capital plan						
Estates option paper for Bensham site discussed and agreed at Trust Board						
Assurance (Level 3 – external)						
External Assessment of the Estate against the 6 facets identified in Estatecode including, Estate condition.						

Strategic Aim 2: we will be a great organisation with a highly engaged workforce	
Strategic objective:	Caring for our people in order to achieve the sickness absence and turnover standards by March 2025
Executive Owner:	Group Executive Director of People and OD
Board Committee Oversight:	People and OD Committee
Date of Last Review:	May-25
Summary risk	

There is a risk that our people may be absent from work or leave the Trust. This may be caused by a range of internal factors and / or external factors (i.e. those factors not directly within the control of the Trust). This may result in increased vacancies, reductions in morale, poor reputation as an employer and ultimately impact negatively on our ability to deliver high quality care to our patients

CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
5	3	15	3	3	9

Links to risks on the ORR:

4714 - 2025/26 planned activity is not achieved resulting in the Trust not achieving planned income - 12

4417 - Increase in incivility and disrespectful behaviours being reported - 15

3132 - Exposure to incidents of violence and aggression in ECC - 12

Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Health and wellbeing lead in place	New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24	Sept - tier 2 meetings now in place alongside GHLG. Effectiveness to be assessed within 6 months. Action to be considered for closure Jan 25 - action agreed as closed.	
Dedicated health and wellbeing resource and links accessible to staff - Balance	Vaccination programme - challenge of no bank staff support for 24/25 this year and low levels of uptake in 23/24	Executive Director of POD	Dec-24	Jan 25 - Uptake levels still low 33% - Dec '24 date passed Jan 25 - low levels of uptake in 24/25. As 24/25 draws to a close it was agreed to close out this action and review next year to identify learnings and strategies	
Zero tolerance campaign in place	Low uptake of exit interviews - target to achieve a 25% uptake.	Executive Director of POD	Dec-24	Currently at 12% uptake. Further work being carried out by People Promise Exemplar programme. Jan 25 - Dec '24 date passed March 25 - Propose to close this action, increasing % completion with exit interviews to 25% isn't a priority as we know the themes coming from this data and will continue to work to review the feedback from this and also via the focus groups	
Show Racism the Red Card training provided with further sessions planned	~~Lack of adherence to Managing Attendance policy. Sickness absence policy not adhered to by managers in respect of progressing individuals through the stages. More focus required on sickness actions to strengthen control environment~~ Actions to address sickness are not having a demonstrable impact on the sickness absence - further measures to be operationalised and triangulate sickness absence trends to identify additional actions needed (Committee agreed to reword original gap)	Executive Director of POD	~~24/01/2025~~, ~~31/03/2025~~ 30/0920/25	Sickness absence training being rolled out to managers. Jan 25 - Complete Action to be considered for closure Jan 25 - Committee agreed to merge the gaps around sickness absence controls into one. March 25 - Committee agreed to extend deadline for this action to Sept 25. May 25 - the Committee agreed this action to be closed given the controls measures have been operationalised.	

Nursing is fully established		Turnover not reducing from 11.7% - need a detailed overview on retention data	Executive Director of POD	~~01/11/2024~~ Jan 26	Nov 24 - Committee noted turnover rate increase and requested more assurance over controls March 25 - Work ongoing via the People Promise Exemplar to support turnover but acknowledgement that current financial pressures may impact on turnover over next 12 months.	
New governance structure provides a greater focus on workforce and culture through the POD Tier 2 and Tier 3 groups		Staff survey and its supporting freetext indicates more work is required around the health and wellbeing offered - Committee identified this as a gap	Executive Director of POD	May-25	May 25 - Staff Survey comments to be reviewed with a health and wellbeing lens and incorporated as part of the Absence Taskforce. Propose to close. May 25 - Committee agreed with the recommendations to close.	
FTSU Guardian in place full-time and supported by FTSU Champions						
Refreshed Managing Attendance policy in place with associated training plan						
People strategy in place						
Occupational health pilot in place						
Absence Taskforce in place						
Additional sickness absence controls in place including triangulation of trends						
Good visibility on sickness						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
POD team meetings in place to review people metrics		POD Steering Group not yet in place	Executive Director of POD	Jul-24	POD Steering group commenced July 2024 with monthly meetings now in place.	
POD Steering Group now in place		Absence levels remain higher than plan - POD Committee to receive a deep dive report in July 24	Executive Director of POD	Jul-24	Deep dive report received July 2024, further updated paper to follow September 24	
SMT - specific topic discussions on absence		WRES and WDES data identify challenges in relation to bullying and harassment, which indicate further work is required to ensure colleagues with protected characteristics do not suffer detriment	Executive Director of POD	~~24/01/2025~~ ~~May 25~~ Jan 26	Comparison of staff survey data (WRES /WDES) with info collected by FTSU data. Detailed analysis as to appropriate actions that need to be put into place. Application of Disciplinary policy and effectiveness in respect of data collected. Detailed analysis to be undertaken to understand the specific allegations raised and appropriate actions to be taken. May 25 - Committee agreed proposed date change and noted this should be viewed as an ongoing activity rather than a specific action. It was noted that this is broader and relates wider than sickness absence and turnover	
		Further work required to triangulate themes and trends in relation to sickness absence and turnover in order to gain greater improvements and impact and target work in the right areas	Executive Director of POD	~~24/01/2025~~ 31/03/2025	Oversight being picked up as part of People & OD Steering Group. Propose to close. May 25 - Committee agreed with proposal to close.	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Leading Indicator report and people metrics presented to POD Committee for assurance						
Assurance reports to POD demonstrate the vacancy rate remains well below the 5% threshold						
POD Steering Group Metrics report - once finalised						
Robust discussions on sickness absence at the Oct 24 POD Committee - recognise issues and remaining gaps						
Deep dive report on sickness absence received at October POD meeting						
Deep dive report on turnover received at October POD meeting						

Triangulation of sickness absence taking place at POD Steering Group	[redacted]					
Absence deep dive report received at July POD Committee for assurance						
Assurance (Level 3 – external)						
Engagement score on NHS staff survey is above average						
Internal audit report on absence management - reasonable assurance						

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

Strategic objective:	Growing and developing our people in order to improve patient outcomes, reduce reliance on temporary staff and deliver the 24-25 workforce plan
Executive Owner:	Group Executive Director of People and OD
Board Committee Oversight:	People and OD Committee
Date of Last Review:	May-25
Summary risk	

There is a risk that the composition of our workforce does not align with our strategic intent and plans, caused by incremental historic growth without reference to the ambition of the Trust. This results in a risk that operational plans and the strategic ambition of the Trust is not achieved, impacting on patient outcomes, our reputation and financial challenges should this result in the use of agency staff.

CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
4	4	16	2	4	8

Links to risks on the ORR:

4714 - 2025/26 planned activity is not achieved resulting in the Trust not achieving planned income - 12

4525 - Risk of lack of a strategic workforce planning - was 12 now 9

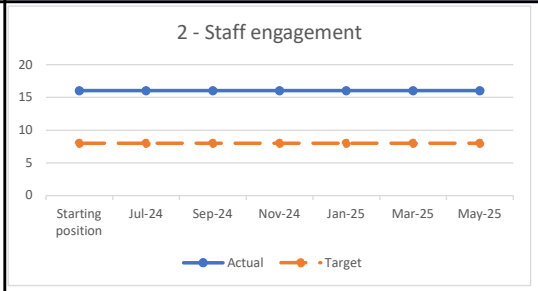
4713 - The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis - 16

4694 - Non achievement of a 2025-26 break-even 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
Operational plan for 24-25 developed in consultation with the Board and Governors.	Integrated approach to workforce planning not currently in place - plans to adopt an approved methodology	Executive Director of POD	Jan-25	6 step methodology agreed, workforce planning group meeting weekly to align workforce planning with business planning. 2 Trustwide planning sessions taking place in September to embed in the divisions Sept 24 - POD Committee agreed to amend the timescale to Jan 25 Jan 25 - 6 step methodology being implemented as part of the current Trust planning process, where possible. Update controls to reflect approach rolled out, and update gaps to reflect effectiveness of approach. March 25 - Recommendation to close action as 6 step methodology is now in place. May 25 - confirm whether action can be closed. May 25 - Committee agreed action as closed	
Agency spend authorisation process in place	Medical staffing function and processes under review, including establishment, budget and control environment	Executive Director of POD	Dec-24	New MD in post and discussions ongoing re transition of the team. Jan 25 - Team transitioned on 1st December 2024 - recommend for closure May 25 - confirm whether action can be closed May 25 - Committee confirmed action as complete	

Planning group in place to respond to industrial action		Workforce alignment to strategic intent not yet completed.	Executive Director of POD	Jan 25 to July 25	Jan 25 - Recommend change in timescale to start of new financial year Jan 25 - Committee approved new timescale to align with the strategy development work	
Managing and Leading Well programmes in place to support learning and development		New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Jan-25	Sept - tier 2 meetings now in place alongside GHLG. Effectiveness to be assessed within 6 months. Action to be considered for closure Nov 24 - action agreed for closure as new structures now in place	
GAiN apprenticeship programme in place		Long term workforce plan implications and associated funding not confirmed	Executive Director of POD	July 25 - January 2026	Elections have delayed the confirmation of funding and timescales. Sept 24 - POD Committee agreed the timescale to be adjusted to Jan 25. Jan 25 - Propose to extend timescale as no national info yet available March 25 - Timescale extended as no national info yet available	
Engagement and involvement in the Healthcare Academy to support workforce progression		Challenge between the WTE reduction and increases training places/capacity needed in the LTWFP	Executive Director of POD	~~24/01/2025~~ July 2025	Jan 25 - Propose to extend timescale as currently undergoing planning process so specific challenges not yet clear March 25 - Timescale extended as no national info yet available	
Reduction in reliance on temporary staffing evidencing that there is a stronger control environment in place		Training space limited and not always fit for purpose	Executive Director of POD	~~01/01/2025~~ March 25 to July 25	Discussions ongoing re the Estates strategic plan Sept 24 - POD Committee agreed the timescale to be adjusted to Jan 25 Jan 25 - Propose to amend timescale as currently no capital budget for 25/26 to cover training provision March 25 - Discussions ongoing re the Estates strategic plan	
New governance structure supporting greater controls and the flow of assurance through to POD Committee		Managing and Leading Well programmes are being reviewed in line with clinical led, management support and servant leadership models.	Executive Director of POD	May-25	May 25 - Met on 02/05/2025 and proposal to flow to Clinical Strategy Group in May and People and OD Steering Group in June with view of launching in July. Propose to close. May 25 - Committee confirmed action as closed	
Integrated approach to workforce planning now in place		Lack of detailed plans in place in relation to the workforce related element of the cost reduction requirements. Detailed information to be brought to the Committee in July.	Executive Director of POD	Jul-25		
6 step methodology to workforce planning now in place						
Medical staffing function has been adjusted to strength the controls and processes in place						
Management and leading training offered under review with plans in place to launch new approach in July						
Professional Nurse Advocacy programme in place to support reflection and learning						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Agency spend monitored in financial reports		POD Steering Group not yet in place	Executive Director of POD	Jul-24	POD Steering group commenced July 2024 with monthly meetings now in place.	

Dashboards showing workforce information shared via numerous professional forums and wider	[redacted]					
POD team meetings						
POD Steering Group now in place						
Education and training group - sub group of POD steering group						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Development of workforce plans reported to Board and POD Committee						
POD metrics on workforce establishment, recruitment reported to POD Committee						
Nursing fully established and reported to POD Committee						
Assurance (Level 3 – external)						
Positive feedback from the ICB on the consistency and robustness of the operational plan						
Internal audit - QEF staff contracts audit						
Internal audit medical staffing follow-up audit - reasonable assurance						
Internal audit on raising concerns - good assurance						

Strategic Aim 2: we will be a great organisation with a highly engaged workforce								
Strategic objective:	Evidence an improvement in the staff survey outcomes and increase staff engagement score to 7.3 in the 2025 survey							
Executive Owner:	Group Executive Director of People and OD							
Board Committee Oversight:	People and OD Committee							
Date of Last Review:	May-25							
Summary risk								
There is a risk that the Trust's culture does not reflect the organisational values. This may be caused by pockets of poor behaviour which is not appropriately addressed and / or resourcing pressures which impact on the ability of our people to work to the best of their ability. The result is that our people may feel disengaged, disempowered or discriminated against, leading to reduced retention rates, loss of reputation and poor staff survey results - ultimately impacting on our ability to be a good employer delivering excellent care to our patients.		**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		4	**4**	**16**	**2**	**4**	**8**
Links to risks on the ORR:	4417 - Increase in incivility and disrespectful behaviours being reported - 15 3132 - Exposure to incidents of violence and aggression in ECC - 12 4694 - Non achievement of a 2025-26 break-even 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							

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Zero tolerance programme in place	New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	24/01/2025	Sept - tier 2 meetings now in place alongside GHLG. Effectiveness to be assessed within 6 months. Jan 25 - Action to be considered for closure Jan 25 - action agreed as closed	
FTSU resource and focus increased with a full time FTSU Guardian and a network of champions	Staff networks not providing strategic input to the Board or EMT. Further support required to re-define the networks and what/how the network groups feed into the Board and EMT	Executive Director of POD	~~01/12/2024~~ ~~May 25~~ Sept 25	Jan 25 - Recommend extension of timescales as networks review ongoing March 25 - Awaiting a network review paper. Proposal to change date to May 25. May 25 - Limited capacity to action but will be built into review of corporate functions. Propose to change timescale to Sept 2025. May 25 - Committee agreed revised timescale	

Processes in place to respond to staff survey results and take action on a local level		Staff survey feedback shows unacceptable behaviours in terms of racism, discrimination and sexual safety	Executive Director of POD	~~24/01/2025~~ March 25 Sept 25	Jan 25 - Recommend extension of timescales as we include more recent staff survey feedback March 25 - 2024 staff survey data shows that this still remains a concern and this will continue to be monitored. May 25 - work continues, propose extension to timescale to Sept 2025. May 25 - Committee agreed revised timescale	
Anti-racism charter in place with Unison		Board Member appraisals do not all include an EDI objective - to address through latest appraisal round	Executive Director of POD	Jan-25	Actions underway to include in all Board members appraisals for 24/25. Jan 25 - Action complete, recommend for closure Jan 25 - action agreed as closed	
Pulse surveys held during the year		Strategic direction and timescales for EDI work requires further development	Executive Director of POD	Jan-25	Time out session held with HREDI group to focus priorities for 24/25. Action complete, recommend for closure Jan 25 - action agreed as closed	
Tea and chat engagement events		Low uptake of Pulse survey - identify mechanisms to encourage greater response rate to provide greater insight and assurance	Executive Director of POD	~~01/12/2024~~ March 25 to May 25	March 25 - Improved uptake on pulse survey but further work to do to encourage greater response with for the April 2025 pulse survey. Proposed new timescales of March 25 to May 25	
EDI dashboard in progress		Lack of internal oversight on WTE growth and bank positions being filed. Need to understand where the growth is and plans to address	Executive Director of POD	~~01/12/2024~~ March 25	Jan 25 - Recommend to extend timescales as currently undergoing planning process Jan 25 - agreed to amend timescale to March 25. May 25 - Work ongoing to understand the WTE growth in corporate services, using the corporate benchmarking data, plans are for this to be communicated throughout May. Delivery of the workforce plans and CRP via the CRP steering group. Propose complete. May 25 - the committee agreed that there is now appropriate oversight in place and agreed this action as closed	
EDI strategy in place						
Active staff networks in place						
People Strategy in place						
Northumbria patient and staff experience work being shared						
EDI priorities for 24/25 defined						
New governance structure in place to support appropriate scrutiny, assurances and escalations						
Board member appraisals contain an EDI objective						

Controls in place to protect against unintentional workforce growth						
Zero tolerance programme in place						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
POD team meetings		POD Steering Group not yet in place	Executive Director of POD	Jul-24	POD Steering group commenced July 2024 with monthly meetings now in place.	
POD Steering Group now in place		Culture programme group not yet reformed	Executive Director of POD	Nov-24	Initial meeting with AV/TD/LF took place in August to review focus of culture programme. Sept 24 - POD Committee agreed the timescale to be adjusted to Nov 24	
Culture Programme Group						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Staff survey outcomes and actions presented to the POD Committee and Board						
EDI Dashboard						
ADQM report received at POD Committee						
Assurance (Level 3 – external)						
NHS Staff Survey results provide valuable intelligence						
GMC Survey						
WRES and WDES national reports						
Internal audit reports						
Internal audit on raising concerns - good assurance						

Strategic Aim 3: we will enhance our productivity and efficiency to make the best use of our resources	
Strategic objective:	Improve the quality of care delivery and accessibility for patients by meeting the locally agreed stretch standards by March 2025.
Executive Owner:	Group Chief Operating Officer
Board Committee Oversight:	Finance and Performance Committee
Date of Last Review:	Apr-25
Summary risk	

There is a risk that the Trust is unable to meet the locally agreed stretch standards as described in the Leading & Breakthrough Indicators, due to resource pressures (such as demand and capacity imbalances) or external factors (for example reliance on other providers, impact of Industrial Action or regulatory requirements). This may result in reduced responsiveness for patients, reputational damage and loss of confidence in the organisation

CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
3	4	12	2	4	8

Links to risks on the ORR:

~~2438 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures - 8~~. Risk removed from ORR as a result of the positive impact of the discharge liaison team in facilitating timely discharges

4714 - 2025/26 planned activity is not achieved resulting in the Trust not achieving planned income - 12

~~4591 - Risk of significant service disruption due to GP collective actions including reduction in shared care service provision - 15.~~ Risk de-escalated from ORR

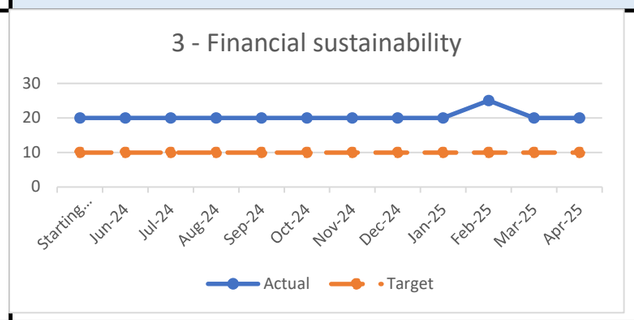
~~2969 - Risk of patient harm due to length of stay in ED - 20~~. Risk replaced by 4734 - risk of patient harm due to inability to meet 4 hour ED emergency care standard - 16

4705 - risk of considerable clinical and operational impact to patient care due to instability of the PACS environment - 20

Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Annual plan developed and in place	New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24	Sept - tier 2 meetings now in place alongside GHLG. Effectiveness to be assessed within 6 months. Dec 24 - action agreed as closed.	
Leading & Breakthrough Indicators developed to support monitoring of performance	No clear documented process in place for the approval of mutual aid arrangements	Chief Operating Officer	Jul-24	Oct 24 - Surgery now providing a divisional update. A one page summary process document to be developed to outline the controls which have been put in place	
New business intelligence post in place	Revision of information and reporting required	Chief Operating Officer / Director of Finance	Jul-24	Oct 24 - key projects underway to streamline reporting. A number of examples of new and revised reports added under the 'assurance' section. Dec 24 - Action recommended for closure as the required changes have been implemented	

Membership and participation in the UEC strategic board	Patient Access Policy to be reviewed and updated	Chief Operating Officer	Sep-24	Oct 24 - work ongoing to streamline the Patient Access Policy with other organisations	
Membership and participation in the Strategic Elective Care Board					
Leadership of the Theatres and Perioperative Medicine regional workstream					
Weekly performance meetings in place					
New governance structure implemented which strengths the controls environment in relation to the process for reporting and escalating performance related issues, risks and assurances					
Key projects underway to streamline reports and enhance the business intelligence offer					
Patient Access Policy in place					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Monthly corporate oversight meetings	Operations Oversight Group under development	Chief Operating Officer	Jul-24	July- now launched.	
Weekly Access and Performance Meetings	Tier 3 groups specifically focussed on activity monitoring / operational capital programme delivery being implemented	Chief Operating Officer	Aug-24	Jan 25 - Tier 3 groups now established. **Action recommended for closure.**	
Operations Oversight Group meeting is in place	Deep dive reports needed to understand actions re: 4 hour and 12 hr performance	Chief Operating Officer	Aug-24	Sept - deep dive reports were presented at the August meeting, giving some assurance. Action to remain open until impact of the work can be seen. Dec 24 - agreed that the action can be closed as deep dives and follow up received.	
New reports in place to support operational management - e.g. planned care report, CDC reporting, wait for first outpatient reporting, enhanced discharge reporting, sit-rep reports for pharmacy and winter					
Open referral stratification reporting in place, supporting operational waiting list management of follow-up patients					
Assurance reports demonstrate good progress in meeting 52 week target by year end					
Assurance reports evidence improvements against KPIs					
Enhanced elective care activity plan reporting to weekly planning group and Tier 3 groups reporting into Operational Oversight Group					
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					

Finance and Performance Committee receive the Leading Indicators and Elective Recovery report	[redacted]					
Board receives the Leading Indicators report at every meeting						
Mutual aid report presented to the Finance and Performance Committee						
Performance reported and discussed at the regional ICB Performance Improvement and Oversight meeting monthly						
Assurance (Level 3 – external)						
Regional benchmarking report provides assurance over the Trust's relative performance						

Strategic Aim 3: we will enhance our productivity and efficiency to make the best use of our resources						
Strategic objective:	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.					
Executive Owner:	Group Director of Finance and Digital					
Board Committee Oversight:	Finance and Performance Committee					
Date of Last Review:	Apr-25					
Summary risk						
There is a risk that the Trust does not achieve its activity, efficiency and income generation plans by March 2025. This may be caused by a lack of grip and control on spending and / or the inability to meet planned activity and growth targets due to demand and resource pressures. This will result in significant challenges in returning to financial balance by 25/26, further regulatory intervention and may result in an inability to invest in our services and people		**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		4	**5**	**20**	**2**	**5**	**10**
Links to risks on the ORR:	4714 - 2025/26 planned activity is not achieved resulting in the Trust not achieving planned income - 12 4694 - non achievement of a 2025/26 break even revenue plan and likely deterioration from 2024/25 planned deficit - 20 4713 - the 25/26 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						

Controls		**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Annual plan developed and in place		Efficiency plans not yet fully developed within each division and corporate area	Group Director of Finance & Digital	**TBC**	July 24 - fully articulated plan not yet in place Jan 25 - efficiency planning process is underway for 25/26 with a new CRP lead in place to support the development of the plans March 25 - efficiency planning is in progress as evidenced through Board development session. Dedicated Board meeting to be held on the consideration of difficult decisions April 25 - difficult decisions extraordinary Board meeting held to agree the principles behind decision-making. This supports the delivery of efficiency plans on a timely basis during the year	

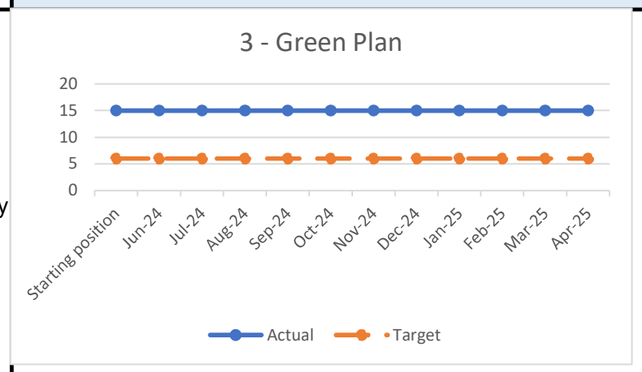
Agreed budgets in place for each division and corporate area	New business case process not yet fully aligned with the business planning cycle	Group Director of Finance & Digital	**TBC**	Jan 25 - planning process is underway with an update due to be presented to Board Feb 25 - annual planning process underway including engagement across the Alliance	
SFIs and Scheme of Delegation updated in 2024	New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24	Sept - tier 2 meetings now in place alongside GHLG. Effectiveness to be assessed within 6 months. Dec 24 - action agreed as closed.	
Leading Indicators developed to support monitoring of performance	Capital plan for 24/25 not yet approved by Board. Capital plan to be presented for approval in June 24.	QEF Managing Director	Jun-24	25/06 - Committee noted that the capital plan was approved by Board in June 2024 and therefore this gap has been addressed and closed.	
New business intelligence post in place	Gaps in controls identified in relation to medical staffing	Medical Director	**TBC**	Strategic workstream identified with Medical Director as the Exec lead Oct 24 - new Associate Director post now in place. Senior Medical Staffing Manager also in post with new procedures developed and increased team capacity. Risk reduced from 20 to 16. Dec 24 - agreed to keep this action open as the impact of this action has not yet been evidenced. March 25 - as per discussions at ERMG the medical staffing risk in relation to the team structure has been reduced but a mismatch between budgets and actual rosters remains May 25 - medical staffing no longer considered to be a top 3 risk for the Trust given the work undertaken. To consider this action for closure	
More detailed information now available to support forecasting	Appointment of service manager for medical staffing not yet in place	Chief Operating Officer	Sep-24	August - the COO to verify if this appointment has taken place and report back in September Oct 24 - Associate Director for Medical Staffing now in place. Action therefore recommended for closure Dec 24 - action agreed as closed given post now recruited to	

Financial sustainability framework in place	Grip and control actions in place but not realistic to deliver a balanced plan for 2025/26. Consideration of additional actions and difficult decisions as part of the 2025/26 planning	Group Director of Finance and Digital	Mar-25	March 25 - development session held with the Board in March 25 with further time for discussion later in the month April 25 - difficult decisions extraordinary Board meeting held to agree the principles behind decision-making. This supports the delivery of efficiency plans on a timely basis during the year. May 25 - action recommended for closure given plans submitted and difficult decisions identified for working through	
Medical staffing team increased with new Associate Director post and Senior Medical Staffing Manager in place. New SOPs developed					
New governance structure implemented which strengths the controls environment in relation to the process for reporting and escalating finance related issues, risks and assurances					
Set of principles agreed by Board for difficult decision-making					
Capital plan for 2024/25 in place following Board approval					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Oversight meetings include review of financial performance	To include forecasting information in more detail in the finance report for the next meeting	Group Director of Finance and Digital	Sep-24		
Financial sustainability framework being utilised for Medicine division	Midwifery and ED staffing papers deferred from the agenda - to be provided in October	Group Director of Finance and Digital	Oct-24	Nov 24 - paper on midwifery staffing received in October's meeting. ED staffing schedule for November May 25 - items were received at Board for decision. Action recommended for closure.	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Leading Indicators and finance report presented to F&P Committee					
QEF financial performance reported to F&P Committee					
CRP options paper developed and presented at F&P to identify alternative options for delivery given financial position					
Assurance (Level 3 – external)					

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

Strategic objective:	Review and revise the 22-25 Green Plan and align with the group structure by the end of Q2
Executive Owner:	Managing Director, QE Facilities
Board Committee Oversight:	Finance and Performance Committee
Date of Last Review:	Apr-25
Summary risk	

There is a risk that the Group cannot articulate or fully understand the Green Plan. This may be caused by a lack of visibility on the Green Plan and its delivery through the governance structure and therefore a lack of strategic leadership and prioritisation of resources at a senior level. This may result in the Trust not meeting its environmental sustainability targets (locally and nationally). This impacts on the reputation of the Trust and its ability to demonstrate that it is well-led and socially responsible.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
5	**3**	**15**	**2**	**3**	**6**

Links to risks on the ORR:	4694 - non achievement of a 2025/26 break even revenue plan and likely deterioration from 2024/25 planned deficit - 20

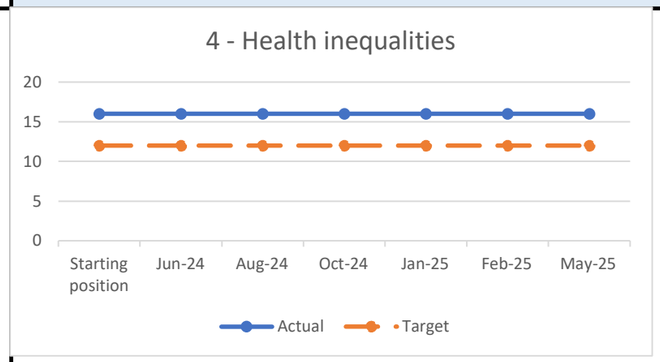
Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
The Green Plan has been agreed by Board covering the period for 22-25.	The governance arrangements detailed in the Green Plan are not reflected in the new Governance arrangements - A new reporting structure is to be agreed.	QEF MD	~~Sept 24~~ Jan 25	Oct 24 - A meeting has been held with the Sustainability Teams for Northumbria and Newcastle to discuss the potential for a peer review to provide recommendations to support best practice. With the QEF Sustainability Manager now back in post this review is expected to be completed by the 31st December 2024.	
Board members received in-depth environmental sustainability training	There is no regular reporting taking place against the Targets detailed within the Green Plan - A standardised reporting process to be agreed.	QEF MD	~~Aug 24~~ Jan 25	Oct 24 - This will form part of the review as detailed above.	
A clear set of targets, objectives and actions are detailed within the agreed Green Plan.	The SHEQ role is currently vacant. - The SHEQ post is to be recruited into.	QEF MD	Aug-24	Oct 24 - Following a successful recruitment process the new Head of SHEQ is expected to be in post on the 2nd December 2024. Dec 24 - action agreed as closed as the postholder is now in place	
Identified senior management with specific responsibility for the Environment and sustainability.					

SHEQ post recruited to and appointee now in place					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Quarterly monitoring of performance against the agreed metrics detailed in the Green Plan.	Green Plan no longer reported to Board or Finance and Performance Committee - to address reporting lines as part of the new governance structure	QEF MD / Company Secretary	~~Sept 24~~ Jan 25	25/06 - Committee discussed gap in assurance. KM to discuss further with GE to determine if quarterly updates to come via F&P Oct 24 - See update on the delivery of a peer review by Northumbria and Newcastle Sustainability Teams.	
	The current governance arrangements do not include a group with specific responsibility for monitoring sustainability that includes cross Group membership. - An Environmental Sustainability Group to be incorporated in to the new Group governance arrangements.	QEF MD	~~Sept 24~~ Jan 25	Oct 24 - See update on the delivery of a peer review by Northumbria and Newcastle Sustainability Teams.	
	Green Plan in development and will report to F&P twice a year and Board annually	QEF MD	Jul-25		
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Quarterly update on progress against the targets detailed in the Green Plan to the Finance & Performance Committee.					
Assurance (Level 3 – external)					

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

Strategic objective:	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
Executive Owner:	Medical Director
Board Committee Oversight:	Quality Governance Committee
Date of Last Review:	May-25
Summary risk	

There is a risk that the Trust does not deliver its services in a manner which supports the reduction in health inequalities. This is caused by a lack of access to key data (which enables health inequalities to be identified sufficient early and patient outcomes to be tracked) plus a lack of resource and focus on tackling health inequalities. This results in poor patient outcomes and also an inability to deliver on our strategic intent to be a women's health centre of excellence and an outstanding district general hospital, therefore impacting upon our reputation



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
4	**4**	**16**	**3**	**4**	**12**

Links to risks on the ORR:	4402 - Inability to support legislation and best practice associated with records management - 16

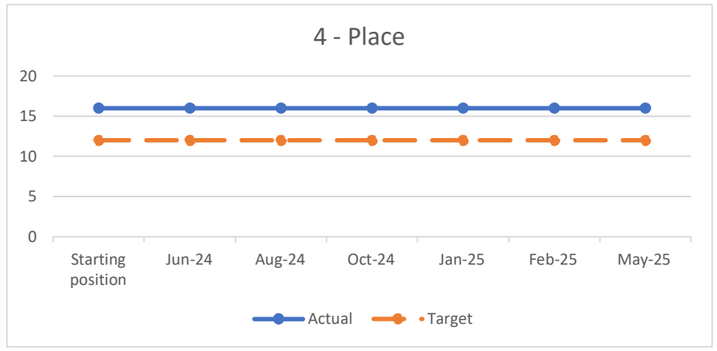
Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Health inequalities strategy approved by Quality Governance Committee	New governance structure currently being implemented and requires time to fully launch and embed	Chief Nurse / Company Secretary	Sep-24	Sept - tier 2 meetings now in place alongside GHLG. Effectiveness to be assessed within 6 months. **Action to be considered for closure**	
Public Health engagement and involvement in health inequalities within the Trust	Trust Health Inequalities Group to refine approach to focus on women's health issues	Medical Director	Sep-24	Dec 24 - paper was presented at the Oct 24 meeting. Resulting discussion identified the need to ensure that women's health was a key priority for the refreshed HE Group. **Action recommended for closure.**	
Health inequalities gap analysis completed	Key data set incomplete and requires manual data collation whilst development of a comprehensive dashboard / reporting tool is developed	Medical Director / Deputy Director of Performance	Jan-25		
Health Inequalities Group in place	Reporting of health inequalities not clear under the new governance structure. Medical Director to work with Chief Nurse and Company Secretary to ensure reporting route is clarified.	Medical Director	Nov-24	Nov 24 - update report to QGC outlined proposed new reporting from Health Inequalities Group to the GH Leadership Group. **Action recommended for closure.**	

Core20plus5 ambassadors in place		Health inequalities strategy in development	Medical Director	TBC	May 25 - full strategy is in development but an early delivery plan was presented to QGC in May	
Health inequalities interim plan in place whilst the strategy is developed						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Health inequalities agenda to be embedded into operational business unit work schedules		Board visibility on health inequalities is limited - to consider how the profile can be raised at Board level to provide visible leadership on this agenda	Medical Director	Sep-24	Nov 24 - paper to QGC proposed inclusion of consideration into the terms of reference of each Board committee plus an annual health inequalities Board report	
Operational business unit oversight meetings to specifically consider access, waiting well and health inequalities issues		Visibility of health inequalities management within the operational business units to be enhanced and embedded into business as usual reporting	Medical Director /Chief Operating Officer / Deputy Director of Performance	Jan-25	Nov 24 - proposals outlined to develop a Data Oversight Group to support divisional understanding of health inequalities within performance reporting	
Stakeholder event planned for 9 May to scope our delivery plans against each priority						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Health Inequalities Assurance report received at QGC						
Early delivery plan presented at May's Quality Governance Committee meeting						
Early deliverable metrics outlined in the interim plan, which will be monitored by the Health Inequalities Group						
Assurance (Level 3 – external)						
Trust Health Inequalities Group represented within Gateshead Place Health and Wellbeing Board working towards shared agendas and strategy						

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

Strategic objective:	Work collaboratively as part of the Gateshead system to improve health and care outcomes to the Gateshead population
Executive Owner:	Medical Director
Board Committee Oversight:	Quality Governance Committee
Date of Last Review:	May-25
Summary risk	

There is a risk that the health and care outcomes for the Gateshead population are not improved. This may be caused by the lack of appropriate engagement and involvement in collaborative working at place-level and the lack of effective use of funds and resources across Gateshead place. This may result in poor patient outcomes and an inability to deliver place-based plans.



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 25/26 cost reduction programme is not achieved both in year and on a recurring basis - 16

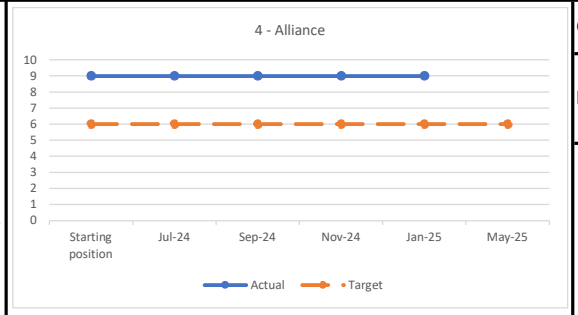
2438 - Quality - Risk of quality failures in patient care due to external causes such as delayed discharges and external pressures – 8

~~2425 - Activity is not delivered in line with planned trajectories, leading to reduction in income - 16~~
Risk replaced by 4714 - 2025/26 planned activity is not achieved resulting in the Trust not achieving planned income - 12

~~2969 - Risk of patient harm due to length of stay in ED - 20~~. Risk replaced by 4734 - risk of patient harm due to inability to meet 4 hour ED emergency care standard - 16

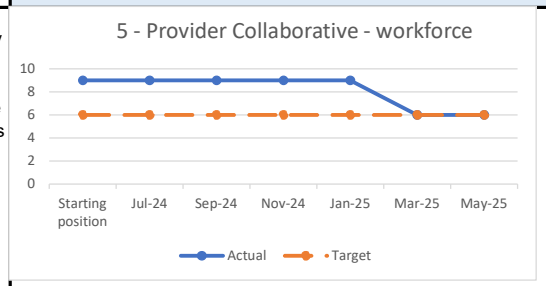
Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Senior engagement in Gateshead Cares meetings	Review and monitor external meeting membership and attendance to ensure appropriate engagement	Medical Director	Sep-24	Nov 24 - controls updated to reflect meeting representation. **Consider whether action can be closed**	
Appropriate director level attendance at Gateshead Overview and Scrutiny and Health and Wellbeing Boards					
Gateshead Health CEO chairing Gateshead Cares Board					
Direct engagement with GPs and PCNs through PCN meetings and GP weekly meetings					
Regular LMC liaison with local GPs					
Representation on SEND Strategic Board via Director of Ops for Medicine, Community and OPMH					
Representation at the Better Care Fund Working Group					

Partner on the Integrated Commissioning Group meeting					
Work underway to review the community contract at place level					
Representation on the Children's Strategic Board via Director of Ops for Medicine, Community and OPMH					
Systems approach taken to winter planning					
Place presentation planned for October to be delivered by CEO, Place Director and the CEO of the local authority on the benefits of collaborative working at place - evidence of good place relationships					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Operational business unit clinical delivery aligned to best practice, NICE and GIRFT recommendations	Enhance monitoring of external engagement activities via Quality Governance Committee and Executive Management team	Medical Director / Chief Nurse / Chief Operating Officer / Company Secretary	Sep-24	Feb 25 - note that updates flow through the governance structure as part of the intelligence shared at Gateshead Health Leadership Group. **Action recommended for closure**	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Clinical outcome data and quality reports shared via Quality Governance Committee					
Clinical pathway developments within Gateshead Place and the GNHA and their innovation impacts reported Quality Governance Committee					
Approach to winter planning at place level shared formally with the Board in Sept 24					
Assurance (Level 3 – external)					
Fully engage with and work into developing Great North Healthcare Alliance partnership arrangements to maximise potential population benefits					
Collaborate within the ICB population health agenda seeking innovative ways of healthcare provision and additional funding opportunities					

Strategic Aim 4: we will be an effective partner and be ambitious in our commitment to improving health outcomes							
Strategic objective:	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'						
Executive Owner:	Group Chief Executive						
Board Committee Oversight:	Board of Directors						
Date of Last Review:	Jan-25						
Summary risk							
There is a risk that the Trust is unable to sufficiently influence key directions of travel re delivery of system performance metrics, financial frameworks (incl system medium term financial plan), workforce development and clinical strategy locally and across the system and Alliance footprint. This may be caused by a lack of appropriate engagement and involvement in key Alliance discussions and meetings. This may result in poorer patient outcomes and an inability to meet performance and finance targets, impacting upon sustainability		**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		3	3	9	2	3	6
Links to risks on the ORR:	~~2424 - Risk that efficiency requirements are not met.~~ Risk replaced by 4713 - The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis - 16 ~~2425 - Activity is not delivered in line with planned trajectories, leading to reduction in income - 16~~ Risk replaced by 4714 - 2025/26 planned activity is not achieved resulting in the Trust not achieving planned income - 12						

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Engagement and involvement in key Alliance meetings	Committees in Common model under development which will strengthen governance and accountability	Company Secretary	Jun-24	Model now in place and reporting to Board - 2 meetings held to-date	
Alliance Steering Group in place	Alliance risk management framework under development	Interim Director of Strategy, Planning and Partnerships	Jun-24	Risk management framework developed and risks reported to and reviewed at every Committee in Common meeting	
Alliance Formation Team member in place - Director of Strategy and Partnerships	Once the Shared Chair is appointed there will need to be programme of work to develop the controls and protocols to ensure this operates effectively in practice	CEO, Chair and Company Secretary	Oct-25		
Weekly CEO meeting in place for Alliance					
Risk management framework and risk register in place at Alliance level					
Committees in Common established					
Joint Committee model developed to cover 3 Trusts - terms of reference and Collaboration Agreement in place for this					
4-3-2 model agreed and in place					
Joint Nominations Committee forming to lead the Shared Chair recruitment					

Extension of GHFT Chair agreed to provide stability and continuity towards the move to a Shared Chair model						
Non-Executive Director scrutiny in place via the Joint Committee structure						
Shared Chair recruitment process approved by all 3 Councils						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Regular updates provided to internal leadership forums and to JCC/LNC etc						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Alliance updates provided at every Board meeting						
Alliance updates provided at Finance and Performance Committee						
Alliance updates provided to COG on quarterly basis						
Alliance update monthly at PLB						
Second Alliance event held to share progress and discuss Alliance strategy with all 4 Boards in Dec 24						
First Alliance event held for Governors of all 4 trusts with positive feedback received						
Regular reporting to the Joint Nominations Committee on Shared Chair progress						
Alliance workplan shared with the Board						
Assurance (Level 3 – external)						
ICB engaging with Alliance leaders - Dec 24						

Strategic Aim 5: we will look to utilise our skills and expertise beyond Gateshead							
Strategic objective:	Contribute effectively as part of the Provider Collaborative to maximise the opportunities presented through the regional workforce programme						
Executive Owner:	Group Executive Director of People and OD						
Board Committee Oversight:	People and OD Committee						
Date of Last Review:	May-25						
Summary risk							
There is a risk that the Trust is unable to sufficiently influence key directions of travel re delivery of system performance metrics, financial frameworks (incl system medium term financial plan), workforce development and clinical strategy locally and across the regional system. This may be caused by a lack of appropriate engagement and involvement in key regional discussions and meetings. This may result in poorer patient outcomes and an inability to meet performance and finance targets, impacting upon sustainability		**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		2	**3**	**6**	**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 4714 - 2025/26 planned activity is not achieved resulting in the Trust not achieving planned income - 12 4525 - Risk of lack of a strategic workforce planning - 12						

Controls		Gap in controls and corrective action	Owner	Timescale	Update	Action status
POD Director member of regional HRD Network		Lack of strategic intent and willing to discuss region wide approaches	Executive Director of POD	~~Dec 24~~ Jan 25	Nov 24 - agreed to revise due date to Jan 25 to reflect capacity March 25 - Propose to move this to a control as there is strategic intent to work region wide. Recommend to be closed.	
POD Director meeting with Alliance HRDs to discuss opportunities		Challenge of provider collaborative, ICB and Alliance groups, discussions and programmes of work. Corrective Action - to understand the priorities and 'must-do's'. Capacity and space to Volume of work and having space to consider innovative approaches across the region	Executive Director of POD	~~Dec 24~~ ~~Jan 25~~ July 25	Nov 24 - agreed to revise due date to Jan 25 to reflect capacity March 25 - propose to amend date to July 25	
Gateshead CEO as regional Workforce Lead		Lack of regional discussions on regional sickness reduction by 1%. Director to lead discussions on this asap.	Executive Director of POD	Mar-25	March 25 - Propose to move this to a control as the group has been initiated. Recommend to be closed.	
Workforce Sharing Agreement in Place						
Close working with ICB People team - members of HRD network and meet weekly						
CDC is contributing to the regional workforce programme						

POD Director SRO for regional bank workstream						
Members of the senior POD team aligned to Scaling Up Regional Groups						
Strategic alignment for region wide approaches						
Regional discussions underway re: regional sickness reduction						
GHFT CEO chairs the regional workforce group						
The Chief Operating Officer is leading the medicine workforce for the Provider Collaborative						
Strategic intent established and willingness to discuss region wide approaches						
Consistent approach agreed across the region in relation to voluntary severance - ensures appropriate controls are in place						
Absence Task Force established to target set to reduce sickness regionally by 1%.						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Feedback from regional meetings to EMT						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Assurance (Level 3 – external)						
NHS England reports on an ad hoc basis						

Strategic Aim 5: we will continuously improve the quality and safety of our services for our patients

Strategic objective:	Evidenced business growth by March 2025 with a specific focus on Diagnostics, Women's health and commercial opportunities
Executive Owner:	Group Chief Operating Officer and QEF Managing Director
Board Committee Oversight:	Finance and Performance Committee
Date of Last Review:	May-25
Summary risk	

There is a risk that the Group will miss opportunities to utilise skills and expertise to generate income for reinvestment in patient care and staff wellbeing. This may be caused by a lack of focus on innovation and emerging opportunities, resulting in increased pressures on existing funding and an inability to deliver our ambitions regarding being a centre of excellence for diagnostics and women's health

CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
2	2	4	2	2	4

Links to risks on the ORR:	4713 - the 25/26 cost reduction programme is not achieved both in year and on a recurring basis - 16

Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Innovations Manager in place	Commercial strategy not in place	QEF Managing Director	~~Aug 24~~ Nov 24	Oct 24 - The Business Development Strategy was discussed at a Board Strategy Workshop on the 15th August 24 with the completed Strategy document to be presented to the QEF Board on the 17th October 24. Feb 25 - based on previous updates consider action for closure	
A Board Agreed QEF Business Development Strategy.	The existing Business Development Strategy has not been ratified by Board.	QEF Managing Director	~~Sept 24~~ Nov 24	Oct 24 - This strategy will be presented to the Board on ratification by the QEF Board at the Strategy Development Workshop on the 17th October 24. Feb 25 - based on previous updates consider action for closure	
A 12 month Business Development Plan with a qualified opportunities pipeline.	There is no Business Development Plan in place for 2024 / 25. - A Business Development Plan for QEF to be developed and submitted to Finance & Performance Committee for ratification.	QEF Managing Director	~~Aug 24~~ Nov 24	Oct 24 - Following the development of the Business Development Strategy we are agreeing the Business Development Process with a focus of developing detailed Business Plans for 25/26. Feb 25 - based on previous updates consider action for closure	

Senior management with specific responsibility for business growth.		The existing Business Development role within QEF is a dual role and is insufficient to support additional growth. - A review of the Business Development Management structure within QEF to be carried out.	QEF Managing Director	~~July 24~~ Nov 24	Oct 24 - Interviews for the role of Commercial Director are to be held on the 15th October 24. Dec 24 - Commercial Director now in place. Action agreed as closed	
Regular contract review meetings for existing contracts.		There is no standard process for carrying or recording contract review meetings. - A contract review process to be implemented.	QEF Managing Director	~~Sept 24~~ Nov 24	Oct 24 - The draft Terms of Reference for an “Occupied Healthcare Facility Contract Review Group” have been provided to the Trust and it is hoped that the first meeting will take place in November 24.	
Commercial Director now in place						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
		No specific reporting on commercial opportunities within the governance structure	QEF Managing Director	Mar-25	Oct 24 - The reporting of the targeted commercial pipeline will form part of the detailed business plans expected to be in place by 31st March 25.	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Assurance (Level 3 – external)						

Gateshead Health NHS Foundation Trust

Agenda Item: 10i

Report Title:	**Organisational Risk Register (ORR)**			
Name of Meeting:	Board of Directors			
Date of Meeting:	21st May 2025			
Author:	Marie Malone, Corporate and Clinical Risk Lead.			
Executive Sponsor:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals/Deputy CEO			
Report presented by:	Gill Findley, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals/Deputy CEO			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	To ensure the Board and Committees are clearly sighted on those risks that have an organisational -wide impact, the organisational risk register is compiled by the Executive Risk Management Group (ERMG) of those risks that impact on the delivery of strategic aims and objectives. This includes risks included within the Board Assurance Framework (BAF) as well as risks identified by the Group for inclusion as having an organisational impact and impact on delivery of strategic aims and objectives. The supporting report shows the risk profile of the ORR, includes a full register, and provides details of review compliance, and risk movements.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	The attached report is received into the Gateshead Health Leadership Group (GHLG) Meeting, the Executive Risk Management Group meeting every month, as well as relevant committees.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience*	Risks on the ORR were comprehensively discussed at previous ERMG meetings in April and May 2025. The following updates and movements agreed:			

<table>
<tr><td>

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

</td><td colspan="6">-In the period of 19th March- 19th May 2025, there was 1 risk added, 1 escalations, 2 reduction, 5 risks removed from the ORR.
- 14 risks in total on the Organisational risk register
- Risks with no movement in 6-month period highlighted for information.
-Summary of Movements over 12-month period is shown within the attached report.
-Compliance with reviews is static in period and sits at 100% for risks and 89% for associated actions. (This is in comparison to 89% and 100% respectively within previous 2 months data set.)</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">The Board are asked to:

• Review the risks and actions on the report and discuss and seek further information relating to risks as appropriate.
• Note movements over 12-month period listed in the attached report.
• Take assurance that risks are reviewed in line with risk management arrangements.
• Be sighted on the top risks for the organisation.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="5">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="5">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="5">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="5">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☒</td><td colspan="5">We will look to utilise our skills and expertise beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="6">Each risk is linked to a corporate objective, see report.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Safe
☒</td><td>Effective
☒</td><td>Caring
☒</td><td>Responsive
☒</td><td colspan="2">Well-led
☒</td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and InPhase reference)</td><td colspan="6">Included in report</td></tr>
</table>

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 March 2025- 19th May (extraction date for this report).

Organisational Risk Register

2. Movements in period

Following ERMG meetings in April and May 2025, 1 risk has been added to the ORR.

There have been 1 escalation, 2 reductions, and 0 closures and 5 risks removed from the ORR.

There are currently 15 risks on the ORR, agreed by the group as per enclosed report.

Risks added to the ORR:
There has been 1 new risk raised and escalated to the ORR in period.

- **4734 (Medicine)** Risk of patient harm due to inability to meet 4-hour ED Emergency Care standard. Resulting in potential regulatory action and poor patient experience. (16)
    - Escalated as a Top Organisational Risk
    - Model of care improvement work currently being undertaken
    - Current Opel +GEL level framework to support escalation and management of time in department.
    - Daily validation for all 4-hour breaches

Risks escalated:
1 risk has been escalated in April, and reduced in May:

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

The declaration of a PACS critical incident in April and the magnitude of the scale of the impact on patients, staff and the wider organisation, warranted an escalation of the following risk from 20 to 25 in April:
However, following official step down of critical incident on 18th April, it was agreed that the likelihood could be reduced to 20, given the System is currently stable, with acknowledgement that significant risk remains for the Organisation.

  - A Recovery plan is underway which includes impact assessment analysis which may support further reduction in the future.
  - Risk has been de-escalated as a top organisational risk.

Risks reduced:
1 risk has reduced in period:

- **4525 (POD)** There is a risk that the lack of a strategic workforce plan that delivers our specific future priorities (women's health, diagnostics, etc) leads to a lack of appropriate skilled staff and negative impacts on service delivery, patient safety and staff engagement and an increase in costs for temporary staffing. (9)
  - Reduced from 12 to 9.
  - Recognition of the integrated approach to planning that has been undertaken as part of recent operational planning round and adoption of 6- step approach to planning.

Risks removed from the ORR
5 risks in total have been removed

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

- **2969 (Medicine)** Risk of patient harm due to length of stay in ED resulting in potential regulatory action and poor patient experience. (12)
  - Reduced from 20 to12
  - Significant improvement in performance metrics for 12-hour time in department noted between January and March 2025
  - De-escalated from the ORR and superseded by a new risk regarding 4 hour waits in ED.

- **4575 (Digital)** Risk that the trusts failure to meet the mandatory 20-day turnaround for Freedom of Information requests could increase the likelihood of complaints/reports to the ICO from requestors, resulting in potential financial and reputational damage and complaints. (8)
  - reduced from 12 to 8

  - Significant action activity undertaken to progress the backlog of requests and a strong leadership push to improve performance against new requests.
  - continual improvement in the associated KPI

- **4576 (Digital)** Risk that as the trust is failing to meet the mandated turnaround time of a calendar month for Subject Access Requests (below 95% tolerance), complaints to the ICO from requestors could increase, causing financial and reputational damage and complaints. (8)
  - Reduced from 12 to 8
  - Task and finish group established
  - Continual improvement in the associated KPI

- **4591 (CEO)** Risk of significant disruption to services due to GP collective action to "work to contract" including withdrawal from shared care agreements. The impact of this is currently unknown, however, may result in sub optimal quality of care, reduced performance against targets, financial implications, as well as realignment of clinical resources and reputational harm. (12)
  - Reduced from 15 to 12
  - the financial element of the risk has not been as impactful as initially thought.
  - The political landscape currently forecasts the number of GPs taking part will not be as significant as previously suggested.

1 risk have been de-escalated from the ORR, no change to score.

- **2438 (NMQ)** There is a risk of quality failures in patient care (patient safety, patient experience and effectiveness) due to external causes such as delayed discharges and pressures from other Trusts resulting in patient harm, regulatory action, and reputational impact (8)
  - Risk added to ORR July 2022
  - Discharge liaison team facilitate timely discharges with fewer concerns raised.

Risks closed:

0 Risks have been closed.

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

There are 7 risks on the ORR with no movement in the past 6 months (December 2024-May 2025)

Risk ID	Risk Stage	Risk Title	Owner	Business Unit	Service	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025
2341	Current Risk	There is a risk to ongoing business continuity of service provision due to ageing trust estate	Anthony Pratt	QE Facilities	Estates	16	16	16	16	16	16
4402	Current Risk	Inability to support legislation and best practice associated with records management	Catherine Bright	Digital	Health Records	16	16	16	16	16	16
3107	Current Risk	Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings	Fiona Gow	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
4541	Current Risk	Risk of governance failure as we transition to new governance arrangements	Gill Findley	Nursing, Midwifery & Quality	Corporate Nursing	12	12	12	12	12	12
4574	Current Risk	A risk of being unable to relocate in the event of an evacuation due to capability and capacity issues within the estate that may potentially result in patient safety issues	David Patterson	Chief Operating Officer	EPRR	12	12	12	12	12	12
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 at March's meeting:

1- **Finance**- non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m
2- **POD-** Increase in incivility and disrespectful behaviours being reported.
3- **Medicine** – Risk of patient harm due to inability to meet 4-hour ED Emergency Care standard

- **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)

- **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)

- **4734 (Medicine)** Risk of patient harm due to inability to meet 4-hour ED Emergency Care standard. Resulting in potential regulatory action and poor patient experience**.** (16)

5. Current compliance with Risk reviews:

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

This is on trend with previous reporting period. (89% and 100% respectively)

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

6. Recommendations

The Board of Directors are asked to:

- Review the risks and actions and discuss and seek further information relating to risks as appropriate.
- 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. May 2025.

Total Risks (Current/Managed)
15

People 4

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Wellbeing	People & OD	4417	Increase in incivility and disrespectful behaviours being reported	15
Staff Safety	QE Facilities	3132	Exposure to incidents of violence and aggression	12
Resources	Chief Operating Officer	4574	A risk of being unable to relocate in the event of an evacuation due to capability and capacity issues within the estate that may potentially result in patient safety issues	12
	People & OD	4525	Risk of Lack of a strategic workforce planning	9

Quality 4

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Safety	Digital	4705	Risk of considerable clinical and operational impact to patient care due to failure of PACS environment.	20
Safety	Digital	4554	Cyber Threats and Vulnerabilities	10
Safety	Medical Services	4734	Risk of patient harm due to inability to meet 4 hour ED Emergency Care standard	16
Safety	Surgical Services	3107	Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings	15

Finance 4

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

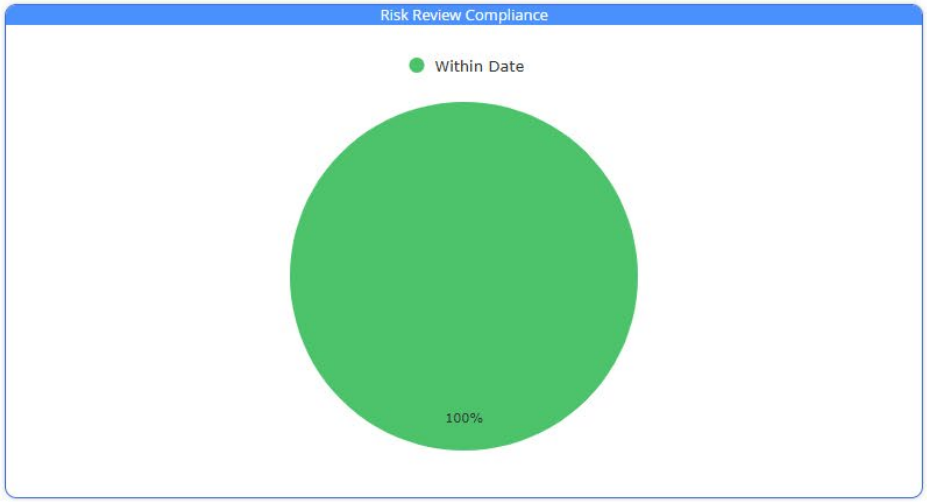
Regulation 3

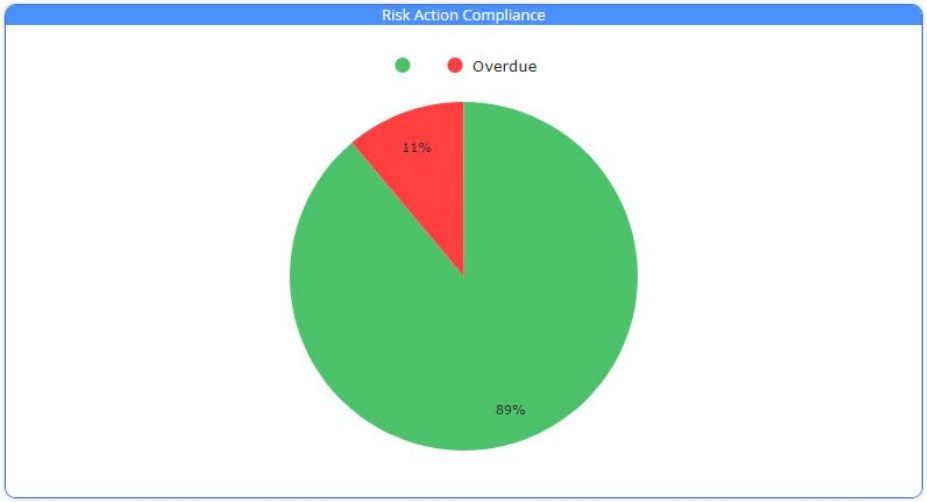
Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Compliance	Digital	4402	Inability to support legislation and best practice associated with records management	16
Compliance	Digital	4405	Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure.	8
Compliance	Nursing, Midwifery & Quality	4541	Risk of governance failure as we transition to new governance arrangements	12

Changes to Current Score over 12 Months

Risk ID	Risk Stage	Risk Title	Owner	Business Unit	Service	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025
4694	Current Risk	Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m	Jane Fay	Finance	Finance									20	20	20	20
4705	Current Risk	Risk of considerable clinical and operational impact to patient care due to failure of PACS environment.	Gill Findley	Digital	Systems										20	25	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	16	16	16	16	16	16
4402	Current Risk	Inability to support legislation and best practice associated with records management	Catherine Bright	Digital	Health Records	16	16	16	16	16	16	16	16	16	16	16	16
4713	Current Risk	The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis	Jane Fay	Finance	Finance										16	16	16
4734	Current Risk	Risk of patient harm due to inability to meet 4 hour ED Emergency Care standard	Jo Halliwell	Medical Services	Med 1												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	15	15	15	15	15	15
4417	Current Risk	Increase in incivility and disrespectful behaviours being reported	Amanda Venner	People & OD	Workforce Development	12	12	12	12	12	15	15	15	15	15	15	15
3132	Current Risk	Exposure to incidents of violence and aggression	Kate Clark	QE Facilities	Facilities	15	15	15	15	15	15	15	15	12	12	12	12
4541	Current Risk	Risk of governance failure as we transition to new governance arrangements	Gill Findley	Nursing, Midwifery & Quality	Corporate Nursing	16	16	16	16	12	12	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	12	12	12	12	12
4714	Current Risk	2025-26 planned activity is not achieved resulting in the Trust not achieving planned income targets	Jane Fay	Finance	Finance										12	12	12
4554	Current Risk	Cyber Threats and Vulnerabilities	Gill Findley	Digital	IT	15	15	15	15	15	15	15	10	10	10	10	10
4525	Current Risk	Risk of Lack of a strategic workforce planning	Natasha Botto	People & OD	Human Resources	12	12	12	12	12	12	12	12	12	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	16	16	16	16	16	16	8	8	8	8	8	8

Risk review and action review compliance. May 2025





Top Organisational Risks

Risk Id	Division	Description	Initial Risk Grade	Grade	Target Grade
4417	People & OD	There is a risk that promoting an environment that encourages speaking out and creating a psychologically safe culture has led to increased reports of poor behaviour. This could have a negative impact on staff and require additional time and capacity to appropriately address the concerns. This could result in further health and well being concerns and staff absence.	15	15	6
4694	Finance	Risk that the Trust will not achieve 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
4734	Medical Services	Risk of patient harm due to inability to meet 4 hour ED Emergency Care standard. Resulting in potential regulatory action and poor patient experience.	20	16	8

Committee Escalation and Assurance Report

Name of Board Committee	Finance and Performance Committee
Date of Board Committee:	29 April 2025
Chair of Board Committee:	Mr M Robson

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

The Committee identified the following Alert items:

- To advise the Board that the financial plan for 2024/25 has been met in delivering to a deficit of £2.1m, subject to Audit. (for information)

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

The Committee identified the following items:

- Green Plan – The Committee received an update which set out recommended improvements to the governance arrangements for oversight of the Green Plan/Net Zero Agenda for the Trust. This will be managed via a new 'Greener NHS Group' to be chaired by the Medical Director which will meet twice yearly, supported by a member of the Divisional Leadership Team. The Green Plan is now due to be published in September 2025, with a need for Board consideration in July 2025.
- An update on the submitted financial plan for 2025-26 was presented to the Committee.
- The Committee received an update on the PACS Critical Incident and were provided with the first version of the report on response and recovery.
- The Committee noted the achievement in relation to 52 week waits at the end of March 2025.
- The Committee noted the beginnings of improved performance in relation to the '4hr standard' and 'Time in Department', but this is likely to be impacted by the PACS outage.
- 'Fragile Services' – There is a need for the Board to have a clear understanding of what the Executives consider to be fragile Services and for a list to be provided to the Board.
- Patient Monies Policy – this needs to be moved forward in order to allow internal audit actions to be closed ahead of the next meeting.

Assure

(key assurances received and any highlights of note for the Board)
The Committee received the following assurances: • There are no new Internal Audit Reports – although it was noted that a report on Waiting List Management had received a good rating – this will be reported to a future meeting of the Committee as it falls within Performance. • The update to the financial plan was noted.
Risks (any new risks / proposed changes to risk scores)
There were no changes to risk scores but additional assurance information to be added to the BAF in relation to: SA3 - For assurance – a formal plan for a Green Plan for the end of the year
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:	2 May 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)

- For information – the Committee received an update on clinical risk relating to the PACS outage. A plan is in place to identify any patients impacted and a follow up report was requested by the Committee to provide further assurance.

- An issue was highlighted via the Health and Safety Group Triple A report in relation to incidences of security staff being left to oversee vulnerable patients. The seriousness of this issue was recognised. Action is being taken to ensure this does not happen and a further report for assurance was requested by the Committee.

- Regulation 28 – The Committee noted that there had been notification of a Regulation 28 report from the Coroner to NHS England relating to digital systems. To be aware that although this is not directly for the Trust, it relates to an incident at the Trust.

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:

- Paediatric Hearing Services – in light of the public inquiry announced at a national level into this issue, the Committee requested a further paper on the impact in Gateshead. The ICB noted that good assurance had been provided by the Trust.
- DTIs – It was noted that 5 cases of Deep Tissue Infection (DTI) had been reported, along with an increase in C Difficile cases. The Committee requested a report on Infection Control and Prevention for the next meeting.
- CQC inspection report on the Sister Winifred Laver Centre – the Committee was briefed on the latest position but noted that this is Local Authority managed and they are taking the lead on actions to address the CQC report.
- Falls – It was recognised that a number of actions had been taken to address falls but an improvement had not been seen – the Committee requested that a regular update on falls be provided.
- Patient Safety – concerns raised about delays to investigations and the need for greater ownership by divisions for taking investigations forward in a timely way.

- Delays re incidents in Inphase and complaints backlog – it was recognised that the new policy was having a positive impact but the Committee requested further assurances on progress.

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

Positive assurances were agreed in relation to:

- Children in Care – funding approved by the ICB and therefore the outstanding action relating to this has been closed.
- Safecare clinical leadership is now fully in place.
- Maternity – oversight and caesarean section deep dive received following request at previous committee – positive assurance gained.
- Positive performance on RTT 52 week wait performance – zero patients waiting longer than 52 weeks.
- Health Inequalities report
- Complaints position has improved – a further report will be provided in August.
- Oversight of Independent Mental Health Homicide Review into the tragedies in Nottingham.
- FTSU Internal Audit Report – good compliance rating and acknowledgement of role of the Committee in supporting this.

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

- It was agreed that the likelihood risk score for Strategic Aim 4 – work collaboratively as part of the Gateshead system to improve health and are outcomes to the Gateshead population - be reduced to 3 giving an overall score of 12, which is the target score. This is based on assurance to be added in relation to the health inequalities report, including the plan and metrics

Cross-referrals to Executive Directors

- There were no cross referrals.

Escalation and Assurance Report

Name of Committee / Group:	People and OD Committee
Date of Committee / Group:	Tuesday 13 May 2025
Chair of Committee / Group:	Mrs Maggie Pavlou

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

- **Sickness Absence –** the Committee noted the positive impact of the revised policy and support from front line managers feeding into some reduction in in-month sickness absence rates, but this remains below target and concern was raised about whether sickness absence for medical staffing is being managed in the same way and the need for consistency across all staff groups.
- **WRES and WDES Data Report** – the data in the report was not complete and there is a need to update the data to include the in year staff survey data for 2024-2025 and recirculate to the Committee ahead of the national submission of the data during May 2025. A request was also made that assurance is provided that the data being submitted meets the national reporting requirements.
- **Nursing and Midwifery National Job Profiles** – progress is being made, particularly in relation to the Band 5 job descriptions, but there is a lot of work still to do before the beginning of June 2025 when the newly updated national role descriptors are published. Some risks were identified in relation to capacity of nursing team given the number of current job descriptions to be reviewed.

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

The Committee identified the following advisory issues:

- **Attendance at tier 3 meetings** – an issue was raised about the impact of attendance/quoracy issues for tier 3 meetings – agreed this should feed into the review of the new governance arrangements being undertaken by the Company Secretary, to also include mapping of membership across committees and a review of the frequency of meetings.
- **Star Awards** – A decision is needed on the best approach to the star awards this year with three options being put forward for consideration by the Clinical Strategy Group and GHLG. *Post Meeting update*- Star Awards will be an in person event at The Fed brewery but include a broader celebration of fantastic achievements in services to showcase more members of staff.
- **Voluntary Severance Scheme** – national approval has been granted the NENC for a Voluntary Severance Scheme. A plan is being worked through around how this will

be rolled out from 19th May 2025. This will be open to corporate, management and admin staff, however discussion and consideration is being given to whether this should be opened up to all across the organisation. *Post Meeting update* – to be opened up to all staff

- **Job Descriptions and Job Evaluation** – An acknowledgment of the wider implications around the large number and variety of job descriptions across the workforce and the need to consider this more broadly in relation to the consolidation of an agreed set of standard job descriptions. POD team working on a plan for this.
- **Guardian of Safe Working Exception Reporting** – reports received and acknowledgement of the improved timescales for resolution of exception reports. Acknowledgement that there is a need to better understand the reasons behind exception reporting and what is needed to address these issues as well as understand the range of impacts, including possible generational workforce expectations.
- **MHPS Policy** – progress and level of engagement on the policy was noted but final approval has been delayed due to the need to re-submit to the Practice Practitioner Advice Service (PPAS). Comments from NEDS to be reviewed in relation to incorporating learning, and the final draft policy to be shared with Adam Crampsie for any further comments ahead of discussion at Policy Review Group on 20th June 2025.

Assure
(key assurances received and any highlights of note)

Positive assurances were agreed in relation to:

- Absence Management Audit Update – cross referral closed
- Medical Staff Job Planning Audit – 3 out of 5 actions complete and no overdue actions.
- Freedom to Speak Up Audit – good level of assurance achieved.
- Audit Plan 2025-26 received for information
- Triple A Reports from POD Steering Group received and Alerts discussed.
- People Strategy Annual update noted.
- Revised People and OD Committee Terms of Reference approved.
- Organisational Risk Register noted.
- Board Assurance Framework updated following discussions.

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

- There were no changes to risk scores.

Cross-referrals to Committees or Executive Directors

There were no cross-referrals.

Escalation and Assurance Report

Name of Committee / Group:	Digital Committee
Date of Committee / Group:	2 April 2025
Chair of Committee / Group:	Mr A Moffat

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

- Outline Business Case – GHFT Digital Records Programme – The Digital Committee approved in principle progress to a full business case. This is subject to a finance review of the project and the development of an operational delivery plan, with a paper to be presented to the Board in May 2025.

- To inform the Board that the target risk score for the Digital BAF Objective has been achieved through a reduction of the risk score from 6 to 3.

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)

- PACS Project – The Committee was informed of the PACS project. It was agreed that the workplan needs to be made more visible across the whole organisation through increased messaging supported by experts.
- Digital KPIs – these were reviewed and some additions recommended.
- Terms of Reference for the Digital Committee – reviewed and amended, including some additions to regular attendees.
- Audit Actions – there is one action where an extension has been agreed and this should be closed next time.

Assure
(key assurances received and any highlights of note)

The Committee received assurance in relation to:

- CDC Update – informative presentation provided on the digital aspects of the CDC and the Committee commended the team on progress. It was noted that there are some areas, particularly in relation to ECGs that may be able to be rolled out more widely in the Trust.
- Business Intelligence – the Committee received an informative presentation setting out the vision.
- Internal Audit Plan – this was received.
- Dave Elliott and Andrew Besford (observer) from Northumbria were in attendance and provided useful insights to the meeting.

• KPIs – the Committee was assured by improved performance shown in KPIs, particularly as a number had been identified as alerts earlier in the year.
Risks (any new risks / proposed changes to risk scores)
• Digital BAF – risk reduced from 6 to 3 which is the target risk level.
Cross-referrals to Tier 1 Board Committees (by exception)
• None

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 12

Report Title:	**Board Walkabout Feedback**			
Name of Meeting:	Board of Directors			
Date of Meeting:	21 May 2025			
Author:	Dr Gill Findley, Chief Nurse / Deputy Chief Executive Dr Gerry Morrow, Non-Executive Director Maggie Pavlou, Deputy Chair Hilary Parker, Non-Executive Director			
Executive Sponsor:	Dr Gill Findley, Chief Nurse / Deputy Chief Executive			
Report presented by:	Dr Gill Findley, Chief Nurse / Deputy Chief Executive			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To provide Board Members with an overview of observations and reflections from Board walkabouts, supporting triangulation with other sources of information and assurance			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☒
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	-			

Key issues:
Briefly outline what the top 3-5 key points are from the paper in bullet point format
 	
Consider key implications e.g.
• *Finance*
• *Patient outcomes / experience*
• *Quality and safety*
• *People and organisational development*
• *Governance and legal*
• *Equality, diversity and inclusion*
	• This report seeks to formally share the feedback from Board Member walkabouts at public Board.
	• This supports Board Members in their triangulation of information from different sources and will feature on every Board agenda.
	• Over time this will enable key themes and trends to be identified, as well as any material actions from visits.
	• This report covers four visits:
	  • Maternity – Pregnancy Assessment Unit and labour ward – 19 March 2025;
	  • Community Diagnostic Centre – 20 March 2025;
	  • Main outpatients and Windy Nook outpatients - 27 March 2025; and			

- Maternity and Women's Health – 8 May 2025.

Maternity – March 2025

- Consistent with previous visits to Maternity, staff were welcoming and helpful.
- It was noted that the team had taken the initiative to rearrange the available space to ensure that the waiting area could be kept under observation, which demonstrated a real focus on patient safety.
- Board Members were impressed by the physical environment which was in the process of being enhanced with wall art commissioned by the Gateshead Health Charity.
- The visit identified that staff were concerned about the potential lack of an identified medical clinical lead when the current postholder leaves.

Community Diagnostic Centre, Metro Centre

- It was noted that the environment was clean and tidy with visible health and safety information displayed in the staff areas,
- Colleagues praised the responses of security team to unwarranted visits from non-patients.
- Board Members reflected that there is scope to make the environment more inviting and make better use of the large space available, both for staff and patients.
- Overview Board Members were impressed by the facility and the opportunities this presents going forwards.

Main Outpatients and Windy Nook Outpatients

- It was noted that the department flowed well with minimal queuing for patients.
- The café was closed following a trial opening and feedback indicated that the opening hours may not have aligned effectively to the busiest times.
- The estate is old and is geographically spread which can make staffing challenging. Whilst the department was well organised the layout was prohibitive.
- There was scope to refresh the wall notices and ensure they are relevant and appropriately displayed.
- Colleagues were passionate and knowledgeable about the department.
- The team spoke of the impact of the PACS outage for both staff and patients.

<table>
<tr><td></td><td colspan="2"><u>Maternity and Women's Health – May 2025</u>

• The close working with the Maternity Voices Partnership was evident and positive feedback was received from a representative of the partnership.
• The staff survey highlighted the lack of an area for all partners to stay with women as a key concern and colleagues remain concerned about the lack of a clinical lead for obstetrics.
• The visit was again positive and the engagement with the team was appreciated.

<u>Walkabout Wednesdays</u>

In addition to the Executive Director and Non-Executive Director walkabouts a new Walkabout Wednesdays initiative has been launched. This provides protected weekly time for Executive Directors to visit clinical and non-clinical areas. The aim is to ensure all teams are visited and that teams have an opportunity to meet with Executive Director colleagues in a relaxed and informal manner. It provides opportunities to speak with colleagues, listen to feedback, answer questions and gain insights into the challenges and successes of each department. Recent visits have included:
• Physiotherapy
• Colposcopy
• Orthotics
• SALT
• Bank and healthroster teams
• Breast radiology and screening
• Main radiology department
• Ultrasound
• Ward 23</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="2">Board Members are requested to review the feedback from the walkabout process and consider this in the context of other items on the Board's agenda for consistency and triangulation.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td>We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td>We will be a great organisation with a highly engaged workforce</td></tr>
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☐</td><td>We will enhance our productivity and efficiency to make the best use of resources</td></tr>
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☐</td><td>We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td>We will develop and expand our services within and beyond Gateshead</td></tr>
</table>

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

Board of Directors' Walkabout Feedback

1) Maternity – March 2025

Board Members in attendance:	Gill Findley – Chief Nurse and Deputy Chief Executive Gerry Morrow– Non Executive Director
Area visited:	Maternity – Pregnancy assessment unit and labour ward
Date of visit:	19.3.25
Observations about the environment visited if applicable (e.g. clean, tidy, welcoming, health and safety considerations, colleague wellbeing or patient wellbeing considerations)	We visited the labour ward and spoke to staff including a member of staff who had recently returned to work in Gateshead from abroad. Staff were welcoming and helpful. We visited the pregnancy assessment unit and saw the team had rearranged the available space to provide a waiting area for patients so they could be kept under observation while waiting for their appointment. This provided a much safer environment for the patients
What were you impressed by?	As we visited there was an artist completing some wall art, that had been commissioned using charitable funds. The art work has transformed a dull long wall into a much more pleasant environment.
Any areas of concern / things to follow up?	Main area of concern was the lack of an identified medical Clinical Lead for when the current incumbent moves to a new post. This is causing some anxiety for the team.
Overall summary	Overall positive meeting. Good to see the team making the best use of the environment that they have.

2) Community Diagnostic Centre

Board Members in attendance:	Maggie Pavlou, Hilary Parker, Non-Executive Directors
Area visited:	CDC
Date of visit:	20/03/25
Observations about the environment visited if applicable (e.g. clean, tidy, welcoming, health and safety considerations, colleague wellbeing or patient wellbeing considerations)	Clean, tidy & new. No obvious obstructions or defects in the environment. Main area was welcoming despite all seats pointing to a tv that wasn't on, whilst the windows and natural light were behind the visitors. Entry from the Metro Centre itself was slightly sterile and less inviting. Access via the Metro Centre was well signed, but a large / stark / empty area that requires some thought in terms of how it can be better used e.g. seating, digital signage, breakout areas.

	Breastfeeding room and baby change facilities were inviting, clean and tidy, but practicality was questioned. Baby feeding room is single occupancy. Baby changing facility has little 'work surface' area or smart waste solutions. The baby change device attached to the wall is awkwardly placed, and of a size that is most suitable only for small babies. Neither room had an entrance for a double buggy, and little space inside for parking a buggy whilst using the room. There does not appear for anyone on their own, with a baby, to access a bathroom.
What were you impressed by?	Condition and scale of the facility. Visible health and safety information in staff only areas. Reports of excellent security response to very occasional visits by children who are not service users.
Any areas of concern / things to follow up?	Sink in staff room out of order, poor signage relating to the issue, no signposting to alternative. Use of ad-hoc signage and adhesive / blue-tack used to secure to walls. Waste: Large monitor still boxed and unused in meeting room. Requires appropriate mount and IT involvement or to be reassigned Commercial displays / monitors provided instead of TV's – each monitor requires a PC & networking to display messages. Wifi / Smart TV's would make more sense. Explore swap of devices within QE estate. There is scope to make greater use of the CDC across the partnership. Several consulting rooms are apparently rarely used. The meeting room is too small for the number of people working there already
Overall summary	Gareth gave a comprehensive overview, and it is good to see the CDC growing and successful. We were struck by the available capacity and noted the requirement for wider use by the partners, and the opportunity to provide patient transport if budget could be established.

3) Outpatients

Board Members in attendance:	Gill Findley – Chief Nurse and Deputy Chief Executive Maggie Pavlou– Deputy Chair/Non Executive Director
Area visited:	Main Outpatients and Windy Nook Outpatients
Date of visit:	27.3.25
Observations about the environment visited if applicable (e.g. clean, tidy, welcoming, health and	The visit took place in an afternoon with Sharon and Alastair. The team said that the department was less busy than usual. The department was flowing well, with patients moving quickly

safety considerations, colleague wellbeing or patient wellbeing considerations)	through the department and minimal queues in the reception area. We noted the café was closed, and understand that this has now been closed after a trial period of reopening. Sharon and Alastair said that it was a big miss, and commented that during the trial period, the cafe appeared to have been open at times that were not in line with the busy times of the department itself, which may have accounted for the lack of footfall. They also commented that some clinics had now been moved to the unit from Tramwell, which may now lead to a higher footfall. The estate is old and is showing some signs of age. The departments are very spread out, making it quite difficult to manage staffing. We observed lots of paper signs and handwritten information stuck to the walls with bluetack and tape and some old covid notices were still visible.
What were you impressed by?	The people who showed us round were knowledgeable and passionate about outpatients. They said they felt informed and clear about what was happening. Uniforms were smart and IPC rules were being followed.
Any areas of concern / things to follow up?	The team discussed a llack of responsiveness from the digital team to minor irritations such as particular PCs always going wrong etc. They described that the recent PACS outage had had a massive impact on the service, with lots of delays and frustrations for staff and patients.
Overall summary	The department appeared to be well organised and run well, but could be operated more efficiently with a better room layout.

4) Maternity and Women's Health – May 2025

Board Members in attendance:	Gill Findley – Chief Nurse and Deputy Chief Executive Gerry Morrow– Non Executive Director
Area visited:	Women's health clinic and maternity
Date of visit:	8.5.25
Observations about the environment visited if applicable (e.g. clean, tidy, welcoming, health and safety considerations, colleague wellbeing or patient wellbeing considerations)	We met with the senior maternity and neonatal team and went through the action plan and the patient survey feedback. We also met with a representative of the maternity voices partnership, who was complimentary about the services being provided and offered some helpful insight into patient experiences.
What were you impressed by?	The close working with the maternity voices partnership representatives

Any areas of concern / things to follow up?	The main issue from the staff survey is the lack of a definitive area for all partners to stay with women. We remain concerned about the lack of a clinical lead for obstetrics.
Overall summary	Another positive visit. Thank you to everyone who supported the visit.

Report Cover Sheet Agenda Item: 13

Report Title:	**Consolidated Finance Report – Part 1**			
Name of Meeting:	Board of Directors			
Date of Meeting:	21st May 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 *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	The purpose of this paper is to provide assurance against financial corporate objectives and address financial risks			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	N/A			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity, and inclusion*	The Trust has an approved 2025-26 planned deficit of **£8.621m** before adjustments for donated asset depreciation, and **£8.381m** after. As of April 2025 the Trust has reported an actual deficit of **£1.550m** after adjustments for donated asset depreciation. This is an adverse variance of **£0.272m** 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 April 2025, the Trust has capital spend on schemes totalling **£0.795m**. Cash balances are at **£32.433m** at 30th April 2025 and **£12.090m** above planned levels for the reasons detailed in the body of this report.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The recommendation to the Trust Board 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, capital and cash 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 April 2025 is detailed in Table 1.

Finance KPIs	M1 - Apr-25 Budget £ '000	Actual £ '000	Variance £ '000	RAG
I&E (Surplus) / Deficit (adjusted perf.)	1,278	1,550	272	
Operating Income	(35,778)	(35,376)	402	
Pay Expenditure	24,492	24,387	(105)	
Non Pay Expenditure	12,018	12,198	180	
Non Operating Income	(55)	(246)	(191)	
Non Operating Expenditure	621	619	(2)	
Remove capital donations / grants I&E impact	(20)	(32)	(12)	
Agency Expenditure	97	73	(213)	
CRP Delivery	(2,188)	(1,671)	517	
Capital Expenditure	1,561	795	(766)	
Cash position	(20,404)	(32,433)	(12,029)	
Liquidity (days)	6.3	(5)	1.6	
Better Payment Practice Code (BPPC)				
NHS (value)	95.0%	93.3%	-1.7%	
Non NHS (value)	95.0%	99.6%	4.6%	
Aged Debt				
Receivables over 90 days NHS	10%	9.8%	-0.2%	
Receivables over 90 days non NHS	10%	10.0%	0.0%	

Table 1: Finance KPIs

2.2 The Trust has reported a deficit of **£1.550m** which is an adverse variance of **£0.272m** against plan, with the actual deficit informed by an assumption elective recovery income is on plan due to activity files being received one month in arrears.

2.3 The adverse variance from plan of **£0.272m** is mainly due to slippage against the cost improvement target of **£0.517m** due to a number of schemes not yet approved to be transacted including technical adjustments offset by small underspends on pay.

2.4 The achievement of elective recovery income targets and the 25-26 cost reduction target are identified as two of the main financials risks for 2025-26.

2.5 A summary of the overall income and expenditure position is provided in Appendix A.

3. Cost Reduction Programme

3.1 As detailed in section 2 delivery of the Trusts cost reduction programme is a financial risk.

3.2 Performance against the year to date target is £1.671m against a target of £2.188m and is summarised in Table 2, with slippage totalling £0.517m. Of this slippage £0.212m relates to technical adjustments which is expected to catch up by month 3.

	Plan as at M1 - Apr 25	Actual as at M1 - Apr 25	Variance as at M1 - Apr 25	Annual Achieved	Achieved Non-Recurring	Achieved Non-Recurring	Total
	£000	£000	£000	£000	£000	£000	£000
Commercial	(0.061)	(0.019)	(0.042)	(0.030)	(0.030)	0.000	(0.030)
Corporate Restructure	(0.071)	(0.017)	(0.054)	(0.208)	(0.208)	0.000	(0.208)
Cost Reduction - spending controls	(0.188)	(0.195)	0.007	(0.474)	(0.459)	(0.015)	(0.474)
Cost Reduction - Workforce	(0.050)	0.000	(0.050)	0.000	0.000	0.000	0.000
Cost Reduction Productivity	(0.772)	(0.989)	0.217	(5.052)	(4.384)	(0.668)	(5.052)
Drugs	(0.027)	0.000	(0.027)	0.000	0.000	0.000	0.000
Income	(0.033)	(0.033)	0.000	(0.400)	(0.400)	0.000	(0.400)
Income Productivity	(0.183)	(0.119)	(0.064)	(0.030)	(0.030)	0.000	(0.030)
Other - Technical Adjustment	(0.500)	(0.288)	(0.212)	(3.461)	0.000	(3.461)	(3.461)
Procurement	(0.022)	(0.001)	(0.021)	(0.220)	(0.220)	0.000	(0.220)
Service Change	(0.005)	(0.005)	0.000	(0.055)	(0.055)	0.000	(0.055)
Skill Mix - Workforce	(0.016)	(0.005)	(0.011)	(0.064)	(0.064)	0.000	(0.064)
Unidentified	(0.260)	0.000	(0.260)	0.000	0.000	0.000	0.000
Total	**(2.188)**	**(1.671)**	**(0.517)**	**(9.994)**	**(5.850)**	**(4.144)**	**(9.994)**
% of Overall Target				**30.40%**	**17.80%**	**12.61%**	**30.40%**

Table 2 Cost Reduction Performance

3.2 From an annual perspective the Trust has achieved £9.994m of its £32.800m cost reduction target of which £5.850m (18%) has been achieved on a recurring basis.

3.3 Slippage against other schemes 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 has an objective to improve its underlying deficit of £61.6m to £26.8m as detailed in Table 3. The achievement of the £5.850m on a full year effect recurring reduces the Trust underling deficit to £55.7m.

	25-26 Plan £m	Underlying £m
25-26 Underlying (Deficit)/Surplus	-61.6	-61.6
25-26 Cost Reduction Target	32.8	32.8
25-26 Deficit Support Funding	5.3	0.0
25-26 ICB Support Funding	9.0	0.0
25-26 Vacancy Factor	3.9	0.0
25-26 Elective Recovery Ceiling	2.0	2.0
2025-26 Financial Plan (Deficit)	**-8.6**	**-26.8**

Table 3: Underlying Deficit

5. Capital

5.1 The Trusts 2025-26 capital plan totals £20.076m as summarised in Table 4. Spend in the month of April totals £0.795m against the Colposcopy and Paediatrics schemes. Due to this being the first month in the financial year no risks to delivery of the capital plan have been identified.

External Capital Plan 2025-26	25/26 External Plan
CDC Phase 2	£5,468,000
Physiological Sciences	£106,000
Day Care Service Improvements	£50,000
UEC Creation of a Surgical Assessment Area	£562,000
EPAC Expansion	£700,000
Same Day Emergency Care (SDEC)	£585,000
Sub-total Constitutional Standards	**£7,471,000**
Sub-total Estates Safety - Backlog Maintenance	**£5,000,000**
Sub-total Medical Equipment Replacement	**£941,000**
Sub-total Digital	**£800,000**
Colposcopy	£2,319,000
Paediatrics	£2,945,000
X-Ray Room 5	£600,000
Sub-total Strategic Schemes	**£5,864,000**
Total Capital Programme	**£20,076,000**

Table 4: 2025-26 Capital Plan

6. Cash Balances

6.1 Group cash as of 30th April 2025 totalled £32.433m, a favourable variance of £12.029m, mainly due to an increase in trade payables including the non-payment of the 2025-26 pay award.

7. Conclusion

7.1 For April 2025 the Trust has a planned deficit of **£1.298m** before adjustments for donated asset depreciation, and **£1.278m** after (adjusted performance).

7.2 The Trust has reported an adjusted deficit of **£1.550m** for the period ending 30th April 2025, which is an adverse variance of **£0.272m**.

7.3 The Trust has reported total capital spend of **£0.795m**, against schemes carried forward from 2024/2025.

7.4 The Trust has reported achievement of £1.671m cost reduction against a target of £2.188m; of which £0.648m is on a recurring basis in the month of and £5.850m on an annual basis.

Kris Mackenzie, Group Director of Finance
May 2025

Appendix A – Statement of Comprehensive Income (SOCI)

Statement of Comprehensive Income	As at April 25 Budget £ '000	Actual £ '000	Variance £ '000
Operating Income from Patient Care activities			
Income From NHS Care Contracts	(32,502)	(32,350)	152
Income From Local Authority Care Contracts	(8)	(40)	(32)
Private Patient Revenue	(57)	(63)	(6)
Injury Cost Recovery	(42)	(53)	(11)
Other non-NHS clinical revenue	(21)	(36)	(15)
Total Operating Income From Patient Care activities	**(32,630)**	**(32,542)**	**88**
Other Operating Income			
Education and Training Income	(987)	(1,108)	(121)
R&D Income	(48)	(84)	(36)
Other Income	(2,113)	(1,642)	471
Donations & Grants Received	0	0	0
Total Other Operating Income	**(3,148)**	**(2,834)**	**314**
Total Operating Income	**(35,778)**	**(35,376)**	**402**
Operating Expenses			
Employee Expenses - Substantive	23,607	23,245	(362)
Employee Expenses - Bank	667	952	285
Employee Expenses - Agency	97	73	(24)
Employee Expenses - Other	121	117	(4)
Total Employee Expenses	**24,492**	**24,387**	**(105)**
Purchase of Healthcare - NHS bodies	636	900	264
Purchase of Healthcare - Non NHS bodies	118	175	57
Purchase of Social Care	0	0	0
NED's	16	16	0
Supplies & Services - Clinical	3,832	3,649	(183)
Supplies & Services - General	283	231	(52)
Drugs	2,071	2,035	(36)
Research & Development expenses	0	1	1
Education & Training expenses	172	180	8
Consultancy costs	56	30	(26)
Establishment expenses	344	378	34
Premises	1,583	1,575	(8)
Transport	158	111	(47)
Audit Fees	16	18	2
Clinical Negligence	783	813	30
Operating Leases	221	180	(41)
Other Operating expenses	453	580	127
Operating Expenses included in EBITDA	**10,742**	**10,872**	**130**
Depreciation & Amortisation	1,276	1,298	22
Impairment & Revaluation	0	28	28
Operating Expenses excluded from EBITDA	**1,276**	**1,326**	**50**
Total Operating Expenses	**36,510**	**36,585**	**75**
(Profit)/Loss from Operations	**732**	**1,209**	**477**
Non-Operating Income			
Finance Income	(55)	(246)	(191)
Total Non-Operating Income	**(55)**	**(246)**	**(191)**
Non-Operating Expenses			
Finance Expense	70	60	(10)
Gains / (Losses) on Disposal of Assets	0	0	0
PDC dividend expense	426	426	0
Total Finance Costs (for non-financial activities)	**496**	**486**	**(10)**
Other Non-Operating Expenses			
Misc. Other Non-Operating expenses	0	0	0
Total Non-Operating Expenses	**496**	**486**	**(10)**
(Surplus) / Deficit Before Tax	**1,173**	**1,449**	**276**
Corporation Tax	125	133	8
(Surplus) / Deficit After Tax	**1,298**	**1,582**	**284**
Balancing Adjustment to NHSE Plan			0
(Surplus) / Deficit After Tax from Continuing Operations	**1,298**	**1,582**	**284**
Remove capital donations / grants I&E impact	(20)	(32)	(12)
Adjusted Financial Performance (Surplus) / Deficit	**1,278**	**1,550**	**272**

Appendix B
Statement of Financial Position

	2025/2026 April 2025 Group Plan	2025/2026 April 2025 Group Actual	Variance
	£000's	£000's	£000's
Assets			
Non-Current Assets			
Investments	80	80	0
Property, Plant and Equipment, Net	171,450	169,446	(2,004)
Right of Use Assets	13,131	13,556	426
Trade and Other Receivables, Net	2,272	2,197	(75)
Finance Lease - Intragroup			
Trade and Other Receivables - Intragroup Loan	0	0	0
Total Non Current Assets	186,933	185,279	(1,654)
Current Assets			
Inventories	5,110	3,891	(1,219)
Trade and Other Receivables - NHS	6,161	11,743	5,582
Trade and Other Receivables - Non NHS	15,067	14,411	(656)
Trade and Other Receivables - Intragroup			
Trade and Other Receivables - Other	0	0	0
Cash and Cash Equivalents	20,404	32,433	12,029
Total Current Assets	46,742	62,478	15,736
Liabilities			
Current Liabilites			
Deferred Income	2,310	4,044	1,734
Provisions	2,573	2,573	0
Trade and Other Payables	42,951	53,811	10,860
Lease Liabilities	1,584	2,697	1,113
Trade and Other Payables - Capital	250	2,696	2,446
Other Financial Liabilities - Borrowings FTFF	999	999	0
Total Current Liabilities	50,667	66,820	16,153
NET CURRENT ASSETS (LIABILITIES)	(3,925)	(4,342)	(417)
Non-Current Liabilities			
Deferred Income	1,983	1,995	12
Provisions	2,445	2,105	(340)
Trade and Other Payables - Other	36	159	123
Lease Liabilities	11,959	11,746	(213)
Other Financial Liabilities - Accruals	0	0	0
Other Financial Liabilities - Intragroup Borrowings	0	0	0
Other Financial Liabilities - Borrowings FTFF	10,013	10,014	1
Finance Lease - Intragroup			
Total Non-Current Liabilities	26,436	26,020	(416)
TOTAL ASSETS EMPLOYED	**156,572**	**154,917**	**(1,655)**
Tax Payers' and Others' Equity			
PDC	173,190	172,316	(874)
Taxpayers Equity	0	0	0
Share Capital	0	0	0
Retained Earnings (Accumulated Losses)	(29,897)	(30,168)	(271)
Other Reserves	0	0	0
Revaluation Reserve	13,180	12,671	(509)
Misc Reserve	99	99	0
TOTAL TAXPAYERS EQUITY	156,572	154,917	(1,655)
TOTAL ASSETS EMPLOYED	**156,572**	**154,917**	**(1,655)**

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 14

Report Title:	Strategic Objectives & Constitutional Standards			
Name of Meeting:	Tier 1 and Tier 2 Committees			
Date of Meeting:	Wednesday 21st May 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 *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☒
	This report presents progress, risk and assurance in relation to our Strategic Objectives & Constitutional Standards for M1 2025/26			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*				
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal*	**We will continuously improve the quality and safety of our services for our patients**. **Maternity:** Continues to report 100% compliance with Ockenden recommendations and Maternity Incentive Scheme. **Quality Improvement Plan:** April's performance is below planned levels with 76% of Key delivery areas and actions on track. Areas requiring improvement or remain challenging are: Daily resus checks & safe storage of COSHH, appraisal rates and implementation of the PSIRP workstream plans. **PSIRP**: The volume of falls and falls harm rates have decreased significantly in April, bi-monthly meetings are now in place to improve engagement. In support of identification and prevention of Venous Thromboembolisms (VTE) 99% of all patients admitted in April were risk assessed (in accordance with NICE guidance criteria). Meeting the national standard of 95%.			

• *Equality, diversity and inclusion*	**QA**: The Trust has reported 4 cases of C. difficile in M1. The Trust's annual threshold has not yet been allocated. In month rates per 100k bed days have decreased to 28.7 in line with the average rate. At ten point action plan is in place and community prevalence continues to be higher than expected levels, in line with the national and regional trends. **QA**: Performance against learning disability and autism training at 68.31% remains static and below target levels of 85%. Discussions continue re: regional hub delivery model and issues in digital updates to monitoring systems. Mental Health Act Policy training has improved 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 will progress to Board in May, including an extension of current PAS contract beyond Dec 27. **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 April, a total of 20 estate risks with a combined critical infrastructure risk score of 244. Representing a decrease in score of 12, and closure of 1 risk. • There were 9 patient safety incidents reported linked to estate issues. Noise disruption in the vicinity of audiology tests accounted for 2 of the issues – there we no obvious correlation of themes in the other 7 reported incidents. • Multi-disciplinary PLACE audits have taken place in three areas across the Trust in April. No major concerns were noted and estates actions are being taken to address the issues noted. **We will be a great organisation with a highly engaged workforce.** • Vacancy rates are not reported in M1 due to budget setting. • Staff engagement score decreased from 6.2 to 6.17% in the Quarterly Pulse survey, remains below target levels of 7.3. The completion rate was at 8% of the Trust's workforce. Targeted work is on-going to improve rates via multiple routes. • Turnover rates remain above target levels of 9.7% with M12 performance at 11.8%.

	• Sickness absence rates of 5.7% remain above target levels of 4.9%. • Temporary staffing spend as a proportion of pay bill is at 0.4% and remains below the planning target of 2.3%. **We will enhance our productivity and efficiency to make the best use of our resources.** **Improve the quality-of-care delivery and accessibility for patients by meeting locally agreed stretch targets.** • The ED 4-hr standard deteriorated in M1 with performance at 72.5% against a plan: driven by Type 1 performance at 55% (10% below plan). • Less than 1% of our patients spent more than 12 hours in ED. Remaining within the national tolerance of <2% and continuing to demonstrate significant improvements upon last year's annual performance of 4.7%. • 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 14:12 mins in April against the national standard of <15mins. NEAS regional average is 20:48. One handover in April exceeded 60 mins. • The number of ambulance conveyances were 12% higher than the same period last year representing an average increase of 8 per day more. Improvement activities are 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 • IPC issues in the hospital have also impacted on the ability to create flow. • Average NEL length of stay increased in month to 8.7 days in April. • Discharge remains problematic, the daily average of patients no longer meeting the criteria to reside at 43 in March (~10% of open bed base). • In April there were 465 beds open, an increase of 16 more per day than last month and on average 4 more beds than the same period last year. The waiting list decreased by 269 patients in month to 13,067 representing just over 2% reduction, however this is a 10.8% growth over the last 12 months. The growth is driven by an increase in outpatient waiters by 17% over 12m, although there has been a slight in month reduction of 222 (2%) in outpatient waiters in month. Inpatient waiting list has reduced by 8% over the 12 month period.

	A deep dive into the drivers behind the Waiting lists position is re-scheduled for review at Operational Oversight. • Current waiting list is above planned trajectory. • Increases in outpatient waiters are driving the overall increase in the waiting list. • Key Waiting list pressures remain in Gynaecology, Urology, Breast, COTE, Cardiology, Gastroenterology, Rheumatology and Respiratory. April's RTT performance is at 71%. There were 16 T&O 52week waiters at the end of April. 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 in April the Trust declared a Major Incident in digital reporting because of the PACS system outage. Subsequently the 28 Day Faster Diagnosis Standard fell below expected planned levels at 76%. This issue will impact on the ability to diagnose and treat patients in Q1. The Trust is now in recovery phase: an impact assessment is underway to understand clinical risks and the impact on backlog waiters. Diagnostics: Waiting List is at 6,668 representing an in month increase of 177 waiters (3%) and 6% growth over previous 12 months. DM01 performance is at 77%, below planned for levels of 84% and represents a 6% negative performance variance from last month. Challenged modalities remain in NOUS with performance at 77% against a plan of 84%. Trust level recovery is forecast in Dec-25, with local modality complaint recovery plans: Audiology May-25, Echocardiology Sep-25 and NOUS Dec-25, this recovery trajectory will need to be revisited following the PACS system outage in April. **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 M1 the Group had a planned deficit of £1.278m with performance at £ 1.550m, demonstrating a negative variance of £272k. Deficit position is largely driven by unachieved CRP.

	Cost Reduction Plan (CRP) delivered in month is at £1.671m, demonstrating a negative variance of £517k against plan of £2.188m. Focus remains in identifying and delivering recurrent savings schemes to support financial sustainability The cash position did not fall below the £5m target set within the Trust plan. **We will be an effective partner and be ambitions 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 were maintained at 29 weeks in month. Service plans to support recovery are in development to improve waiting times. Paediatric autism assessments and diagnosis waiting times have reduced significantly in month to a median wait of 60 weeks. **We will develop & expand our services within and beyond Gateshead.** Work is ongoing in April to increase external income as part of business efficiency plans. QEF generated income is down in April compared to previous years and has been impacted by IT procurement framework Apr-25.	
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The recommendations to the Committee are to receive this report, discuss the potential implications and note the improvement or challenge in key areas.	
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

<table>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">All Strategic Objectives.</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td></td><td colspan="5">Key areas to establish reporting:
• PLACE audit scores not yet generated from PLACE Lite
• Medication updates are included in the narrative section.

Areas requiring attention:
Quality & Safety:
• Quality Improvement Plans
• Mental Health Act & Disability & Autism Training

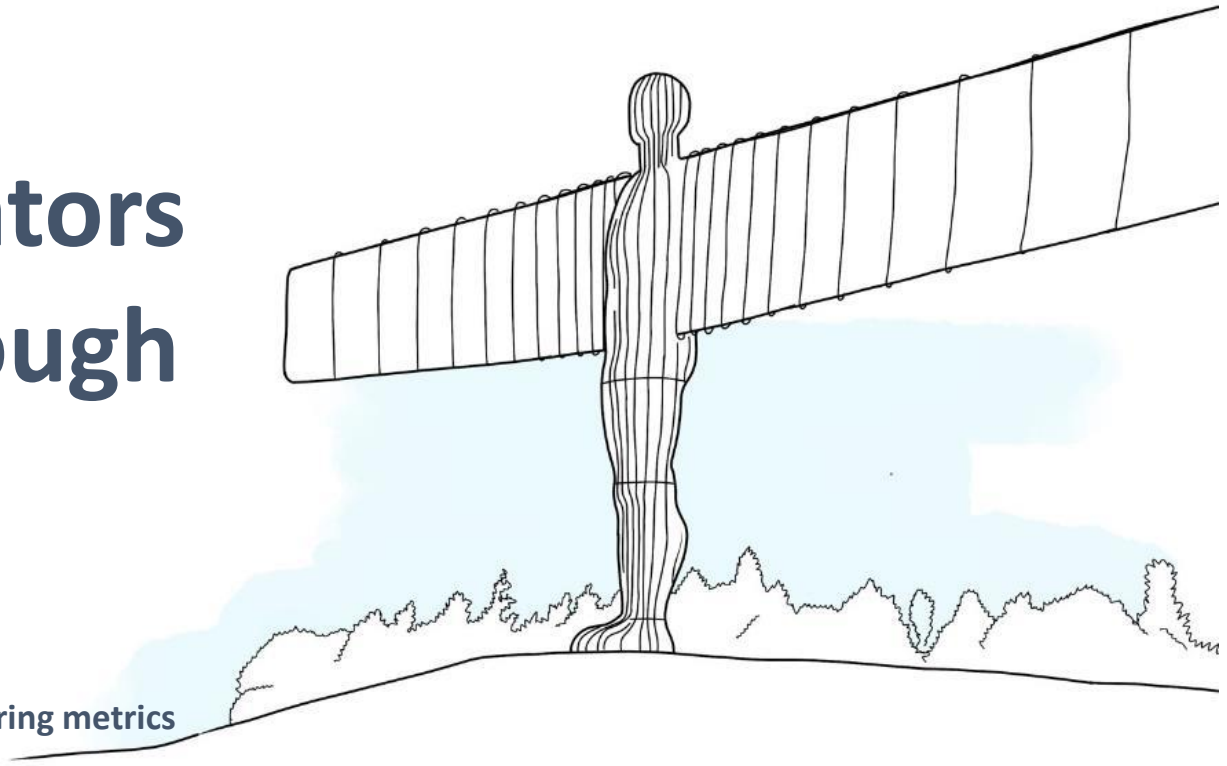
Workforce: Staff engagement, turnover rates, vacancy & sickness absence rates.

Productivity & Efficiency risks:
• PACS system outage
• Higher than planned waiting lists
• Staffing gaps in key operational areas
• Emergency Care metrics: 4hr A&E target.
• Maintaining financial sustainability, reducing expenditure and achieving CRP.</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

NHS
Gateshead Health
NHS Foundation Trust

Strategic Objectives 2025/26

Leading Indicators and Breakthrough Objectives



Including Constitutional standards monitoring metrics

Reporting Period: April 2025

Strategic Objectives 2025/26 | **What are we aiming for**

NHS Gateshead Health NHS Foundation Trust

Our patients Our people Our partners

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

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

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

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

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

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

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

Our Strategic aims:

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

Our strategic intent:

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

Strategic Objectives 2025/26 — Executive Summary

NHS Gateshead Health NHS Foundation Trust

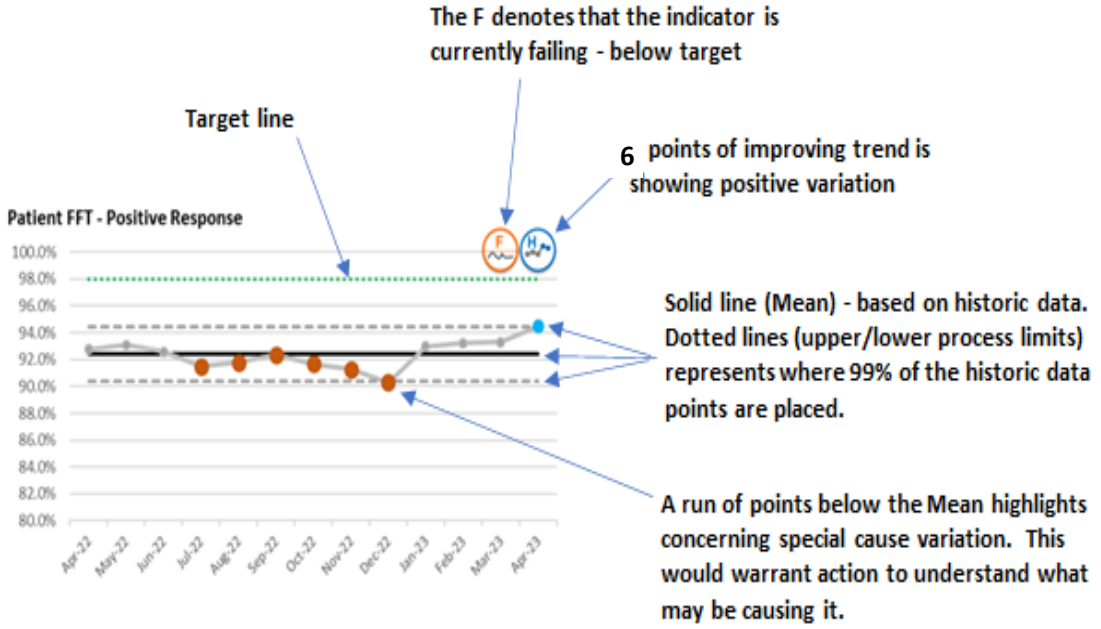
Improved	No Change	Needs further attention
We will continuously improve the quality and safety of our services for our patients		
Ockenden recommendations	Scoring in domains in areas of PLACE inspection not available	Strategic approach to development of EPR
Maternity Incentive Schemes		Mental Health Act Training for all registered staff
		Severity of risk scores linked to estates
		Quality Improvement Plans
		Harm rate from falls
		C.Difficile rate
		Reduction in patient safety incidents linked to estate issues
		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		
	Review and revise Green Plans	Average non-elective length of Stay < 4 Days
	Reduce New & Follow up non value added activity to 67%	Reduce the number of patients with no Criteria to Reside
		Achievement of 4-hr A&E target (Below planned trajectory and target)
		Achievement of the trajectory to achieve 60% RTA to Bed within 1 hour
		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	

Strategic Objectives 2025/26 | **How to interpret the SPC icons and charts** | Gateshead Health NHS Foundation Trust

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

What are Statistical Process Control (SPC) charts

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



SPC Rules

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

Icon Colours Explained

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

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

Strategic Objectives 2025/26	Leading Indicator and Breakthrough Objectives Assurance Heatmap

NHS Gateshead Health NHS Foundation Trust

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

Strategic Objectives 2025/26

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

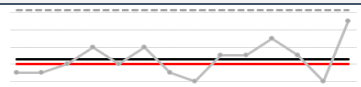
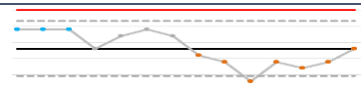
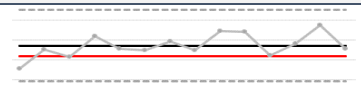
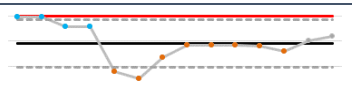
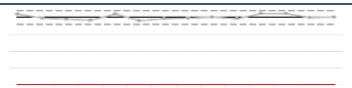
NHS Gateshead Health NHS Foundation Trust

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

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

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

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

Metric	Target	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	Ass/Var	Trend
LEADING INDICATORS																	
Ockenden Recommendations % compliance with Total Recommendations	100%	77.7%	78.0%	78.0%	74.0%	74.0%	89.0%	90.0%	95.2%	97.4%	98.0%	100.0%	100.0%	100.0%	100.0%	H F	
Maternity Incentive Schemes % compliance with Total Recommendations	100%		62.9%	70.8%	76.4%	77.5%	83.0%	89.0%	89.0%	89.0%	96.0%	96.0%	100.0%	100.0%	100.0%		
Reduction in patient safety incidents linked to estate issues	<=4	3	3	4	6	4	6	3	2	5	5	7	5	2	9	?	
Compliance with the quality improvement plan indicated by the % of actions on track	100%	88%	88%	88%	76%	84%	88%	84%	72%	68%	56%	68%	64%	68%	76%	L F	
BREAKTHROUGH OBJECTIVES																	
Scoring in domains in areas of PLACE inspection composite score > 95%	> 95%																
Reduction in severity of risk score linked to estates	TBA		252	252	252	267	279	284	280	280	272	256	252	256	244		
Harm falls rate per 1000 bed days (5% reduction)	3.2	2.58	3.53	3.17	4.21	3.57	3.50	3.93	3.49	4.44	4.42	3.24	3.81	4.77	3.56	?	
C.Diff Healthcare associated rate per 100,000 occupied bed days	<=3.20	21.0	21.1	20.9	22.1	28.4	27.8	42.0	6.7	28.6	13.2	26.7	31.4	70.1	28.7		
90% of staff to complete Mental Health Act training.	90%	89.7%	89.7%	87.9%	87.9%	78.9%	77.6%	81.8%	84.2%	84.2%	84.2%	84.0%	83.0%	85.0%	86.0%	F	
Venous thromboembolism (VTE) risk assessment	95%	99.2%	99.0%	98.9%	98.8%	99.2%	98.8%	98.9%	99.0%	99.0%	98.9%	99.2%	99.2%	99.0%	99.0%	P	
85% of staff to complete GHFT Level 1 learning disability and autism training from April 2024. Develop plans for Level 1 Face to face interactive training as part of mandatory training offer.	85%				33.72%	41.53%	46.93%	50.76%	54.95%	57.36%	59.97%	61.80%	64.21%	68.31%	68.31%		

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	April compliance 100%, MIS compliance with all elements of Saving Babies Lives Care Bundle confirmed Audits complete for IAEs 5&7, continue to monitor compliance.
	Maternity incentive schemes % compliance with total recommendations	The Trust is reporting compliance at 100%. Annual LMNS assurance report received, Q3 LMNS assurance meeting completed, MIS compliance reporting period ended 30/11/2024 Final ratification of updated Maternity Risk Management Guideline completed – January Safecare - Safety action 7. Update of maternity governance structure in line with Trust, recruitment to midwifery and consultant vacancies.
2	Compliance with the quality improvement plan indicated by the % of actions on track.	Latest reported data relates to April 2025 with 76% of the Improvement Plan actions delivered. April'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: Resus daily checks and safe storage of COSHH as part of the 2019 CQC action plan, Trustwide appraisal rates, Staff retention, local induction checklist compliance, Implementation of falls PSIRP workstream plan, Reduction of harm from falls. The following actions have now been fully implemented: Mental Capacity Act, Duty of Candour, Mortality, Documentation Audit, Implementation of the 6 PSIRF workstreams, Patient Safety shared learning, Implement Medicines Optimisation training strategy, Mental Health Act, Embed the action plan from the newly developed MH strategy, CERA actions. Challenges continue for resus checks daily checks taking place and COSHH files being up to date. The Chief Matrons are working with the matrons and Health and Safety Team to improve the continuous low compliance against both of these. To note there has been a marked improvement in both areas over the past two months. Low compliance with trustwide appraisal rates, local induction rates and staff retention rates are being monitored via Tier, 1,2 and 3 POD meetings. The trust has Developed a new complaints process to ensure all complaints are responded to with 40 days or to a timescale agreed with the complainant in line with Trust policy, this has been approved at Policy Review Group and shared with all divisions. 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.
	85% of staff to complete GHFT Level 1 learning disability and autism training from April 2024. Develop plans for Level 1 Face to face interactive training as part of mandatory training offer.	Ongoing discussions continue regarding next steps with regards to LD and Autism awareness training, scoping delivery models when national guidance produced. Ongoing discussions within the alliance to the delivery model approach. Challenge remains regarding regional hub where e-learning is hosted which at times is impacting completion being noted in the system, discussions ongoing regarding a fix for this, however the team are supporting to update compliance as required as compliance is increasing month on month
	Improve Mental Health Act Policy Training Compliance to 90% for all *registered* staff via training and audit.	Mental health staff trained is currently standing at 86% which is an increase from 85% in March. 93% of qualified staff are compliant with training. 71% of HCAs & support workers are currently compliant. The CPN team, memory hub and mental health liaison team are all at 100% compliance with training. Training dates have been set for 2025, bespoke training is available on request. It is identified that training compliance for 38 staff will expire during 2025. Staff on Sunniside and Cragside have been booked onto training sessions throughout this year.47 acute staff have been trained. Ward managers and site resilience staff have been emailed by Safeguarding Training administrator to book onto training.
	Improve our IPC C.Difficile infection rates per 100 000 occupied bed days.	Rates per 100 000 bed days have reduced to 28.7, 4 cases in April. 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 then normal levels, reflecting national and local elevated levels of CDiff.
	Medicines	The Women's Health and Childrens Services Pharmacist has been in post since April and is now well established, presenting the role to the Great North Pharmacy Conference in July. Work to review IV iron infusions is ongoing this financial year and guidelines implemented in December 24. Further development of mandatory e-Learning for syringe drivers and the development of a Palliative Care presentation for preceptorship training are hoped to be implemented for the next financial year.
	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 April performance reported at 99%.
	Harm related falls will reduce by 5% by March 2025.	Falls with harm have reduced significantly this month. There has been no Falls Steering Group work as the meetings were stood down. Further meetings have been arranged bi-monthly to optimise attendance.
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. This will progress to trust board in May 2025. 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. Initial discussions have taken place with the Cabinet Officer and EPR Investment Board to establish process for approvals/controls. Current drivers are due to the contractual limitations of the existing provision decision regarding strategic route will be require extensions to existing provision. 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. 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	April position, 20 Risks with combined critical infrastructure risk score of 244 (decreased from 256 in March). One risk closed (ref 4531-laparoscopic theatre- theatre 8)
	Reduction in patient safety incidents linked to estate issues	9 patient safety incidents related to estates issues in April 2025. These figures currently exclude incidents related to pressure damage and incidents reported as Harm not related to Gateshead on Inphase. Noise in the vicinity of audiology was causing disruption for 2 cases, there were no other obvious themes.
	Scoring in domains in areas of PLACE inspection composite score > 95%	PLACE lite implementation is still awaited to produce percentage scores. In April ward 22, ward 28 and SCBU have been reviewed, one session stood down as most attendees were on annual leave. No major concerns raised, Estates logged any faults and life cycle works.
	Reduction in value of backlog maintenance score as reported via the ERIC return	There is now a clinically prioritised plan to review and deliver the backlog maintenance programme. The challenges are limitations on capital available to support the plan & CDEL allocation. Rationalisation of our existing aging estate is required to meet the 25% reduction target (equating to £3.5m reduction). The capital programme has been confirmed and an update will be available when capital projects are completed.

Strategic Objectives 2025/26

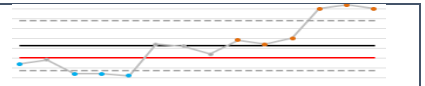
We will be a great organisation with a highly engaged workforce

NHS Gateshead Health NHS Foundation Trust

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

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

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

Metric	Target	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	Ass/Var	Trend
LEADING INDICATORS																	
Maintain the vacancy rate at <=2.5%	<=2.5%	2.4%	1.7%	1.7%	1.6%	3.2%	3.1%	2.7%	3.4%	3.2%	3.5%	5.0%	5.2%	5.0%			
Improve the staff engagement score to 7.3	>=7.3		6.60			6.63						6.20			6.17		
BREAKTHROUGH OBJECTIVES																	
Achievement of the internal turnover standard of 9.7%	<=9.7%	12.5%	12.0%	11.8%	12.1%	11.7%	11.7%	11.7%	11.2%	11.4%	11.5%	11.7%	11.3%	11.5%	11.8%		
Achievement of the internal sickness absence standard of 4.9%	4.90%	5.2%	5.5%	5.7%	5.8%	5.8%	5.7%	5.6%	5.6%	5.6%	5.7%	5.7%	5.7%	5.7%	5.7%		
Reduction in temporary staffing spend of pay bill evidenced month on month	<=2.3%		1.4%	1.0%	0.9%	0.4%	0.5%	0.4%	0.6%	0.5%	0.4%	0.5%	0.5%	0.5%	0.4%		

Measures requiring focus this month

Measure	Summary
Maintain the vacancy rate at <=2.5%	Vacancy rate in March was 5.0%, a 0.2% decrease compared to February 25. Both contracted WTE and Budgeted WTE decreased from February to March 2025. Vacancies add pressure to the group and our ability to provide a safe and high-quality service. Our current vacancy rate is above the target, this could include critical vacancies that are causing operational pressure and additional work spend. A review of the VCF process is in place to ensure there is tighter scrutiny in place for all vacancies.
Improve the staff engagement score to 7.3	The quarterly pulse survey result for Apr 25 was 6.17 with a 9.0% completion rate. The engagement score has decreased since it was last reported at 6.22 in January 25, with a 0.3% reduction in completion rates from 9.3% completion rate for the group.
Achievement of the internal turnover standard of 9.7%	Turnover increased by 0.3% to 11.8% in April 25. Staff are leaving the NHS across all providers given the significant work pressures and burnout.
Achievement of the internal sickness absence standard of 4.9%	High levels of deprivation and external factors along with challenging roles are driving some of our sickness absence. Sickness remained at 5.7% for a rolling 12 months in April 25.
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 0.4% and has been consistent over the last 12 months.

Strategic Objectives 2025/26

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

NHS Gateshead Health NHS Foundation Trust

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

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

Metric	Target	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	Ass/Var	Trend
LEADING INDICATORS																	
Average Length of Stay Non-Elective <4 days *Reset April 2025 to align with 2025/26 operational guidance definitions*	<=4	4.46	5.19	7.62	6.87	7.17	7.73	7.96	7.24	8.26	7.24	7.88	7.31	7.18	8.70		
Achievement of the 4 hours trajectory	>78%	72.2%	71.8%	72.0%	76.3%	71.0%	72.2%	71.4%	67.8%	73.0%	65.6%	71.2%	73.6%	74.5%	72.5%		
Achievement of the 52 week RTT standard	0	76	72	109	88	81	108	123	106	111	102	83	66	0	16		
Achievement of 2024/25 financial Plan - Variance (£k)	Figure in brackets favourable		2,312	2,609	0.009	(0.004)	(0.073)	(0.042)	0.026	(0.143)	(0.1)	(0.1)	(0.167)	(0.046)			
Finance - Forecast Out-turn Deficit (Plan)	tbc		12,650	12,650	12,650	12,650	12,650	7,088	7,088	7,088	7,088	2,192	2,192	2,146	1,278		
BREAKTHROUGH OBJECTIVES																	
Achievement of the trajectory to reduce >12 hour total time in Emergency Department (Type 1)	0	362	358	413	225	531	391	395	749	495	1036	466	208	71	52		
Reset April 2025 to align with 2025/26 operational guidance definitions	0.2%	3.6%	3.8%	4.1%	2.3%	5.4%	4.4%	4.4%	7.6%	5.1%	10.5%	5.2%	2.5%	0.7%	0.9%		
Reduce the number of patients with no Criteria to Reside	<10	36	35	35	55	48	46	38	45	41	40	44	46	47	43		
Achievement of the trajectory to achieve RTA to Bed within 1 hour	60.0%	13.6%	9.7%	5.5%	6.1%	5.2%	5.6%	6.3%	3.7%	4.7%	4.2%	4.3%	5.7%	6.3%	6.4%		
Reduce % of Follow up Outpatient without procedures *Reset April 2025 to align with 2025/26 operational guidance definitions*	<=67%	72.1%	70.1%	69.4%	69.8%	70.8%	71.7%	71.3%	69.6%	67.2%	66.3%	66.9%	67.3%	67.6%	68.6%		
2024-25 CRP Delivery Variance	Figure in brackets favourable		0	0	98	0	(570)	680	1,157	2,539	2,994	2,082	73	0	(1671)		
No less than £5m cash as per forecast at March 2025	>=£5m		£5m	£5m	£5m	£5m	£5m	£5m	£5m	£5m	£5m	£5m	£5m	£5m	£32m		

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

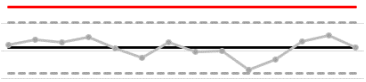
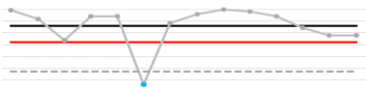
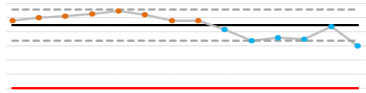
Measure		Summary
1	**Average Length of Stay Non-Elective <4 days**	Length of stay increased during April. There were a number of challenges during the month including the PACS challenges which slowed the pace of work within the Trust and the ongoing closure of the intermediate care beds within the system. Ongoing work targeting those with no criteria to reside and ensuring they are discharged appropriately as well as focusing on those with a stay of 7, 14 or 21 days continues to be the focus of improvement work to further reduce this target.
	Achievement of the 4 hours trajectory	Performance at 72.5 % showed a deterioration in March's position and remains below the required 78% standard. Availability of beds on EAU and back of house is key to achieving this objective. Focus on ensuring flow earlier in the day, use of the discharge lounge, estimated date of discharge and actual date of discharge enable this to be reviewed. Patient discharge early in the day, achieving this would enable us to ensure that patients did not remain within ED. Also reviewing non admitted waits to understand times of day and improvements required. The discharge improvement project is focusing on measurably improving discharges. Further changes to the Dashboards have been implemented and a review at all patient flow meetings is now in place. Further enhanced patients flow meetings have been introduced to support better flow and improve this target.
	Achievement of the trajectory to reduce >12 hour total time in Emergency Department	Performance at 0.9% showed a slight deterioration, but an overall sustained improvement since December. To achieve this reduction, further improvement work took place to ensure that patients were moved from ED in a timely manner. The Trust has set a stretch target for 0.5% in this year's planning submission.
	Achievement of the trajectory to achieve 60% RTA to Bed within 1 hour	Performance of 6.4%. This is driven by late bed availability in the day, specifically EAU. Appropriate streaming to SDEC. Discharge profile is later in day, address planning for tomorrow's discharges today. Discharge work and review of mechanism to alert Patient Flow team to timeframe.
	Reduce the number of patients with no Criteria to Reside	Average number of patients per day who do not meet the criteria to reside was 43, this number is a slight reduction on previous months. Availability of services in the Community to support patients who no longer need acute hospital care and ensuring that we are maximising our use of our own services is a key risk. Challenge in improving the process and outcomes for patients who do not need a hospital bed but do need support in the Community. Daily review with Social Care, review by Discharge Liaison Nurses, service improvement plan developed. There have been a number of complex patients requiring specialist placement in the bed base since February which has caused challenges.
	Achievement of the 52 week RTT standard by end Q1 and delivery of the trajectory for 40 weeks	We achieved the revised ambition of zero 52 week waiters by March 25. Unfortunately we did see an increase in April 25 due to a variety of reasons, PACS disruption, consultant sickness due to surgery and one consultant working non operatively. Plans are in place to achieve the 0 standard in May.
	Increase in New Outpatient activity	The target has been changed in 25/26 to reduce the % of follow up outpatient without procedure. Unfortunately we fell slightly short of the target in April but are revisiting our plans in line with the operational guidance moving into 25/26 to decrease this figure.
2	**Evidence achievement of the 24-25 financial plan**	The Trust had a planned deficit at M1 of £1.278m and actual performance of £1.550m deficit which is an adverse variance of £0.272m. The deficit variance is largely driven by under achievement of £0.52m CRP target (slippage against some schemes not yet approved to be transacted and technical adjustment), offset by higher interest receivable income and small underspends on pay. The Trust planned CRP target at M1 of £2.188m and actual performance of £1.671m of which £0.648m delivered recurrently. Focus remains on identifying recurrent savings schemes to support future financial sustainability. Cash at the 30th April 2025 was £32.433m and above the £5m minimum carrying cash balance target.
3	**Review & revise the 2022/25 green plan & align with the group structure by the end of Q2.**	Q1 - Q2 plans to embed the Green plan governance structure and align with group governance. The first sustainability was held in June, where 10 workstreams will provide update reports aligned to our sustainability objectives. Work plan priorities include: waste, active travel, fleet, procurement, estates & facilities, workforce/communications, sustainable care, medicine, digital transformation and adaptation. Q4 plans include a survey of understanding across the Board/EMT and Senior Leadership Group members.

Strategic Objectives 2025/26

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

NHS Gateshead Health NHS Foundation Trust

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

Metric	Target	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	Ass/Var	Trend
BREAKTHROUGH OBJECTIVES																	
Increase in the number of digital devices repurposed to the local community	>300		100	100	50	58	0	0	10	0	0	0	0	0	0		
Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients by March 2025	>=98%	91.1%	92.1%	91.6%	92.5%	90.5%	88.8%	91.6%	89.9%	90.0%	86.5%	88.4%	91.7%	92.8%	90.6%	F	
Reduction in the wait for gynaecology outpatients to no more than 26 weeks	<=26	40	36	27	37	37	8	34	38	40	39	37	32	29	29	?	
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 by March 2025	<=30	78	80	81	83	85	82	78	78	72	64	66	65	74	60	L F	

Measures requiring focus this month

Measure	Summary
Evidence a reduction in the number of 'fragile' and 'vulnerable' services as a direct outcome of Alliance working	This will be reviewed quarterly as part of the Provider Collaborative Sustainability review. Outputs and products from this work will be reviewed to inform the annual planning process and is contained in the Project Plan for 2024/25 to support planning for 2025/26.
Evidence in an improvement in health inequalities in the key focus areas linked to the determinants of Health for Gateshead	Key determinants of Health for Gateshead are to be defined through the Health Inequalities Group workstream. Evidence/measures and controls will be implemented as part of the focused work to progress in 2024/25.
Increase in the number of digital devices repurposed to the local community	Digital exclusion is where members of the population have inadequate access and capacity to use digital technologies that are essential to participate in society. The risk to this target is that the quantity of devices being made available for recycling and repurposed is dependant on Trust usage and need. This is therefore entirely variable throughout the course of the year. In 24/25 318 devices reached end of life, the Trust will continue to recycle equipment as swiftly and efficiently as possible.
Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients by March 2025	Smoking status recording on admission decreased to 90.6% (1572/1636) from 92.8% (1569/1691) last month. The number with 'No Status Recorded' or 'Non Smoker History Unknown' is showing a month on month reduction, however the number of patients recorded as 'Unknown' is showing an increase to 121 admissions, equating to 7.0% of the total in April. Gateshead Health NHS FT has the highest performing Smoking Status Recorded on Admission the NENC ICB region (Q4 2024), this has been consistent for >12 months. Actions being taken to improve compliance are: Accurate smoking status questions on Nervecentre - Remove the 'unknown' option to align with NHS digital spec, process to remove this option is in progress. Training of all staff so that they are aware where the question is located in their Nervecentre profile - ongoing. Training on wards both ad hoc and planned is ongoing. Regular focussed training sessions on Tobacco Dependency. Ongoing Communication Strategy including regular updates via email, posters, screensaver, intranet, staff zone, staff Facebook. The Tobacco Dependency Treatment Service is providing weekend provision which is improving smoking status collection providing an equitable service for all patients with 7 day / week coverage.
Reduction in the wait for gynaecology outpatients to no more than 26 weeks by March 2025.	The median wait has continued to decrease since Nov 24 and currently at 29 weeks. Work continues with the clinical team to review OP pathways to maximise opportunity for additional new appointments. Consultant left post in April 25 and awaiting new replacement starting June 25. Job plans have been reviewed and signed off with changes enacted to clinic templates and structures to provide additional OP capacity.
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 weeks by March 2025	Current median wait has reduced to 60 weeks and overall waiting list size continues to decrease each month. Monitored weekly through Access & Performance meetings.

Strategic Objectives 2025/26

We will develop and expand our services within and beyond Gateshead

NHS Gateshead Health NHS Foundation Trust

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

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

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

Measures requiring focus this month

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. April external income is down compared to prior year - mainly due to an unusually high April income for the IT Procurement Framework in April 2024 which was not matched in April 2025.

NHS
Gateshead Health
NHS Foundation Trust

Constitutional Standards 2025/26

Reporting Period: April 2025

Constitutional standards 2025/26	Constitutional Standards metrics Assurance Heatmap

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

Constitutional Standards

Metrics

NHS Gateshead Health NHS Foundation Trust

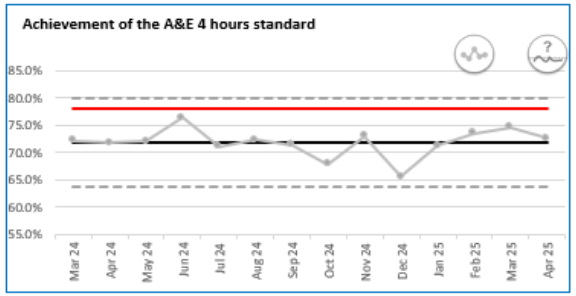
Metric	Target	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	Ass/Var
Achievement of the A&E 4 hour standard	>78%	72.2%	71.8%	72.0%	76.3%	71.0%	72.2%	71.4%	67.8%	73.0%	65.6%	71.2%	73.6%	74.5%	72.5%	
12 hour trolley waits (DTA to left department)	0	0	1	4	0	3	0	0	3	1	30	0	0	2	0	
% of ED attendances > 12 hours in department (Type 1) *Reset April 2025 to align with 2025/26 operational guidance definitions*	0.2%	3.6%	3.8%	4.1%	2.3%	5.4%	4.4%	4.4%	7.6%	5.1%	10.5%	5.2%	2.5%	0.7%	0.9%	
Ambulance handover delays 30-60 minutes	0	0	0	2	1	10	4	3	3	10	43	21	4	6	11	
Ambulance handover delays 60 minutes +	0	0	0	0	0	13	0	0	0	1	51	14	0	7	1	
Achievement of the RTT 18 week standard	>92%	67.9%	68.9%	70.6%	70.6%	70.3%	69.2%	68.6%	68.5%	69.2%	69.8%	70.6%	71.3%	71.0%	68.7%	
Achievement of the 52 week RTT standard	0	76	72	109	88	81	108	123	106	111	102	83	66	0	16	
Achievement of the 6 week diagnostic standard	>95%	91.2%	88.8%	86.0%	83.8%	84.7%	84.3%	86.4%	88.3%	86.8%	83.3%	81.4%	86.4%	82.6%	77.4%	
Achievement of the Cancer 28 day standard	>80%	81.1%	79.7%	82.1%	80.7%	80.5%	79.7%	77.7%	82.0%	83.2%	84.1%	77.0%	80.7%	80.5%	76.0%	
Achievement of the Cancer 31 day standard	>96%	97.9%	99.1%	100.0%	100.0%	98.9%	99.8%	100.0%	99.1%	98.5%	98.9%	99.4%	100.0%	100.0%		
Achievement of the Cancer 62 day standard	>75%	73.9%	75.7%	67.6%	71.4%	69.8%	74.7%	66.8%	81.0%	74.8%	75.6%	80.2%	81.0%	82.1%		

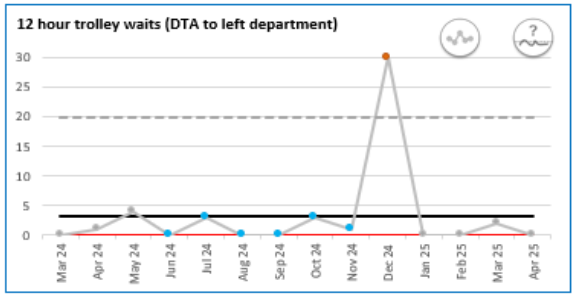
Validated data unavailable at time of report

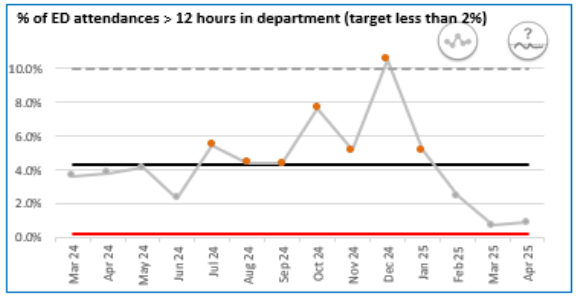
Constitutional Standards

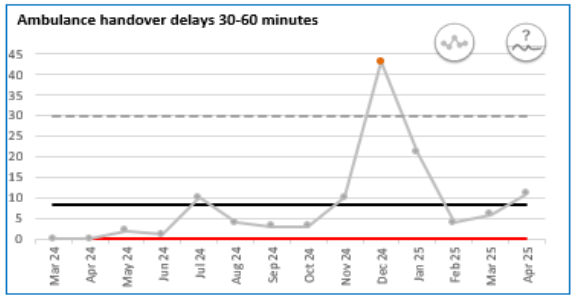
Metrics (SPC)

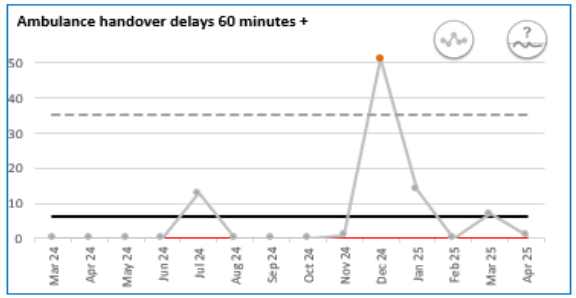
NHS Gateshead Health NHS Foundation Trust

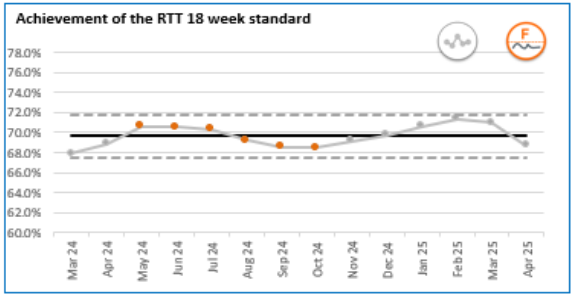


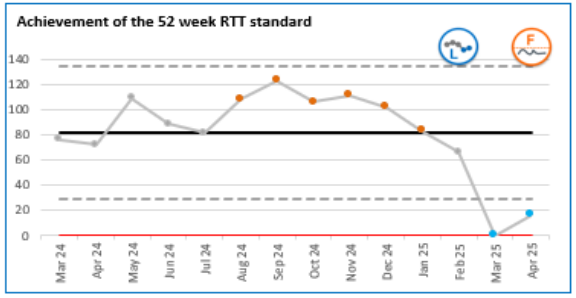


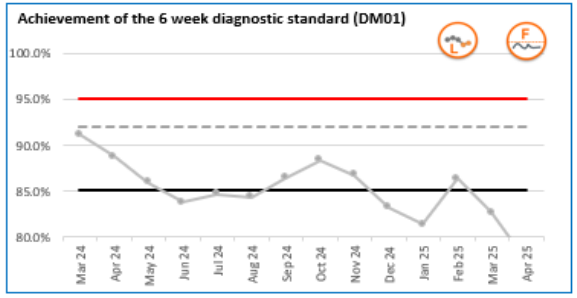


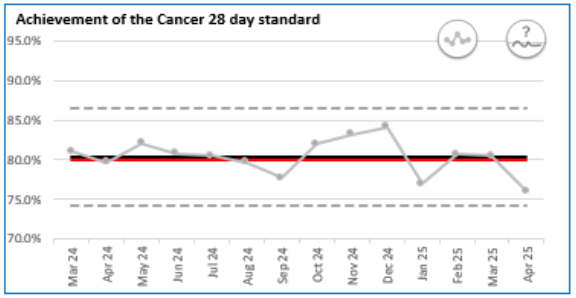


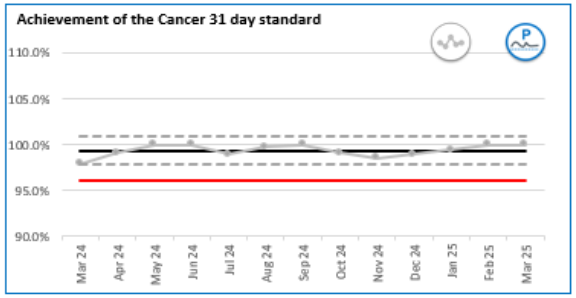


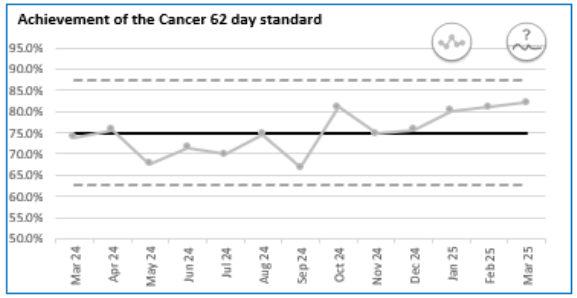












Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 15

Report Title:	**Maternity Integrated Oversight Report – April 2025**			
Name of Meeting:	Trust Board			
Date of Meeting:	Wednesday 21st May 2025			
Author:	Ms Abbie McCready, Lead Midwife for Risk and Patient Safety			
Executive Sponsor:	Dr Gill Findley, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Ms Karen Parker, Lead Midwife for Risk and Patient Safety/Head of Midwifery			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	This report presents a summary of the maternity indicators for the Trust from the month of April 2025			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Maternity Safecare 13/5/2025 SBU Ops Board 28/5/2025 Safecare Steering Group 20/5/2025 Trust Board 21/5/2025			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	**Maternity dashboard:** • In April 2025, there were 135 births, 0 MNSI cases and 0 perinatal losses. • Exceptions reported – positive outlier continues for breastfeeding rates & smoking. Lower rates of instrumental birth continue. • Moderate harm incidents – 0 incidents reported **Q4 PMRT (Perinatal Mortality Review Tool)** – scheduled quarterly report **Exception reporting:** • Positive external feedback received • Emerging risk #4726 – Women's Health Centre Workfroce			
Trust Strategic Aims that the report relates to:	**Aim 1** ☒	We will continuously improve the quality and safety of our services for our patients		

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

Trust corporate objectives that the report relates to:					
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks and DATIX reference)					
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐		**No** ☐		**Not applicable** ☒

Gateshead Health NHS Foundation Trust

Maternity Integrated Oversight Report

Maternity data from April 2025

Maternity IOR contents

- Maternity Dashboard 2025/26:
  - April 2025 data

- Exception reports:
  - Maternity dashboard exceptions

- Exception reports:
  - Risk 4726
  - Positive Exception

- Items for information:
  - Perinatal Mortality Review Tool (PMRT) – Q4 2024/25 reports

Maternity Oversight Report SPC Tool

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Births	Apr 25	135	-			163	122	203
Spontaneous vaginal deliveries	Apr 25	63	-			75	52	97
Assited births	Apr 25	72	-			88	56	120
Induction of Labour	Apr 25	46	-			59	31	87
Maternity Readmissions	Apr 25	3	-			3	-2	8
Neonatal Readmissions	Apr 25	2	-			5	-1	11
Smoking at time of booking	Apr 25	8.04%	15.00%		P	7.04%	0.23%	13.86%
Smoking at time of delivery	Apr 25	5.22%	6.00%		?	5.72%	-0.68%	12.12%
In area CO at booking	Apr 25	97.49%	90.00%		?	92.39%	78.68%	106.11%
In area CO at 36 weeks	Apr 25	86.51%	80.00%		?	83.42%	72.80%	94.04%
Admitted directly to NNU (SCBU) (>37 weeks)	Apr 25	6	4		?	7	-1	16
Percentage Admitted directly to NNU (SCBU) (>37 weeks)	Apr 25	4.62%	6.00%		?	4.75%	-0.89%	10.39%
Preterm birth rate <=36+6 weeks at birth	Apr 25	3.70%	6.00%		?	5.49%	-0.22%	11.20%
Continuity of Carer: Percentage placed on pathway (29 we	Mar 25	20.27%	-			17.09%	8.32%	25.87%
Continuity of Carer: Percentage from BAME backgrounds /	Mar 25	21.62%	-			26.52%	3.67%	49.37%
Spontaneous Vaginal Births (%)	Apr 25	46.67%	-			46.10%	34.38%	57.81%
Induction Rate	Apr 25	34.33%	-			36.52%	24.97%	48.07%
Instrumental Delivery Rate	Apr 25	9.70%	-	↓		12.74%	4.99%	20.49%
Elective C Section Rate	Apr 25	22.96%	-			18.78%	9.76%	27.80%
Emergency C Section Rate	Apr 25	20.74%	-			22.59%	12.71%	32.47%
C Section Rate	Apr 25	43.70%	-			41.37%	31.03%	51.71%
3rd or 4th degree tear (Total) Precentage	Apr 25	2.24%	3.00%		?	1.19%	-1.41%	3.79%
Massive PPH >=1.5L (All births)	Apr 25	5	2		?	8	0	16
Breastfeeding: Percentage of Initiated Breasfeeding	Apr 25	76.87%	66.20%		P	78.28%	68.73%	87.83%
Breastfeeding: Breasfeeding at Discharge (Transfer to Com	Apr 25	61.07%	56.20%		?	60.41%	47.42%	73.40%

Safe

Responsive

Maternity

NHS

Gateshead Health

NHS Foundation Trust

Maternity Dashboard 2024/245

Maternity Dashboard 2024/25

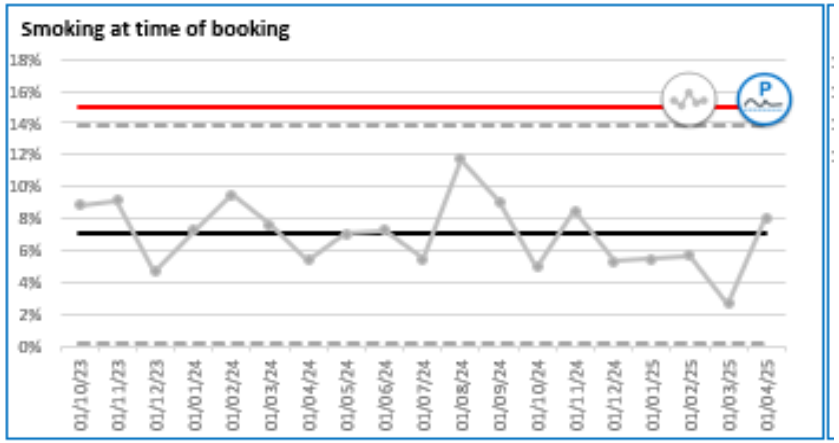
Maternity

NHS

Gateshead Health
NHS Foundation Trust

Safe

Responsive



- **Background**
  - Decrease in smoking at booking rates over previous quarter
  - NHS Long Term Plan ambition to reduce smoking at time of delivery (SATOD) rates to <6% by 2030
- **Assessment**
  - Significant Increase in April
- **Actions**
  - Continue to monitor
  - Agree target for improvement with LMNS for Element 1 of Saving Babies Lives Care Bundle
- **Recommendations**
  - Continue to implement Element 1 of SBLCBv3.2
  - Submit Quarterly findings to LMNS for SBL assurance

Maternity Dashboard 2024/25

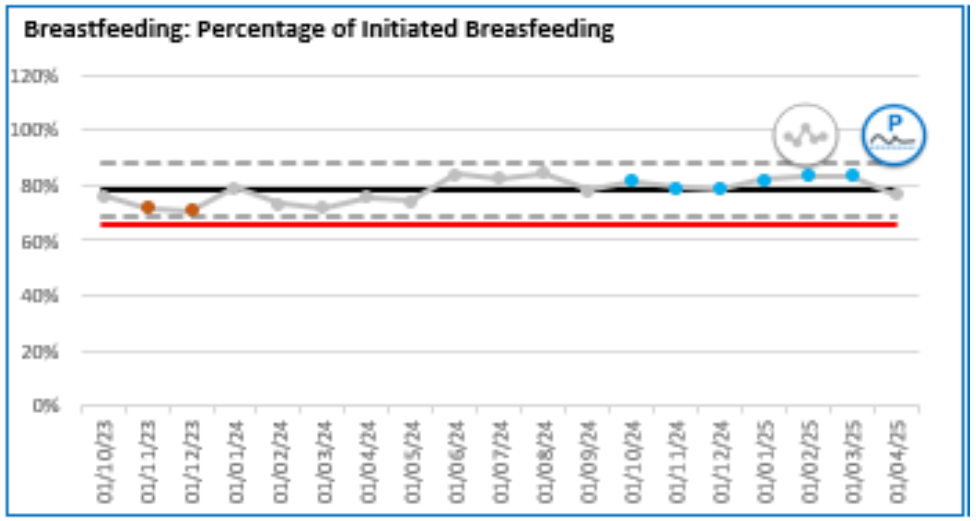
Maternity

NHS

Gateshead Health
NHS Foundation Trust

Safe

Responsive



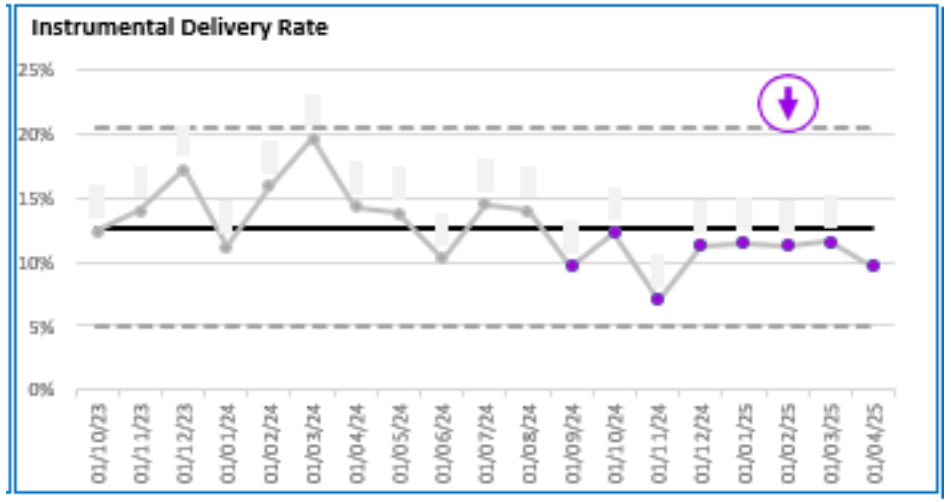
- **Background**
  - Breastfeeding rates are audited as part of the UNICEF standards
- **Assessment**
  - Initiation rates demonstrate sustained improvement over last 6 months - slight decrease in April
- **Actions**
  - Continue to sustain target initiation of breastfeeding
  - Working with system partners to share expertise & develop collaborative infant feeding strategy
- **Recommendations**
  - To work towards UNICEF Stage 3 for Maternity & Stage 1 for Neonatal services as per NHS 3-year delivery plan for Maternity & Neonatal services
  - "We will implement the Maternity and Neonatal Three Year Delivery Plan“ as one of Gateshead Health Quality priorities for 2025/26
  - QIP relating to early breast milk for preterm infants & improvement in feeds <1 hour of birth

Responsive

Gateshead Health NHS Foundation Trust

Maternity Dashboard 2024/25

Safe



- **Background**
  - Instrumental deliveries recorded via Badgernet
- **Assessment**
  - Sustained decrease in instrumental delivery rate for previous 6 month with a slightly further decrease in April.
- **Actions**
  - Continue to monitor as per dashboard
- **Recommendations**
  - Instrumental delivery rate to continue to be monitored via dashboard
  - Failed instrumental deliveries or deliveries requiring more than one instrument will continue to be reported via InPhase and review appropriately.

2025/26			April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Number of perinatal losses			0											
Number of MNSI cases			0											
Number of incidents logged as moderate harm or above			0											
Minimum obstetric safe staffing on labour ward			100%											
Minimum midwifery safe staffing including labour ward (average fill rates)		Day shift												
		Night shift												
		CHP PD*												
Service user feedback	FFT “Overall how was your experience of our service” – total score for very good and good responses		100%											
	Complaints		2											
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust			0											
Coroner Reg 28 made directly to Trust			0											

Exception Report – Risk 4726

Woman's Health Centre Workforce- Grade rating 12

Safe

Gateshead Health NHS Foundation Trust

What is the risk?	**There is not a calculated or sufficient workforce model in place to support all the services that are required to be delivered from the WHC. The WHC provides a wide variety of clinics from the QE site and Blaydon including antenatal care, gynae, RAC, EPAC, urogynae, scanning. Clinics have increased in number and capacity on an drift basis with no review of staffing required to support these, in particular from a HCA & clinic manager resource. There are a number of temporary HCA staff in post yet remains "over-recruited" compared to funded establishment, clinical midwifery time is providing an admin management function and there are insufficient rooms or support available to meet current demand. Services within WHC are core deliverables and need to be sustained.**
Existing Controls	• **Temporary contracts extended on month-by-month basis** • **Use of bank staff to fill gaps in rotas** • **BR+ provides workforce required for delivering maternity care, no tool available to support planning for other services delivered.**
Assurance	• **Audit of demand activity and workforce required to be commenced and compare with general adult outpatients model.** • **Current HCA workforce work flexibly to support all services and sites as needed.** • **Task & finish group established to review staffing model & make recommendations**
Gaps in Controls	• **Members of current staff requesting to reduce working hours/flexi-retire due to impact of workload - if unable to recruit to replace will result in additional bank requests**

Positive Exception Reporting

Safe

NHS Gateshead Health NHS Foundation Trust

Positive feedback received about Sarah Browbank and the new service improvement.

Service Improvement	• **Improve the supply of medication for pregnant women in conjunction with local pharmacies.**
Feedback	1. Strategic Head of Medicines Optimisation for Newcastle-Gateshead commented on the great work you've done to improve the supply of medication for pregnant women in conjunction with local pharmacies. This is fantastic – well done and thank you! 2. Sarah is our brilliant Women's Health and Paediatric Pharmacist. 3. This a very clear and will help clarify the provision of medication to pregnant patients in the community enormously. Sarah has revolutionised huge aspects of our service since starting in the department and we are so grateful to her! 4. Sarah is invaluable & a brilliant addition to our team.

Exception reporting by schedule

Caring Responsive Safe Maternity

Gateshead Health NHS Foundation Trust

Perinatal Mortality Review Tool (PMRT) – Q4 2024/25 reports

Number of Completed Cases in this Quarter (see notes)		**2**	**Number of meetings held**	**2**	**% of meetings external reviewer present**	**100%**
Any issues with MIS compliance for reporting		N/A				
Number of Cases Graded C or D in Quarterly PMRT Meetings		0	**Number of these cases referred / or under investigation as PSII or MNSI**	0		
Number of cases where issues associated with FGR Management Identified	**0**	**Actions Taken and Learning Shared**				
Number of cases where issues associated with RFM Management Identified	0	**Actions Taken and Learning Shared**				
Number of cases where prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	0	**Actions Taken and Learning Shared**				
Other Themes and Actions from PMRT Cases: ***Please also detail any specific themes/actions relating to socioeconomic deprivation and ethnicity.***		-LFT bloods added to IUD package on ICE -Location of maternity unit in relation to main theatres				

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 16

Report Title:	**Nursing Staffing Exception Report**			
Name of Meeting:	Board of Directors Part 1			
Date of Meeting:	21st May 2025			
Author:	Helen Larkin, Clinical Lead E-rostering			
Executive Sponsor:	Gillian Findley, Chief Nurse, Deputy CEO and Professional Lead for Midwifery and AHPs			
Report presented by:	Gillian Findley, Chief Nurse, Deputy CEO and Professional Lead for Midwifery and AHPs			
Purpose of Report	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	This report is to provide assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis to provide adequate staffing levels.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by:				
Key issues:	This report provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls within the month of April 2025. April has demonstrated some areas with staffing challenges relating to sickness absence and enhanced care requirements. During April, we continued to experience periods of increased patient activity with surge pressure resulting in escalation areas open in Ward 11. Additionally escalation beds continue to be open on wards 9, 10, 12, 22, 24 and 25. This has affected staffing resource. There is continued focused work around the retention of staff and managing staff attendance. Wards where staffing fell below 75% of the funded establishment are shown within the paper. Detailed context and actions taken to mitigate risk are			

<table>
<tr><td></td><td colspan="5">documented. A staffing escalation protocol is now in operation across all areas within the organisation and assurance of this operating as expected, is provided by the number of staffing incident reports raised through the incident reporting system.</td></tr>
<tr><td>Recommended actions for this meeting:</td><td colspan="5">The Group is asked to:
• receive the report for assurance
• note the work being undertaken to address the shortfalls in staffing</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
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<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5"></td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☐</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks and DATIX reference)</td><td colspan="5">There were 14 nurse-staffing incidents raised via InPhase during the month of April, of which four reported low physical harm, eight incidents recorded low psychological harm.</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

Gateshead Health NHS Foundation trust
Nursing and Midwifery Staffing Exception Report
April 2025

1. Introduction

This report details the staffing exceptions for Gateshead Health NHS Foundation Trust during the month of April 2025. The staffing establishments are set by use of the Safer Nursing Care staffing tool (SNCT). This is a recognised, nationally used evidence-based tool that matches the acuity of patients with the staffing requirements for acute medical and surgical wards. Mental health Services use the Mental Health Optimal Staffing Tool (MHOST) and Maternity use the Birth Rate Plus tool. These are reported to Quality Governance Committee and the Trust Board separately.

2. Staffing

The actual ward staffing against the budgeted establishments from April are presented in Table 1. Whole Trust wards staffing are presented within this report in appendix 1, broken down into each ward areas staffing. In addition, the Trust submit monthly care hours per patient day (CHPPD) as a national requirement to NHS Digital.

Table 1: Whole Trust wards staffing April 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 (%)**
88.3%	**86.9%**	**98.2%**	**96.7%**

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

Exceptions:

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

Safer Nursing Care Tool (SNCT) data collection is usually completed bi-annually in January and July each year. Patient acuity and dependency data is triangulated with key performance indicators and professional judgement templates in line with the Developing Workforce Safeguards and Safe Staffing Recommendations (NHSi 2018). A revised SNCT tool has been introduced, which incorporates 1-1 enhanced care requirements along with considerations for single side room environments to support establishment reviews. Data collection is completed on a six-monthly basis, with the most recent collection haven taken place in January 2025.

Contextual information and actions taken

Critical Care reported a reduction in Registered Nursing workforce for dayshift, at 72.1%. The team report they have one VCF awaiting approval. They are currently holding three Band 5 posts for two displaced nurses and one who is on secondment, due to return in August. There are three supernumerary band 5s, three band 5s on long-term sick, two Band 7s on long-term sick, one band 6 on long-term sick, two HCAs on short term sick. Throughout the month of April there were twelve re-deployments both qualified and HCAs. Three shifts were placed out to bank, two of which were covered.

SCBU report Registered Nurse fill rates of 70.2% during the month of April, this is 4% less than previous month. There were 3 members of Registered staff on long-term sick with a further one member on maternity leave. To mitigate against risk senior nurses worked clinically on the unit and shifts were sent to bank with almost 50% getting covered. One nurse staffing related Inphase was raised and zero red flags.

Ward 28 report a registered nurse fill rate of 67.5% for days. This position is improved from the month of March. Ward 28 continues to have two WTE on Maternity leave. The Ward Manager ensured staffing levels were safe and relative to the occupancy and acuity levels throughout the month.
Additionally Ward 28 demonstrate HCA fill rates days at 35.6% and 40% for nights. Healthcare assistants (HCA) were rostered relative to the peaks in activity. There is a noted 6.8 WTE vacancies within their non-registered workforce; however, a review of their nursing establishment is planned following the January SNCT process.
CHPPD for Ward 28 is 19.8, which demonstrates higher than the Trust average and an increase from March.

Cragside Court report 58.9% fill rates for Registered Nurse nightshifts. Mitigations for safer staffing were with additional HCA staff rostered at night to support dependency and enhanced observations the fill rate for HCAs at night was 179.8%. They also operate with a model that has one qualified nurse who works between the two units of Cragside and Sunniside, Sunniside report a qualified nurse fill rate of 117.3% and were also slightly over with HCAs at 123% .

Ward 21 T&O has had another challenging month for HCSW dayshifts with four staff on long-term sick, multiple episodes of short-term sickness and two staff on maternity. The ward have mitigated against this utilising and efficiently rostering the over established qualified staff to cover the shortfalls. Help was also sought from Ward 28 through redeployment and utilising the nurse bank.

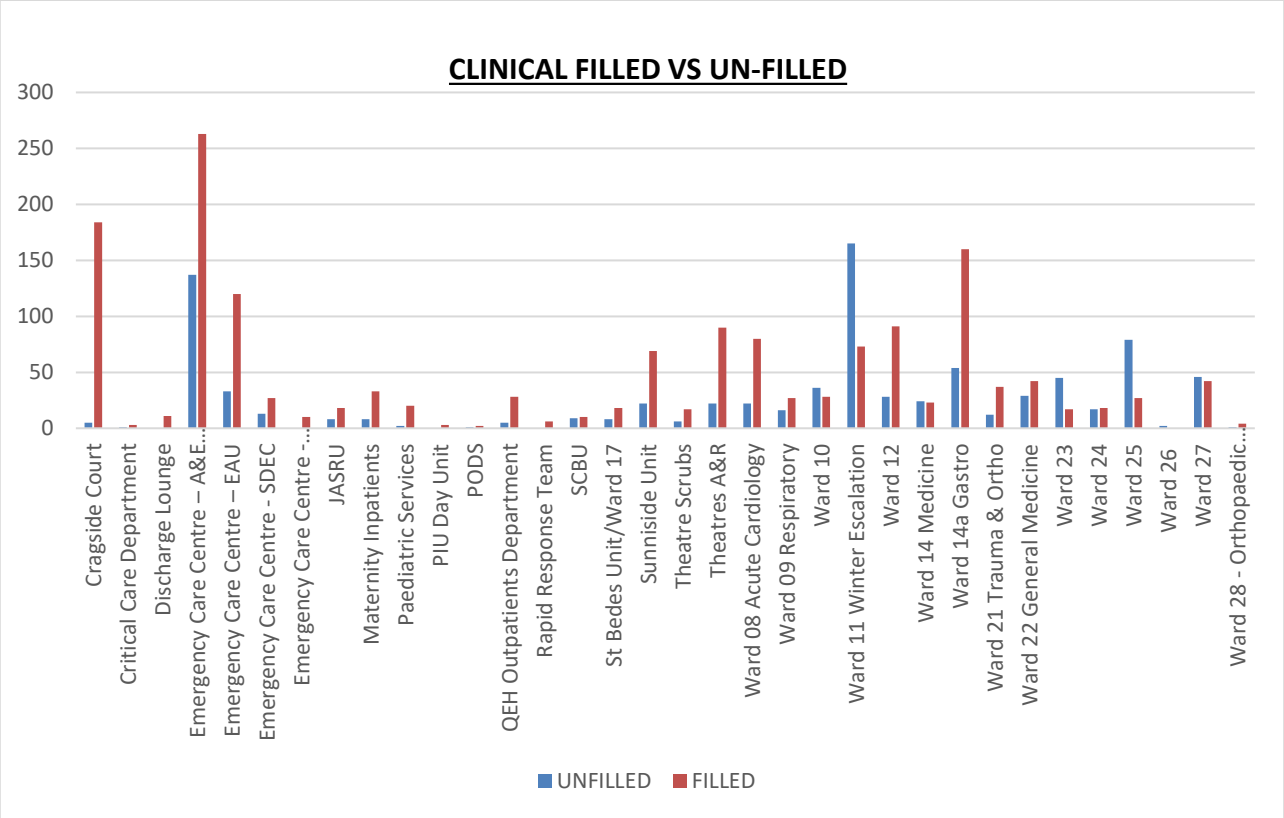
Ward 23 report Healthcare support worker days at 57.8%, during April there were two staff members on long-term sick and one on Maternity leave.

Ward 22 report HCSW Night fill rate of 71.7%, they report vacancy within the team and one member of staff on Maternity leave. Bank shifts were raised to mitigate against this and shortfalls were escalated as per policy.

Ward 25 demonstrated 74.3% for Healthcare support worker nights. They currently have Band 3 vacancies. Four members of staff had long-term sickness during April. In addition, a number of staff had episodes of short-term sickness and one member of staff on maternity leave. Unfilled duties were sent to bank however many remained unfilled. Ward 25 raised two nurse staffing related inphases and 20 red flags. The ward manager during the month of April was required to

move healthcare staff from night shift to dayshift to ensure a safe level of cover across dayshift and nightshift.

Below is a chart for April which highlights number of shifts both filled and not filled per clinical area.



Incidents related to nurse staffing raised via Inphase and as a Red Flag are still demonstrated within the paper to highlight any identified concerns related to safer staffing within the department.

The exceptions to report April are as below:

April 2025	
Registered Nurse Days	**%**
Critical Care	72.1%
SCBU	70.2%
Ward 28	67.5%
Registered Nurse Nights	**%**
Cragside Court	58.9%
Healthcare Support Worker Days	**%**
Ward 21	64.2%
Ward 23	57.8%
Ward 28	35.6%
Healthcare Support Worker Nights	**%**
Ward 22	71.7%
Ward 25	74.3%
Ward 28	40.0%

In April, the Trust worked to the agreed clinical operational model, which meant at times some wards listed above had lower patient occupancy and staff were redeployed appropriately to areas with the greatest clinical need. Throughout April, areas of deficit were escalated as per staffing policy and mitigations were put in place by the Matron teams using professional judgement as to the acuity and demand in each area, which included:

- Redeployments of Registered Nurses and HealthCare assistants on a daily and at times hourly basis between wards according to patient acuity and demand.
- Concentrated support from the Matrons and the People and Organisational Development team to address the sickness absence levels within the divisions and to recruit to vacant posts.

3. Care Hours Per Patient Day (CHPPD)

Following the Lord Carter Cole report, it was recommended that all trusts start to report on CHPPD this is to provide a single consistent way of recording and reporting deployment of staff working on inpatient wards/units. It is calculated by adding the hours of registered nurses to the hours of support workers and dividing the total by every 24 hours of inpatient admissions. CHPPD is relatively stable month on month, but they can show variation due to a number of factors including:

- Patient acuity and dependency
- Patients required enhanced care and support
- Bed occupancy (activity)

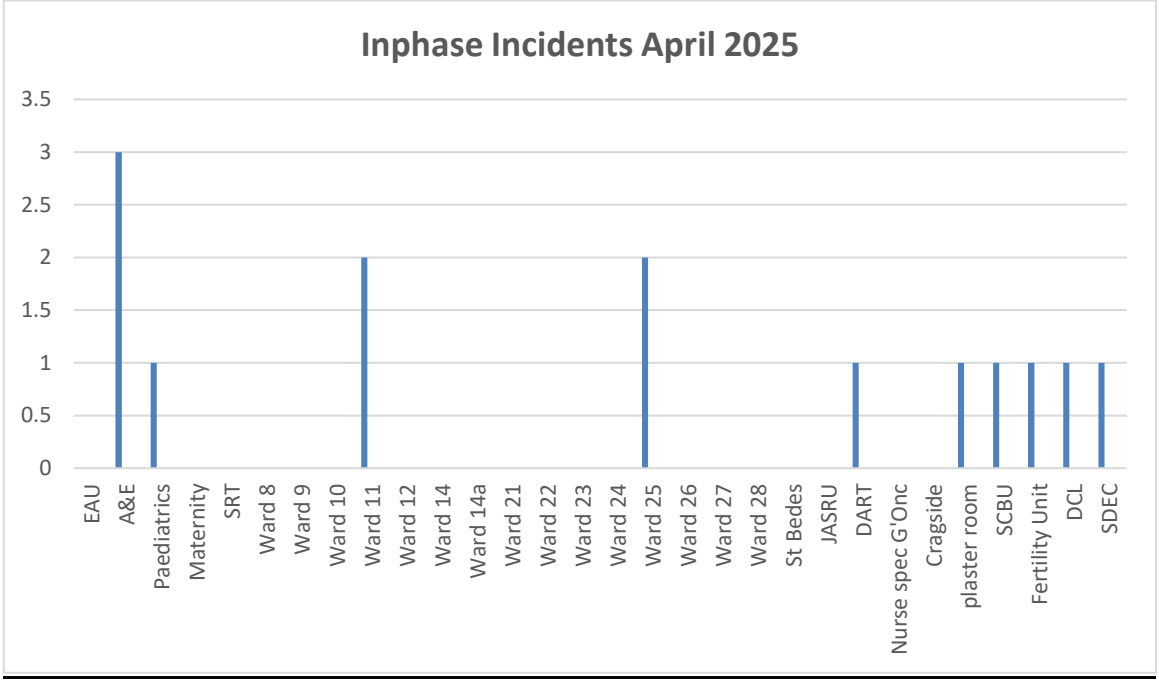
Following discussion with the National Safer Staffing faculty, it was recommended CHPPD is an unsuitable metric for Paediatric services, therefore has been removed from this report. This is due to the model of care including Emergency department care and outpatient services. The CHPPD metric accounts for patients occupying a bed at midnight, therefore providing an unwarranted depiction of their current care delivery.

Ward level CHPPD is outlined in Appendix 1. For the month of April, the Trust total CHPPD was 7.6. This compares slightly lower when benchmarked with other peer-reviewed hospitals.

4. Monitoring Nurse Staffing via Incident Reporting system

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

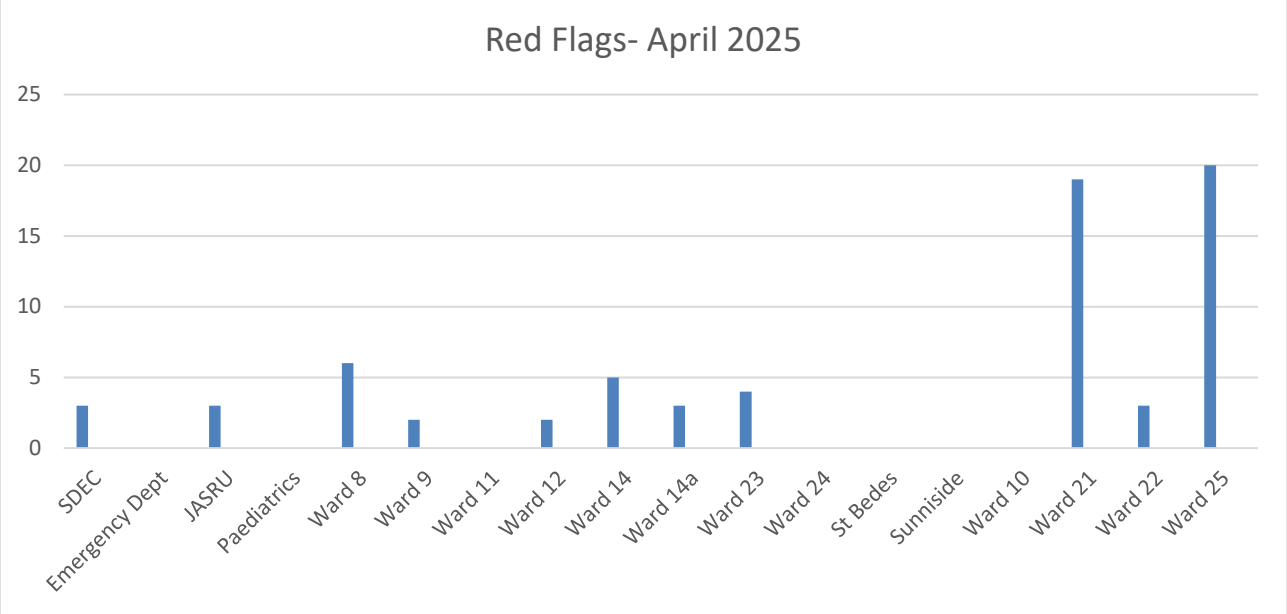
There were fourteen reported Nurse staffing incidents raised via InPhase.



Nursing Red Flags

The National Institute for Health and Care Excellence (NICE) guideline for Safe Staffing for nursing in adult inpatient wards in acute hospitals (2014) recommend the use of nursing Red Flag reporting. A Nursing red flag can be raised directly because of rostering practice/shortfall in staffing or by the nurse in charge if they identify a shortfall in staffing requirements resulting in basic patient care not able to be delivered. Throughout the month of April there were 70 nursing red flags reported. This compares to 62 red flags reported in March. Additional to raising a red flag on the system, the owner of the red flag escalates this timely to the Matron of senior nurse for mitigation.

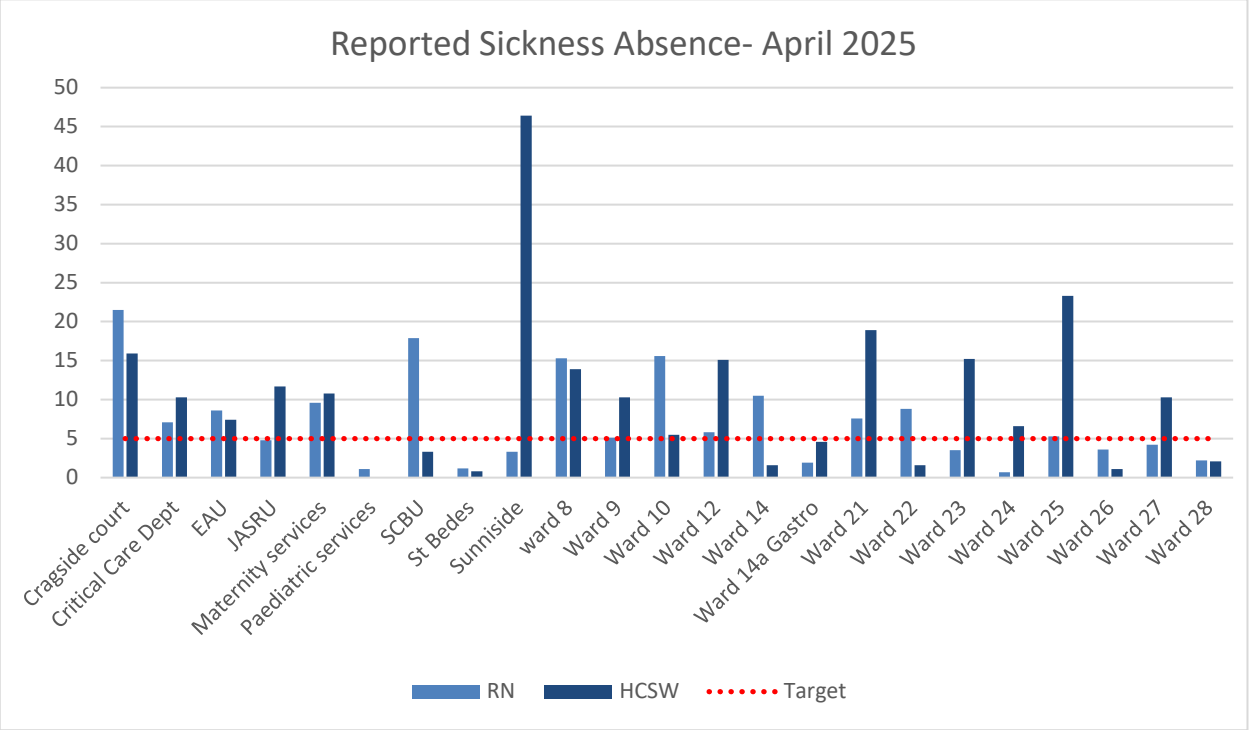
The graph below outlines the number of red flags raised per department through the month of April.



The Red Flags raised by areas that also report a fill rate below 75% were:- Ward 14 with 11 Red Flags, all of which were raised during daytime hours, five of these were for missed intentional rounding, four demonstrate a shortfall in RN time and on two occasions there was delay in providing pain relief. JASRU raised five Red Flags; three were due to missed intentional rounding and on two occasions because there was shortfall in RN time. Ward 21 raised one red flag due to a level 2 patient. Ward 22 also raised one Red Flag overnight for missed intentional rounding.

5. Attendance of Nursing workforce

The below table displays the percentage of sickness absence per staff group for April. Data is extracted from Health Roster.



6. Governance

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

7. Conclusion

This paper provides an exception report for nursing and midwifery staffing for April 2025, outlining ongoing work to present triangulated workforce metrics. Collaborative work is underway to provide monthly dashboard metrics, triangulating vacancy, sickness absence, and bank spend with ward quality measures and patient safety.

8. Recommendations

The Board is asked to receive this report for assurance.

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

Appendix 1- Table 3: Ward by Ward staffing April 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	↑ 98.9%	↑ 109.5%	↓ 58.9%	↑ 179.8%	↑ 273	↓ 5.9	↓ 10.3	↓ 16.2
Critical Care Dept	↑ 72.1%	↓ 76.9%	↑ 98.0%	↓ 84.0%	↓ 249	↑ 30.2	↓ 3.4	↑ 33.6
Emergency Care Centre - EAU	↑ 82.6%	↑ 91.9%	↓ 94.1%	↑ 91.1%	↓ 1339	↑ 5.5	↑ 4.0	↑ 9.4
JASRU	↓ 91.5%	↑ 80.8%	↑ 105.6%	↑ 88.4%	↓ 590	↓ 3.6	↑ 3.7	↑ 7.2
Maternity Unit	↓ 80.2%	↑ 110.1%	↑ 98.4%	↑ 94.6%	↓ 515	↑ 15.2	↑ 5.0	↑ 20.2
Special Care Baby Unit	↓ 70.2%	↑ 128.3%	↓ 109.1%	↑ 90.0%	↓ 97	↑ 18.4	↑ 5.0	↑ 23.4
St. Bedes	↑ 97.4%	↑ 95.3%	→ 101.8%	↓ 109.1%	↓ 285	↑ 5.6	↑ 3.9	↑ 9.5
Sunniside Unit	↑ 98.4%	↓ 99.8%	↑ 117.3%	↑ 123.0%	↑ 288	↓ 6.2	↓ 4.4	↓ 10.6
Ward 08	↑ 99.4%	↓ 82.0%	↑ 101.7%	↓ 97.5%	↑ 613	↑ 4.5	↓ 2.6	↑ 7.1
Ward 09	↑ 90.2%	↓ 82.8%	↓ 103.7%	↑ 94.3%	↑ 840	↓ 2.5	↓ 1.9	↓ 4.4
Ward 10	↑ 78.8%	↑ 88.5%	↑ 102.1%	↑ 108.3%	↑ 758	↓ 2.5	→ 2.3	↓ 4.8

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Ward 12	95.1%	107.1%	103.2%	101.4%	768	2.8	2.5	5.3
Ward 14 Medicine	75.6%	106.9%	76.9%	101.6%	733	3.0	2.7	5.7
Ward 14a Gastro	113.4%	123.4%	96.2%	137.2%	764	3.1	3.1	6.2
Ward 21 T&O	119.6%	64.2%	101.5%	99.7%	819	3.6	2.5	6.2
Ward 22	93.0%	84.2%	99.6%	71.7%	897	2.6	2.3	4.9
Ward 23	94.1%	57.8%	130.8%	77.9%	703	3.0	2.1	5.1
Ward 24	104.2%	78.2%	93.5%	84.8%	909	2.7	2.3	4.9
Ward 25	95.6%	85.7%	97.0%	74.3%	888	2.6	2.4	5.0
Ward 26	109.3%	94.9%	104.6%	98.9%	804	3.3	2.7	6.0
Ward 27	112.7%	76.5%	99.7%	108.0%	825	3.2	2.3	5.6
Ward 28	67.5%	35.6%	102.9%	40.0%	107	13.9	5.8	19.8
QUEEN ELIZABETH HOSPITAL - RR7EN	**88.3%**	**86.9%**	**98.2%**	**96.7%**	**14064**	4.5	3.0	7.6

Meeting:	Trust Board
Chair:	Alison Marshall
Financial year:	2025/26

	Lead	Type of item	Public/Private	May-25	25 June 25 (year end only)	Jul-25	Sep-25	Nov-25	Jan-26	Mar-26
Standing Items			Part 1 & Part 2							
Apologies	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√	√	√
Declaration of interests	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√	√	√
Minutes	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Action log	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Matters arising	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Chair's Report	Chair	Standing Item	Part 1	√		√	√	√	√	√
Chief Executive's Update Report	Chief Executive	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Cycle of Business	Company Secretary	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Patient & Staff Story	Company Secretary	Standing Item	Part 1	√		√	√	√	√	√
Questions from Governors	Chair	Standing Item	Part 1	√		√	√	√	√	√
Items for Decision			Part 1 & Part 2							
Annual Declarations of Interest	Company Secretary	Item for Decision	Part 1							√
Approval of new Strategic Objectives	Director of Strategy and Partnerships	Item for Decision	Part 1		√					√
Board Assurance Framework - approval of opening position	Company Secretary	Item for Decision	Part 1			√				
Board Assurance Framework - approval of closing position	Company Secretary	Item for Decision	Part 1			√				√
Standing Financial Instructions, Delegation of Powers, Constitution and Standing Orders - annual review	Company Secretary / Group Director of Finance	Item for Decision	Part 1			√				
Calendar of Board Meetings	Company Secretary	Item for Decision	Part 1					√		
Winter Plan	Chief Operating Officer	Item for Decision	Part 1				√			
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							√
CQC Statement of Purpose and Registration	Chief Nurse	Item for Decision	Part 1							√
Items for Assurance			Part 1 & Part 2							
Board Committee Assurance Reports	Committee Chairs	Item for Assurance	Part 1	√		√	√	√	√	√
Board Assurance Framework - updates	Company Secretary	Item for Assurance	Part 1	√			√		√	
Organisational Risk Register	Chief Nurse	Item for Assurance	Part 1	√		√	√	√	√	√
Annual Staff Survey Results	Group Director of People & OD	Item for Assurance	Part 1 & Part 2						√	√
Finance Report	Group Director of Finance	Item for Assurance	Part 1	√		√	√	√	√	√
Strategic Objectives and Constitutional Standards Report	Group Director of Finance	Item for Assurance	Part 1	√		√	√	√	√	√
Maternity Integrated Oversight Report	Chief Nurse	Item for Assurance	Part 1	√		√	√	√	√	√
Maternity Staffing Report	Chief Nurse	Item for Assurance	Part 1	√						
Nurse Staffing Exception Report	Chief Nurse	Item for Assurance	Part 1	√		√	√	√	√	√
Bi-annual Inpatient Safer Nursing Care Staffing Report	Chief Nurse	Item for Assurance	Part 1	deferred		√		√		
Learning from Deaths (quarterly report)	Group Medical Director	Item for Assurance	Part 1	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				√		√	
WRES and WDES Report	Group Director of People & OD	Item for Assurance	Part 1				√			
Green Plan	QEF Managing Director	Item for Assurance	Part 1	deferred		√				
Board Walkabout Feedback	Chief Nurse	Item for Assurance	Part 1	√		√	√	√	√	√
Great North Healthcare Alliance Progress Report	Director of Strategy and Partnerships	Item for Assurance	Part 1 & Part 2	√		√	√	√	√	√
Items for Information			Part 1 & Part 2							
Register of Official Seal	Company Secretary	Item for Information	Part 1				√			
Ad Hoc Items (i.e. items emerging during the year)			Part 1 & Part 2							
Organisational Structure - Clinical Leadership GHLG Apr 2026	Group Medical Director	Item for Assurance	Part 1							
Cyber Assurance Framework report	Group Director of Finance	Item for Assurance	Part 1				√			
Charitable Funds Audited Financial Performance	Group Director of Finance	Item for Board of Trustees	Part 1						√	