AGENDA

Gateshead Health
NHS Foundation Trust

Board of Directors (Part 1 – Public)

A meeting of the Board of Directors (Part 1 – Public) will be held at 12:30pm on Friday 5th December 2025, in Room 3, Education Centre, Queen Elizabeth Hospital / via Microsoft Teams

AGENDA

No	Item	Purpose	Lead	Paper / Verbal
1.	Welcome	Information	Chair	Verbal
2.	Declarations of interest	Information	Chair	Verbal
3.	Apologies for absence	Information	Chair	Verbal
4.	Minutes of the last meeting held on 25 September 2025	Decision	Chair	Paper
5.	Action log and matters arising	Assurance / decision	Chair	Paper
6.	Top Organisational Risks	Information	Chair	Paper
	None at this time			
7.	Chair's Report	Assurance	Chair	Paper
8.	Acting Chief Executive's Report	Assurance	Acting Chief Executive	Paper
9.	Great North Healthcare Alliance Progress Report	Assurance	Company Secretary	Paper
10.	Governance Reports:			
	i) Organisational Risk Register	Assurance	Interim Chief Nurse	Paper
11.	Assurance from Board Committees:			
	i) Finance and Performance Committee – October and November 2025	Assurance/ Decision	Chair of the Committee	Paper
	ii) Quality Governance Committee – November 2025	Assurance	Chair of the Committee	Paper
	iii) Digital Committee – November 2025	Assurance	Chair of the Committee	Paper
	iv) People and Organisational Development Committee – September and November 2025	Assurance	Chair of the Committee	Paper
12.	Finance Report	Assurance	Group Director of Finance	Paper
13.	Strategic Objectives and Constitutional Standards Report	Assurance	Group Director of Finance	Paper
14.	Learning from Deaths Quarterly Report (Quarters 1 and 2)	Assurance	Group Medical Director	Paper
15.	Maternity Integrated Oversight Report	Assurance	Associate Director of Midwifery/SCBU	Paper
	i) Maternity Safety Champion Report	Assurance	Maternity Safety Champion	Paper
16.	Nurse Staff Exception Report	Assurance	Interim Chief Nurse	Paper
17.	Cycle of Business 2025/26	Information	Company Secretary	Paper

No	Item	Purpose	Lead	Paper / Verbal
18.	Questions from Governors in Attendance	Discussion	Chair	Verbal
19.	Any Other Business	Discussion	Chair	Verbal
20.	Date and Time of Next Meeting – 9:30am on Wednesday 28th January 2026	Information	Chair	Verbal

1. Welcome

Presented by the Chair

2. Declaration of Interest

Presented by the Chair

3. Apologies for Absence

Presented by the Chair

4. Minutes of the Meeting Held on 25 September 2025

Presented by the Chair

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Board of Directors (Part 1 – Public)

Minutes of a meeting of the Board of Directors (Part 1) held at 9.30am on Thursday 25th September 2025 in Rooms 9&10, Education Centre, Queen Elizabeth Hospital and via MS Teams.

Name	Position
Members present	
Mrs Alison Marshall	Chair
Mr Andrew Besford	Non-Executive Director
Mr Gavin Evans	Managing Director for QE Facilities
Dr Sean Fenwick	Acting Chief Executive
Dr Gill Findley	Deputy Chief Executive / Chief Nurse
Mr Neil Halford	Medical Director of Strategic Relations
Dr Carmen Howey	Group Medical Director
Mr Robert Hughes	Non-Executive Director
Mrs Kris Mackenzie	Group Director of Finance
Dr Gerry Morrow	Non-Executive Director
Mrs Hilary Parker	Non-Executive Director
Mrs Maggie Pavlou	Vice Chair / Non-Executive Director
Mrs Amanda Venner	Group Director of People & Organisational Development
Attendees present	
Mrs Jennifer Boyle	Company Secretary
Ms Nicola Bruce	Director of Strategy and Partnerships (25/09/10)
Mrs Helen Fox	Head of Communications and Engagement
Mrs Karen Parker	Associate Director of Midwifery and Special Care Baby Unit
Ms Diane Waites	Corporate Services Assistant
Mrs Pauline Wetton	Patient (25/09/07)
Governors and Observers	
Mr Steve Connolly	Lead Governor
Mr Michael Loome	Deputy Lead Governor
	3 x Members of Keep our NHS Public North East group
Apologies	
Mr Adam Crampsie	Non-Executive Director
Mr David Elliott	Chief Digital Officer
Mrs Joanne Halliwell	Group Chief Operating Officer
Mr Martin Hedley	Non-Executive Director / Senior Independent Director

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25/09/01	**Chair's Business:** The meeting being quorate, Mrs A Marshall, Chair, declared the meeting open at 9.30 am and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. She welcomed those present including the Trust Governors and observers. Mrs Marshall highlighted that this will be the first public Board meeting for Sean Fenwick as Acting Chief Executive and Rob Hughes as Non-Executive Director.	

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	This will also be the last meeting for Mrs Marshall as her term of office ends on 30th September 2025. Sir Paul Ennals will take up the post of Chair from 1st October 2025.	
25/09/02	**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.	
25/09/03	**Apologies for Absence:** Apologies were received from Mr A Crampsie, Mrs J Halliwell and Mr M Hedley.	
25/09/04	**Minutes of the Previous Meeting:** The minutes of the meeting of the Board of Directors held on Wednesday 30th July 2025 were approved as a correct record.	
25/09/05	**Action Log and Matters Arising from the Minutes:** The Board reviewed the action tracker as below: • Action 24/09/08 and Action 24/09/09 relating to updating the Standing Orders and Scheme of Delegation to reflect changes to Terms of Reference and National Pay Award. Updates have now been made and the Corporate Governance Manual is included on the agenda with a recommendation from the Audit Committee to approve the changes. Action agreed for closure. • Action 25/03/17 relating to further discussion taking place at a Board Development Day in relation to system support around complex employment cases. This action was reopened at the last meeting until the session is rescheduled. 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.	
25/09/06	**Top Organisational Risks:** The top organisational risks were noted as follows: • **Risk 4694 (Finance)**. Risk that the Trust will not achieve its revenue plan for 2025-26 and a deterioration from the 2024-25	

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	planned deficit, resulting in a deterioration to the Trust's NHS Oversight Framework rating. (Risk Score 20) • **Risk 4704 (Digital)** Risk of failure to review appropriate clinical information due to multiple sources and lack of interoperability of data stored across a variety of digital systems and in paper format. This could result in patient harm or sub optimal care. (Risk Score 16) • **Risk 4417 (POD)** Risk that promoting an environment that encourages speaking out and creating a psychologically safe culture has led to increased reports of poor behaviour. This could have a negative impact on staff and require additional time and capacity to appropriately address the concerns. This could result in further health and well-being concerns and staff absence. (Risk Score 15) The Board were reminded to consider the top risks whilst the reports from today's agenda were presented and discussed at the meeting.	
25/09/07	**Patient Story – Mrs Pauline Wetton:** The Board welcomed Mrs Pauline Wetton to the meeting who shared some concerns she had raised in relation to her husband's care when he was admitted to hospital following a fall. Mr Wetton suffered with dementia and his condition deteriorated whilst in hospital where he later sadly died. Mrs Wetton read out a letter from her daughter in which she raised some concerns and felt that more could have been done to manage his condition particularly when he was transferred to an escalation ward and subsequent end of life pathway. Mrs Wetton suggested that further awareness and education around dementia patients would be beneficial to support both families and staff for example providing the blue daisy emblem above dementia patients' beds. She has been invited to provide a "lived experience" discussion at the UK Dementia Congress in Manchester in November and offered to support any similar discussions locally. Dr G Findley, Deputy Chief Executive and Chief Nurse has met with Mrs Wetton and provided an apology. Learning from Mr Wetton's experience will be taken forward and improvements are already being developed particularly around the management of the escalation ward to ensure that the right staff and medications are in place. Further discussion will take place with the family around concerns raised around end of life care. Mrs Marshall thanked Mrs Wetton for sharing her story and enabling learning to be developed around the management and resources required in relation to dementia care. Mrs Wetton left the meeting.	

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25/09/08	**Calendar of Board Meetings 2026/27:** Mrs J Boyle, Company Secretary, presented the planned Board meeting dates for 2026/27. She explained that the proposed dates follow a similar pattern to previous years and have been distributed to provide advanced visibility in relation to forward planning. After consideration, it was: **RESOLVED:** to approve and receive the dates of the Board of Directors' meetings and Board Development dates to be held in 2026/27.	
25/09/09	**Corporate Governance Manual – Standing Orders, Standing Financial Instructions, and Scheme of Reservation and Delegation of Powers:** Mrs K Mackenzie, Group Director of Finance, provided the Board with a summary of proposed changes to the Corporate Governance Manual. Mrs Mackenzie reported that it is best practice to review the Standing Orders, Standing Financial Instructions, and Scheme of Reservation and Delegation of Powers on an annual basis and this recognises the changes to Trust governance. The full Corporate Governance Manual has been provided with tracked changes enabled to illustrate the amendments and all changes have been approved by the Group Audit Committee, which recommends that the Board ratifies the revisions. Mrs Mackenzie also wished to thank Mrs Jane Fay, Deputy Director of Finance and Mrs Jennifer Boyle, Company Secretary, for their work in updating the Corporate Governance Manual. Following consideration, it was: **RESOLVED:** to ratify the changes to the Corporate Governance Manual as recommended by the Group Audit Committee.	
25/09/10	**Trust 5 Year Strategy:** Ms N Bruce, Director of Strategy and Partnerships, provided the Board with a copy of the Trust's Corporate Strategy 2025-2030 for final approval. She reminded the Board that a draft of the strategy was agreed in principle in June 2025 pending the publication of the NHS 10 Year Plan with a further update shared at the July 2025 meeting. With the 10 Year	

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	Plan published on 3rd July 2025, a read across demonstrated good alignment with the national priorities and ambitions and the Board agreed that no changes should be made to the Trust strategy. Attention since the last meeting has been on populating the supporting chapters within the strategy ahead of the launch and publication. Mrs Bruce drew attention to the strategic response which has been developed with system partners and provides a number of aligned priorities which are based around a shared intent and thanked Mrs Marshall for her support with this. She also drew attention to the Strategy on a Page which highlights the four identified goals and ambitions with narrative on how to achieve these which will inform work plans going forward. Work is currently taking place in relation to the clinical strategy and other enabling strategies and the Board Assurance Framework has been updated to reflect the updated strategic goals and ambitions. Mrs Bruce explained that this is a living document to enable any required responses to further change and will be monitored on an annual basis. Mrs Marshall thanked Mrs Bruce, Mr Halford and Mrs Taylor for the significant work that has taken place to produce the strategy. She queried whether the subsequent enabling strategies will also require Board approval. Mr N Halford, Medical Director for Strategic Relations, reported that discussions will need to take place with Board Committee Chairs but it may be beneficial for the Board to review the Clinical Strategy for oversight once completed. Following a query from Mrs M Pavlou, Vice Chair and Non-Executive Director, in relation to communication plans around the launch of the strategy, Mrs H Fox, Head of Communications and Engagement, highlighted that the launch will begin next week with an event in the Hub as well as Team Brief session. Material will also be available to ensure clear understanding of key elements and will be communicated throughout the organisation. Mrs Bruce reported that this could be shared with the Board for oversight. Dr S Fenwick, Acting Chief Executive, felt that it was important to ensure that staff are able to see how the strategy is aligned to work across the Trust and Mr Halford explained that staff contribution is key and will be shared across all groups. After further discussion, it was: **RESOLVED:** to approve the proposed Corporate Strategy 2025-2030 and support the launch and publication of the strategy	
25/09/11	**Winter Plan 2025/26:** Dr C Howey, Group Medical Director, (on behalf of Mrs J Halliwell, Group Chief Operating Officer) presented the overview of the winter plan for	

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	2025-26 which includes endorsement of the Board Assurance Statement. Dr Howey reminded the Board that the draft strategic overview for winter planning was received at the last meeting and planning has been developed with engagement from system partners. A regional event recently took place which was hosted by NHS England to stress test draft plans. Dr Howey explained that the Board is also required to submit a Board Assurance Statement signed by the Chief Executive and Chair by 30 September 2025 and has been distributed for review prior to the meeting. Following a query from Mrs M Pavlou, Vice Chair and Non-Executive Director, in relation to Mental Health Trusts, Dr Howey explained that those plans will be submitted to the Integrated Care Board and will be aligned to acute provider plans. After consideration, it was: **RESOLVED:** to receive the winter plan for assurance and approve the Board Assurance Statement for submission.	
25/09/12	**Green Plan:** Dr C Howey, Group Medical Director, presented the Green Plan which provides oversight as part of the required Board approval process prior to the publication of the plan in October 2025. She reported that the plan covers the Group's legal duty to reduce emissions and meet the net zero targets, whilst highlighting the impact of climate change upon health. The plan details current emissions and achievements to date in tackling climate change whilst also setting out actions and metrics to help reduce emissions in line with required projections. Dr Howey highlighted that the plan has been developed with Alliance partners and includes 10 key focus areas which will be monitored via a tier 3 group with representation from both the Trust and QE Facilities with oversight provided by the newly established Bi-Annual Greener NHS Group chaired by the Group Medical Director. Mr G Evans, QE Facilities Managing Director, reported that good progress has been made over the last four years and supported the new leadership from the Group Medical Director which will encourage clinical buy-in and engagement. Following a query from Mr R Hughes, Non-Executive Director, in relation to whether the plan in relation to electric vehicles is ambitious enough, Mr Evans explained that whilst good progress has been made there are limitations in relation to electrical infrastructure which limits the level of ambition that can be applied. Mr S Fenwick, Acting Chief Executive,	

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	explained that this has been recognised within the corporate strategy work and opportunities will also be explored as part of the Alliance work. It was suggested that it would also be useful to provide a joint foreword statement from both Mrs Davies and Mr Fenwick. Following further discussion, it was: **RESOLVED:** to approve the Green Plan prior to the NHS England mandated publication date of 31st October 2025.	GE
25/09/13	**Premises Assurance Model (PAM) 2024/25:** Mr G Evans, QE Facilities Managing Director, provided the Board with an update on assurances against compliance with the NHS Premises Assurance Model (PAM) toolkit undertaken by QE Facilities and provides results achieved for the year 2024/25. Mr Evans explained that the toolkit provides a structured self-assessment of estates and facilities performance across efficiency, effectiveness, safety, governance and patient experience. He reported that the 2024/25 assessment highlights strong levels of assurance overall with 85% of domains rated good or outstanding which is consistent with or above national benchmarks. An action plan has been developed to address any identified gaps and will be monitored via the Operated Facilities Healthcare Governance Group. Mr R Hughes, Non-Executive Director, felt that it may be useful to RAG rate the action plan and Mr Evans explained that this will be reviewed at the next Group meeting to agree timelines and priorities. After consideration, it was: **RESOLVED:** to approve the 2024/25 PAM self-assessment prior to NHS England submission due by the end of September 2025.	
25/09/14	**Responsible Officer Assurance Report and NHSE submission:** Dr C Howey, Group Medical Director, presented the report which sets out information and metrics that the Trust is expected to report through the Higher Level Responsible Officer to ensure compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards for the period 1st April 2024 to 31st March 2025. Dr Howey reported that the Trust continues to run a robust process for appraisal and revalidation and has made strong progress against the	

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	actions in the 2023/24 assurance report, with only four actions deemed outstanding from the 2023/24 report. She drew attention to some issues raised, one relating to General Medical Council Connect Data however highlighted that rapid action was taken. The other relates to the Trust not having a named professional standards function within the Medical Staffing Team, noting that interviews for this position are taking place today. A review of the Revalidation and Appraisal Process for Senior Medical Staff Policy is taking place which will flow through to the Policy Review Group and Gateshead Health Leadership Group for approval. Following consideration, it was: **RESOLVED:** to confirm that the Trust is compliant with the Medical Profession (Responsible Officers) Regulations 2010 and approve the statement of compliance for submission to NHS England by the end of October 2025.	Cycle of business
25/09/15	**National Agenda for Change Pay Award:** Mrs K Mackenzie, Group Director of Finance, provided an update on the financial impact of the 2025/26 NHS pay award. She reminded the Board that the 2025/26 pay award was announced by the government in May 2025 with effect from 1st April 2025 which resulted in an overall 4.83% increase and has impacted on the Trust's underlying deficit position. Mrs Mackenzie highlighted that overall actual costs are expected to be £0.809m more than income received recurrently and £0.593m less after the receipt of non-recurrent income. This will therefore require additional cost reduction programme plans to mitigate any further deterioration to the underlying financial outturn. Mrs A Venner, Group Director of People and Organisational Development, highlighted that a recent visit from the NHS Pay Review Body had taken place at the Trust and meetings with the Remuneration Committee Chairs will also be taking place. Mrs Marshall felt that that this may be a helpful opportunity to provide further awareness of the impact of the pay award to deficit positions. After consideration, it was: **RESOLVED:** i) to note the detail of the 2025/26 pay award and how it has been applied to delegated budgets ii) to note the in-year and recurrent impact on the Trust's underlying deficit position ii) to support the recommendation of increasing Cost Reduction Plans to mitigate any further deterioration to the underlying finance outturn iv) to approve the pay award.	

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25/09/16	**Chair's Report:** Mrs A Marshall, Chair, gave an update to the Board on some current issues, events and engagement work taking place across the organisation. Mrs Marshall reminded the Board that Dr Sean Fenwick has now formally commenced in post as Acting Chief Executive and since the last update, the Trust has also welcomed Professor Barry Hill as the appointed Governor for Northumbria University. The elections for the staff and public Governor positions are currently underway and the deadline for nominations is 5.00pm on Thursday 25th September 2025. Mrs Marshall drew attention to the Star of the Month nominations and congratulated Samual Oshagbami who was recognised for his work as a domestic within the Trust. Mrs Marshall reminded the Board that this is her last Board meeting as Chair and Sir Paul Ennals will commence as Chair from 1st October 2025. Dr Gerry Morrow will also take on the role as Vice Chair to support Paul in his role and thanked Mrs Maggie Pavlou for her dedication to the role as Vice Chair. After consideration, it was: **RESOLVED:** to receive the report for assurance.	
25/09/17	**Chief Executive's Report:** Dr S Fenwick, Acting Group Chief Executive, gave an update to the Board on current issues which have been aligned to the Trust's new Strategic Aims. Dr Fenwick drew attention to the key areas in relation to national policy, context and operating models and highlighted the recent publication of the new guidance for Boards around assessing provider capability which includes the requirement to undertake a self-assessment. This will discussed in further detail at the next Board Development Session. He also drew attention to the launch of the NHS England 10 Point Plan which is a national programme to improve resident doctors' working lives and includes the recommendation for Board representation although the national specification around this is currently awaited. In relation to the Trust's key operational performance headlines, Dr Fenwick highlighted that the average length of stay for non-elective patients remains consistent with the previous month at 7.66 days and is above the threshold of 4 days. The Trust also reported zero cases of C.	

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	difficile in August which demonstrates the hard work that is being undertaken across the Trust and QE Facilities teams. Dr Fenwick drew attention to the Trust's Strategic Aim for Excellent Patient Care and highlighted that the Children's Bladder and Bowel department have been awarded the 'Gold Standard for Autism Acceptance' from the North East Autism Society. In relation to Great Place to Work, two members of the maternity support team have received the Chief Nursing Officer Award in recognition of their exceptional contribution to maternity care. In relation to Working Together for Healthier Communities, work is underway to deliver improved facilities to enhance care for women, children and young people across the region and work is continuing on the development of the new colposcopy department and children and young people's unit which is due to open this autumn. In relation to Fit for the Future, Dr Fenwick reminded the Board that the Trust's new 5 year corporate strategy has just been approved and thanked Mrs Nicola Bruce and Mr Neil Halford for their work around this. Following a query from Mrs M Pavlou, Non-Executive Director, in relation to the Trust's waiting list for diagnostics and whether this indicates patients waiting for appointments or test results, Dr Fenwick explained that this relates to first interventions and this will be made clearer in the report going forward. Mrs H Parker, Non-Executive Director, raised a query in relation to the Board representation for resident doctors and further information on how this would operate. Dr Fenwick explained that Trusts are currently waiting for the national role description. It provides the opportunity to develop relationships with the resident doctors and consideration will be undertaken around ensuring this provides mutual support. After further discussion, it was: **RESOLVED:** to receive the report for assurance.	
25/09/18	**Governance Reports:** **Board Assurance Framework (BAF):** Mrs J Boyle, Company Secretary, presented the first iteration of the Board Assurance Framework which has been mapped to the new 5 year strategy and strategic objectives. She reminded the Board that a Board Development session was held in August 2025 to engage with Board Members on the summary risks and their scores and the controls and assurances will continue to be	

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	populated by the leads via the Board Committee meetings prior to coming back to the Board in March 2026. After consideration, it was: **RESOLVED:** to receive the report for assurance. **Organisational Risk Register (ORR):** Dr G Findley, Chief Nurse and Deputy Chief Executive, presented the updated ORR to the Board which shows the risk profile of the ORR, top ORR risks and provides details of reviewed compliance and risk movements, including movement over the previous 12 months. This report covers the period 19th July 2025 to 19th September 2025. Dr Findley reported that there are currently 19 risks on the ORR. Following the Executive Risk Management Group meetings in August and September 2025, there have been 4 risks has been added to the ORR, no escalations, one reduction and no closures or de-escalations from the ORR. One of the new risks relates to the stability of the Executive Team as well as the ability of the Board to develop its unitary function due to external secondment of the Chief Executive Officer and changes to Board Members. The risk that has been reduced relates to extended length of stay and this has been reduced due to continued good performance. Dr Findley highlighted that there has been an improvement on both risk and action compliance for the reporting period and thanked colleagues for their contributions. After consideration, it was: **RESOLVED:** to receive the report for assurance.	
25/09/19	**Assurance from Board Committees:** The Board reviewed the Committee escalation and assurance reports which identify areas of concern and ongoing monitoring of assurances. **Finance and Performance Committee:** Mrs K Mackenzie, Group Director of Finance, on behalf of the Committee Chair, provided a brief verbal overview to accompany the narrative reports from the August 2025 meeting and drew attention to the most recent meeting which took place on 22nd September 2025. She highlighted the current alerts which will be discussed in more detail via the Finance Report (Agenda Item 20) and drew attention to the recommendations which relate to approvals of the Pay Award, Green Plan and Premises Assurance Model which have been addressed earlier in the meeting.	

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	Quality Governance Committee: Dr G Findley, Deputy Chief Executive and Chief Nurse, on behalf of the Committee Chair, provided a brief verbal overview to accompany the narrative report following the August 2025 meeting. Dr Findley reported that there were three issues requiring escalation to the Board, one relates to the risk of being non-compliant with the Maternity Incentive Scheme due to having no Clinical Lead for Obstetrics however Dr Carmen Howey, Group Medical Director, highlighted that there are now plans in place to cover this. Another alert relates to surgical site infections and Dr Findley highlighted that that there have been no further cases and a consolidated action plan is in place. A formal report will be provided to the Committee at the next meeting. The final alert highlights the positive results received from the Cancer Patient Experience Survey and Dr Findley reminded the Board of previous discussions relating to the Trust being identified as an outlier within the National Maternity and Perinatal Audit in relation to post-partum haemorrhage (which the Trust had already identified and acted upon) and poor APGAR (Appearance, Pulse, Grimace, Activity, Respiration) scores. She reported that the APGAR score outlier status was subsequently removed prior to publication of the audit. **Digital Committee:** Mr A Besford, Committee Chair, provided a brief verbal overview to accompany the narrative report following the September 2025 meeting. Mr Besford reported that there were two issues requiring escalation to the Board, one relates to the Digital Records Programme and discussions took place at the Committee on how best to progress this which is being taken forward with the Digital team. The other relates to a recommendation to renew into the second year extension for the System C contact however this will require further discussion at the Supplies and Procurement Committee. The Committee received positive assurance in relation to digital benefits realisation and it was felt that that this could be discussed further at a future Board Development session. The Committee also received an internal audit report on Clinical Safety in Systems Changes which received a reasonable assurance rating and Mr Besford felt that this could pose a risk to the organisation therefore follow-up actions are in progress. Mrs Marshall felt that this was a positive meeting and encouraged all Non-Executives to consider attending due to the emphasis on future digital services.	

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	Group Audit Committee: Mr R Hughes, Audit Committee Chair, provided a brief verbal overview to accompany the narrative report following the September 2025 meeting. Mr Hughes reported that there was one issue requiring escalation to the Board which relates to a new fraud regulation "failure to prevent fraud offence" which came into effect from 1st September 2025. This will apply to the Group and means that the Trust / QE Facilities Boards could be criminally liable for fraud offences committed by employees / agents if they are intended to derive benefit for the organisation and there were not reasonable fraud prevention procedures in place. Mr Hughes explained that the Committee will receive a briefing on this at the next meeting in December 2025 around how assurance on compliance will be reported. There are some areas subject to ongoing monitoring in relation to the revised Internal Audit Plan and Mrs Mackenzie explained that discussions are taking place to allocate the 98 contingency days to specific audits. This links to the discussion that took place around the development of the compliance assurance map to support the Corporate Governance Manual. The report also highlights discussion took place around the impact of the absence of the Freedom to Speak Up Guardian however it was noted that an interim appointment has now been made. Dr Findley highlighted that Andrew Lamb has been appointed to the role and felt that it would be beneficial to introduce him to the Board in the near future. **Group Remuneration Committee:** The Board received the assurance report for information and no queries were raised. Mrs Marshall thanked the Committee Chairs for their reports. After consideration, it was: **RESOLVED**: to receive the reports for assurance	
25/09/20	**Finance Report:** Mrs K Mackenzie, Group Director of Finance, provided the Board with assurance against delivery of the approved 2025/26 revenue and capital plan as at 31st August 2025 (Month 5). Mrs Mackenzie reported that the Trust has reported an actual deficit of £5.9m which is a favourable variance from plan of £0.027m and relates to reduction in costs. The Trust has achieved its current cost reduction programme target of £11.5m and £19.5m of its £32.8m full year target which includes £10.4m recurrent savings. The Trust is reporting a	

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	forecast shortfall of £3-5m therefore some mitigation plans are still required. Good progress and achievements have been made by teams. There remains pressure on the Trust's cash position and this remains a focus of discussion. Following a query from Mrs Marshall on whether NHS England and the Integrated Care Board were aware of the cash position, Mrs Mackenzie highlighted that they have recognised the challenges and further discussions may need to take place in the future. After consideration, it was: **RESOLVED:** to receive the Month 5 financial position and note partial assurance for the achievement of the 2025/26 planned financial targets.	
25/09/21	**Strategic Objectives and Constitutional Standards Report:** Mrs K Mackenzie, Group Director of Finance, presented the progress, risks and assurance in relation to the Trust's strategic objectives and constitutional standards for Month 5 2025/26. Mrs Mackenzie drew attention to some of the main headlines which includes continued improvements within emergency department performance and ambulance handovers. There are currently some patients waiting over 52 weeks which relates to some unexpected capacity challenges however plans are in place to address this. Mrs Mackenzie highlighted that the sickness absence rates for August are 4.7% which is below the 4.9% target level and the Board acknowledged that this was a significant achievement and demonstrates the hard work taking place within the operational teams. Following consideration, it was: **RESOLVED:** to receive the report for assurance and note the key areas of improvement and challenge.	
25/09/22	**Emergency Preparedness, Resilience and Response (EPRR) Core Standards Self-Assessment Report:** Dr C Howey, Group Medical Director, presented the report on behalf of the Group Chief Operating Officer, which provides an overview of the NHS EPRR Core Standards assurance process and timelines for 2025/26. Dr Howey drew attention to the EPRR Annual Assurance Process and timeline for submission 2025-26 which was received from NHS England	

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	in July 2025. There are no significant changes to the standards and there are no requirements to undertake a thematic deep dive however a robust internal governance process has been put in place and the Trust has taken part in an external peer review. Dr Howey highlighted that the Trust's compliance rating for 2024 was substantial compliance, and this is expected to be sustained. The final core standards self-assessment submission and annual report will be presented at the January 2026 Board meeting. Following discussion, it was: **RESOLVED:** to receive the report for assurance and information and note that the final core standards submission and annual report will be presented to the Board in January 2026.	
25/09/23	**Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Reports 2024-2025** Mrs A Venner, Group Director of People and Organisational Development, provided a summary of the data and associated actions in respect of the WRES and WDES standards prior to submission in October 2025. The report is also required to be presented to the People and Organisational Development Committee on 30th September 2025. Mrs Venner drew attention to the main areas of focus which includes bullying and harassment against disabled and Black Minority Ethnic (BME) colleagues from patients and staff; disabled and BME colleagues being more likely to enter into formal disciplinary or capability process; and disabled colleagues feeling more pressure to come to work despite not feeling well enough. Mrs Venner explained that lots of work has been taking place across the organisation in relation to civil unrest and poor behaviours and has been addressed via numerous team briefs however there is an acknowledgement that more can be done although cultural change can take many years. Mrs Venner drew attention to the key achievements and high level forward actions for both standards including the development of the EDI (Equality, Diversity and Inclusion) metrics dashboard which is produced and updated on a quarterly basis and discussed at the HREDI (Human Rights, Equality, Diversity and Inclusion) Group meetings and the increase in Cultural Ambassadors. There is also staff training packages available including Inclusivity and Zero Tolerance and staff continue to be encouraged to robustly manage those whose behaviour is unacceptable, and communicate outcomes where appropriate. It was acknowledged that there was a lot of work to do and actions will be prioritised within longer term plans. Mrs Venner emphasised the	

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	importance of strong communications across the organisation and it was felt that it would be beneficial to arrange a future Board Development session to discuss this further. After consideration, it was: **RESOLVED:** to receive the reports for assurance, noting that further discussion will take place at the People and Organisational Development Committee on 30th September 2025.	JB / AV
25/09/24	**Maternity Integrated Oversight Report:** Mrs Karen Parker, Associate Director of Midwifery and Special Care Baby Unit (SCBU), presented a summary of the maternity indicators for the Trust for August 2025. Mrs Parker reported that there has been no new exceptions this month and births have remained within the cap. She highlighted that there has been a decline in midwifery safe staffing levels and this has impacted on the management service however further detail will be provided within the staffing report. There is a potential emerging concern in relation to the Maternity Incentive Scheme relating to training compliance however this is being supported regionally and the Integrated Care Board are commissioning a piece of work around this. Discussion took place around the national maternity review however Mrs Parker highlighted that no trusts within the North East and North Cumbria Integrated Care System have been identified. An interim report is expected in December 2025. Following discussion, it was: **RESOLVED:** to receive the report for assurance. **Maternity Safety Champion Report:** Dr G Findley, Deputy Chief Executive and Chief Nurse, presented the report on behalf of Dr G Morrow, NED Maternity Safety Champion. She explained that this is new report recommended by Sir Paul Ennals, incoming Chair, and will be presented on a quarterly basis. The report provides additional assurance to support the Maternity Integrated Oversight Report based on regular discussion with people, patients and maternal and neonatal voices partnership (MNVP) service users. Dr Findley drew attention to the current pressures within the Women's Health Clinic mainly relating to staff levels and patient flow and a paper has been submitted to the Gateshead Health Leadership Group (GHLG)	

Gateshead Health NHS Foundation Trust

Agenda Item No		Action Owner
	to outline possible routes for improvement. It is intended to review the situation following the implementation of these improvements. After consideration, it was: **RESOLVED:** to receive the report for assurance in conjunction with the Maternity Integrated Oversight Report, noting that updates on the key issues will be provided in the next report.	
25/09/25	**Maternity Staffing Report:** Mrs K Parker, Associate Director of Midwifery and Special Care Baby Unit (SCBU), presented the report which provides the Board with an overview of midwifery staffing and provides assurance that there is an effective system of midwifery workforce planning and monitoring of safe staffing levels. Mrs Parker explained that this report covers the period of Quarter 1 2025/26 and demonstrates compliance with the Maternity Incentive Scheme Year 7 Safety Action 5 (midwifery workforce). As previously discussed, the report highlights that there has been a decline in midwifery fill rates and recruitment and retention remains a key priority with processes underway including a robust preceptorship programme for newly qualified staff. Turnover and sickness levels remain high however positive work is taking place with support from the People and Organisational Development Team. Assurance was provided that staffing remains safe due to the clinical and managerial actions taken. The Board acknowledged the positive work moving forward and Dr S Fenwick, Acting Chief Executive, highlighted that this supports the Trust's strategic vision and it is important to continue to deliver effective leadership to support the national review. After further consideration, it was: **RESOLVED**: to receive the report for assurance.	
25/09/26	**Nurse Staffing Exception Report:** Dr G Findley, Chief Nurse and Deputy Chief Executive, presented the report for August 2025 which provides assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis to provide adequate staffing levels. Dr Findley highlighted that the main pressures are related to healthcare assistant posts whilst the new model is being implemented and current	

Gateshead Health NHS Foundation Trust

Agenda Item No		Action Owner
	national pressures in relation to student nurse placements however this is being reviewed across the region. Following a query from Mrs Marshall in relation to increased alerts, Dr Findley reported that daily monitoring continues to take place and rates are currently within tolerance therefore there are no current concerns. Following discussion, it was: **RESOLVED:** to receive the report for information and assurance.	
25/09/27	**Register of Official Seal;** Mrs J Boyle, Company Secretary, provided the Board with details of the use of the Trust's official seal between 1 September 2024 and 31 August 2025. She explained that this report is presented to the Board each September in accordance with the cycle of business and formally documents the use of the official seal in accordance with Standing Order paragraph 25.5. The seal has been used on two occasions in relation to the sale and purchase of certain shares of Heathcall Solutions Limited and shareholders agreement in March 2025. Following consideration, it was: **RESOLVED:** to formally note the use of the official seal during this current year (September 2024-2025).	
25/09/28	**Cycle of Business 2025/26:** Mrs J Boyle presented the cycle of business for 2025/26 which outlines forthcoming items for consideration by the Board. This provides advanced notice and greater visibility in relation to forward planning however requested Board members to provide any feedback to ensure this is reflective of the required Board business. After consideration, it was: **RESOLVED:** to review the cycle of business for the financial year 2025/26.	
25/09/29	**Questions from Governors in Attendance:** Mr S Connolly, Lead Governor, shared a query he had received in relation to the closure of ward 23 and whether this related to a significant	

Gateshead Health NHS Foundation Trust

Agenda Item No		Action Owner
	transaction. Mrs J Boyle, Company Secretary, explained that the closure has been previously discussed on a number of occasions with the Council of Governors and provided assurance that Governors have been fully informed and made aware of difficult decisions that may be required as part of achieving sustainability. Mrs Marshall highlighted that there has been an acknowledgement that there are some learning around communications of the closure and this is being picked up. Dr G Findley, Chief Nurse and Deputy Chief Executive, reported that there was not the requirement for a public consultation and did not result in a service change as the service is still in place. Mr Connolly commented on the patient story received from Mrs Wetton and expressed disappointment of the care received from the escalation ward. Dr Findley highlighted that sincere apologies have been shared with Mrs Wetton and it has been acknowledged that the area was not ready to be used at that time and processes have been put in place to avoid this in the future. Mrs Marshall felt that it was important to learn from these experiences and continue to celebrate the good work taking place across the organisation.	
25/09/30	**Any Other Business:** Mrs Marshall ended the meeting by wishing the Board and Governors well in the future and shared that it has been a pleasure working for the Trust during her term as Chair.	
25/09/31	**Date and Time of Next Meeting:** The next meeting of the Board of Directors will be held at 9.30am on Friday 5th December 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.		

5. Action Log and Matters Arising Presented by the Chair

Gateshead Health NHS Foundation Trust

PUBLIC BOARD ACTION TRACKER

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

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
25/03/17	26/03/2025	Freedom to Speak Up Guardian Report	To consider whether further discussion to take place at Board Development Day in relation to system support around complex employment cases	21/05/2025	JB	May 25 – added to the agenda for the next Board development day on 25 June. July 25 – note that this item was deferred due to unavoidable circumstances. Recommendation to reopen action until the session can be rescheduled. September 25 – to invite the interim FTSUG to the Board **Oct 25 – this will be factored into the work the Chair, Acting CEO and Company Secretary will undertake on a forward Board development plan.**	
25/09/12	25/09/2025	Green Plan	To provide a joint forward statement from both Mrs Davies and Mr Fenwick	31/10/2025	GE	Oct 25 – completed and plan submitted. **Action recommended for closure.**	
25/09/23	25/09/2025	WRES and WDES reports	To arrange a future Board development session to discuss organisational plans	05/12/2025	JB / AV	**Oct 25 – added to the forward plan for Board development. To agree which date would be most appropriate for the session. The Chair, Acting CEO and Company Secretary will be working to develop a robust forward plan of Board development.**	

Closed Actions from last meeting

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
24/09/08	24/09/2024	Terms of Reference	To ensure that the Standing Orders and Scheme of Delegation are updated to reflect changes to Terms of Reference	~~29/01/2025~~ ~~30/07/2025~~ 25/09/2025	JB	Nov 24 – to be scheduled for January's Board meeting. Added to cycle of business therefore action agreed for closure Jan 25 – it was noted that the updated Standing Orders and Scheme of Delegation will be deferred until March meeting. Feb 25 – recommendation to reopen the action until updates are made – expected at July Board meeting to allow review by the Audit Committee. May 25 – recommended that they will now presented at the September Boad meeting due to other organisational priorities September 25 – updates made and the Corporate Governance Manual is included on the agenda with a recommendation from the Audit Committee to approve the changes**.** **Action agreed for closure.**	
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~~ 25/09/2025	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 May 25 – recommended that they will now presented at the September Boad meeting due to other organisational priorities	

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
						September 25 – updates made and the Corporate Governance Manual is included on the agenda with a recommendation from the Audit Committee to approve the changes. **Action agreed for closure.**	

6. Top Organisational Risks

Gateshead Health NHS Foundation Trust

Top Organisational Risks – November 2025

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

Risk Id	Risk Owner	Division	Description	Initial Risk Grade	Grade	Target Grade
4694	Kris Mackenzie	Finance	Risk that the Trust will not achieve its revenue plan for 2025-26 and a deterioration from the 2024-25 planned deficit, resulting in a deterioration to Trusts NHS Oversight Framework rating.	25	20	10
4704	David Thompson	Digital	Risk of failure to review appropriate clinical information due to multiple sources and lack of interoperability of data stored across a variety of digital systems and in paper format. This could result in patient harm or sub optimal care.	20	16	8

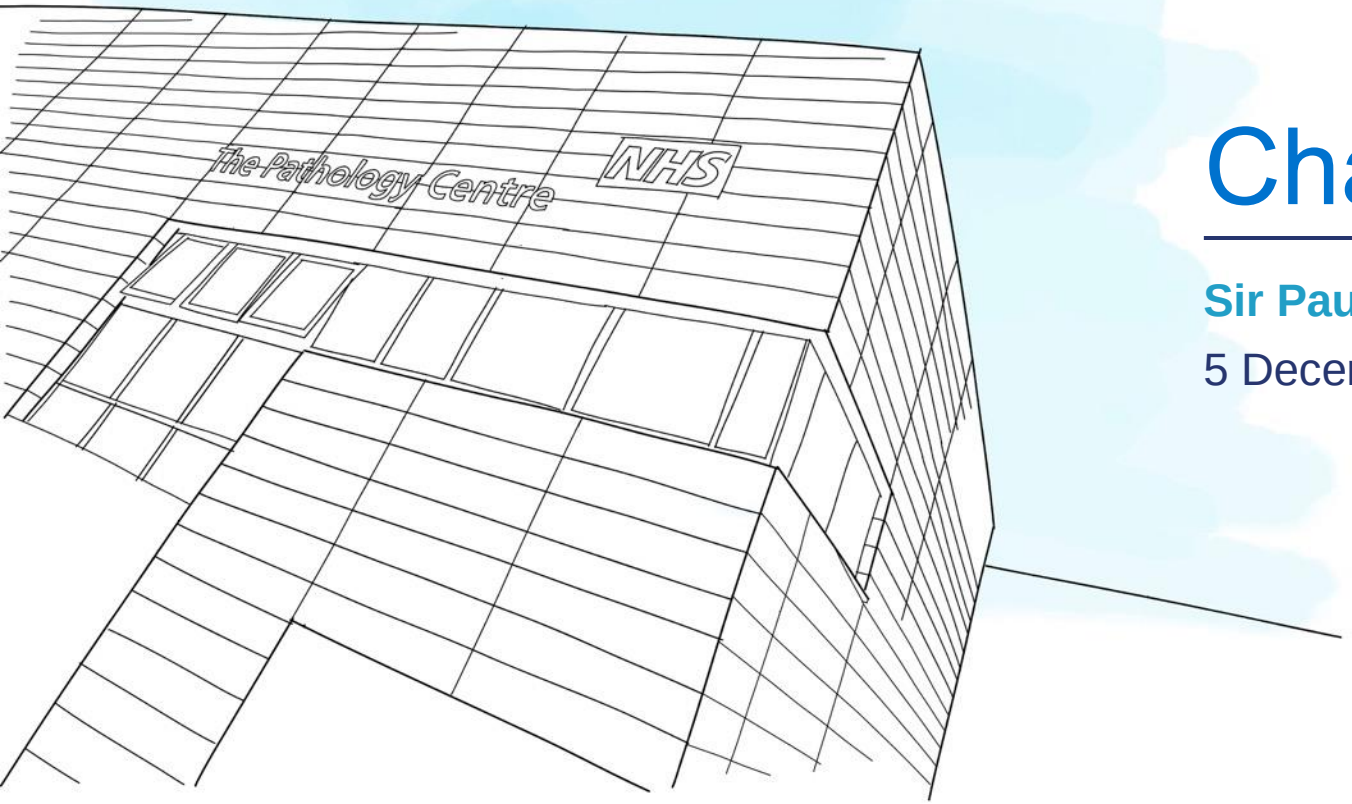
ITEMS FOR DECISION - none

ITEMS FOR ASSURANCE

7. Chair's Report

Presented by the Chair

Gateshead Health NHS Foundation Trust



Chair's Report

Sir Paul Ennals, Chair of the Board of Directors

5 December 2025

Gateshead Health NHS Foundation Trust

New Chair

- I was delighted to formally commence in post as Chair of Gateshead Health NHS Foundation Trust on 1 October 2025.
- In my role as Shared Chair I am also the Chair of both Northumbria Healthcare NHS Foundation Trust and The Newcastle-upon-Tyne Hospitals NHS Foundation Trust, as well as the Great North Healthcare Alliance.
- My role as Chair across the three Trusts enables me to work together with the Boards of Directors to harness each Trust's strengths, share innovation and open up opportunities for delivering our services in the most effective and responsive way for patients.
- Governors formally appointed Dr Gerry Morrow, Non-Executive Director, as the Vice Chair and he commenced this role on 1 October 2025. The Vice Chair role in each Trust will be key in supporting me to work effectively across all three Trusts. Gerry is already building relationships with our Governors and attending a range of our Board committees on my behalf. I would like to formally record my thanks to former Vice Chair Maggie Pavlou for her commitment to the role.
- During my extended induction period over the summer months I have already visited a wide range of different areas across the Trust and met with many colleagues. I am truly impressed by the dedication, care and compassion shown by our people and their commitment to patients and communities.
- I am looking forward to spending more time meeting and engaging with colleagues in the coming months.

Sir Paul Ennals

Gateshead Health Leadership Arrangements

- I am pleased to formally confirm that Dr Sean Fenwick, Acting Chief Executive, will remain with the Trust until the end of April 2026, following the agreement of a three-month extension to his secondment from his substantive role at South Tyneside and Sunderland NHS Foundation Trust.
- Since the last Board meeting we have said goodbye to Dr Gill Findley, Chief Nurse and Deputy Chief Executive, who left the Board to take up a unique new joint role as Professor with the University of Cumbria and Chief Nurse at North Cumbria Integrated Care NHS Foundation Trust. This means that Gill will continue to contribute to Great North Healthcare Alliance discussions and workplans. We wish Gill all the very best for her new role and record our sincere thanks on behalf of the Board.
- We were delighted to welcome Beth Swanson as Interim Chief Nurse. Beth joins the Board from North Tees and Hartlepool NHS Foundation Trust where she is Director of Nursing and Deputy Chief Nurse. Beth brings more than 30 years of nursing experience and a strong record in improving quality, safety and workforce resilience.
- Hilary Parker, Non-Executive Director, will be leaving the Board on 31 December 2025 after five and a half years of service. Hilary has played an integral role on both the Trust and QE Facilities' Boards and we formally record our sincere thanks for her dedication and commitment.
- We will shortly be advertising for a Non-Executive Director with a legal qualification and significant legal experience to commence with us early in 2026.

Gateshead Health NHS Foundation Trust

Governor and Member Updates

- I chaired my first Council of Governor meeting on 19 November, which was an excellent opportunity to meet our Governors and discuss key topics such as Freedom to Speak Up, the work of QE Facilities and the work of our Gateshead Health Charity.
- I was honoured to present Helen Jones, Public Governor for Central and Eastern Gateshead, and Les Brown, Public Governor for Western Gateshead, with certificates of service as they leave the Council. Helen has served as a Governor for 9 years and Les for 6 years, both showing an outstanding contribution to our patients, people and communities.
- On 26 November I attended the Governor induction to welcome several of our new Governors to the Council, prior to their formal start dates in January 2026 (subject to the completion of pre-volunteering checks). The full election results are enclosed in this report.
- Since taking up post I have held monthly meetings with the Lead and Deputy Lead Governors. This has been an excellent way of ensuring that I understand the issues of most importance to our Council and can work with colleagues to ensure that we have the appropriate reports and assurances featured within our Council of Governors and associated meetings / workshops.

Governor Election Results

Gateshead Health NHS Foundation Trust

Constituency	Type of election	Elected candidates
Public: Central and Eastern	Unopposed	Steve Connolly – re-elected to third term of office (5 Jan 2026 – 4 Jan 2029)
Public: Central and Eastern	Unopposed	Brenda Webb – re-elected to third term of office (5 Jan 2026 – 4 Jan 2029)
Public: Central and Eastern	Unopposed	Susan McKenna – elected to first term of office (5 Jan 2026 – 4 Jan 2028)
Public: Central and Eastern	Unopposed	Ashley Rawlings – elected to first term of office (5 Jan 2026 – 4 Jan 2029)
Public: Western	Unopposed	Ray Dennis – re-elected to second term of office (5 Jan 2026 – 4 Jan 2028)
Public: Western	Unopposed	Sarah Craig – elected to first term of office (5 Jan 2026 – 4 Jan 2029)
Public: Western	Unopposed	Moira Ledger – elected to first term of office (5 Jan 2026 – 4 Jan 2028)
Public: Western	Unopposed	Jon Twelves – elected to first term of office (5 Jan 2026 – 4 Jan 2029)
Staff	Contested	Dr Kiran Singisetti – re-elected to second term of office (5 Jan 2026 – 4 Jan 2029)

Star Awards

Gateshead Health NHS Foundation Trust

Finally, I was honoured to attend the Gateshead Health Star Awards 2025 on 7 November. The event celebrated the exceptional people who make a difference across our services every single day. Congratulations to all our winners and nominees!

8. Acting Chief Executive's Report

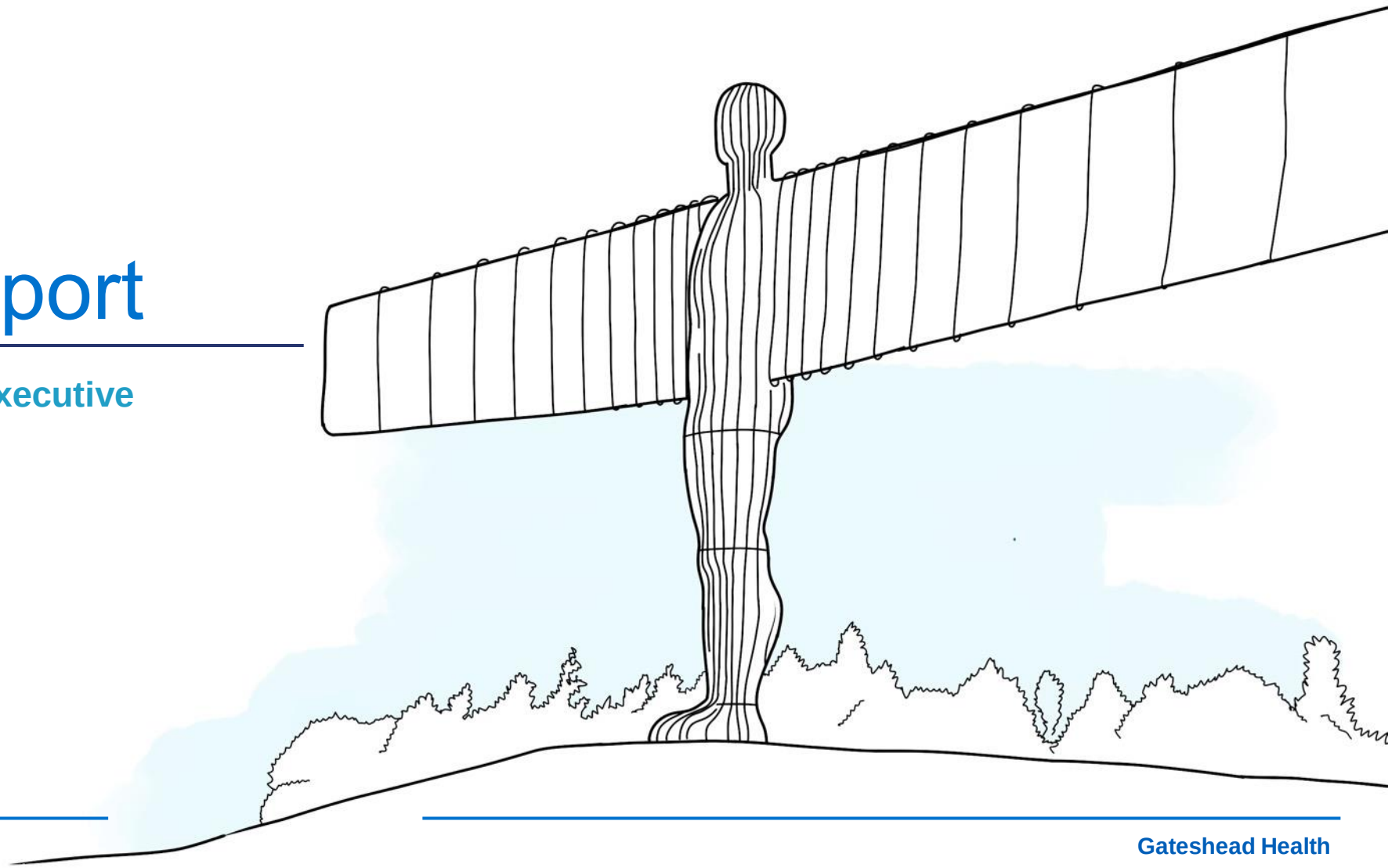
Presented by the Acting Chief Executive

Gateshead Health NHS Foundation Trust

Acting Chief Executive's Report

Dr Sean Fenwick, Acting Chief Executive

5 December 2025



Gateshead Health NHS Foundation Trust

National statistics and context

National policy, context and operating models

Publication of the Medium Term Planning Framework 2026-29

Publication of the Strategic Commissioning Framework to support Integrated Care Boards (ICBs) in meeting the ambitions for the future of strategic commissioning

Resident doctors strike occurred for 5 days from on Friday 14 November

Due shortly– publication of the NHS England Management and Leadership Framework

Draft Advanced Foundation Trust Framework published and currently out for consultation

Due shortly – Neighbourhood Health Planning Framework and Model Neighbourhood Framework

Gateshead Health NHS Foundation Trust

National performance headlines

National performance – September and October 2025

Flu wave has hit the NHS earlier than usual – as at 6 November flu cases were triple what they were at this time last year

There were 4,008 mental health-related attendances that lasted over 24 hours, 9% of all attendances for mental health in type 1 and 2 A&E departments and 0.3% of all attendances *(new NHSE experimental data set)*

74.1% of patients in A&E seen within 4 hours (Oct), an improvement on last year (73%), but below the 78% aim.

10.8% of patients spent more than 12 hours in A&E in October, above the threshold of 10% and a 21% increase on last month

67.9% of referrals met the 62-day cancer standard in September, a slight improvement on last year.

In September 73.9% of patients with an urgent referral were told they have cancer, or it was excluded within 28 days. This is down slightly from last year (75%)

In September 77% of patients were seen within 6 weeks for diagnostic tests, which is a slight improvement from the previous month, but far from the 99% constitutional standard

Waits over 18 weeks are equivalent to 61.8% of all waits (Sept), with progress needed to meet the aim for 65% of treatments to be waiting no longer than 18 weeks by March 2026

Winter

Gateshead Health NHS Foundation Trust

- Supporting patients to access the care they need quickly and in the most appropriate place is key to ensuring that we maintain safe services over Winter
- To support this ensuring how patients move through the hospital safely and efficiently is one of the biggest factors in how we manage winter pressures.
- We are carefully balancing emergency and elective care.
- The Internal Winter Oversight Group meets regularly to monitor pressures, share learning, and coordinate responses across wards and departments. Everyone's role contributes to safe patient care - whether that's supporting discharge, maintaining infection control standards, or helping ensure flow across the hospital.
- Attendances have increased by 6% compared to this time last year, although admissions are only up by 3% - reflects the impact of our work to avoid unnecessary admissions and support safe discharge.
- Current position – challenging. Why?
  - Flu is earlier and more impactful than predicted
  - More Children and Young People affected
  - Early challenges with Norovirus and associated impact on flows
  - Higher than average numbers of patients experiencing a delayed discharge (OOA)

Winter Oversight Group Internal & System	Board-approved Winter Plan
Clinically-led tactical plan	Ward 11 escalation area
Vaccinations	Information and adaptation

Excellent patient care

Gateshead Health NHS Foundation Trust

- Our teams engaged in robust planning for the new period of **industrial action** from resident doctors, which ran from 7am on 14 November to 7am on 19 November, Our primary goal was to keep our patients safe, maintaining our inpatient services and elective activity wherever possible without impacting on patient care. This was well managed by our teams with minimal impact on the provision of patient care during this time. Nationally more than 95% of planned elective activity continued to be delivered during the strike.
- We are encouraging all of our colleagues and anyone eligible for the **flu jab** to take up the opportunity of receiving the vaccine to protect themselves, their families and friends and our patients. Governors can help us by encouraging colleagues and contacts to get the flu vaccine. We know that flu is hitting earlier this year – getting the flu jab early in the flu season can help to stamp out the early wave of flu.
- We are delighted that our **Secondary Prevention Service** won the prestigious Health Service Journal (HSJ) Award for Medicine, Pharmacy and Prescribing Initiative of the Year. The service supports patients to manage potential risks (such as cholesterol, diabetes and blood pressure) following cardiovascular events.
- Congratulations also go to the **Speech and Language Therapy Parkinson's Rapid Response Project** who were finalists in the HSJ Award for Transforming Care for Older People.
- Our **pharmacy team** were recently inspected by the General Pharmaceutical Council. The Council confirmed that all standards were being met. This is a great achievement which evidences the team's dedication to safe, high-quality care.
- The **orthopaedics team** achieved 100% compliance for the National Joint Registry (NJR) data quality. As a result we have been awarded gold status, which recognises excellence in supporting patient safety standards through compliance with mandatory NJR data submission quality audit processes.

Great place to work

Gateshead Health NHS Foundation Trust

- We have been encouraging our colleagues to complete this year's **NHS Staff Survey** ahead of the survey closing on 28 November to help the Board understand what is working well and what could be better. It is a vital tool which provides rich intelligence to support us to make improvements for our colleagues, which ultimately impacts on the care and experience of our patients. The outcome of the survey will be shared with the Board when it is released in 2026.
- We are committed to acting upon **NHS England's 10 Point Plan to improve the working lives of our resident doctors**. In line with the Plan we have appointed the 2 named leads for ensuring the resident doctor issues have appropriate visibility at Board. Dr Carmen Howey, Medical Director, is the named lead for resident doctor issues and we are delighted to welcome Dr Ruby Hodges as our resident doctor peer representative.
- The **2025 Star Awards** took place on 7 November. The evening recognised staff achievements in care, innovation, teamwork and patient experience across 10 different awards. Congratulations to all the winners and nominees!

Working together for healthier communities

Gateshead Health NHS Foundation Trust

- 24 October 2025 marked the first anniversary of the **Community Diagnostic Centre**, in partnership with The Newcastle-upon-Tyne Hospitals NHS Foundation Trust.
- In just one year, more than 55,000 people have accessed vital tests quickly and locally. That not only improves outcomes but also reduces demand on hospital sites.
- The CDC is a great example of the NHS 10-Year Plan in action, by improving access to care, supporting earlier diagnosis and delivering services closer to home.

Gareth Davies, CDC Clinical Manager of Gateshead Health said: “Being part of the team here has been incredibly rewarding. We know how important early diagnosis is, and being able to offer patients quick, local access to tests is making a real difference. We aim to deliver the best diagnostic service we can for Gateshead and Newcastle. All future additional diagnostics to the CDC will allow us to support even more patients with faster, more accessible care.”

Margaret Wilson, 65, from Gateshead said: “I have been coming to the CDC for 6 months for regular blood tests. It is easy to get to, and if I am early, I get seen straight away, no waiting around. It’s a great place, and I grab a coffee when I’m done and have a look around the shops”

Fit for the future

Gateshead Health NHS Foundation Trust

- We are working through the **Medium Term Planning Framework** and preparing for the initial submission of the plan on 19 December 2025. The Framework includes ambitious targets across elective care, cancer, diagnostics, urgent and emergency care, community services, primary care, mental health, learning disabilities and autism. There are also clear expectations regarding productivity, workforce and finance.
- The detailed supporting guidance documents have recently been published. The guidance links closely to the first phase of the NHS 10 Year Plan and also connects to our own 5 year strategy and strategic intent. In summary we are required to develop the following for the first submission:
    - 3-year revenue and 4-year capital plan return
    - 3-year workforce return
    - 3-year operational performance and activity return
    - Integrated planning template showing triangulation and alignment of plans
    - Board assurance statements confirming oversight of process.
- We launched our **new Clinical Operational Standards** at the end of November. The new standards link together the Getting It Right First Time and NHS England best practice approach with our local Gateshead culture of putting the patient's needs first. The standards describe how and when the referrals are made within the non-elective care pathways, setting expectations for specialty response and building on the foundations of our organisational values. The launch of these standards represents a shared commitment across all services to ensure that patients move safely through the hospital and receive care from the right team at the right time in the right place.

9. Great North Healthcare Alliance Progress Report presented by the Company Secretary

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 9

Report Title:	**Great North Healthcare Alliance Progress Report**			
Name of Meeting:	Trust Board (Part 1)			
Date of Meeting:	5th December 2025			
Author:	Nicola Bruce, Director of Strategy and Partnerships and other members of the Alliance Formation Team			
Executive Sponsor:	Sean Fenwick, Acting Chief Executive			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☒
	To provide Trust Board with an update on the Great North Healthcare Alliance			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	New report			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	The paper provides an update on: 1. Great North Healthcare Alliance progress, specifically progress against the Strategic Objectives for 2025/26 2. Governance – following from a discussion at the Alliance Steering Group there is an update on the proposed updates to the Alliance governance arrangements, specifically the Committees in Common and Joint Committee.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board are asked to note the updates.			

Gateshead Health NHS Foundation Trust

Trust strategic priorities that the report relates to:	☒	Excellent patient care
	☒	Great place to work
	☒	Working together for healthier communities
	☒	Fit for the future
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	9. We will collaborate with system partners with an emphasis on maximising efficient use of collective resources across health and care services 10. We will ensure effective and efficient use of our resources identifying opportunities to improve productivity and ensure best use of public money	

Links to CQC Key Lines of Enquiry (KLOE):	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):					

Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

NHS
Great North
Healthcare Alliance
Gateshead | Newcastle | North Cumbria | Northumbria

Great North Healthcare Alliance Update – Progress and governance updates

1. Progress update

The Great North Healthcare Alliance is a partnership between the NHS Trusts in Gateshead, Newcastle, Northumbria and North Cumbria.

As a reminder, the Alliance is overseen by an Alliance Steering Group that meets monthly in two formats, a Committees in Common with Board level members from all four Trusts in the Alliance, and a Joint Committee with Board level members from Gateshead, Newcastle and Northumbria Trusts. This arrangement reflects the greater delegated powers for some functions agreed between those three Trusts as part of the development of the Alliance.

Trust Boards are asked to note appendix 1, a progress summary against the Alliance's strategic objectives for 2025/26 previously signed off by the Alliance Steering Group.

Boards should note that the Alliance Trust Chief Executives are midway through a series of discussion to review the strategic intent and direction of the Alliance. It is expected that the substantive outputs of these discussions will be presented to and discussed with the Steering Group and Trust Boards in late 2025 and early 2026.

2. Governance update:

Trust Boards are also asked to note some updates to Alliance governance arrangements that were discussed at the October Alliance Steering Group Committees in Common.

The Terms of Reference for both Alliance Committees – Committees in Common (CiC) and Joint Committee (JC) – are due to be reviewed annually. More specifically, there was a requirement in the Alliance Joint Committee Terms of Reference to review the membership of the Joint Committee by 30 June 2025 (see appendix 2, paragraph 5.4.4).

With the agreement of the Committees in Common, the Alliance Formation Team undertook a review during the summer and presented the following to the Alliance Steering Group for discussion ahead of updating Boards and seeking approval where necessary.

In this update there are no items for approval by Trust Boards – as set out below these will follow in due course.

3. Committees in Common

Non-Executive Director attendance as non-members - Since May 2025, Non Executive Director representatives have attended the Committees in Common meetings as attendees, but not as members. This was initially to provide additional oversight and assurance over certain agenda items, but also helped correct against perceived imbalance between Committees in Common and the Joint Committee.

The Steering Group agreed that Non-Executive attendance at the Committees in Common should continue, with the same individual Non-Executive Directors attending as proposed in section 4 below. No changes are required to the Committees in Common terms of reference as there is space within these for the Committees in Common to "invite such persons as considered relevant". Non-Executive Directors attending would not have a vote or count to quoracy.

No other changes are proposed to the Committees in Common arrangements.

4. Joint Committee Membership and Attendees

Membership – When the Joint Committee was established in January 2025 individual Non-Executive Director attendance was due to be reviewed after 12 months (see appendix 2, section 4). Whilst no substantive changes to the membership formulation of the Committee are proposed, a proposal was supported by the Steering Group that the attending Non-Executive Director members be updated to be Vice Chairs of the three ‘East Coast’ Trusts and we move away from specific Non-Executive Director portfolios being represented. This would reflect the movement to a Shared Chair for the three East Coast Trusts.

Attendance by non-members – The Steering Group also supported a proposal to add the Chair of North Cumbria and a Non-Executive Director as attendees at the Joint Committee (see appendix 2, section 5). This would remove the need for the Chair of North Cumbria Integrated Care NHS Foundation Trust and a Non-Executive Director to ‘leave’ an Alliance Steering Group mid-meeting where the Committees in Common and Joint Committee run concurrently, and ensure an equal visibility on issues being discussed across the four Trusts.

Delegations – the delegations will need to be updated prior to the next financial year, in particular the finance delegation which was narrowly defined to the contract negotiations for 2025/26 which have concluded. It is proposed that these be more substantively reviewed in early 2026 following the conclusion of the Alliance strategic intent discussions that are flagged in section 1 above.

Suggested topics that the Steering Group has mentioned at this stage include: medium term financial planning delivery, possible special-purpose vehicle (SPV), neighbourhood health, and use of digital solutions. Subject to these updated delegations, we might wish to have additional Non-Executive Director attendance at the Joint Committee to support the development of and provide assurance on specific pieces of work.

The above proposals would require amendments to the Terms of Reference. Subject to Trust Board views it is proposed that these amendments be made as one in early 2026.

5. Other considerations

Possible future arrangements – as we review the Alliance governance there is an opportunity to consider whether the Committees in Common and Joint Committee should be streamlined into one Committee. The long-held ambition is for all four Trusts to be members of the Joint Committee, and with the new membership and attendance arrangements at the Joint Committee mirroring the Committees in Common, Committees in Common business could be heard in the Joint Committee. Changes to this would require the Alliance Collaboration Agreement to be updated.

The Steering Group also considered the monthly frequency, timing and location of the meetings and agreed to not make changes at present.

6. Recommendation

The Trust Board is asked to note this update and governance proposals for future approval.

Report by Nicola Bruce
Director of Strategy and Partnerships
Prepared by the Great North Healthcare Alliance Formation Team

27 November 2025

NHS
Great North
Healthcare Alliance
Gateshead | Newcastle | North Cumbria | Northumbria

Fair progress is being made on the 2025/26 priorities for the Alliance agreed in March 2025

NHS
Great North
Healthcare Alliance

25/26 Priorities	Progress to date	
• To have **addressed known weaknesses in services** across neighbouring trusts by working together as good bilateral partners	Positive executive level working together on bilateral basis. 3 bilaterals now in place and meeting monthly with a focus on problem solving particularly operational and performance issues in clinical services. Further to go, for example, through the planned NCIC:NUTH clinical summit, to ensure existing examples of working together at clinical lead and middle manager levels become the norm,.	
• To have **improved productivity and efficiency** and reduced unwarranted variation in clinical and back office services to become financially sustainable	This continues to be hard to do but is a recognised purpose of most Alliance work including bilaterals. Alliance benchmarking information on relative cost and efficiency of clinical and back office services shared at exec level and sometimes used at service level. Little push back on data quality. Progress mainly made in clinical pathways around operational and performance issues because that information is readily available, whereas a lack of information and comparable information on outcomes and experience. Not yet seeing clinical or back office leaders stepping forward to drive opportunities on Alliance wide basis, but some ideas surfacing on bilateral basis.	
• To have **shifted towards community and out of hospital care** and have secured support for our plan to transform care AND have fit for purpose buildings that enable us to deliver efficient high-quality care	Significant area of focus within FTs and with place based partners to co-design neighbourhood work. Given additional emphasis by 10 Year Health Plan. Each trust at different starting point. Alliance level work focussing on levelling up FT offers to primary care and agreeing direction of travel re supporting Northumbria IHO ambition ahead of wider move to IHO model by other FTs. Alliance Construction Programme has continued market engagement with event in July and bilaterals due to complete September. Discussions focussed on current funded 4 year programme and indicative settlement ahead of the longer, as yet, unfunded ambitions. 4 trust estates and facilities senior teams discussing previously agreed priorities and greater collaboration	
• To have **improved our digital services** so that staff find it easier to do their work and we have released back-office costs to reinvest in improving our services	Joint Chief Information Officer appointed across Northumbria, Gateshead and Newcastle. Current focus on stabilising safe digital foundations ahead of longer term transformation ambitions. Work underway on structures inside the digital teams and operating model. Opportunities for efficiencies between services being identified. Scale of opportunities outlined in 10 Year Health Plan exceed current resource levels in some areas.	
• To have **deepened our collaboration** and strengthened our shared leadership as the NHS moves to a more decentralised model based on local leadership	Deepened collaboration and move to decentralised through; 3 bilaterals between FTs; strengthened neighbourhood planning work at place level with partners. Shared leadership evidenced by: close working of CEOs; appointment of Shared Chair and Shared CIO across Gateshead, Newcastle and Northumbria; appointment of Trudie within the Alliance to interim CEO at NCIC; bringing NEDs into Committees in Common; Alliance director and AFT.	

Fair progress is also being made on the wider set of milestones proposed for this year

NHS Great North Healthcare Alliance

Milestones for 25/26 delivery (set summer 2024)	Progress	
CQC Good (or better) x 3	Improvements in performance in many areas. NUTH deescalated from previous CQC concerns. CQC rating change in 25/26 not likely due to CQC internal rebuilding and reinspection programme. NOF ratings range from 1 -4.	
Begin comprehensive review of NCIC sub/tertiary specialties with NUTH. Begin phased transfers of any agreed upon specialties	Closer exec level working between NCIC and NUTH, including monthly bilaterals and planned Exec to Exec and joint Clinical Summit. Services prioritised for joint exploration. Collation of SLAs undertaken.	
Shared culture model and leadership programme in place	Culture is becoming for much more collaborative but work on a specific culture model not progressed. Sharing some leadership roles across Alliance. Some cross trust participation in leadership progs.	
Joint recruitment campaigns in place to attract talent in high need areas – particularly in NCIC	Some collaboration around specific posts to aid recruitment. Discussions underway between NUTH and NCIC around models of joint appointments and other measures to aid recruitment.	
Clinical framework agreed – with info on estates & digital	Medical directors leading work to develop shared clinical principles ahead of likely developing a broader clinical framework in conjunction with directors of nursing and operations.	
Medium Term Financial Plan in place	Plan in development. Shared 3 year forecasts completed.	
Analysis of NCICs structural deficit and potential measures	Work undertaken by NCIC. Discussions with DoFs as part of development of medium term finance plan	
Deliver significant improvements in quality and access towards recovery of constitutional standards	Alliance performance on each of the main access standards is improving (A&E, RTT, cancer 28 & 62 day, and diagnostics) but remains well below the best levels achieved historically.	
Compact written between primary and secondary care	Primary care workstream looking to level up offer from secondary care. Supports neighbourhood discussions.	
Early adopter integrated Neighbourhood Health Service teams	Significant area of focus within FTs and with place based partners to co-design neighbourhood work.	
Specialty Improvement Plans developed	Current focus is on doing these on bilateral basis. May become more of a feature of Alliance wide clinical pathway reviews on back of clinical framework currently being drafted by Medical Directors.	
Joint research and life science strategy agreed	Work underway with research and innovation focus. Big innovation event scheduled October 2025.	
Big Build: reviewed top 20 strategic sites for neighbourhood health centres; first FBCs written; joint shared venture developed	Discussion re neighbourhood health centres part of place discussions. Alliance Construction Programme continued market engagement. Longer term ambitions unfunded. 4 FT estate teams discussing greater collaboration	
Co-brand all initiatives Trust and Alliance	Examples include cobranding Community Diagnostic Centre, Big Innovation Conversation, Carol Service, website	
Review Joint Committee and lead director areas	6 month review of joint committee arrangements done by AFT with recommendations to next Steering Group.	
Aligned Staff Survey questions	Deprioritised as a current area of focus within overall workforce programme.	

Appendix 2 – Joint Committee Terms of Reference

GREAT NORTH HEALTHCARE ALLIANCE JOINT COMMITTEE

Terms of Reference

1. Status of Joint Committee

1.1 The Newcastle upon Tyne Hospitals NHS Foundation Trust, Northumbria Healthcare NHS Foundation Trust and Gateshead Health NHS Foundation Trust (the "**Trusts**") together with North Cumbria Integrated Care NHS Foundation Trust are parties to a strategic collaboration known as the Great North Healthcare Alliance.

1.2 To facilitate joint working across the Trusts, the Trusts have agreed to establish and constitute a joint committee pursuant to sections 65Z5 and 65Z6 of the National Health Service Act 2006 with these terms of reference ("**Terms of Reference**"), to be known as the "Great North Healthcare Alliance Joint Committee" (the "**Joint Committee**").

1.3 The Joint Committee is a committee of the boards of each of the Trusts and therefore its decisions are binding on each Trust. The Joint Committee is authorised by each of the Trusts' boards to carry out the functions set out in these Terms of Reference to ensure the Joint Committee can fulfil its purpose.

1.4 The Joint Committee does not replace the Alliance Committees, which are the committees in common established in accordance with the Collaboration Agreement by the Trusts and North Cumbria Integrated Care NHS Foundation Trust.

2. Purpose of the Joint Committee

2.1 The purpose of the Joint Committee is to ensure appropriate governance arrangements are in place to enable joint decision making in relation to the functions described in these Terms of Refence and the Annex which the Trusts have agreed to exercise jointly.

2.2 The Joint Committee will be responsible for setting the strategic direction and associated oversight of the functions described in these Terms of Reference and the Annex ("the Joint Committee Work Plan").

3. Responsibilities of the Joint Committee

3.1 The general responsibilities of the Joint Committee are to:

3.2 formulate, agree and implement strategies for delivery of the Joint Committee Work Plan specifically finance, digital and research and life sciences matters and provide overall strategic oversight in respect of the Joint Committee Work Plan;

3.3 review and scrutinise strategic key deliverables and ensure adherence to the required timescales;

3.4 obtain assurance that all applicable law is being complied with in relation to the Joint Committee Work Plan;

3.5 review the risks associated with the Joint Committee Work Plan and the performance of any of the Trusts in terms of the impact of the Joint Committee Work Plan and recommend remedial and mitigating actions across the Trusts;

3.6 obtain assurance that risks associated with the Joint Committee Work Plan are being identified, managed and mitigated;

3.7 agree the overall budget, financial contribution and use of resources in respect of the Joint Committee Work Plan.

3.8 The Joint Committee has the specific responsibilities set out in the Annex to these Terms of Reference.

3.9 Functions not delegated to the Joint Committee in accordance with these Terms of Reference are retained by the Trusts' boards or other Trusts' committees.

3.10 Unless authorised by the Trust Boards or set out within the Scheme of Delegation, the Joint Committee may not:

3.10.1 form sub-committees;

3.10.2 pool budgets or establish any risk-gain share arrangements;

3.10.3 commit a Trust to any spend, loan or investment (including capital investment) or acquire or dispose of Trust property;

3.10.4 commit a Trust to enter into a contract, other than as permitted by these Terms of Reference; or

3.10.5 carry out any function which is governed by a statutory process or reserved in law to a statutory committee of a Trust, including constitutional amendments and Trust board appointments, or which may not be exercised jointly according to law or NHS England guidance.

3.11 The Joint Committee is authorised by the Trust boards to obtain independent legal or other professional advice and to secure the attendance of such persons with relevant experience or expertise at any meeting of the Committee.

3.12 In carrying out its functions, the Joint Committee will abide by the Nolan Principles and shall have regard to NHS England's statutory guidance on arrangements for delegation and joint exercise of statutory functions (as may be updated from time to time).

4. Membership

4.1 The members of the Joint Committee shall be:

4.1.1 the Chief Executive Officer of each of the Trusts; and

4.1.2 the Chair of each of the Trusts.

4.1.3 A Non-Executive Director from each of the Trusts, one whose Trust portfolio is Finance, one whose Trust portfolio is People and the other whose Trust portfolio is Quality. The Non-Executive Director members will rotate with new members appointed every twelve (12) months.

4.2 Each of the members shall nominate a deputy to attend Joint Committee meetings on their behalf when necessary ("**Nominated Deputy**"), provided that:

4.2.1 the Nominated Deputy for a Non-Executive Director shall be a Non-Executive Director;

4.2.2 the Nominated Deputy for an Executive Director shall be an Executive Director; and

4.2.3 the Nominated Deputy must be a voting board member of the respective Trust.

4.3 Where Nominated Deputies are attending Joint Committee meetings on behalf of a member they shall be entitled to:

4.3.1 be counted towards the quorum of a meeting; and

4.3.2 exercise voting rights.

4.4 The Trusts will ensure that, except for urgent or unavoidable reasons, their respective member (or their Nominated Deputy) attends and fully participates in the meetings of the Joint Committee.

4.5 The first chair of the Joint Committee shall be the chairperson of Gateshead Health NHS Foundation Trust ("**Joint Committee Chair**"). The Joint Committee Chair will rotate between the Chairs of the Trusts every twelve (12) months.

4.6 In the absence of the Joint Committee Chair at any meeting, the members present shall nominate one of the other Non-Executive Director members to chair the meeting.

5. Attendance by non-members

5.1 The Joint Committee may invite such persons as considered relevant to any agenda item to attend meetings of the Joint Committee but such persons shall not count towards the quorum or have the right to vote at such meetings.

5.2 Attendance by non-members shall be recorded in the shared minutes of the Joint Committees.

5.3 Meetings of the Joint Committee will be regularly attended by:

5.3.1 the Chief Executive Officer of North Cumbria Integrated Care NHS Foundation Trust;

5.3.2 the Finance Director of Northumbria Healthcare NHS Foundation Trust;

5.3.3 the IT Director of Northumbria Healthcare NHS Foundation Trust,

5.3.4 the Director for Commercial Development and Innovation of the Newcastle upon Tyne Hospitals NHS Foundation Trust; and

5.3.5 at least one Member of the Alliance Formation Team.

("**Regular Attendees**")

5.4 Regular Attendees:

5.4.1 will receive advance copies of the notice, agenda and papers for meetings, unless the Joint Committee directs otherwise;

5.4.2 may be invited, at the discretion of the Joint Committee Chair, to ask questions and address the meeting;

5.4.3 will not have a vote and will not count for the purposes of quorum; and

5.4.4 will be reviewed on or before 30 June 2025.

5.5 Any non-member may be asked to leave a meeting, or part of a meeting, at the discretion of the Joint Committee Chair.

6 Meetings and decision making

6.1 Subject to the provisions of this paragraph, the Joint Committee may regulate its proceedings as it sees fit.

6.2 The Joint Committee will meet at least monthly, at a time and date consistent with the Alliance Committees in Common.

6.3 The members will be given no less than five (5) clear business days' notice of its meetings. This will be accompanied by an agenda and supporting papers which shall be sent to each member no later than five (5) clear business days' before the date of the meeting.

6.4 A member may give notice to the Joint Committee Chair that an urgent meeting of the Joint Committee is required. Where such notice is provided the Joint Committee Chair shall liaise with the members to arrange an urgent meeting.

6.5 Meetings of the Joint Committee shall take place in private to facilitate discussion and decision making on matters which are commercially sensitive or confidential.

6.6 For a meeting to be quorate each of the Trusts must be represented by one of their Executive Directors (or Nominated Deputy for their Executive Director) and one of their Non-Executive Directors. No decision may be taken at any meeting unless a quorum is present.

6.7 If any member is disqualified from voting due to a conflict of interest pursuant to section 8 of these Terms of Reference, they shall not count towards the quorum.

6.8 The Joint Committee will seek to make decisions on a consensus basis. Where consensus is reached the Joint Committee Chair shall ensure that the consensus agreement is understood by all members and it shall be recorded in the minutes.

6.9 Where the Joint Committee is unable to reach a consensus and the decision is put to a vote, the decision shall require unanimity to pass.

6.10 Each member shall have one vote.

6.11 Any member of the Joint Committee may participate in its meetings by secure telephone or video conference, provided that all members are able to hear each other such that they can contribute to discussions and decisions.

7. Administrative

7.1 Administrative support shall be provided by a Trust Secretary from one of the three Trusts. This responsibility shall rotate between the Trusts every twelve (12) months..

7.2 A schedule of meetings of the Joint Committee shall be drawn up for each financial year and circulated to the Trusts .

7.3 The agenda for the Joint Committee shall be determined collectively by the members.

7.4 The Joint Committee will prepare an annual report for the Trusts' boards on its performance.

8. Conflicts of Interest

8.1 Each member must declare any actual or potential conflicts of interests in relation to an item of scheduled or likely business at the start of each meeting. For the avoidance of doubt, where a potential conflict of interest arises during the course of a meeting, the relevant member must declare such conflict of interest without delay.

8.2 Declared conflicts of interests will be recorded in the minutes.

9. Reporting requirements

9.1 The Joint Committee shall provide such reports and updates as may be required each of the Trusts' boards from time to time which may include updates to board meetings in private or committee meetings.

9.2 The minutes of the Joint Committee shall be provided to the Trust Secretary for each of the Trusts for inclusion on the private agenda for each Trusts' board meetings.

10. Review and amendment

10.1 Subject to section 10.2, these Terms of Reference will be reviewed annually.

10.2 These Terms of Reference may be reviewed at any time to reflect strategic developments and the evolving nature of the work between the Trusts. Any amendments must be approved by the boards of the Trusts prior to amendments taking effect.

Annex 1 – Specific Responsibilities for the Joint Committee Work Plan.

Finance	• Agreement of activity and financial contracts with the Integrated Care Board for financial year 2025/26 for the three Trusts. • The Lead Director to be the lead negotiator, but will work closely with the respective Trust Finance Directors to do this as part of their respective statutory responsibilities.

Digital and Information Technology (I.T.)	• Specific activities in support of the Alliance Digital Ambition – as agreed at the Alliance Committees in Common.
	• Activities that cover:
	  ○ Scoping project that identifies what action is required in each Trust to ensure strong and equitable foundations for future development.
	  ○ Identification of any costs that are required to provide strong and equitable foundations across the three Trusts.

Research and Life Sciences	• Scoping project to identify and understand what activity is undertaken in each organisation, alongside specific opportunities for joint or collaborative projects in the future.

10. Governance Reports

i) Organisational Risk Register

Presented by the Interim Chief Nurse

Gateshead Health NHS Foundation Trust

Agenda Item: 10i

Report Title:	**Organisational Risk Register (ORR)**			
Name of Meeting:	Board of Directors			
Date of Meeting:	5th December 2025			
Author:	Marie Malone, Corporate and Clinical Risk Lead.			
Executive Sponsor:	Elizabeth Swanson, Interim Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals			
Report presented by:	Elizabeth Swanson, Interim Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	To ensure the Board and Committees are clearly sighted on those risks that have an organisational -wide impact, the organisational risk register is compiled by the Executive Risk Management Group (ERMG) of those risks that impact on the delivery of strategic aims and objectives. This includes risks included within the Board Assurance Framework (BAF) as well as risks identified by the Group for inclusion as having an organisational impact and impact on delivery of strategic aims and objectives. The supporting report shows the risk profile of the ORR, includes a full register, and provides details of review compliance, and risk movements.			
Proposed level of assurance – *to be completed by paper sponsor:*	**Fully assured** ☒ *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 October and November 2025. The following updates and movements agreed: ➢ In the period of 17th September - 17th November 2025, there were 2 risks added to the ORR, 2 escalations, 2			

• *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	reductions, 3 risks closed and 2 removed from the ORR. ➢ 16 risks in total on the Organisational risk register Risks with no movement in 6-month period are highlighted for information and discussion. Summary of Movements over 12-month period is shown within the attached report. Compliance with reviews remains positive in period and sits at 93% for risks and 90% for associated actions. (This is in comparison to 95% for risks and 88% for associated actions within previous 2 months data set.)
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board are asked to: • Review the risks on the report and discuss and seek further information as appropriate. • Note movements over 12-month period listed in the attached report. • Note risks with no movement in the previous 6-month period. • Take assurance that risks are reviewed in line with risk management arrangements. • Be sighted on the top risks for the organisation.
Trust Strategic Priorities that the report relates to:	☒ Excellent Patient Care ☒ Great Place to Work ☒ Working Together for Healthier Communities ☒ Fit For the Future
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	1. We will be a clinically-led organisation focused on delivering safe, high-quality care and improving health outcomes for our patients 2. We will ensure our patients experience the best possible compassionate care and make every contact count 4. We will care for our people, creating a fair, inclusive and respectful environment where everyone can thrive in their role 6. We will be an employer and training provider of choice within the local Community recognising our role as an anchor institution 7. We will work in collaboration with our partners to improve the health of our population and reduce health inequalities 8. We will develop our neighbourhoods in line with the NHS 10-year plan

	9. We will collaborate with system partners with an emphasis on maximising efficient use of collective resources across health and care services 10. We will ensure effective and efficient use of our resources identifying opportunities to improve productivity and ensure best use of public money 11. We will be a data informed, digitally enabled organisation using technology to transform the way we plan and deliver care 12. We will focus on productive utilisation of our estate to facilitate care in the right setting and providing our services in an environmentally sustainable way				
Links to CQC Key Lines of Enquiry (KLOE):	Safe ☒	Effective ☒	Caring ☒	Responsive ☒	Well-led ☒
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):	Included in report				
Has a Quality and Equality Impact Assessment (EQIA) 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 17th September- 17th November (extraction date for this report, Via Inphase).

Organisational Risk Register

2. Movements in period

Following ERMG meetings in October and November 2025, 2 risks has been added to the ORR.

There have been 2 escalations, 2 reductions, 3 closures and 2 de-escalations from the ORR.

There are currently 16 risks on the ORR, agreed by the Executive Risk Management Group as per enclosed report.

Risks added to the Organisational risk register:
There have been 2 risks added to the ORR in period, with 1 risk also being increased in score:

- **2984 (Surgery)** There is a risk to our ability to continue to run maternity services from the designated building due to the age and quality of the estate resulting in an increased clinical risk, financial deterioration and capital requirements which cannot be met. (20)
    - Increased in score from 16 to 20

- Escalated to the ORR due to the ongoing concerns around resilience of the estate and infrastructure, including reduced resilience in the steam supply heating system.
- Strengthening of an enacted BCP is required, to understand the impact this would have on the wider organisational footprint, as well as system partners.

- **4820 (MD's Office)** Risk of significant and cumulative impact to services due to industrial action of resident Doctors which could impact on patient safety, experience and outcomes, and well as financial implications. (16)
  - New Industrial Action episode announced from 11th November 2025
  - Risk also highlighted as being potentially financially impactful
  - Impact assessments undertaken scrutinising rotas to ensure safe level of cover during the period.

Risks Escalated:
1 further risk has increased in score in period:

- **4702 (Finance)** The Group's cash balance is reducing due to the Organisation operating with an underlying deficit. Reducing cash balance increases the risk of the Group having to access revenue cash support during 2025-26. (20)
  - Increased from 16 to 20
  - Increase in likelihood to 5 given further deterioration in cash position

Risks reduced:
2 risks have reduced in score in period:

- **4714 (COO)** Risk of under recovery of income captured in the 25-26 financial plans due to an under delivery of the planned levels of activity resulting in a deterioration in the Trusts financial position and non-achievement of the agreed plan. (9)
  - Reduced from 12 to 9
  - Delivery of core activity within clinical teams has improved financial performance forecast.

- **4734 (Medicine)** Risk of patient harm due to extended lengths of stay within the Emergency Department resulting in poor patient outcomes and an increase in clinical risk. Monitored and evidenced by variable compliance with the national four-hour emergency care standard. (8)
  - Risk reduced from 12 to 8
  - Evidenced improvement in performance demonstrated, acknowledging that the risk may change dynamically over the winter period.

Risks removed from the Organisational Risk register:
2 risks have been de-escalated from the ORR:

- **4574 (COO)** A risk of being unable to relocate in the event of an evacuation due to capability and capacity issues within the estate that may potentially result in patient safety issues and impact quality. (12)
    - Risk is being managed as part of ongoing business resilience planning

- **4554 (Digital)** There is a risk that the trust is not sufficiently protected against the current and evolving cyber threats. (10)
    - Cyber exposure/vulnerability score remains consistent, acknowledging that cyber risks will always remain.

Risks closed:
3 Risks have been closed in period:

- **4763 (MDs Office)** Risk of significant and cumulative impact to services due to industrial action of resident Doctors which could impact on patient safety, experience and outcomes. (12)
    - At time of closure, no further Industrial Action had been announced.
    - Risk superseded by new Industrial Action risk.

- **4541 (NMQ)** There is a risk of the failure of governance arrangements as we transition to a new governance structure.
    - The Transition has now been undertaken, and chairs of the meetings take ownership of the governance and escalation arrangements via Triple A processes.

- **4771 (POD)**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.
    - Iteration of risk no longer relevant and has been reframed to emphasise the impact the risk could have on patient quality and staff morale.

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

There are 10 risks on the ORR with no movement in the past 6 months (June - November 2025) [excluding newly raised risks] as displayed below.
The board are asked to be fully cognisant that lack of movement with scores could pose a threat to the achievements of the Organisations Priorities and objectives, noting however, that mitigating actions have been applied during this time.

Changes to Current Score over 6 Months

Risk ID	Risk Stage	Risk Title	Owner	Business Unit	Service	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025
4694	Current Risk	Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m	Kris Mackenzie	Finance	Finance	20	20	20	20	20	20
2341	Current Risk	There is a risk to ongoing business continuity of service provision due to ageing trust estate	Anthony Pratt	QE Facilities	Estates	16	16	16	16	16	16
3132	Current Risk	Exposure to incidents of violence and aggression	Kate Clark	People & OD	Human Resources	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
4704	Current Risk	Risk of failure to review appropriate clinical information due to multiple sources of data stored across a variety of digital systems.	David Thompson	Digital	Systems	16	16	16	16	16	16
4713	Current Risk	The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis	Kris Mackenzie	Finance	Finance	16	16	16	16	16	16
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
4705	Current Risk	Risk of considerable clinical and operational impact to patient care due to failure of PACS environment.	David Thompson	Digital	Systems	15	15	15	15	15	15
4525	Current Risk	Risk of Lack of a strategic workforce planning	Natasha Botto	People & OD	Human Resources	9	9	9	9	9	9
4405	Current Risk	Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure.	Dianne Ridsdale	Digital	Digital Transformation and Assurance	8	8	8	8	8	8

4. Top Organisational Risks:

The following 2 risks were agreed as top risks in November's meeting:

1- **Finance**- non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m
2- **Digital-**Risk of failure to review appropriate clinical information due to multiple sources of data stored across a variety of digital systems.

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

- **4704 (Digital)** Risk of failure to review appropriate clinical information due to multiple sources and lack of interoperability of data stored across a variety of digital systems and in paper format. This could result in patient harm or sub optimal care. (16)

Further discussions are to be held to determine the final top 3 risk, which will be confirmed by Chief Executive Officer in due course.

5. BAF and Trust Corporate Strategic Priorities

The Board of Directors are asked to take assurance that all Organisational Risks have been aligned with the new BAF, as well as to the newly launched Strategic Priorities and Objectives/ambitions over the next 5 years.

6. Current compliance with Risk reviews:

Risk review compliance for November was 93%. Action review compliance was 90%.

This is similar compliance with risks and actions for the previous reporting period. (95% for risks and 88% associated actions.)

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

7. Recommendations

The Board of Directors are asked to:

- Review the risks and discuss and seek further information relating to risks as appropriate.
- Note limited movement of ORR risks in the 6-month period
- Have full sight of the agreed top Organisational risks.
- Take assurance over the development and review of the Organisational Risk Register as per risk governance framework.

Organisational Risk Report- November 2025.

Total Risks (Current/Managed)

16

People 2

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Staff Safety	People & OD	3132	Exposure to incidents of violence and aggression	16
Resources	People & OD	4525	Risk of Lack of a strategic workforce planning	9

Quality 6

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Safety	Surgical Services	2984	Health & Safety concerns due to the age and condition of the maternity estate and infrastructure.	20
Safety	Surgical Services	3107	Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings	15
Safety	Digital	4704	Risk of failure to review appropriate clinical information due to multiple sources of data stored across a variety of digital systems.	16
Safety	Digital	4705	Risk of considerable clinical and operational impact to patient care due to failure of PACS environment.	15
Safety	Medical Director's Office	4820	Industrial Action - Resident Doctors	16
Safety	Medical Services	4734	Risk of patient harm due to variability in meeting 4 hour ED Emergency Care standard	8

Finance 5

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	4702	Reducing Cash Balances	20
Finance	Finance	4713	The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis	16
Finance	Chief Operating Officer	4714	2025-26 planned activity is not achieved resulting in the Trust not achieving planned income targets	9
Business Continuity	QE Facilities	2341	There is a risk to ongoing business continuity of service provision due to ageing trust estate	16

Regulation 2

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

Reputation 1

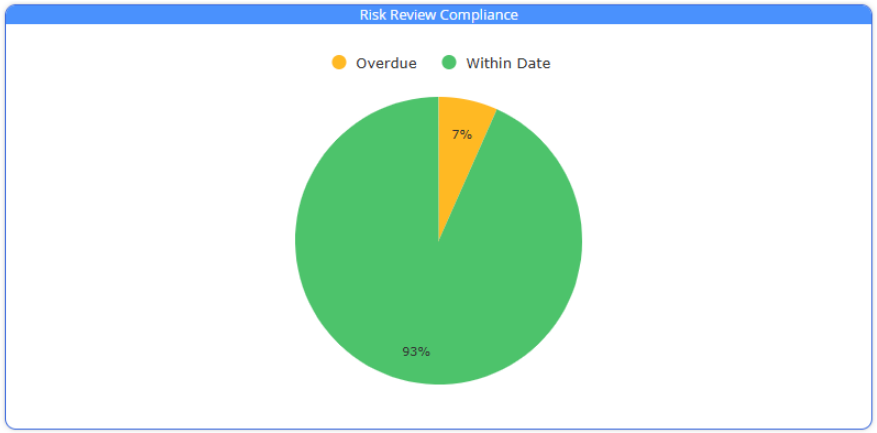
Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Reputation	Chief Executive Office	4772	Risk of Potential instability of the Board of Directors due to secondment of Chief Executive Officer.	12

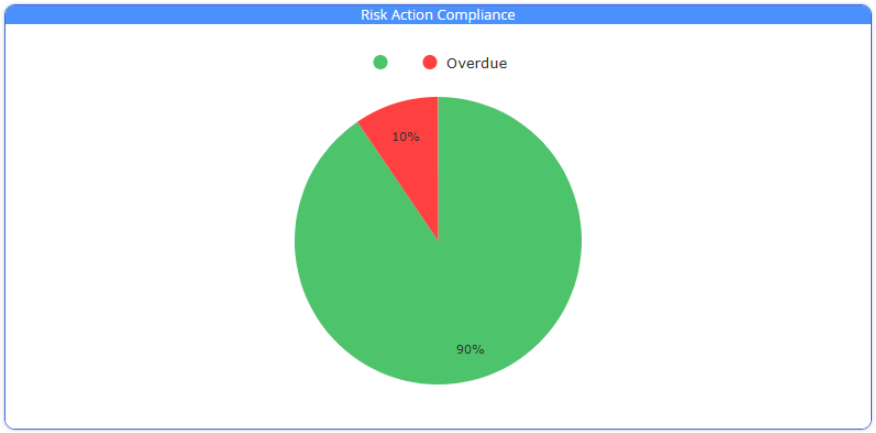
All Organisational Risks- Movements in Scores over 12 Months. December 2024- November 2025

Changes to Current Score over 12 Months

Risk ID	Risk Stage	Risk Title	Owner	Business Unit	Service	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025
2984	Current Risk	Health & Safety concerns due to the age and condition of the maternity estate and infrastructure.	Karen Parker	Surgical Services	Obstetrics	16	16	16	16	16	16	16	16	16	16	20	20
4694	Current Risk	Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m	Kris Mackenzie	Finance	Finance			20	20	20	20	20	20	20	20	20	20
4702	Current Risk	Reducing Cash Balances	Kris Mackenzie	Finance	Finance			16	16	16	16	12	16	16	16	20	20
2341	Current Risk	There is a risk to ongoing business continuity of service provision due to ageing trust estate	Anthony Pratt	QE Facilities	Estates	16	16	16	16	16	16	16	16	16	16	16	16
3132	Current Risk	Exposure to incidents of violence and aggression	Kate Clark	People & OD	Human Resources	15	15	12	12	12	12	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
4704	Current Risk	Risk of failure to review appropriate clinical information due to multiple sources of data stored across a variety of digital systems.	David Thompson	Digital	Systems			16	16	16	16	16	16	16	16	16	16
4713	Current Risk	The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis	Kris Mackenzie	Finance	Finance				16	16	16	16	16	16	16	16	16
4820	Current Risk	Industrial Action - Resident Doctors	Ross Peddie	Medical Director's Office	Medical Directorate												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
4705	Current Risk	Risk of considerable clinical and operational impact to patient care due to failure of PACS environment.	David Thompson	Digital	Systems				20	25	20	15	15	15	15	15	15
4772	Current Risk	Risk of Potential instability of the Board of Directors due to secondment of Chief Executive Officer.	Sean Fenwick	Chief Executive Office	Chief Executive Office								12	12	12	12	12
4525	Current Risk	Risk of Lack of a strategic workforce planning	Natasha Botto	People & OD	Human Resources	12	12	12	9	9	9	9	9	9	9	9	9
4714	Current Risk	2025-26 planned activity is not achieved resulting in the Trust not achieving planned income targets	Jo Halliwell	Chief Operating Officer	Planned Care				12	12	12	12	12	12	12	9	9
4405	Current Risk	Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure.	Dianne Ridsdale	Digital	Digital Transformation and Assurance	8	8	8	8	8	8	8	8	8	8	8	8
4734	Current Risk	Risk of patient harm due to variability in meeting 4 hour ED Emergency Care standard	Jo Halliwell	Medical Services	Med 1						16	16	16	12	12	8	8

Risk review and action review compliance- November 2025





Top Organisational Risks- November 2025

Risk Id	Risk Owner	Division	Description	Initial Risk Grade	Grade	Target Grade
4694	Kris Mackenzie	Finance	Risk that the Trust will not achieve its revenue plan for 2025-26 and a deterioration from the 2024-25 planned deficit, resulting in a deterioration to Trusts NHS Oversight Framework rating.	25	20	10
4704	David Thompson	Digital	Risk of failure to review appropriate clinical information due to multiple sources and lack of interoperability of data stored across a variety of digital systems and in paper format. This could result in patient harm or sub optimal care.	20	16	8

11. Assurance from Board Committees

i) Finance and Performance Committee - October and November 2025 - presented by the Chair of the Committee

ii) Quality Governance Committee - November 2025 - presented by the Chair of the Committee

iii) Digital Committee - November 2025 - presented by the Chair of the Committee

iv) People and Organisational Development Committee - September and November 2025 - presented by the Chair of the Committee

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Committee Escalation and Assurance Report

Name of Board Committee	Finance and Performance Committee
Date of Board Committee:	28 October 2025
Chair of Board Committee:	Mr M Hedley

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

The Committee identified the following Alert items:

- **Cash Position** – cash balances are above plan but are expected to reduce significantly by March 2026. Work is underway to explore options for cash support with Alliance and regional partners in the first instance.

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

The Committee identified the following advisory items:

- **CRP –** concerns identified in relation to:
  - the small unmitigated gap in relation to the CRP annual target (£2.45m) – there is a focus on identifying new schemes to be brought forward or non-actions to manage spend in year.
  - shortfall in cost reduction savings on a full year effect recurring basis.
- **Performance** – there has been a deterioration in performance across a number of measures in September including 4hr standard, nationally declarable DTA breaches, elective recovery, waiting lists, and length of stay.
- **Planning Guidance** – this has been published with a draft medium-term plan due to be submitted by 18 December 2025.

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

The Committee received assurances in relation to the following:

- Finance Report – year to date financial position is on plan.
- Audit One Report – Follow up audit – QEF Reverse SLA – good level of assurance received with 1 recommendation.

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

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• There were no new risks identified.
Cross-referrals to other Committees (by significant exception only)
• There were no cross referrals.

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Committee Escalation and Assurance Report

Name of Board Committee	Finance and Performance Committee
Date of Board Committee:	25 November 2025
Chair of Board Committee:	Mr G Morrow

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:

- Urology – The Triple A report from the Operational Oversight Group is flagging that the number of patients awaiting a Urology first outpatient appointment has increased with 200 patients over 42 weeks, 92 without an appointment currently and 20 patients forecast to breach the 52-day national standard at the end of November. The service is delivered via an SLA with Newcastle Hospitals – discussions are taking place between the most senior leadership of both organisations to resolve the position. At this point there are several actions in train but no definitive plan to sustainably resolve the position.

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

The Committee identified the following advisory items:

- **Cash Position –** the Committee received a report setting out the plan for managing the cash position with a report for decision expected to the Committee and Trust Board in January 2026.
- **Planning Update –** the planning process has been challenging but work is progressing on the draft plan for approval and submission by the December deadline.
- **Contract Award Approval – Laundry Service –** the proposal for an extension of the existing contract for the provision of Laundry Services was approved for onward recommendation to Trust Board.
- **Cancer Standards –** there is a challenge in relation to the 28 and 62 day cancer performance.

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

The Committee received assurances in relation to the following:

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• Finance Report – year to date financial position is on plan and CRP is on track. • QEF Report • Community Diagnostic Centre – Phase 1 activity is seeing a recovery. • Industrial Action – the Trust maintained over 95% of activity during the period of industrial action.
Risks (any new risks / proposed changes to risk scores)
• There were no new risks identified.
Cross-referrals to other Committees (by significant exception only)
• There were no cross referrals.

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Committee Escalation and Assurance Report

Name of Board Committee	Quality Governance Committee
Date of Board Committee:	5 November 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)

- There were no alert items

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:

- Cancer Standards – concern noted in relation to the 28 and 62 day standards and a detailed report requested for the next meeting in December to provide more assurance.
- Safeguarding – updates to the report requested - the report to be reviewed with executive support and brought back to the next meeting in December.
- Ante-natal Clinic – concern was noted about capacity and overbooking – a paper is being taken to GHLG for resource from within the division to support the staffing need and actions being taken around training/support for new and bank HCA staff.
- SSIs – positive assurances were received by the Committee but ongoing improvement work has been identified and is being taken forward.
- Health and Safety – to ensure clarity in the organisation around the ownership of Health and Safety with the Trust as the responsible owner and QEF as a supporting service.

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

Positive assurances were agreed in relation to:

- SSI – the Committee were fully assured that the investigation had not identified anything causal in relation to the SSI cluster.
- PSIRF Transition – the transition to PSIRF is now fully complete.
- Safecare in Surgery discussion.
- Patient Experience – friends and family rating of 93%.
- Complaints – positive improvement seen in relation to numbers and management of complaints.
- Overdue incidents – positive action to reduce the backlog.

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• Internal Audit – good level of assurance for the Safe Staffing audit.
Risks (any new risks / proposed changes to risk scores)
• There were no new risks identified. • The risk rating for risk 3132 – violence and aggression to be reviewed as it may be possible to lower the rating given the sustained and improved position in relation to incidents of violence and aggression reported to the Committee.
Cross-referrals (by exception only)
• There were no cross referrals. • Dr C Howey and Mr M Shaw to highlight via Digital Committee the issues discussed with the Badger Net system - interoperability and difficulties with continuity of data with partner organisations.

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Escalation and Assurance Report

Name of Committee / Group:	Digital Committee
Date of Committee / Group:	20 November 2025
Chair of Committee / Group:	Mr Andrew Besford

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

- There were no alert items identified.

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

- Digital Records Programme – it is proposed that the business case and a separate case for Digital nurse and other digital support roles is submitted to the Trust Board in March 2026. The Committee noted the need to progress this. It was also highlighted that recent feedback from the Foundation Doctors had flagged digital systems in Gateshead as a potential negative factor for trainees.
- PACs upgrade – this is now due to take place on 2 December.
- Digital Strategy – increased engagement needed to develop the Digital chapter of the Trust Strategy.
- Alliance review of risks – to note that a cross-Alliance review of digital risks and how they are reported is being undertaken. This may identify risks that are not presently identified.
- Clinical Safety Officer Training – training needs to continue. Two places are being made available at a forthcoming training course at Northumbria but there is a need to consider how funding could be identified to allow more CSOs to be trained.

Assure
(key assurances received and any highlights of note)

The Committee received assurance in relation to:

- Clinical Safety - Update received and further updates and follow up on training to be considered by the Committee.
- Digital Delivery – assurance provided.
- Board Assurance Framework (BAF) – the Committee noted the current BAF with one key objective. It was agreed there is a need to split out this objective for the next iteration of the BAF.

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Risks (any new risks / proposed changes to risk scores)
• There were no new risks identified.
Cross-referrals to Tier 1 Board Committees (by exception)
• There were no cross-referrals.

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Escalation and Assurance Report

Name of Committee / Group:	People and OD Committee
Date of Committee / Group:	Tuesday 30 September 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)

1. **Standing down of tier 3 meetings –** The Committee were concerned that both Triple A reports presented from the POD Steering Group had highlighted an issue around tier 3 meetings being stood down. The Committee noted that this Committee had raised a similar alert a number of times previous, and there is a concern about the impact of meetings being stood down and in turn how an there was an effective governance and assurance flow through to the Committee. It was acknowledged this would form part of the governance review undertaken by the Acting CEO and Company Secretary.
2. **Audit actions –** Concern was raised around the unacceptable delivery of audit actions and the number of revised dates potentially reflecting issues of accountability and single points of failure.
3. **WRES/WDES –** Concern that the data being presented indicates that action to date on EDI, the experience of staff in the organisation, and staff networks has not been effective enough. It was agreed that a review and change of approach may be needed which would be taken forward by the Executive Team.
4. **Appraisal compliance** – Low appraisal compliance across the group with an overall compliance of 77%, alerted to the Committee via the POD Steering Group. There was a recognition of the need to prioritize these as it is recognised that as we head into Winter these are likely to decrease further.

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:

5. **Review of Culture Risk (4427)** – to review the wording of the culture risk to ensure the risk reflects support for speaking up and an open culture, as it could be misleading currently
6. **Job Plan Compliance** – There was a recognition that this is a key function of clinical leadership and current compliance levels need to be addressed within the organisation.

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7. **EDI Dashboard** – the Committee felt there was a lack of assurance from the data being presented overlaid with the colleague experience being described. It was therefore queried if what we were doing was working and whether it was making a tangible difference and more work was needed on this.
8. **Staff Survey** – lack of assurance provide that the actions we were taking as a result of staff survey were making a difference and making a difference to individuals working lives.
9. **10 Point Plan for Resident Doctors** – gap analysis has been undertaken and the Trust is broadly compliant - a report will be brought to the next meeting of the Committee in November.
10. **Sickness Absence** – there is a risk that there will again be a spike in sickness rates in October with no assurance able to be provided that the Trust will be in a better position in relation to sickness than it was last October.

Assure
(key assurances received and any highlights of note)

Positive assurances were agreed in relation to:

11. **Improved Sickness absence** – In month sickness absence rate of 4.7% for August which is the lowest rate since May 2021.
12. **ADQM Outcome Report**– positive outcome, reporting a year on year, sustained improvement. This report also provides assurances around elements of the 10-point plan for resident doctors as were there were any concerns of note these would be reflected in the ADQM. It also aligns to the strategic objective of being an employer and training provider of choice.
13. **WRES and WDES final data** – Retrospective sign off for the publication of the data which had been discussed in detail with two Non-executive Directors outside of the meeting and agreed by Trust Board.
14. **Review of Effectiveness** – evidence of good compliance with the terms of reference and positive feedback from members/attendees. Some small changes to be made to the terms of reference - to be referred back to the Committee in November for approval.
15. **Organisational Risk Register Report** - received
16. **Reflective Review of Lessons Learnt** – going forward the reflective review of lessons learnt in POD to feed into the Learning Panel structure that is in place across the Trust.
17. **Workforce Reduction** – mid-year Workforce Planning submission made and as a Trust we are ahead of plan and against the trend across the region.
18. **Cross Referrals** – cross referrals from the Audit Committee and Digital Committee have been closed.

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

From the Organisational Risk Register:

19. **Risk 4417** – (People and OD) Risk that promoting an environment that encourages speaking out and creating a psychologically safe culture has led to increased reports of poor behaviour. Director of People to raise at ERMG to

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	review the wording to ensure the risk reflects support for speaking up and an open culture.
20.	**Risk 4525** – risk that the lack of a strategic workforce plan leads to a lack of appropriate skilled staff – to review the wording of this risk to provide context that it is a longer-term strategic workforce plan that is needed.

Cross-referrals to Committees or Executive Directors
There were no cross-referrals.

Gateshead Health NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	People and OD Committee
Date of Committee / Group:	Tuesday 11 November 2026
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)

There were no Alert items identified.

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

The Committee identified the following advisory issues:

1. **Industrial Action by Resident Doctors –** plans are in place to manage the forthcoming industrial action with established systems and structures in place.
2. **Quoracy of Meetings –** Quoracy of meetings remains a concern in relation to assurance of information flowing through to the Committee - the review of governance arrangements by the CEO is ongoing, will cover the whole corporate structure and be complete in the next few months.
3. **EDI Assurance –** An update was provided in response to concerns raised by the Committee at the last meeting. It was acknowledged that a lot of work is being done but it is not clear that this is having an impact. The CEO is due to meet with the chairs of the Staff Networks as a first step and there is more work needed to define success metrics.
4. **Sickness Absence –** the Committee identified a need for further work in relation to Occupational Health with a focus on the preventative role. There is also a need to understand the reasons behind the high DNA rates for Occupational Health and how these can be addressed.
5. **Gender Pay Gap –** A 6 monthly update was provided - there has not been as much progress as anticipated against the action plan, but this is being progressed.
6. **Job Evaluation –** It was noted that this is a national priority – work is progressing, but it has been necessary to slow progress in Gateshead in order to streamline with the regional position. Further assurance on work plan to come to next committee.
7. **Staff Survey –** the response rate is behind last year's position and amongst the lowest in the Alliance and the region. It was acknowledged that there are multiple

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factors behind this and plans are in place to engage teams in the final weeks and encourage support for front line staff to allow them time to respond.

8. **Violence and Aggression Risk –** This risk score remains high and has not moved for some time – risk and mitigating actions to be reviewed by Exec Director and Risk owner.
9. **Flu Vaccine Uptake –** Flu Vaccine take up is behind target but improved from last years position. Strengthened comms messaging and increased peer and roaming vaccinators have been deployed. This was not covered on the agenda but was highlighted in the Executive Director's summary report.

Assure
(key assurances received and any highlights of note)

Positive assurances were agreed in relation to:

10. **Guardian of Safe Working (GOSW)** – exception reporting in Q2 is higher than Q1 but much lower than the same quarter last year. There has been a deterioration in the timescales for responding to exception reports. It is thought this links to communication issues from the Deanery in relation to the new GSW arrangements which have been postponed and won't now come into place until February 2026.
11. **People Strategy –** there is evidence of progress against the existing plan, with plans to move to a 5-year strategy with annual SMART targets.
12. **POD Targeted Operating Model** – this has now been implemented. Detail of impact on services provided to be shared with the Committee NEDs.
13. **Sickness Absence** – positive progress with change being felt within the organisation and a culture shift being recognised, although the long-term trajectory towards a challenging target is uncertain.
14. **Job Evaluation** – it was confirmed that the Board Assurance return has been submitted and a summary update will be provided to Board via email.
15. **10 Point Plan for Resident Doctors** – the self-assessment highlighted that the Trust meets or partially meets the majority of the points in the 10-point plan and there is an action plan and timescales for those areas that are not currently met. Ruby Hodges has been appointed as the Resident Doctor Peer Lead and attended the meeting of the POD Committee for this item.
16. **Annual Revalidation Report** – Statement of Compliance submitted – NHSE had some queries about the data, but these have been addressed.

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

There were no new risks identified

Cross-referrals to Committees or Executive Directors

There were no cross-referrals.

12. Finance Report

Presented by the Group Director of Finance

NHS Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 12

Report Title:	**Consolidated Finance Report – Part 1**			
Name of Meeting:	Board of Directors			
Date of Meeting:	5th December 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 *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	N/A			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	The Trust has an approved 2025-26 planned deficit of **£8.621m** before adjustments for donated asset depreciation, and **£8.381m** after. As of October 2025, the Trust has reported an actual deficit of **£7.015m** after adjustments for donated asset depreciation. This is a favourable variance of **£0.185m** 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 £9.008m PDC supported. As of October 2025, the Trust has capital spend on schemes totalling **£6.970m**. Cash balances are **£23.957m** at 31st October 2025 and £18.358m above planned levels for the reasons detailed in the body of this report.			

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Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The recommendation to the Board of Directors is to receive the report, and record partial assurance for the achievement of its 2025-26 planned financial targets.				
Trust strategic priorities that the report relates to:	☐	Excellent patient care			
	☐	Great place to work			
	☐	Working together for healthier communities			
	☒	Fit for the future			
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	We will ensure efficient and effective use of our resources, identifying opportunities to improve productivity and ensure best use of public money.				
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):					
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Gateshead Health NHS Foundation Trust

1.0 Introduction

1.1 This report intends to provide assurance against delivery of the approved 2025-26 revenue and capital plan.

1.2 Reporting for 2025-26 is against the Trusts approved financial plan, updated for in year contract variations and agreed service changes.

2.0 Key Financial Performance Indicators

2.1 Performance against key performance indicators for October 2025 is detailed in Table 1.

Finance KPIs	Month 07 - Oct-25 Budget £ '000	Actual £ '000	Variance £ '000	RAG	YTD Budget £ '000	Actual £ '000	Variance £ '000	RAG
I&E (Surplus) / Deficit (adjusted perf.)	406	395	(11)		7,200	7,015	(184)	
Operating Income	-35,905	-35,396	509		-252,374	-250,246	2,128	
Pay Expenditure	24,370	23,353	(1,017)		171,928	168,366	(3,562)	
Non Pay Expenditure	11,424	11,950	526		84,024	85,458	1,434	
Non Operating Income	-56	-94	(39)		-389	-875	(487)	
Non Operating Expenditure	600	616	16		4,202	4,539	337	
Remove capital donations / grant I&E Impact	-34	-34	0		-237	-227	10	
Balancing adj to NHSE Plan	6	0	(6)		46	0	(46)	
Agency Expenditure	84	105	21		501	663	162	
CRP Delivery	2,830	2,830	0		16,893	16,893	0	
Capital Expenditure	3,148	1,036	(2,112)		12,146	6,970	(5,176)	
Cash position	-381	2,383	2,764		5,599	23,957	18,358	
Liquidity (days)	20	14	(6.3)		20	14	(6.3)	
Better Payment Practice Code (BPPC)								
NHS	95.0%	63.9%	-31.1%		95.0%	67.6%	-27.4%	
Non NHS	95.0%	96.2%	1.2%		95.0%	97.0%	2.0%	
Aged Debt								
Receivables over 90 days NHS	10.0%	34.0%	24.0%		10.0%	34.0%	24.0%	
Receivables over 90 days non NHS	10.0%	30.9%	20.9%		10.0%	30.9%	20.9%	

Table 1: Finance KPIs

2.2 The Trust has reported a **£0.395m** deficit for the month of October; which is a favourable variance of **£0.011m** against plan.

2.3 Year-to-date the trust position is **£7.015m** deficit, a favourable variance from plan of **£0.185m.** This is mainly due to overspends on medical staffing within Medicine and Community Business Unit and being offset by pay underspends elsewhere within the trust.

2.4 As at M7 the key risks to the delivery of the plan are summarised as slippage against the cost reduction target as well as medical pay overspends within Medicine and Community.

Gateshead Health NHS Foundation Trust

2.5 A Statement of Comprehensive Income is presented in Appendix A.

3.0 Cost Reduction Programme

3.1 Performance against the year-to-date target overall is currently on plan at **£16.883m** and is summarised in Table 2.

					Annual Achieved		
Scheme Thense	Target as at M7 Oct 25 £000	Actual as at M7 Oct 25 £000	Variance as at M7 Oct 25 £000	Annual Achieved as at M7 Oct 25 £000	Recurring £000	Non Recurring £000	Total £000
Commercial	871	2,038	(1,167)	2,626	1,638	988	2,626
Corporate Restructure	856	731	125	1,273	975	298	1,273
Cost Reduction - Productivity	2,792	2,052	740	4,065	4,065	0	4,065
Cost Reduction - Workforce	792	1,533	(741)	1,979	1,441	538	1,979
Drugs	190	0	190	0	0	0	0
Income	1,167	1,281	(115)	1,281	713	568	1,281
Income - Productivity	467	596	(129)	606	970	-364	606
Non Pay Spend Controls	1,374	1,158	215	1,607	235	1,371	1,605
Procurement	263	70	193	243	287	-44	243
Service Change	83	156	(73)	287	48	239	287
Skill Mix Workforce	103	28	75	48	6	42	48
Technical Adjustment	3,500	4,251	(751)	6,038	12	6,030	6,043
Vacancy Control	2,597	2,989	(392)	2,999	0	2,999	2,999
Unidentified	1,829	0	1,829	0	0	0	0
Total	**16,883**	**16,883**	**0**	**23,052**	**10,392**	**12,664**	**23,055**

Table 2 Cost Reduction Performance

3.2 To date the Trust has achieved annually **£23.052m** of the £32.871m cost reduction target of which **£10.392m** (31%) is achieved on a recurring basis.

3.3 Performance against the CRP Programme will be reported and monitored via the Cost Reduction Steering Group and in accordance with the CRP Governance Framework.

4.0 Underlying Trust Financial Position

4.1 The Trust objective is to improve its underlying deficit by the end of March 2026 to £26.4m as summarised in Table 3. As at October the Trust is reporting an improvement in its underlying deficit of £19.3m comprising of recurring CRP totalling £14.8m and elective recovery income of £1.5m offset by the 25-26 pay award pressure of £0.7m and £0.1m IFRS16 funding which has been confirmed as non-recurring.

Gateshead Health NHS Foundation Trust

	25-26 Internal Objetive		Annual Plan	Forecast	
	25-26 £m	Underlying £m	As per 25-26 Annual Plan £m	M7 Forecast as per SFBP £m	As per 25-26 M7 Finance Return £m
Opening Deficit	(61.20)	(61.20)	(61.20)	(61.20)	(61.20)
Recurring FFYE CRP Achieved	32.80	32.80	20.10	14.76	20.10
Deficit Support Funding	5.30	0.00			
ICB Support Funding	9.00	0.00			
Non-Recurring Savings - Vacancy Factor	3.90	0.00	3.90	3.90	3.90
ERF Ceiling	2.00	2.00	2.00	1.50	1.50
25-26 Pay Award - New Change	0.00	0.00		(0.75)	(0.75)
IFRS 16 Funding - Advised NR Income	0.00	0.00		(0.12)	(0.12)
Total Exit Deficit	**(8.20)**	**(26.40)**	**(35.20)**	**(41.91)**	**(36.56)**

5.0 Capital

5.1 The 2025-26 capital plan was approved as part of the overall Trust plan at £20.076m. An additional PDC award of £0.134m was made in August in respect of the NHS ChargePoint Accelerator Scheme and a further £0.129m awarded in September in respect of the CDC Pathways (Liver Disease) which increases this to £20.339m.

5.2 As at October 2025 the Trust has reported capital spend totalling £6.970m (£5.176m below Plan) mainly against the Colposcopy and Paediatrics schemes, £0.694 of IT hardware and £2.080m of Backlog Maintenance as summarised in Table 4.

5.3 The revised timeline for the CDC Phase 2 business case to be presented to Trust Board is September. This delay is due to further work required to refine the services being delivered as part of phase 2 due to delays in funding being confirmed. This delay results in certainty that the scheme will not be delivered by March 2026 resulting in slippage against the PDC funding. The Trust has already written to NHSE to ask for support in managing and mitigating the misalignment between capital funding and spending profiles.

5.4 No other risks to the delivery of the capital programme are identified as at the end of October.

Gateshead Health NHS Foundation Trust

Capital Scheme	2025/2026 Annual Plan £000's	Spend to Oct 25 £000's
CDC Phase 2	5,468	99
Physiological Sciences	106	106
Day Care Service Improvements	50	0
UEC Creation of a Surgical Assessment Area	562	0
EPAC Expansion	700	0
Same Day Emergency Care (SDEC)	585	0
Sub-total Constitutional Standards	**7,471**	**205**
Sub-total Estates Safety - Backlog Maintenance	**5,000**	**2,080**
Sub-total Medical Equipment Replacement	**941**	**0**
Sub-total Digital	**800**	**694**
Colposcopy	2,319	2,115
Paediatrics	2,945	1,524
X-Ray Room 5	600	0
Sub-total Strategic Schemes	**5,864**	**3,639**
IFRS16	**0**	**281**
Charitable Funded Schemes	**0**	**71**
Total Capital Programme	**20,076**	**6,970**
Funded By:		
Depreciation	11,004	4,614
Cash	64	0
Public Dividend Capital	9,008	2,285
Charitable Funds	0	71
Total Funding	**20,076**	**6,970**

Table 4: 2025-26 Capital Plan

6.0 Cash Balances

6.1 Group cash as of 31st October 2025 totalled £23.957m, £18.358m more than planned. This favourable variance is due to improvements on working capital balances specifically an increase in trade / other payables of £9.809m and £5.176m of slippage against the capital programme. This is offset by an increase in receivables of £2.052m.

6.2 A position of cash and working balances is presented in Appendix B.

7.0 Conclusion

7.1 The Trust has reported an adjusted deficit of **£0.395m** for the period ending 31st October 2025 against a plan of £0.406m resulting in a favourable variance of **£0.011m**. Year-to-date the Trust reported an adjusted deficit of **£7.200m** against a plan of £7.014m resulting in a favourable variance of **£0.185m**.

7.2 The Trust has reported total capital spend of **£6.970m**, against a plan for the year to date of £12.146m.

7.3 The Trust has reported achievement of £16.883m cost reduction, which is on target for the year to date. On an annual basis, £23.052m (70%) has been achieved against the target of £32.8m, of which **£10.392m (31%)** has been achieved on a full year effect recurring basis.

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7.4 The Trusts is reporting a forecast cost reduction achievement of £31.787m, and shortfall of £1.084m, this shortfall is a risk to the Trust achieving its 25-26 financial plan.

7.5 At this stage in the financial year, the Trust is forecasting achievement of both its revenue and capital plan, but has highlighted unmitigated risk of £5m aligned to the forecast shortfall against the 2025-26 cost reduction target.

7.6 Cash balances at the end of October total £23.857m, however current liabilities are above £64m which when realised, alongside catch up of the capital programme and repayment of PDC and loans will reduce cash balances throughout 2025-26.

7.7 The Trust underlying deficit is forecast to improve by **£19.29m** resulting in a forecast underlying exit deficit totalling **£41.91m**, which is less than Trust plan and internal objective.

Kris Mackenzie, Group Director of Finance
November 2025

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Appendix A – Statement of Comprehensive Income (SOCI)

Statement of Comprehensive Income	Month 07 - Oct-25 Budget £'000	Actual £'000	Variance £'000	YTD Budget £'000	Actual £'000	Variance £'000
Operating Income from Patient Care activities						
Income From NHS Care Contracts	-32,636	-32,155	481	-229,882	-227,671	2,211
Income From Local Authority Care Contracts	-30	-32	(2)	-209	-223	(14)
Private Patient Revenue	-66	-130	(64)	-461	-564	(103)
Injury Cost Recovery	-42	-98	(57)	-292	-296	(4)
Other non-NHS clinical revenue	-14	228	242	-101	155	257
Total Operating Income From Patient Care activities	-32,788	-32,187	**601**	-230,945	-228,599	**2,346**
Other Operating Income						
Education and Training Income	-1,024	-1,194	(170)	-7,230	-7,393	(164)
R&D Income	-92	-85	7	-645	-630	15
Funding outside of System Envelope	0	0	0	0	0	0
Other Income	-2,001	-1,930	71	-13,554	-13,623	(69)
Donations & Grants Received	0	0	0	0	0	0
Cost Improvement Programme - Income	0	0	0	0	0	0
Total Other Operating Income	-3,117	-3,209	**(92)**	-21,428	-21,647	**(218)**
Total Operating Income	-35,905	-35,396	**509**	-252,374	-250,246	**2,128**
Operating Expenses						
Employee Expenses - Substantive	23,606	22,497	(1,109)	166,324	161,265	(5,058)
Employee Expenses - Bank	563	639	76	4,271	5,617	1,346
Employee Expenses - Agency	84	105	21	501	663	162
Employee Expenses - Other	118	112	(6)	833	821	(12)
Cost Improvement Programme - Pay	0	0	0	0	0	0
Total Employee Expenses	**24,370**	**23,353**	**(1,017)**	**171,928**	**168,366**	**(3,562)**
Purchase of Healthcare - NHS bodies	437	813	376	5,093	5,980	887
Purchase of Healthcare - Non NHS bodies	186	225	39	1,084	1,318	234
Purchase of Social Care	0	0	0	0	0	0
NED's	15	12	(3)	107	106	(0)
Supplies & Services - Clinical	3,785	3,682	(102)	26,312	26,597	285
Supplies & Services - General	256	271	15	1,802	1,763	(39)
Drugs	2,069	2,398	330	14,524	15,361	838
Research & Development expenses	0	-1	(1)	4	5	0
Education & Training expenses	212	82	(129)	1,458	848	(610)
Consultancy costs	56	35	(21)	372	152	(219)
Establishment expenses	359	283	(76)	2,493	2,629	136
Premises	1,549	1,702	153	10,720	11,104	384
Transport	174	116	(58)	1,202	902	(301)
Clinical Negligence	783	804	21	5,480	5,297	(183)
Operating Leases	246	39	(207)	1,662	1,021	(641)
Other Operating expenses	346	563	217	3,707	4,474	767
Cost Improvement Programme - Non Pay	0	0	0	0	0	0
Reserves	0	0	0	0	0	0
Operating Expenses included in EBITDA	**10,472**	**11,026**	**554**	**76,019**	**77,556**	**1,537**
Depreciation & Amortisation - Purchased / Constructed	734	948	214	6,654	6,661	7
Depreciation & Amortisation - Donated / Granted	34	34	(0)	237	227	(10)
Depreciation & Amortisation - Finance Leases	253	24	(229)	1,769	1,770	1
Impairment & Revaluation	-69	-81	(12)	-655	-757	(102)
Operating Expenses excluded from EBITDA	**952**	**925**	**(27)**	**8,005**	**7,902**	**(103)**
Total Operating Expenses	**35,794**	**35,303**	**(491)**	**255,953**	**253,824**	**(2,128)**
(Profit)/Loss from Operations	**(111)**	**(93)**	**18**	**3,579**	**3,578**	**(0)**
Non-Operating Income						
Finance Income	-56	-94	(39)	-389	-875	(487)
Total Non-Operating Income	-56	-94	**(39)**	-389	-875	**(487)**
Non-Operating Expenses						
Finance Expense	70	86	16	491	834	343
Gains / (Losses) on Disposal of Assets	0	0	0	0	0	0
PDC dividend expense	426	426	0	2,981	2,982	1
Total Finance Costs (for non-financial activities)	**496**	**512**	**16**	**3,472**	**3,816**	**344**
Other Non-Operating Expenses						
Misc. Other Non-Operating expenses	0	0	0	0	0	0
Total Non-Operating Expenses	**496**	**512**	**16**	**3,472**	**3,816**	**344**
(Surplus) / Deficit Before Tax	**330**	**325**	**(5)**	**6,663**	**6,519**	**(143)**
Corporation Tax	104	104	(0)	729	723	(7)
(Surplus) / Deficit After Tax	**434**	**429**	**(5)**	**7,392**	**7,242**	**(150)**
Balancing Adjustment to NHSE Plan	6		(6)	46		(46)
(Surplus) / Deficit After Tax from Continuing Operations	**440**	**429**	**(11)**	**7,437**	**7,242**	**(195)**
Remove capital donations / grants I&E impact	-34	-34	0	-237	-227	10
Adjusted Financial Performance (Surplus) / Deficit	**406**	**395**	**(11)**	**7,200**	**7,014**	**(185)**

Gateshead Health NHS Foundation Trust

Appendix B Statement of Financial Position

	2025/2026 October 2025 Group Plan	2025/2026 October 2025 Group Actual	Movement from Plan
	£000's	£000's	£000's
Assets			
Non-Current Assets			
Investments	80	80	0
Property, Plant and Equipment, Net	176,413	169,561	(6,852)
Right of Use Assets	11,097	12,336	1,239
Trade and Other Receivables, Net	2,272	2,231	(41)
Finance Lease - Intragroup			
Trade and Other Receivables - Intragroup Loan	0	0	0
Total Non Current Assets	189,862	184,209	(5,653)
Current Assets			
Inventories	5,110	4,240	(870)
Trade and Other Receivables - NHS	6,161	5,250	(911)
Trade and Other Receivables - Non NHS	15,067	18,071	3,004
Trade and Other Receivables - Intragroup			
Trade and Other Receivables - Other	0	0	0
Cash and Cash Equivalents	5,598	23,957	18,359
Total Current Assets	31,936	51,518	19,582
Liabilities			
Current Liabilites			
Deferred Income	2,310	5,294	2,984
Provisions	1,614	2,404	790
Trade and Other Payables	44,450	51,581	7,131
Lease Liabilities	1,584	1,613	29
Trade and Other Payables - Capital	250	2,929	2,679
Other Financial Liabilities - Borrowings FTFF	999	499	(500)
Other Financial Liabilities - Borrowings Other (Non-DHS	0	12	12
Total Current Liabilities	51,207	64,332	13,125
NET CURRENT ASSETS (LIABILITIES)	(15,155)	(12,814)	6,457
Non-Current Liabilities			
Deferred Income	1,983	1,648	(335)
Provisions	2,445	2,143	(302)
Trade and Other Payables - Other	-	0	0
Lease Liabilities	10,447	11,746	1,299
Other Financial Liabilities - Accruals	0	0	0
Other Financial Liabilities - Intragroup Borrowings	0	0	0
Other Financial Liabilities - Borrowings FTFF	9,513	10,014	501
Other Financial Liabilities - Other Borrowings	0	96	96
Finance Lease - Intragroup			
Total Non-Current Liabilities	24,388	25,647	1,260
TOTAL ASSETS EMPLOYED	**146,203**	**145,748**	(456)
Tax Payers' and Others' Equity			
PDC	168,864	168,808	(56)
Taxpayers Equity	0	0	0
Share Capital	0	0	0
Retained Earnings (Accumulated Losses)	(35,940)	(35,830)	110
Other Reserves	0	0	0
Revaluation Reserve	13,180	12,671	(509)
Misc Reserve	99	99	0
TOTAL TAXPAYERS EQUITY	146,203	145,748	(455)
TOTAL ASSETS EMPLOYED	**146,203**	**145,748**	(455)

13. Strategic Objectives and Constitutional Standards Report Presented by the Group Director of Finance

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 13

Report Title:	Strategic Objectives & Constitutional Standards			
Name of Meeting:	Board of Directors			
Date of Meeting:	Friday 5 December 2025			
Author:	Deborah Renwick: Associate Director of Planning & Performance			
Executive Sponsor:	Kris Mackenzie: Group Director of Finance			
Report presented by:	Kris Mackenzie: Group Director of Finance 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 M3 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**. **Quality Improvement Plan:** October performance remains at 84%, below planned levels of key delivery areas and actions on track. Areas requiring improvement or remain challenging are Trustwide appraisal rates, Staff retention, local induction checklist compliance, Implementation of falls PSIRP workstream plan and Reduction of harm from falls of 5%. **PSIRP**: The volume of falls and falls harm rates has increased in October, the falls steering group continue to meet and progress the current action plan. In support of identification and prevention of Venous Thromboembolisms (VTE) 98.9% of all patients admitted in October were risk assessed (in accordance with NICE guidance criteria). Exceeding the national standard of 95%.			

• *Equality, diversity, and inclusion*	**QA**: The Trust reported six cases of C. difficile in October. The Trust's annual threshold has been set at 36, YTD cases stand at 25. In-month rates per 100k bed days were 42.83. A ten point action plan is in place. **QA**: Performance against learning disability and autism training has increased to 83% in month but remains below target levels of 85%. Learning disabilities training will be slowly phased out on a rolling basis as individuals competencies expire and this will be replaced with Oliver McGowan E-learning. Mental Health Act Policy training has decreased to 89%, 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) were approved by Board however, there is no current external funding stream available to support this programme, due to previous funding received. Changes in leadership and the development of the digital strategy chapter will inform the next steps. **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 October, a total of 20 estate risks with a combined critical infrastructure risk score of 240. Representing one closed risk, a reduction in the score of another and an increase of score in another. • There were eight patient safety incidents reported linked to estate issues, three of the six related to the volume levels in Audiology which has previously been reported. • In October visits took place in the Chapel, A&E resus, wards 1&2 and ward 22. The chapel had requested the carpet to be cleaned in the prayer room, this is to be rectified by the end of November. No concerns raised for all areas visited. **We will be a great organisation with a highly engaged workforce.** • Vacancy rates in October increased to 6.7%. • The quarterly pulse survey result for July 25 was 5.63 with a 11.0% completion rate. The engagement score has decreased since it was last reported at 6.17 in April 25, with a 2% increase in completion rates from 9% completion rate for the group.

- Turnover increased to 12.6% in October. Promotion as a voluntary leaving reason has shown an increasing trend since February indicating possible lack of opportunities / career advancement in the Trust.
- Sickness absence rates reduced slightly to 5.5% but still above the target level of 4.9%.
- Temporary staffing spend as a proportion of pay bill increased to 0.5% but 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 decreased in October with performance at 73.7%, below the 78% standard.
- Reducing time in department worsened with 5.68% of our Type 1 patients spent more than 12 hours in ED. Exceeding the national tolerance of <2% and the planned target of 0.2%.
- There were 21 reportable 12-hr delays for admission.
- The Trust remains a top performer in Ambulance Handover times with average hand-over time of 14 mins 28 seconds in October against the national standard of <15mins. 21 handovers exceeded 30 mins in October, eight were more than 45minutes with two of these over 60 minutes.

Improvement activities continue, to support further recovery going into 2025/26 focusing on (i) Model of Care in ED & UTC, (ii) Same Day Emergency Care (iii) Virtual Ward.

- Average NEL length of stay in October increased to 8.1 days, 1.7 days higher than planned levels primarily due to challenges with infection prevention.
- 54% of patients were discharged on their discharge ready date.
- A daily average of 45 patients no longer meet the criteria to reside actions to improve this will be incorporated into the discharge program work.
- In October there were 450 beds open, 32 beds more than planned.

The waiting list reduced by 174 patients to 13,225.

- Current waiting list is 2,434 (22.6%) above planned trajectory.
- Key Waiting list pressures remain in all services.

October RTT performance is 67.9%.
There were 41 T&O 52+ week waiter at the end of the month.

	The revised Elective Recovery Programme combines multiple approaches to ensure waiting times, and the volume of waiters are reduced, themes for recovery include demand management, targeted validation, and capacity realignment. The Trust's cancer position has been affected by the increase in referrals for urgent suspected cancer in Breast from Durham. Due to the volumes of referrals in the Breast service if this tumour site fails the target, it has a significant impact on the Trust overall performance. The unvalidated 28 Day Faster Diagnosis performance in October improved to 76.6%, below the expected national position of 80% by the end of March 2026. The unvalidated 62 day performance was 71.1% in September. Challenges in the breast tumour site and those pathways which are shared with other providers are ongoing Diagnostics: Waiting List at the end of October is 5,614 representing a decrease of 623 waiters. DM01 performance has increased to 86.3%, but remains below the constitutional standard. Challenges remain in the following modalities: NOUS performance at 77.24% and Audiology performance at 71.32%. **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:** The Trust has a planned deficit at M7 of £7.2m and actual performance of £7.015m deficit which is a favourable variance of £0.185m. Risks remain around overspending against delegated budgets and identification and delivery of recurrent CRP targets on a recurring basis. **Cost Reduction Plan** The Trust planned CRP target at M7 is £16.893m and actual performance of £16.8933m; of which £10.210m is delivered recurrently. Focus remains on identifying recurrent savings schemes to support future financial sustainability. Cash is expected to remain within the £5m target set within the trust plan until at least March. However, the headroom between current cash balance and future run rate commitments, should CRP plans not be cash releasing in next 5 months, is challenging. **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

<table>
<tr><td></td><td colspan="5">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 remained at 32 weeks. Service plans to support recovery are in development to improve waiting times. Paediatric autism assessments and diagnosis waiting times have reduced to a median wait of 27 weeks.

We will develop & expand our services within and beyond Gateshead.

Work is ongoing to increase external income as part of business efficiency plans. QEF generated income is down in October from the previous 12 months.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The recommendations to the Committee are to receive this report, discuss the potential implications and note the improvement or challenge in key areas.</td></tr>
<tr><td rowspan="5">Trust Strategic Aims that the report relates to:</td><td>Aim 1
☒</td><td colspan="4">We will continuously improve the quality and safety of our services for our patients</td></tr>
<tr><td>Aim 2
☒</td><td colspan="4">We will be a great organisation with a highly engaged workforce</td></tr>
<tr><td>Aim 3
☒</td><td colspan="4">We will enhance our productivity and efficiency to make the best use of resources</td></tr>
<tr><td>Aim 4
☒</td><td colspan="4">We will be an effective partner and be ambitious in our commitment to improving health outcomes</td></tr>
<tr><td>Aim 5
☐</td><td colspan="4">We will develop and expand our services within and beyond Gateshead</td></tr>
<tr><td>Trust corporate objectives that the report relates to:</td><td colspan="5">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">Areas requiring attention:
Quality & Safety:
• Quality Improvement Plans
• Disability & Autism Training

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

Productivity & Efficiency risks:</td></tr>
</table>

	• Increase in Urgent suspected of Cancer Breast referrals from Durham • Higher than planned waiting lists • Staffing gaps in key operational areas • Maintaining financial sustainability, reducing expenditure, and achieving CRP.		
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

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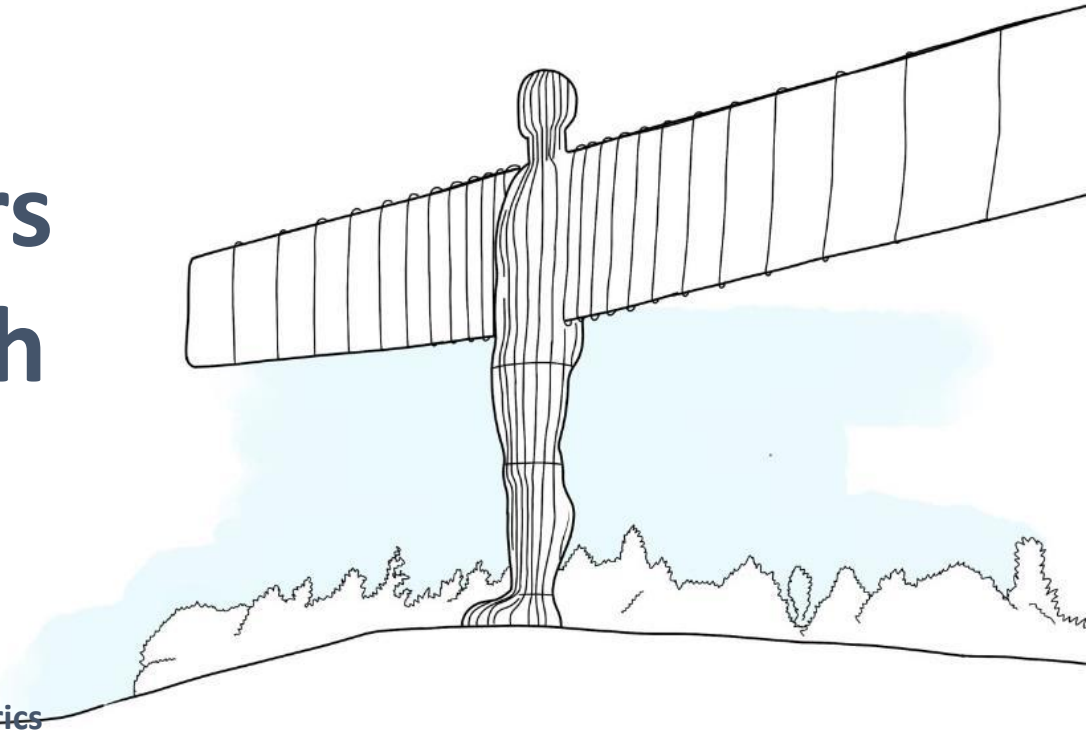
Strategic Objectives 2025/26

Leading Indicators and Breakthrough Objectives



Including Constitutional standards monitoring metrics

Reporting Period: October 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		
Severity of risk scores linked to estates	Scoring in domains in areas of PLACE inspection not available	Compliance with Level 1 training plans for learning Disability & Autism
	Ockenden recommendations	Quality Improvement Plans
	Maternity Incentive Schemes	C.Difficile rate
	Strategic approach to development of EPR	Reduction in patient safety incidents linked to estate issues
	Venous thromboembolism (VTE) risk assessment	Harm rate from falls
	Mental Health Act Training for all registered staff	
We will be a great organisation with a highly engaged workforce		
		Achievement of the internal turnover standard
		Improve the staff engagement score
		Internal sickness absence standard
		Reduction in temporary staffing spend 0.5% of pay bill
		Maintain the vacancy rate at <=2.5%
We will enhance our productivity and efficiency to make the best use of our resources		
Reduce New & Follow up non value added activity to 67%	Review and revise Green Plans	Average non-elective length of Stay < 4 Days
		Reduce the number of patients with no Criteria to Reside
		Achievement of 4-hr A&E 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		
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 weeks	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	Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients
	Number of digital devices repurposed to the local community	
We will develop and expand our services within and beyond Gateshead		
Increase in QEF externally generated turnover		

Strategic Objectives 2025/26

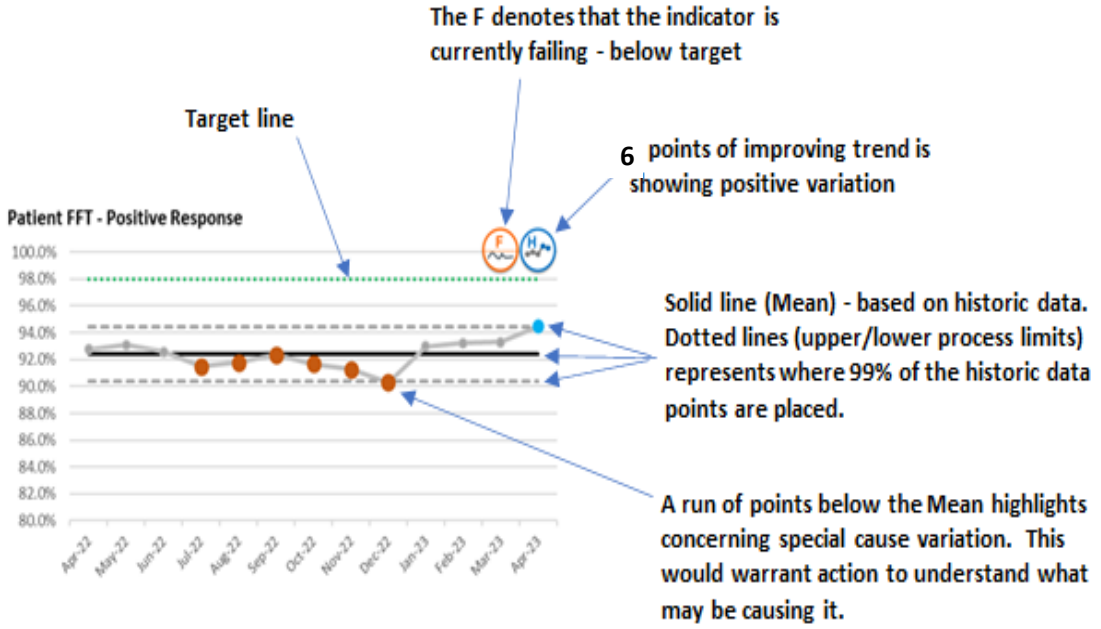
How to interpret the SPC icons and charts

NHS Gateshead Health NHS Foundation Trust

The Trust has adopted the NHSEI 'Making Data Count' methodology and standard templates which demonstrates where historic performance/activity is subject to natural variation or where action may need to be taken where there may be cause for 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		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 90% of staff to complete Mental Health Act training	Achievement of the 52 week RTT standard Maternity Incentive schemes % compliance with Total Recommendations Achievement of the internal sickness absence standard of 4.9% Compliance with the quality improvement plan indicated by the % of actions on track 85% compliance Level 1 learning disability and autism training Reduction in the wait for gynaecology outpatients to no more than 26 weeks	
Neither improving or deteriorating	Reduction in temporary staffing spend of pay bill evidenced month on month Venous thromboembolism (VTE) risk assessment	Harm falls rate per 1000 bed days Achievement of the % to reduce >12 hour total time in Emergency Department Achievement of the trajectory to reduce >12 hour total time in Emergency Department Achievement of the 4 hours trajectory Reduce % of FU Outpatient without procedures C.Diff Healthcare associated rate per 100,000 occupied bed days Reduction in patient safety incidents related to estates issues	Average Length of Stay Non-Elective <4 days 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 Reduce the number of patients with no Criteria to Reside Increase in the number of digital devices repurposed to the local community	
Deteriorating		Reduction in severity of risk score linked to estates	Achievement of the internal turnover standard of 9.7% Maintain the vacancy rate at <=2.5%	
	Consistency in PASSING the target	**Inconsistency in HITTING, PASSING and FALLING SHORT of the target**	**Consistency in FAILING the target**	

NHS Gateshead Health NHS Foundation Trust

Strategic Objectives 2025/26

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

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

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

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

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

Metric	Target	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Ass/Var	Trend
LEADING INDICATORS																	
Ockenden Recommendations % compliance with Total Recommendations	100%	90.0%	95.2%	97.4%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Maternity Incentive Schemes % compliance with Total Recommendations	100%	89.0%	89.0%	89.0%	96.0%	96.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Reduction in patient safety incidents linked to estate issues	<=4	3	2	5	5	7	5	2	9	5	6	2	2	6	8		
Compliance with the quality improvement plan indicated by the % of actions on track	100%	84%	72%	68%	56%	68%	64%	68%	76%	80%	80%	76%	84%	84%	84%		
BREAKTHROUGH OBJECTIVES																	
Scoring in domains in areas of PLACE inspection composite score > 95%	> 95%																
Reduction in severity of risk score linked to estates	TBA	284	280	280	272	256	252	256	244	260	276	266	234	246	240		
Harm falls rate per 1000 bed days (5% reduction)	3.2	3.99	3.37	4.38	4.43	3.11	3.81	4.27	3.49	4.27	3.93	4.61	4.78	4.19	4.02		
C.Diff Healthcare associated rate per 100,000 occupied bed days	<=3.20	42.0	6.7	28.6	13.2	26.7	31.4	70.1	28.7	7.1	28.3	28.9	0.0	46.1	42.8		
90% of staff to complete Mental Health Act training.	90%	81.8%	84.2%	84.2%	84.2%	84.0%	83.0%	85.0%	86.0%	88.0%	86.0%	88.0%	86.0%	91.0%	89.0%		
Venous thromboembolism (VTE) risk assessment	95%	98.9%	99.0%	99.0%	98.9%	99.2%	99.2%	99.0%	99.0%	99.5%	98.9%	99.1%	99.0%	99.3%	98.9%		
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%	50.76%	54.95%	57.36%	59.97%	61.80%	64.21%	68.31%	68.31%	75.74%	76.83%	79.39%	80.86%	81.76%	83.00%		

Strategic Objectives 2025/26

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

NHS Gateshead Health NHS Foundation Trust

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

Measures requiring focus this month

	Measure	Summary
1	Ockenden recommendations % compliance with total recommendations	Compliance 100%, Ongoing work to maintain full compliance including updates to website & personalised care plans in collaboration with our own Maternity & Neonatal Voices Partnership (MNVP) & the Local Maternity & Neonatal System (LMNS). Required audits embedded into ongoing audit plan. No further updates required by LMNS to evidence full compliance with this report.
	Maternity incentive schemes % compliance with total recommendations	The Trust is reporting compliance at 100%. Reported & confirmed by NHS Resolution that Gateshead Maternity Service satisfied the standards for full compliance with Year 6 of the MIS. Year 7 standards released in April 2025.
2	Compliance with the quality improvement plan indicated by the % of actions on track.	Latest reported data relates to October 2025 with 84% of the Improvement Plan actions delivered. October's performance shows progress is below planned levels. Action Plans are in place with the relevant action owners for actions that are reporting risk of non achievement. Non compliant areas: Trustwide appraisal rates, Staff retention, local induction checklist compliance, Implementation of falls PSIRP workstream plan and Reduction of harm from falls of 5% . Actions not yet completed: Quality Strategy : >75% staff to receive the flu vaccination - This action was not achieved. Develop a Quality Oversight Report for Allied Health Professionals in line with Trust strategic aims and ambitions, the Trust AHP 3yr strategy, the national AHP strategy and the NHS long-term workforce plan. Due to organisation change process this work has not yet been enacted. Work to bring all AHP staff together is still ongoing and until this is complete we wont have access to the right data to develop this report. This Action will be reviewed as part of the 2025/26 QIP planning work. Future actions/developments: Reduction in harm caused by falls. The trusts Falls prevention group now meets monthly, Work ongoing work to reduce falls across the organisation, as well as nationally and across the region. A national Enhanced Care program has now been established to support with how we engage with patients to reduce falls. Janet Thompson, Corporate Matron is now strategic lead for this work. The documentation audit is currently paused while the quality team and clinical effectiveness team do some scoping work reviewing the current questions and linking with the CQC KHLOEs.
	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.	Compliance with learning disability is 2% below the compliance level. Learning disabilities training will be slowly phased out on a rolling basis as individuals competencies expire and this will be replaced with Oliver McGowan E-learning.
	Improve Mental Health Act Policy Training Compliance to 90% for all *registered* staff via training and audit.	Mental health staff trained is 89% which is a decrease of 2% from September. Compliance for qualified staff has been maintained at 93%. Compliance for HCAs & support workers has decreased from 82% to 79%. Cragside slightly increased to 85% compliant with training. Sunniside decreased to 70% compliant. The CPN team dropped performance to 94%, the Younger Persons Memory Service, memory hub, mental health liaison team and OT team are currently all at 100% compliance with training. Bespoke training around the consent to treatment provisions of the MHA, has been provided for pharmacy staff working on MH wards to support practice. Bespoke training on Supervised Community Treatment orders was provided for the CPN team in October. It is identified that training compliance for a further 6 staff will expire during 2025. MHA awareness training has been provided for 50 acute staff. Updates on training compliance are emailed out to all ward/ team managers on a monthly basis. Training dates have been arranged for 2026 and are available to book via ESR. Team managers have been informed.
	Improve our IPC C.Difficile infection rates per 100 000 occupied bed days.	Rates per 100 000 bed days have reduced to 42.83, 6 cases recorded in October, 25 cases YTD in 25/26 against a full year target of 36. A 10 point c-diff reduction plan is in place, with a drive to 'back to basics' for clinical areas particularly around hand hygiene, AMP and learning. A review into antimicrobial prescribing is ongoing. Community prevalence continues to be higher then normal levels, reflecting national and local elevated levels of C.Diff.
	Medicines	The Women's Health and Children's Services Pharmacist, work to review IV iron infusions, development of mandatory e-Learning for syringe drivers and the development of a Palliative Care presentation for preceptorship training were completed last financial year.
	Venous thromboembolism (VTE) risk assessment	Healthcare associated venous thromboembolism (VTE), commonly known as blood clots, is a significant international patient safety issue. The first step in preventing death and disability from VTE is to identify those at risk so that preventative treatments (prophylaxis) can be given. This data collection quantifies the numbers of hospital admissions (aged 16 and over at the time of admission) who are being risk assessed for VTE to identify those who should be given appropriate prophylaxis based on guidance from the National Institute for Health and Care Excellence (NICE). The Trust continuously performs well against the standard of 95% with October performance reported at 98.9%.
	Harm related falls will reduce by 5% by March 2025.	There has been an increase in falls with harm this month. The falls steering group continue to meet and progress the current action plan. There was a discussion around the way the data is collated, which may be out of line with national reporting. A paper with a suggested change is being produced by the group to highlight the proposed changes, and will assist in determining new targets for falls prevention.
3	Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.	Outline Business Case was presented and the recommended option supported. The case was also presented to trust board in May 2025, who supported the principle but asked for further information regarding the financial implications of the proposed stages. There is no current external funding stream available to support this programme, due to previous funding received. Changes in leadership and the development of the digital strategy chapter will inform the next steps.
4	Reduction in risks and severity of scores linked to estate issues	October position, 20 Risks with combined critical infrastructure risk score of 240 (decreased from 246 in September). 1 increased risk score to 20 {ref 2984, maternity estate}, 1 risk reduced to 12 [ref 2595 Audiology estate] and 1 risks closed [ref 4530, mortuary fridge]
	Reduction in patient safety incidents linked to estate issues	8 patient safety incidents related to estates issues in October 2025. 3 incidents relate Audiology rooms that are too noisy to perform hearing tests. Similar issues have been raised in previous months Figures exclude incidents related to pressure damage and incidents reported as Harm not related to Gateshead on Inphase.
	Scoring in domains in areas of PLACE inspection composite score > 95%	PLACE lite implementation is still awaited to produce percentage scores. In October visits took place in the Chapel, A&E resus, wards 1&2 and ward 22. The chapel had requested the carpet to be cleaned in the prayer room, this is to be rectified by the end of November. No concerns raised for all areas visited.
	Reduction in value of backlog maintenance score as reported via the ERIC return	A clinically prioritised plan to review and deliver the backlog maintenance programme. The challenges are limitations on capital available to support the plan & CDEL allocation. Rationalisation of our existing aging estate is required to meet the 25% reduction target (equating to £3.5m reduction). The capital programme has been confirmed and an update will be available when capital projects are completed.

Strategic Objectives 2025/26

We will be a great organisation with a highly engaged workforce

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	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Ass/Var	Trend
LEADING INDICATORS																	
Maintain the vacancy rate at <=2.5%	<=2.5%	2.7%	3.4%	3.2%	3.5%	5.0%	5.2%	5.0%	3.2%	5.8%	5.9%	6.6%	6.3%	5.6%	6.7%		
Improve the staff engagement score to 7.3	>=7.3					6.20			6.17			5.63					
BREAKTHROUGH OBJECTIVES																	
Achievement of the internal turnover standard of 9.7%	<=9.7%	11.7%	11.2%	11.4%	11.5%	11.7%	11.3%	11.5%	11.8%	11.9%	11.9%	12.0%	11.7%	12.1%	12.6%		
Achievement of the internal sickness absence standard of 4.9%	4.90%	5.6%	5.6%	5.6%	5.7%	5.7%	5.7%	5.7%	5.7%	5.6%	5.6%	5.6%	5.6%	5.6%	5.5%		
Reduction in temporary staffing spend of pay bill evidenced month on month	<=2.3%	0.4%	0.6%	0.5%	0.4%	0.5%	0.5%	0.5%	0.4%	0.2%	0.5%	0.5%	0.5%	0.3%	0.5%		

Measures requiring focus this month

Measure	Summary
Maintain the vacancy rate at <=2.5%	Vacancy rate stands at 6.7% in October 2025, a 1.1% increase compared to September 25. Budget WTE decreased between September and October 2025, most notably in Surgery with reductions in HCA and Admin budget. Contracted WTE also decreased, most notably for HCA staff in Medicine, contributing to an increased vacancy rate.
Improve the staff engagement score to 7.3	The quarterly pulse survey result for July 25 was 5.63 with a 11.0% completion rate. The engagement score has decreased since it was last reported at 6.17 in April 25, with a 2% increase in completion rates from 9% completion rate for the group.
Achievement of the internal turnover standard of 9.7%	Turnover increased to 12.6% in October 2025. Promotion as a voluntary leaving reason has shown an increasing trend since February indicating possible lack of opportunities / career advancement in the Trust. The retirement leaving reason has shown a mostly decreasing trend over the past few years although is still one of the top reasons recorded for staff leaving the Trust.
Achievement of the internal sickness absence standard of 4.9%	Sickness decreased to 5.5% for a rolling 12 months in October 2025. In-month sickness absence was 5.9% in October 2025, 0.4% lower than the October 2024 rate. Anxiety, stress & depression continues to be the most prevalent reason for absence accounting for 34.4% of all sickness absence in the past 12 months.
Reduction in temporary staffing spend evidenced month on month reduction and no higher than 2.3 % of pay bill.	Agency spend remains under target at 0.5% and has been consistently over the last 12 months. Agency spend increased this month due to increased activity in Surgery.

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	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 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	7.96	7.24	8.26	7.24	7.88	7.31	7.18	8.70	8.38	8.65	7.66	7.66	7.75	8.13		
Achievement of the 4 hours trajectory	>78%	71.4%	67.8%	73.0%	65.6%	71.2%	73.6%	74.5%	72.5%	79.0%	76.7%	82.2%	82.3%	77.4%	73.7%		
Achievement of the 52 week RTT standard	0	123	106	111	102	83	66	0	16	1	18	35	55	52	41		
Achievement of 2025/26 financial Plan - Variance (£k)	Figure in brackets favourable	(0.042)	0.026	(0.143)	(0.1)	(0.1)	(0.167)	(0.046)	0.272	0.224	0.261	0.337	-0.027	-0.174	-0.185		
Finance - Forecast Out-turn Deficit (Plan)	tbc	7,088	7,088	7,088	7,088	2,192	2,192	2,146	8,381	8,381	8,381	8,381	8,381	8,381	8,381		
BREAKTHROUGH OBJECTIVES																	
Achievement of the trajectory to reduce >12 hour total time in Emergency Department (Type 1)	0	395	749	495	1036	466	208	71	52	31	47	16	13	67	337		
Reset April 2025 to align with 2025/26 operational guidance definitions	0.2%	4.4%	7.6%	5.1%	10.5%	5.2%	2.5%	0.7%	0.9%	0.5%	0.8%	0.3%	0.23%	1.19%	5.68%		
Reduce the number of patients with no Criteria to Reside	<10	38	45	41	40	44	46	47	43	46	54	49	45	43	45		
Achievement of the trajectory to achieve RTA to Bed within 1 hour	60.0%	6.3%	3.7%	4.7%	4.2%	4.3%	5.7%	6.3%	6.4%	16.1%	10.8%	19.1%	16.9%	10.3%	8.3%		
Reduce % of Follow up Outpatient without procedures *Reset April 2025 to align with 2025/26 operational guidance definitions*	<=67%	71.3%	69.6%	67.2%	66.3%	66.9%	67.3%	67.6%	67.5%	66.2%	64.6%	66.4%	66.7%	66.5%	67.7%		
2024-25 CRP Delivery Variance	Figure in brackets favourable	680	1,157	2,539	2,994	2,082	73	0	517	523	19	0	0	0	0		
No less than £5m cash as per forecast at March 2026	>=£5m	£5m	£5m	£5m	£5m	£5m	£5m	£5m	£32m	£28m	£16m	£24m	£31m	£22m	£24m		

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

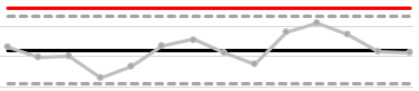
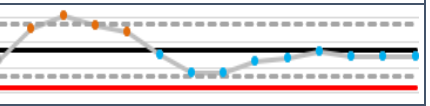
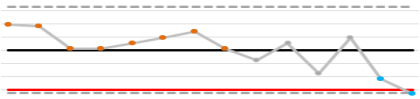
Measure		Summary
1	**Average Length of Stay Non-Elective <4 days**	Length of Stay increased further during October primarily due to challenges with infection prevention and control including two consecutive norovirus outbreaks on the COTE wards preventing discharge directly into care homes .There are ongoing challenges with Intermediate Care within Gateshead and close monitoring of all social care discharges continues.
	Achievement of the 4 hours trajectory	ED performance decreased significantly to 73.7% meaning that the monthly target was not achieved. A renewed focus on the target has commenced during November to recover this fully. We are involved in the GIRFT "Further Faster" program for UEC which is directing programmes of work to ensure improvement.
	Achievement of the trajectory to reduce >12 hour total time in Emergency Department	This increased significantly in October, primarily due to the availability of bed post the IC outbreaks. Ongoing work with CNTW has reduced the number of patients awaiting a mental health provider this month.
	Achievement of the trajectory to achieve 60% RTA to Bed within 1 hour	Performance of 8.3 % represents a further decrease, with further work required to understand availability of beds.
	Reduce the number of patients with no Criteria to Reside	October average patients was 45 - actions to improve this will be incorporated into the discharge program work, and the education from the DLN team to support discharge processes.
	Achievement of the 52 week RTT standard and delivery of the trajectory for 40 weeks	We continue to see a reduction in the total number of patients waiting over 52 weeks for treatment. There were 35 for T&O (Lower Limb) and 7 for Urology. There is a risk that we continue to see an increase in the number of patients waiting over 52 weeks in Urology but we are working through a series of actions to mitigate in conjunction with NUTH. We are forecasting a continued reduction in Lower Limb and hope to achieve 0 for this specialty by end of December 25.
	Increase in New Outpatient activity	The target has been changed in 25/26 to reduce the % of follow up outpatient without procedure. We continue to scope alternative ways of working to reduce this and reviewing at service level with plans to achieve standard through the elective care programme.
2	**Evidence achievement of the 24-25 financial plan**	The Trust has a planned deficit at M7 of £7.200 and actual performance of £7.015m deficit which is a favourable variance of £0.185m. Risks remain around overspending against delegated budgets and identification and delivery of recurrent CRP targets on a recurring basis. The Trust planned CRP target at M7 is £16.893m and actual performance of £16.8933m; of which £10.210m is delivered recurrently. Focus remains on identifying recurrent savings schemes to support future financial sustainability. Cash is expected to remain within the £5m target set within the trust plan until at least March. However, the headroom between current cash balance and future run rate commitments, should CRP plans not be cash releasing in next 5 months, is challenging.
3	**Review & revise the 2022/25 green plan & align with the group structure by the end of Q2.**	Plans to embed the Green plan governance structure and align with group governance. 10 workstreams will provide update reports aligned to our sustainability objectives. Work plan priorities include: waste, active travel, fleet, procurement, estates & facilities, workforce/communications, sustainable care, medicine, digital transformation and adaptation. Plans include a survey of understanding across the Board/EMT and Senior Leadership Group members.

Strategic Objectives 2025/26

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

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	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Ass/Var	Trend
BREAKTHROUGH OBJECTIVES																	
Increase in the number of digital devices repurposed to the local community	>300	0	10	0	0	0	0	0	0	30	64	0	0	66	0		
Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients *Reset September 2025 to align with National definitions*	>=98%	91.6%	89.9%	90.0%	86.5%	88.4%	91.7%	92.8%	90.6%	88.8%	94.1%	95.5%	93.7%	90.8%	90.7%		
Reduction in the wait for gynaecology outpatients to no more than 26 weeks	<=26	31.4	37.7	40.3	38.3	37.0	32.6	28.9	28.9	31.1	31.7	33.0	32.0	32.0	32.0		
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30	<=30	79	78	61	61	65	70	74	61	52	65	42	69	38	27		

Measures requiring focus this month

Measure	Summary
Evidence a reduction in the number of 'fragile' and 'vulnerable' services as a direct outcome of Alliance working	This will be reviewed quarterly as part of the Provider Collaborative Sustainability review. Outputs and products from this work will be reviewed to inform the annual planning process and is contained in the Project Plan for 2025/26 to support planning for 2026/27.
Evidence in an improvement in health inequalities in the key focus areas linked to the determinants of Health for Gateshead	Key determinants of Health for Gateshead are to be defined through the Health Inequalities Group workstream. Evidence/measures and controls will be implemented as part of the focused work to progress in 2025/26.
Increase in the number of digital devices repurposed to the local community	Digital exclusion is where members of the population have inadequate access and capacity to use digital technologies that are essential to participate in society. The risk to this target is that the quantity of devices being made available for recycling and repurposed is dependant on Trust usage and need. This is therefore entirely variable throughout the course of the year. In 24/25 318 devices reached end of life, the Trust will continue to recycle equipment as swiftly and efficiently as possible with 160 devices being recycled in the first half of 2025/26.
Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients	October compliance 90.7%, however these figures now take into account patients that are admitted and discharged on the same day following review of national guidance. Previously only patients with an overnight stay were included in this calculation. The numbers have reduced given the challenges of collecting the smoking status for patients admitted and discharged same day - many of these patient have only been an inpatient for possibly as low as an hour or two. GHNFT has the highest performing smoking status recorded on admission in the NENC ICB region, this has been consistent for >12 months. Ongoing actions to improve compliance are - Training of all staff on Nervecentre. Regular focused Tobacco dependency training on wards both ad hoc and planned. Communication Strategy. The Tobacco Dependency Treatment Service is providing an equitable service for all patients with 7 day a week coverage although sickness absence is a temporary challenge to this. A new team member is joining the QUIT team in September.
Reduction in the wait for gynaecology outpatients to no more than 26 weeks	The median wait has remained at 32 weeks in October. Continue to focus on reducing waits through the elective care transformation group with key workstreams on increasing PIFU, A&G, Reducing DNA's and clinic template review to increase new patient capacity. New single point of access model to commence in November to focus on demand and ensuring patients are seen at the right place by the right team.
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 weeks	Current median wait has decreased further to 27 weeks and the overall waiting list size continues to decrease significantly 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	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Ass/Var	Trend
LEADING INDICATORS																	
0.5% increase in QEF externally generated turnover from previous financial year	>=0.5%	2.2%	3.0%	4.0%	5.0%	6.0%	0.0%	0.0%	0.0%	7.5%	19.3%	24.0%	28.6%	22.9%	20.0%		

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. October is up compared to prior year mainly due to the NUTH Courier Contract £1m additional revenue.

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Constitutional Standards 2025/26

Reporting Period: October 2025

Constitutional standards 2025/26	Constitutional Standards metrics Assurance Heatmap

NHS Gateshead Health NHS Foundation Trust

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

Constitutional Standards

Metrics

NHS Gateshead Health NHS Foundation Trust

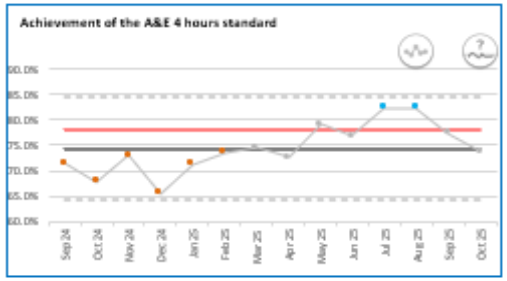
Metric	Target	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Ass/Var
Achievement of the A&E 4 hour standard	>78%	71.4%	67.8%	73.0%	65.6%	71.2%	73.6%	74.5%	72.5%	79.0%	76.7%	82.2%	82.3%	77.4%	73.7%	
12 hour trolley waits (DTA to left department)	0	0	3	1	30	0	0	2	0	1	2	1	0	2	21	
% of ED attendances > 12 hours in department (Type 1) *Reset April 2025 to align with 2025/26 operational guidance definitions*	0.2%	4.4%	7.6%	5.1%	10.5%	5.2%	2.5%	0.7%	0.88%	0.52%	0.77%	0.25%	0.23%	1.19%	5.68%	
Ambulance handover delays 30-60 minutes	0	3	3	10	43	21	4	6	11	4	16	5	1	8	21	
Ambulance handover delays over 45 minutes	0								3	1	5	0	0	0	8	
Ambulance handover delays 60 minutes +	0	0	0	1	51	14	0	7	1	0	0	0	0	0	2	
Achievement of the RTT 18 week standard	>92%	68.6%	68.5%	69.2%	69.8%	70.6%	71.3%	71.0%	69.4%	68.5%	68.3%	68.6%	67.4%	68.3%	67.9%	
Achievement of the 52 week RTT standard	0	123	106	111	102	83	66	0	16	1	18	35	55	52	41	
Achievement of the 6 week diagnostic standard	>95%	86.4%	88.3%	86.8%	83.3%	81.4%	86.4%	82.6%	77.4%	74.2%	77.3%	74.8%	71.1%	81.6%	86.3%	
Achievement of the Cancer 28 day standard *Reset April 2025 to align with 2025/26 operational guidance standard*	>80%	77.7%	82.0%	83.2%	84.1%	77.0%	80.7%	80.5%	70.1%	69.9%	77.2%	76.0%	75.6%	64.9%	76.6%	
Achievement of the Cancer 31 day standard	>96%	100.0%	99.1%	98.5%	98.9%	99.4%	100.0%	100.0%	99.5%	99.5%	97.9%	100.0%	97.9%	96.7%		
Achievement of the Cancer 62 day standard *Reset April 2025 to align with 2025/26 operational guidance standard*	>75%	66.8%	81.0%	74.8%	75.6%	80.2%	81.0%	82.1%	73.7%	67.7%	72.7%	75.3%	70.8%	71.1%		

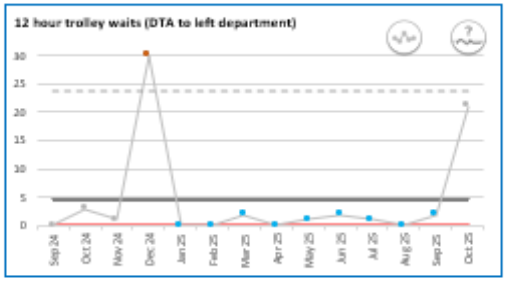
Validated data unavailable at time of

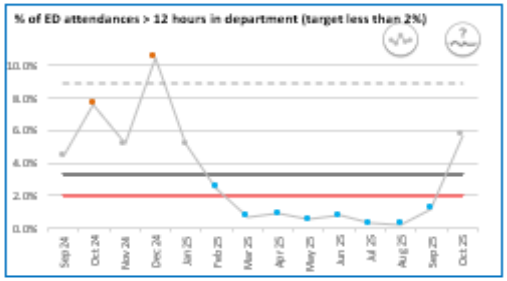
Constitutional Standards

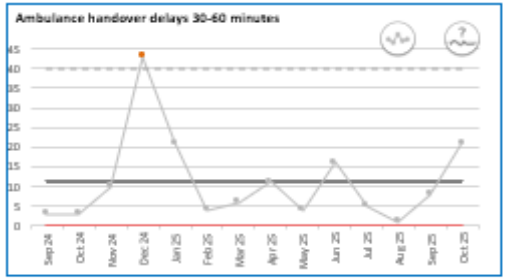
Metrics (SPC)

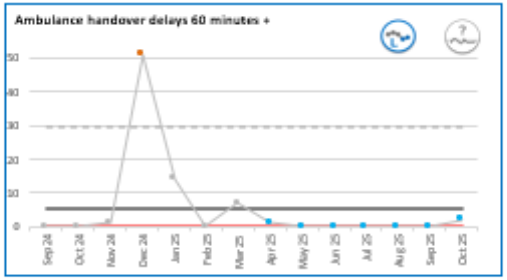
NHS Gateshead Health NHS Foundation Trust

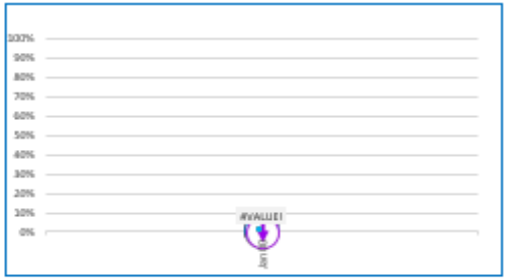


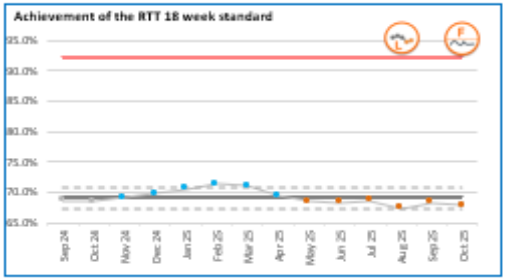


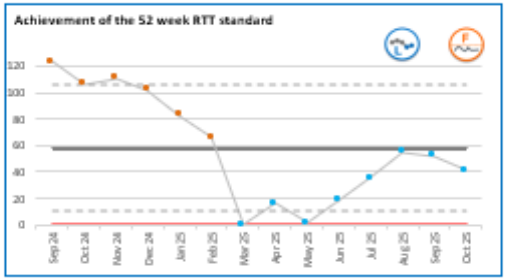


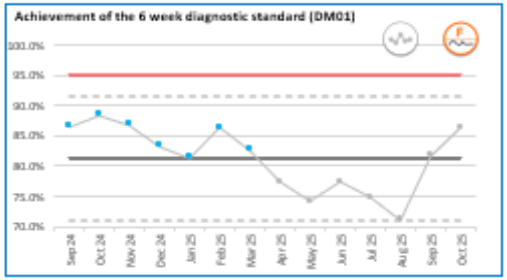


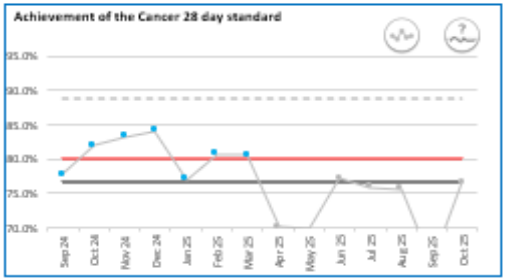


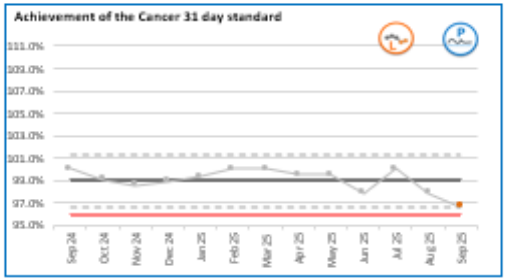


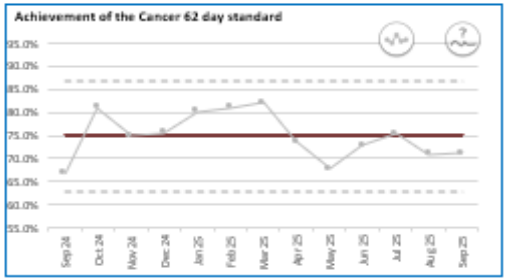












14. Learning from Deaths Quarterly Report (Quarters 1 and 2) presented by the interim Chief Nurse

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Report Cover Sheet Agenda Item: 14i

Report Title:	**Learning from Deaths – Quarter 1 2025/26**			
Name of Meeting:	Trust Board			
Date of Meeting:	5 December 2025			
Author:	Wendy McFadden – Clinical Effectiveness Lead Andrew Ward Senior Information Analyst – Quality & Patient Safety			
Executive Sponsor:	Dr Carmen Howey – Group Medical Director			
Report presented by:	Elizabeth Swanson, Interim Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	Enter purpose here			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Mortality & Morbidity Steering Group Quality Governance Committee			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	The paper outlines the process for review of deaths within the organisation and the way in which those review processes enable learning from good practice and learning where there is evidence that care could be improved. It combines the Mortality Data for Q1 with the learning. Three extraordinary meetings took place through April and May to address the backlog of cases awaiting review. The number awaiting review has reduced from 147 to 105. Considerable progress has been made in the review of the deaths of patients with a Learning Disability, one of the meetings held in April was dedicated to these reviews. Three cases remain outstanding for review by the Mortality Council (these have all been reviewed by the Learning Disability Nurses). There remain 17 deaths awaiting Mortality Council review for deaths for patients with Serious Mental illness, however			

<table>
<tr><td></td><td colspan="5">positive progress has been made with only 2 not having had a specialist review.

The report describes how other sources of data are triangulated with the information from the mortality review processes to ensure a joined-up understanding of any issues related to patient deaths which would cause us concern.

The paper provides partial assurance regarding our internal processes as 105 cases still await review</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">To receive the paper for assurance.

To agree in principle the proposed changes to the timeline for review of deaths to be incorporated to the reviewed Learning from Deaths Policy subject to the usual Policy Review processes.</td></tr>
<tr><td rowspan="4">Trust strategic priorities that the report relates to:</td><td>☒</td><td colspan="4">Excellent patient care</td></tr>
<tr><td>☐</td><td colspan="4">Great place to work</td></tr>
<tr><td>☐</td><td colspan="4">Working together for healthier communities</td></tr>
<tr><td>☐</td><td colspan="4">Fit for the future</td></tr>
<tr><td>Trust strategic objectives that the report relates to (2025 to 2030 strategy):</td><td colspan="5">List strategic objective here</td></tr>
<tr><td>Links to CQC Key Lines of Enquiry (KLOE):</td><td>Caring ☐</td><td>Responsive ☒</td><td>Well-led ☐</td><td>Effective ☒</td><td>Safe ☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):</td><td colspan="5"></td></tr>
<tr><td>Has an Equality and Quality Impact Assessment (EQIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☒</td><td>Not applicable
☒</td></tr>
</table>

Learning from Deaths Report – Quarter 1 2025-26

1 Introduction:

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

The Trust's Learning from Deaths policy explains the agreed process for reviewing and learning from deaths across the organisation. The reviews follow a three-step process (see Appendix 1)

2 Mortality data summary

This section summarises the information included in Appendix 2 Mortality Charts.

2.1 Deaths in Emergency Care and In-patients

There were 25 deaths in the Emergency Care department compared to 10 deaths in the equivalent quarter for the previous year, an increase off 15; however, a trend of low volumes of deaths in A&E was observed in the equivalent previous quarter (see Figure 2) and this change remains within common cause variation.

292 inpatient deaths observed in quarter 1 2025 compared to 264 observed in the equivalent quarter for the previous year, an increase of 28 but remaining within common cause variation on the SPC chart (see Figure 1).

The SHMI (Summary Hospital-level Mortality Indicator) is showing a general increase over the last six months, however remains within the expected range. (see Figure 3).

Observed mortality in the SHMI is deviating from the expected mortality value in recent months leading to an increase in the SHMI. The number of expected deaths shows a general decline as SDEC activity is removed progressively from the rolling 12-month period from May 2024. It was anticipated that this would result in an increasing SHMI. (see Figure 4)

The latest SHMI background data quality report published with the latest dataset advises that 'Trusts with SDEC activity removed from the SHMI data have seen an increase in their SHMI value. This is caused by two factors. Firstly, the observed number of deaths remains approximately the same as the mortality rate for this cohort is very low; secondly, the expected number of deaths decreases because a large number of spells are removed, all of which would have had a small, non-zero risk of mortality contributing to the expected number of deaths. It is expected that all trusts will transition to recording SDEC activity in the ECDS. This means that eventually all trusts will be recording SDEC activity consistently and the amount of SDEC included in the SHMI will decrease over time.'

A dip is noted in the coding depth for both elective and non-elective admissions. Recent figures begin to show a sustained upward trend toward values previously observed. The Trusts coding depth is lower than the England average for Elective spells: 4.7 compared to a national figure of 6.4 codes per spell. Non-Elective spells: 6.0 compared to 6.1 codes per spell. (see Figure 5). The coding team locally advise that our coding is accurate and only includes the coding relevant to the last hospital spell, as it should.

A general increase is observed in the proportion of spells with palliative care coding recorded. 3.0% of spells had a palliative care code compared to 2.1% for England (see Figure 6)

Mortality Alerts from HED remain for Lung Cancer with a singular alert for Pulmonary heart disease in the reporting period. Patients with a cancer diagnosis receive curative treatments at neighbouring Trusts. In addition, the SHMI does not risk adjust for palliative coding which may account for Gateshead having higher observed figures compared to expected; 30 of 43 (69.7%) cases had palliative coding. The majority of cases have been reviewed and all those scored were recorded as ' Definitely not preventable' and' Good Practice'. (see Table 1)

The unadjusted mortality rate varies between trusts and quarters from 2.3% to 5.5%, with a range of 2.3% to 4.8% in the latest period. The SHMI and the unadjusted rate include all deaths in hospital plus deaths within 30 days of discharge; the rates are starting to rise in the four trusts that are no longer reporting SDEC in the Admitted Patient Care (APC) dataset. (see figure 7) In understanding the sharp rise for Gateshead it's necessary to consider the impact of SDEC. The number of discharges reported by the Trusts now submitting SDEC to in the Emergency care data set is reduced so the denominator for the crude mortality calculation is smaller. It is difficult to understand how much the SDEC effect would impact on each trust. Looking at the %change in discharges Gateshead show the largest change: -22% in total discharges between 23-24 and 24-25) Northumbria were next with a 16% reduction and see a similar rise.) We also serve different patient cohorts, Gateshead has the highest comorbidity scoring in the region which may also explain to some degree a higher crude mortality rate.

2.2 Rolling 12 month scrutiny data:

Considering deaths in the Trust in the 12 months preceding the end of quarter one 2025. There were 1,225 deaths, of which 1208 (98.6%) were scrutinised by the Medical Examiner.

Medical Examiner scrutiny deemed 1,166 cases (95.2%) to be 'Definitely not preventable' and 'Good Practice' identified in 1,137 cases (98.2%). 22 cases (1.8%) identified potentially 'Some evidence of preventability' and 'Room for improvement' identified in 52 cases (4.2%). 20 cases (1.6%) were unable to be scored for preventability, and referred to the Mortality Council, 17 cases (1.4%) were not scored. (see Table 2)

Considering all deaths and mortality review during the period 12-month period ending Q1 2025 (ME Scrutiny, Ward Level Reviews, Mortality Council Reviews) provides the following scores.1,130 cases (92.2%) 'Definitely not preventable' and 1,109 cases (90.5%) Good Practice.
One death (0.08%) was judged to be more likely than not to have been due to problems in the care provided to the patient, Hogan 4 or above.
61 cases (5.0%) from the period awaiting Mortality Council review, and 20 cases (1.6%) awaiting a ward review following referral by the Medical Examiner at the time of writing. (see Table 8)

3 Learning from Ward Level Reviews:

21 ward level reviews took place during quarter 1, 21 were 'Definitely not preventable', 12 of these were referred for review by the Medical Examiner.

From the quality of care review perspective, 13 deaths were deemed to be 'Good Practice', 5 'Room to improve in clinical care', 3 'Room to improvement in both clinical and organisational care'. (Appendix 2 Table 3). Where learning or the opportunity to share good practice is identified in a ward review, this will be actioned and shared within Division and across Divisions where this is appropriate.

Ward level reviews are only required to be undertaken following a referral from the Medical Examiner, however, wards can review any of the deaths that have occurred on their wards should they wish. The Medical Examiner team referred 13 deaths to the wards for review, at this time one of these has been reviewed by the ward teams.

3.1 Themes of good practice identified through Ward Reviews:

- Communication with family
- Rapid recognition of acute illness
- Decision making well documented.
- Inter specialty working within the trust and with external partner organisations.
- Involvement of Admiral Nurses to support patient and family
- Use of the Emergency Health Care Plan.

3.2 Learning identified and actions arising from Ward Reviews

Reviewing the narrative from ward level reviews identified thematic trends in relation to nutrition/malnutrition and mouthcare and also specific learning for individual patients:

Nutrition

- In two ward reviews nutrition was identified as not being adequately addressed during a patient's admission though not a causal factor relating to either patient's death.
- Nutrition/malnutrition has also been identified as theme within the Medical Examiner reviews therefore a dedicated Mortality Council has been arranged for 23rd September to review a selection of cases and identify any specific learning or wider actions to be taken.

Mouthcare

- Poor mouthcare was identified as concern which did not contribute to the patient's death but to their experience of care as a dying patient. Mouthcare has been identified as theme from other Mortality Council reviews. The Council are aware of a previously launched campaign – Mouthcare Matters – and the Chief matrons have been tasked with ensuring this campaign is implemented across the wards.

Escalation and timely review

- Timely review and missed escalation opportunities were identified through ward reviews. The DART team now have an SOP that requires a Band 7 DART nurse to oversee the discharge of patients from DART. The issue of clinical leadership for the DART team remains unresolved. The need to escalate care has been fed back to the wards and clinicians involved.

4 Learning from Mortality Council

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

For the period 1st April – 30th June 2025, five Mortality Council meetings took place. Three planned and two additional meetings, resulting in 44 deaths being reviewed within the quarter. 35 cases (79.5%) were deemed to be Definitely not preventable; Good practice was identified in 18 cases (40.9%). One death was judged to be more likely than not to have been due to problems in the care provided to the patient, Hogan 4 or above (see Table 5)

4.1 Thematic Learning from Mortality Council Reviews

Good Practice Identified:

Learning disability deaths:

- Collaborative working with carers allowing familiar faces to assist with meals etc.
- Discussions with family.
- Quick response to deterioration.
- With the expansion of the LD nursing team to 2, they are proactively seeing patients when alerted to the admission through Nervecentre and Careflow rather than waiting for a referral.

Falls:

- AFLOAT tool embedded and being used alongside Safer Nursing Care Tool.
- Risk Assessments completed, no gaps in daily reviews.

Maternal death:

- Excellent documentation – recording all attempts at resus.
- MNSI report – clear leadership, teamwork, registrar in ED outstanding, hot debrief performed.
- Bereavement support afterwards was very positive. Dad and family were able to see the baby due to the hysterotomy. The bereavement midwife was able to support the family with requesting a certificate of birth. This was escalated to the national team and has led to a change in practice.

Learning Identified and actions taken:

Learning disability deaths:

- Evidence of disadvantage when the LD nursing service had reduced or no capacity:
  - MCA 1 and 2/DoLs not completed appropriately during this period.
  - Referrals to the service not made.
- Reliance on family members to carry out fundamentals of care.
- Bowel and bladder management not optimal.
- Delay in requesting/obtaining pressure relieving mattress.
- LD not given due consideration when decisions were made regarding boarding.
- Elements of care no longer on corporate induction e.g. safeguarding, MCA 1 and 2 requirements
- 12 Learning disability deaths were reviewed at Mortality Council in Q1 2025. 11 cases (91.7%) were scored as Definitely not preventable and 1 case with Slight evidence of preventability. Room for improvement was identified in 9 (75.0%) of cases. (see Table 6)

It was agreed that the LD nursing service would continue to support clinical areas with an additional focus on these areas of learning and would escalate the potential impact of the changes to induction through SafeCare Steering Group and the Mental Health, LD, and Autism Group.

Falls:

- Lying and standing blood pressure not conducted.
- Fall investigation could have been completed to a higher standard.

It was agreed that these findings would be incorporated into the work of the Trust wide falls programme.

Documentation:

- The current set up of hybrid documentation across paper and several digital systems continues to cause a risk to patient safety, in relation to recording in multiple places and the time it takes to open all of the relevant systems essential for patient care- Nervecentre for observations, Wellsky for medications, Careflow for old clinical letters, GNCR and A&E record and the paper notes for current episode of care. General surgery continue to use Nervecentre for clinical documentation as this has improved their note keeping however this creates confusion between teams as to where to document.

It was agreed that this risk should continue to be escalated within the Trust as it is a significant clinical risk.

Escalation of the deteriorating patient:

- Patient had a cardiac arrest when undergoing investigations within the radiology department. There was a gap in team awareness of what to do in these circumstances. Comms were shared across the team to address the knowledge gap,

but the Council felt this learning was applicable to the whole organisation as this could occur within any non-ward setting. The Council also queried whether patient facing admin roles part of their core skills programme, and recommended this would be valuable. It was confirmed that this would be offered as part of BLS training which is not part of the core skills for an administrative role. This has been discussed with the Chief matrons and will be escalated to the SafeCare Steering Group for consideration.

Maternal and child death:

- Identified limited access to Badger in Emergency Department meaning that access to maternity and neonatal information was not easily available in an emergency situation.

This has been resolved with Badger re-installed on 2 PCs in Resus.

Intermediate/high risk PEs:

- It became apparent during a Covid spike in 2024 that the national risk stratification for PE was not working effectively for the patients we were seeing. This was during a Covid spike, and it was confirmed with the medical consultants that practice changed during this time to move to earlier thrombolysis.

A system for a fast track CTPA to be conducted within 1 hour has been implemented and used by clinical teams. The guidelines for thrombolysis are being updated by and Acute Medical/ICU consultant.

Acute Oncology Team:

- Communication with family around prognosis and expectations for a patient with a complex cancer diagnosis could have been improved with greater specialist nursing input.

This has been highlighted to the Cancer triumvirate for consideration as to any appropriate actions.

Medication:

- Medication patches left in situ in multiple places on a patient's body, old patches should be removed when a new patch is applied.

Pharmacy are working with Nervecentre and Wellsky to develop a body map and a SOP for patch site of administration noting.

5 Addressing Mortality Council Backlog

At the start of Q1 there were 147 outstanding cases. We addressed these through the following extraordinary meetings and normal scheduled meetings.

Two extraordinary extended three-hour long Mortality Council meetings were held in April, as well as the prescheduled meeting.

A further extended extraordinary meeting took place on 6th May 2025 with a focus on front of house deaths. Unfortunately, the meeting scheduled for 27th May 2025 was stood down due to lack of necessary attendees.

The impact of this was that by the end of Q1 there were 105 number of outstanding cases.

The plan for Q2 for was set as follows:

1st July – additional meeting
8th July – normal scheduled meeting
22nd July – additional meeting
5th August – additional meeting
12th August – normal scheduled meeting
2nd September – additional meeting
23rd September – additional meeting

On average the Mortality Council review seven cases per meeting, however going forwards, to facilitate more timely reviews, the ward teams will be asked to carry out a more in-depth review and present the outcome to the Mortality Council, rather than have the in-depth ward level discussion within the Council. This has potential to allow more deaths to be reviewed within each meeting.

In Mortality and Morbidity Steering Group it was identified that the ward level reviews are not always being added to the mortality database. The teams have been reminded of the need to do this, and a report is being produced to look at the outstanding level 2 reviews by area on a quarterly basis to try and increase compliance with this.

The Mortality and Morbidity Steering Group discussed that by just addressing the backlog in chronological order, opportunities for immediate learning would be missed. Therefore, it was decided that of the two meetings each month, one will focus on the backlog in chronological order and one on the recent deaths. This will continue until the end of 2025, when progress will be reviewed and a decision made as to whether two meetings per month need to continue.

Learning Disabilities deaths – update on backlog of cases for review

Three learning disabilities deaths still require a mortality council review; however, these have been reviewed by the learning disability lead nurse and any immediate learning actioned.

Serious mental illness deaths – update on backlog of cases for review

7 Severe Mental Illness cases were reviewed at Mortality Council. 6 were deemed to be Definitely not preventable, however 1 case was judged to be more likely than not to have been due to problems in the care provided to the patient with a Hogan score of 4 - Probably preventable (more than 50:50). Good Practice was identified in 4 cases and Room for Improvement identified in 3 cases. (see Appendix 2 Table 7).

Positive progress has been made with the backlog of serious mental illness deaths. 17 cases remain outstanding, the oldest case being a death in March 2024. A breakdown of the cases is below:

Under 65s	8 to review: ○ 4 reviews completed by CNTW. ○ 4 no CNTW input in life	Will be listed for Mortality Council review at the earliest opportunity
Over 65s	9 to review: ○ 3 reviews completed by OPMH services ○ 4 no OPMH input in life ○ 2 reviews by OPMH remain outstanding.	The completed seven will be listed for Mortality Council at the earliest opportunity

6 Timescales for review

The existing trust policy - OP93 Learning from Deaths V2.1, stipulates that all deaths meeting the National Quality Board categories should be reviewed within 12 weeks of the date of death. As this policy is due to be reviewed there is an opportunity to revisit these timescales.

12 weeks has not been possible in the majority of cases due to various reasons mainly due to the number of Mortality Council meetings stood down in 2024 and early 2025 due to either the unavailability of a chair or the lack of enough members for the meeting to be quorate to allow an appropriate level of discussion. The interruption to the learning disability service during 2023/24 also added to the backlog as no deceased patients with a learning disability diagnosis were reviewed during this period.

It is proposed to amend the timescales to add in variation against the National Quality Board categories, as described in the table below:

National Quality Board Category	**Proposed timescale for review**
Severe Mental Illness (SMI)	Within 12 weeks of date of death
Learning Disability (LD)	Within 12 weeks of date of death
Elective	Within 12 weeks of date of death
Child deaths	Within 12 months of date of death – this will allow the Child Death Review process to conclude prior to an internal review. The Trust will participate fully in the CDR so learning will not be delayed.
Family concerns (classified as formal complaints or PALs)	Within 6 months of receipt of the complaint to allow appropriate investigation of and response to the complaint. RM21 Managing Concerns and Complaints Policy states that formal complaints should take no longer than 40 days (8 weeks) to conclude, an extension to 60 days (12 weeks)
Medical Examiner referrals indicating a level of preventability*	Within 6 weeks of date of death

*Medical Examiner referrals are not included within the National Quality Board Guidance, this was produced prior to the introduction of the Medical Examiner system

7 Triangulation of Mortality Data

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

Inphase

- Any potential patient safety incidents identified during the course of the medical examiner scrutiny are highlighted either to the treating team to report an incident via Inphase or the Inphase is completed by the Medical Examiner Office.

Patient Safety Team

- The Patient Safety Team is represented on the Mortality Council to ensure that any deaths deemed to be a Hogan 4 are managed appropriately in terms of deciding whether to commission a PSII.

Legal Services

- Deaths referred to the coroner which have the potential to progress to an inquest are shared with the Legal Team by the Medical Examiner Office.

Mortality Council

- For deaths reviewed by the Mortality Council, information is collated in advance of the meeting in relation to complaints/PALs, patient safety, legal and safeguarding, to ensure that the full picture is available for the discussion.
- Formal Complaints received from relatives/carers of the deceased are shared by the complaints team for discussion at the Mortality Council.
- Outcomes and learning from Inquests for individual patients are presented to the Mortality Council.
- A quarterly learning summary from the Mortality Council is developed and shared throughout the organisation.
- Learning from Mortality Council is also shared via Divisional SafeCare Meetings and the Safety Brief which is replacing the learning aspect of the Learning Panel.

8 Summary

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

Although three extraordinary Mortality Councils were held in April and May, it continues to be challenging to work through the existing backlog of cases to be reviewed and opportunities to identify learning and escalate any relevant cases into other governance processes e.g. patient safety and patient experience. Further extraordinary meetings will be required throughout at least the end of 2025 and by reviewing both backlog cases and recent deaths assurance can be given that current learning is not missed.

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

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

9 Recommendation

The Steering Group is asked to receive this paper for information and assurance and agree in principle the changes to review timescales for deaths in the Trust.

Appendix 1

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

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

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

   - Deaths of people with a learning disability - was autistic and was over 18 years old or had a learning disability and was over 4 years old.
   - Deaths of people with serious mental illness (SMI) - all inpatient, outpatient, and community patient deaths of people with serious mental illness (SMI) should be subject to case record review. In relation to this requirement, there is currently no single agreed definition in the Learning from Deaths framework which conditions/criteria would constitute SMI. The term is generally restricted to the psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis, and schizoaffective disorder. It is acknowledged that there is substantive criticism of this definition; personality disorders can be just as severe and disabling, as can severe forms of eating disorders, obsessive compulsive disorder, anxiety disorders and substance misuse problems. The purposes of this policy this apply to the psychoses.
   - Infant or child deaths – these deaths come to the Mortality Council to ensure that Trust have oversight of infant or child deaths, however, they are subject to the child death review process as per the Management of Sudden Unexpected Deaths in Neonates and Children Policy.
   - Stillbirths – are reviewed using the Perinatal Mortality Review Tool as per the Maternity Services Risk Management Operational Policy. A quarterly assurance/learning report is provided to the Mortality & Morbidity Steering Group.
   - Maternal deaths.
   - All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision –a significant concern is defined as a formal complaint or a concern raised via the Patient Advice and Liaison Services (PALS) Team.
   - All deaths in a service specialty, particular diagnosis or treatment group where an ‘alarm’ has been raised with the provider through whatever means (for example, via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the Care Quality Commission or another regulator).
   - All deaths in areas where people are not expected to die – for example, in certain elective procedures.
   - Deaths where learning will inform the provider’s existing or planned improvement work.

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

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

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

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

Appendix 2 – Mortality charts

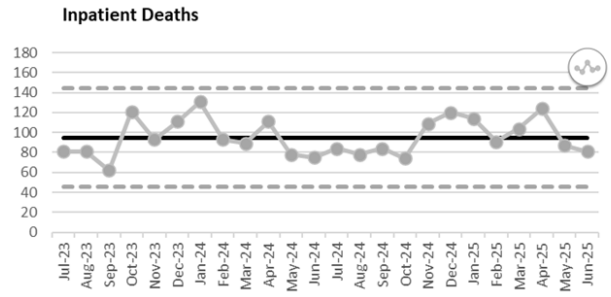


Figure 1: Inpatient Deaths

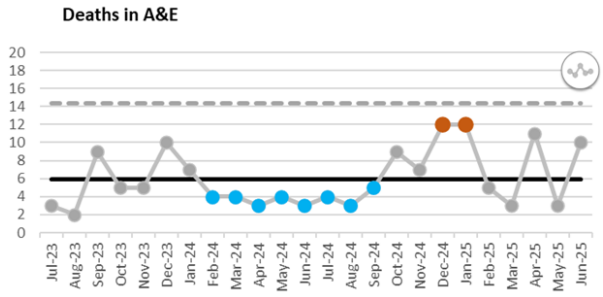


Figure 2: Deaths in A&E

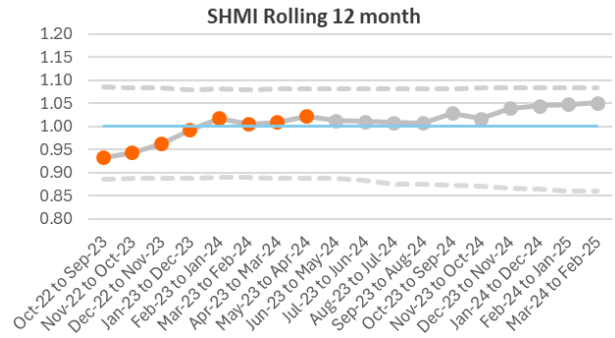


Figure 3: SHMI Rolling 12 months

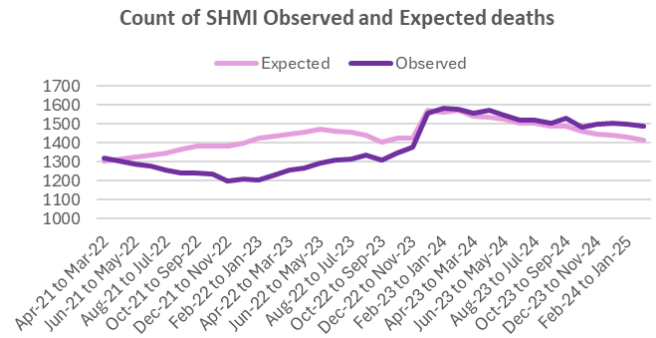


Figure 4: Observed and Expected Deaths

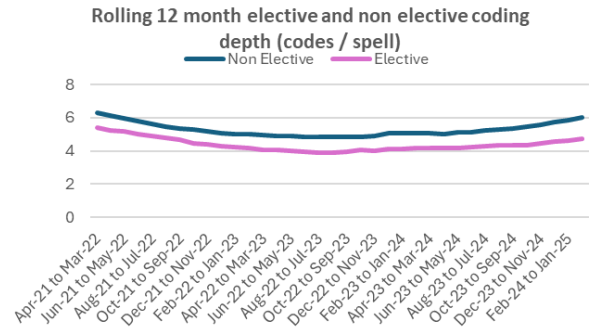


Figure 5: Elective and Non-Elective Coding Depth Rolling 12 months

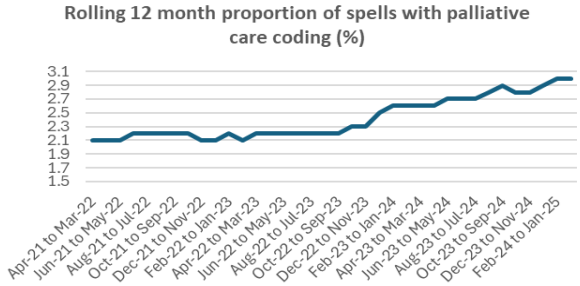
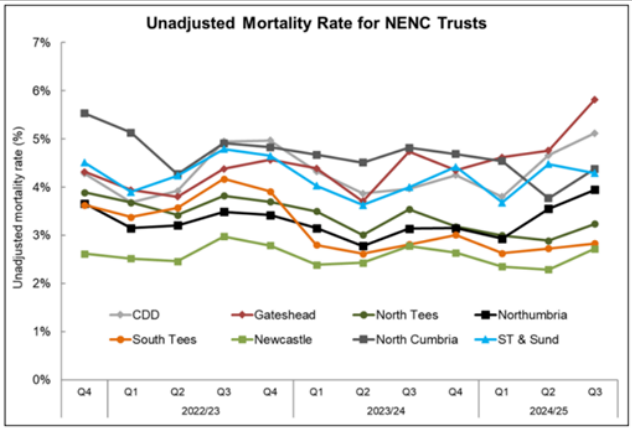


Figure 6: Proportion of spells with palliative care coding Rolling 12 months

	Alert	CCS Diagnostic Group	Period	Observed Deaths	Expected Deaths	Obs -Exp	SHMI	% Reviewed (where death within Trust)	% Definitely not preventable	% NCEPOD Good Practice
	SHMI	Cancer of bronchus; lung	Apr-24 to Mar-25	43 (30 in hospital)	27.6	15.4	156.0	96.6% 29 of 30	100%	100%
	SHMI	Pulmonary heart disease	Apr-24 to Mar-25	16 (11 in hospital)	8.0	8.0	201.1	90.1% 10 of 11	100%	100%

Table 1: Mortality Alerts from Healthcare Evaluation Data (HED)



Trend in unadjusted mortality, Oct 2021 to Dec 2024

Figure 7 Unadjusted Mortality Rate NENC

Medical Examiner Scrutiny	
Deaths in period	1225
Deaths Scrutinised by Medical Examiner	1208
% of Deaths scrutinised by the Medical Examiner	98.6%

Hogan Scores		
Definitely not preventable	1166	95.2%
Some evidence of preventability	22	1.8%
Unable to score - Refer to Mortality Council	20	1.6%
Not scored by the Medical Examiner*	17	1.4%

NCEPOD Scores		
Good practice	1137	92.8%
Room for Improvement	52	4.2%
Unable to score - Refer to Mortality Council	19	1.6%
Not scored by the Medical Examiner*	17	1.4%

Table 2: Medical Examiner Scrutiny 12 months ending Q1 2025 Hogan and NCEPOD Scoring

Hogan Scoring		
1 Definitely Not Preventable	21	100.0%
2 Slight evidence of preventability	0	0.0%
3 Possibly Preventable (Less than 50:50)	0	0.0%
4 Probably preventable (more than 50:50)	0	0.0%
5 Strong Evidence Preventable	0	0.0%
6 Definitely Preventable	0	0.0%
Initial review but not yet scored	0	0.0%
Total	21	100%

NCEPOD Scoring		
1 Good practice	13	61.9%
2 Room for improvement - Clinical Care	5	23.8%
3 Room for Improvement - Organisational Care	3	14.3%
4 Room for improvement - Clinical and Organisational care	0	0.0%
5 Less Than Satisfactory	0	0.0%
6 Insuficient data	0	0.0%
Initial review but not yet scored	0	0.0%
Total	21	100.0%

Table 3: Ward team reviews in the quarter outcomes

Hogan Scoring		
1 Definitely Not Preventable	12	100.0%
2 Slight evidence of preventability	0	0.0%
3 Possibly Preventable (Less than 50:50)	0	0.0%
4 Probably preventable (more than 50:50)	0	0.0%
5 Strong Evidence Preventable	0	0.0%
6 Definitely Preventable	0	0.0%
Initial review but not yet scored	0	0.0%
Total	12	100%

NCEPOD Scoring		
1 Good practice	5	41.7%
2 Room for improvement - Clinical Care	4	33.3%
3 Room for Improvement - Organisational Care	3	25.0%
4 Room for improvement - Clinical and Organisational care	0	0.0%
5 Less Than Satisfactory	0	0.0%
6 Insuficient data	0	0.0%
Initial review but not yet scored	0	0.0%
Total	12	100.0%

Table 4: Ward reviews in the quarter resulting from a Medical Examiner Referral

Hogan Scoring		
1 Definitely Not Preventable	35	79.5%
2 Slight evidence of preventability	3	6.8%
3 Possibly Preventable (Less than 50:50)	2	4.5%
4 Probably preventable (more than 50:50)	1	2.3%
5 Strong Evidence Preventable	0	0.0%
6 Definitely Preventable	0	0.0%
Initial review but not yet scored	3	6.8%
Total	44	100%

NCEPOD Scoring		
1 Good Practice	18	40.9%
2 Room for improvement - Clinical Care	1	2.3%
3 Room for Improvement - Organisational Care	14	31.8%
4 Room for improvement - Clinical and Organisational care	8	18.2%
5 Less Than Satisfactory	0	0.0%
6 Insuficient data	0	0.0%
Initial review but not yet scored	3	6.8%
Total	44	100.0%

Table 5: Mortality Council reviews in the quarter

Hogan Scoring		
1 Definitely Not Preventable	11	91.7%
2 Slight evidence of preventability	1	8.3%
3 Possibly Preventable (Less than 50:50)	0	0.0%
4 Probably preventable (more than 50:50)	0	0.0%
5 Strong Evidence Preventable	0	0.0%
6 Definitely Preventable	0	0.0%
Initial review but not yet scored	0	0.0%
Total	12	100%

NCEPOD Scoring		
1 Good Practice	3	25.0%
2 Room for improvement - Clinical Care	0	0.0%
3 Room for Improvement - Organisational Care	8	66.7%
4 Room for improvement - Clinical and Organisational care	1	8.3%
5 Less Than Satisfactory	0	0.0%
6 Insuficient data	0	0.0%
Initial review but not yet scored	0	0.0%
Total	12	100.0%

Table 6: Learning Disability Deaths

Hogan Scoring		
1 Definitely Not Preventable	6	85.7%
2 Slight evidence of preventability	0	0.0%
3 Possibly Preventable (Less than 50:50)	0	0.0%
4 Probably preventable (more than 50:50)	1	14.3%
5 Strong Evidence Preventable	0	0.0%
6 Definitely Preventable	0	0.0%
Initial review but not yet scored	0	0.0%
Total	7	100%

NCEPOD Scoring		
1 Good Practice	4	57.1%
2 Room for improvement - Clinical Care	0	0.0%
3 Room for Improvement - Organisational Care	1	14.3%
4 Room for improvement - Clinical and Organisational care	2	28.6%
5 Less Than Satisfactory	0	0.0%
6 Insuficient data	0	0.0%
Initial review but not yet scored	0	0.0%
Total	7	100.0%

Table 7: Severe Mental Illness Deaths

Hogan Scoring		
1 Definitely Not Preventable	1130	92.2%
2 Slight Evidence of Preventabiliy	1	0.1%
3 Possibly Preventable (Less than 50:50)	2	0.2%
4 Probably preventable (more than 50:50)	1	0.1%
5 Strong Evidence Preventable	0	0.0%
6 Definitely Preventable	0	0.0%
Awaiting Mortality Council Review	61	5.0%
Awaiting Ward Team Review	20	1.6%
Not reviewed / scored	10	0.8%
Total	1225	100%

NCEPOD Scoring		
1 Good Practice	1109	90.5%
2 Room for improvement - Clinical Care	4	0.3%
3 Room for Improvement - Organisational Care	8	0.7%
4 Room for Improvement Clinical and Organisational Care	10	0.8%
5 Less Than Satisfactory	0	0.0%
6 Insuficient data	0	0.0%
Awaiting Mortality Council review	61	5.0%
Awaiting Ward Team Review	20	1.6%
ME identified room for improvement but not referred	5	0.4%
Not reviewed / scored	8	0.7%
Total	1225	100.0%

Table 8: Scoring outcomes from all mortality review for deaths in the 12-month period ending Q1 2025-26.

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 14ii

Report Title:	**Learning from Deaths – Quarter 2 2025/26**			
Name of Meeting:	Trust Board			
Date of Meeting:	5 December 2025			
Author:	Wendy McFadden – Clinical Effectiveness Lead Andrew Ward Senior Information Analyst – Quality & Patient Safety			
Executive Sponsor:	Dr Carmen Howey – Group Medical Director			
Report presented by:	Elizabeth Swanson, Interim Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	Enter purpose here			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Mortality & Morbidity Steering Group Quality Governance Committee			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	The paper outlines the process for review of deaths within the organisation and the way in which those review processes enable learning from good practice and learning where there is evidence that care could be improved. Four extraordinary meetings took place throughout July, August and September to address the backlog of cases awaiting review. The number awaiting review has reduced from 105 to 77. Considerable progress has been made in the review of the deaths of patients with a Learning Disability, three cases remain outstanding for review by the Mortality Council (these have all been reviewed by the Learning Disability Nurses) and are listed for discussion in the November and December meetings There remain 15 deaths awaiting Mortality Council review for deaths for patients with Serious Mental illness, however			

	positive progress has been made with seven scheduled for discussion in the October meeting. The report describes how other sources of data are triangulated with the information from the mortality review processes to ensure a joined-up understanding of any issues related to patient deaths which would cause us concern. The paper provides partial assurance regarding our internal processes as 77 cases still await review				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	To receive the paper for assurance				
Trust strategic priorities that the report relates to:	☒	Excellent patient care			
	☐	Great place to work			
	☐	Working together for healthier communities			
	☐	Fit for the future			
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	List strategic objective here				
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☐	Responsive ☒	Well-led ☐	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):					
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☒	**Not applicable** ☒		

Learning from Deaths Report – Quarter 2 2025-26

1 Introduction:

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

The Trust's Learning from Deaths policy explains the agreed process for reviewing and learning from deaths across the organisation. The reviews follow a three-step process (see Appendix 1).

2 Mortality data summary

This section summarises the information included in Appendix 2 Mortality Charts.

2.1 Deaths in Emergency Care and In-patients

There were 12 deaths in the Emergency Care department, equalling 12 deaths in the equivalent quarter for the previous year; this measure remains within common cause variation. (see Figure 2)

222 inpatient deaths observed in quarter two 2025 compared to 246 observed in the equivalent quarter for the previous year, a decrease of 28 and remaining within common cause variation on the SPC chart. (see Figure 2)

The SHMI (Summary Hospital-level Mortality Indicator) is showing an increase over the last eight months, however, remains within the expected range. (see Figure 3)

Observed mortality in the SHMI continues to deviate from the expected mortality value in recent months leading to an increase in the SHMI. The number of expected deaths shows a general decline as SDEC activity is removed progressively from the rolling 12-month period from May 2024. It was anticipated that this would result in an increasing SHMI. (see Figure 4).

The latest SHMI background data quality report published with the latest dataset advises that 'Trusts with SDEC activity removed from the SHMI data have seen an increase in their SHMI value. This is caused by two factors. Firstly, the observed number of deaths remains approximately the same as the mortality rate for this cohort is very low; secondly, the expected number of deaths decreases because a large number of spells are removed, all of which would have had a small, non-zero risk of mortality contributing to the expected number of deaths. It is expected that all trusts will transition to recording SDEC activity in the ECDS. This means that eventually all trusts will be recording SDEC activity consistently and the amount of SDEC included in the SHMI will decrease over time.

Coding depth for both elective and non-elective admissions continue to show a sustained upward trend. The Trusts coding depth is lower than the England average for Elective spells:

5.1 compared to a national figure of 6.6 codes per spell. Non-Elective spells: 6.4 compared to 6.2 codes per spell. (see Figure 5). The coding team locally advise that our coding is accurate and only includes the coding relevant to the last hospital spell, as it should.

A general increase is observed in the proportion of spells with palliative care coding recorded. 3.1% of spells had a palliative care code compared to 2.1% for England (see Figure 6)

The mortality alerts for Mortality Alerts from Healthcare Evaluation Data (HED) for Lung Cancer and Pulmonary heart disease reported in the report for quarter one are no longer triggering in the current SHMI period (July 2024 to June 2025).

Cancer of the prostate, testis, and other male genital organs, and Peripheral and visceral atherosclerosis diagnosis groups are triggering alerts in the latest SHMI data.

78% of the Cancer cases had palliative care coding (the SHMI model does not risk adjust for this as standard), adjusting for this would place the SHMI score for these cases within the expected range. Where the deaths occurred in hospital, (8 of 10) all cases have mortality scrutiny and were deemed to be 'Definitely not preventable' and 'Good practice'.

For the Peripheral and visceral atherosclerosis patients 9% of cases had palliative coding and adjusting for this would still show more deaths than expected. However all but one case died in the hospital, and again those cases where patients died in hospital have mortality scrutiny and were all deemed to be 'Definitely not preventable' and 'Good practice'.

The unadjusted mortality rate varies between trusts and quarters across the period April 2022 to March 2025, with the current period ranging from 2.5% at Newcastle to 5.9% at Gateshead. The SHMI and the unadjusted rate include all deaths in hospital plus deaths within 30 days of discharge; the rates are starting to the four Trusts that are no longer reporting SDEC in the Admitted Patient Care (APC) dataset. (see figure 7) In understanding the sharp rise for Gateshead it's necessary to consider the impact of SDEC. The number of discharges reported by the Trusts now submitting SDEC to in the Emergency care data set is reduced so the denominator for the crude mortality calculation is smaller. It is difficult to understand how much the SDEC effect would impact on each trust. Looking at the %change in discharges Gateshead show the largest change: -22% in total discharges between 23-24 and 24-25) Northumbria were next with a 16% reduction and see a similar rise.) We also serve different patient cohorts, Gateshead has the highest comorbidity scoring in the region which may also explain to some degree a higher crude mortality rate.

2.2 Rolling 12 month scrutiny data:

Considering deaths in the Trust in the 12 months preceding the end of quarter two 2025. There were 1,210 deaths, of which 1,193 (98.6%) were scrutinised by the Medical Examiner.

Medical Examiner scrutiny deemed 1,148cases (94.9%) to be 'Definitely not preventable' and 'Good Practice' identified in 1,121 cases (92.6%). 24 cases (1.7%) identified potentially 'Some evidence of preventability' and 'Room for improvement' identified in 53 cases (4.4%). 21 cases (1.7%) were unable to be scored for preventability, and referred to the Mortality Council, 17 cases (1.4%) were not scored. (see Table 2)

Considering all deaths and mortality review during the period 12-month period ending Q1 2025 (ME Scrutiny, Ward Level Reviews, Mortality Council Reviews) provides the following

scores.1,114 cases (92.1%) 'Definitely not preventable' and 1,093 cases (90.3%) Good Practice.
One death (0.08%) was judged to be more likely than not to have been due to problems in the care provided to the patient, Hogan 4 or above.
61 cases (4.7%) from the period awaiting Mortality Council review, and 20 cases (1.7%) awaiting a ward review following referral by the Medical Examiner at the time of writing. (see Table 8)

3 Learning from Ward Level Reviews:

20 ward level reviews took place during quarter 2, 17 were 'Definitely not preventable', 2 'Slight evidence of preventability' and 1 'Possibly preventable (less than 50:50)'.

From the quality of care review perspective, 14 deaths were deemed to be 'Good Practice', 1 'Room to improve in clinical care', 2 'Room to improve in organisational care' and 2 'Room to improvement in both clinical and organisational care'. Where learning or the opportunity to share good practice is identified in a ward review, this will be actioned and shared within Division and across Divisions where this is appropriate.

Ward level reviews are only required to be undertaken following a referral from the Medical Examiner, however, wards can review any of the deaths that have occurred on their wards should they wish. The Medical Examiner team referred five deaths to the wards for review, at this time none of these have yet been reviewed by the ward teams.

3.1 Themes of good practice identified through Ward Reviews:

- Seen promptly by other specialities – critical care, palliative care, care of the elderly, gastro, SALT, respiratory
- Good communication with family re prognosis and DNACPR
- Early recognition of deterioration and appropriate timely transfer to critical care
- Timely MDT discussions

3.2 Learning identified and actions arising from Ward Reviews

Reviewing the narrative from ward level reviews did not identify any thematic trends, there was some learning at an individual patient level, which is summarised below:

- Assessment of falls risk and actions taken: AFLOAT tool advised cohort nursing. This was not achieved. This was due to need for cohorting other patients on the ward.

Ensure incidents are inphased when AFLOAT identified need to cohort / 1:1 and this is unable to be provided with current ward provision.

- Neurological observations: Neurological observations were not performed hourly as requested by doctor. Delay in transfer to neuro-obs on Nervecentre.

Teaching pack on neuro-obs across hospital peer education being rolled out (supported by practice development team)

- Lying and standing BP was not performed during the admission although it was requested. Level 1 mortality review felt this should have been performed

Falls work stream current review of inpatient falls policies ongoing.

- Time spent off ward without an escort: Patient attended radiology unescorted. Level 1 mortality review felt patient should have attended radiology with an escort.

Review if there is a policy that defines which patients require escorts for transfer to radiology overnight and when on neurological observations.

- Was not reviewed by a doctor. It was documented in the notes that a review should take place on return from dialysis. Concerns about delirium and Hb were raised by renal team. Level 1 mortality review felt that patient should have been reviewed.

Plan for handover of evening tasks to move to nervecentre. Discuss at safecare if policy for review on return from other trusts needed.

4 Learning from Mortality Council

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

For the period 1st July – 30th September 2025, seven Mortality Council meetings took place. Three planned and four additional meetings, resulting in 40 deaths being reviewed within the quarter.

4.1 Thematic Learning from Mortality Council Review

Good Practice Identified:

- Excellent support provided from Palliative Care team
- Good end of life care provision
- Good documentation of decision making, explanation of risk and care provided
- Mental Capacity Act assessment carried out appropriately
- Timely cross specialty reviews undertaken and documented

Learning Identified and actions taken:

Winter Escalation Ward

- Following a trend identified by the Medical Examiner, a themed Mortality Council was held to review a group of patients who had passed away on the winter escalation ward, amongst these were complaints from relatives were also considered. Timing constraints only allowed for the review of two patients. The remainder has been scheduled for a later meeting within quarter 3. The reviews identified a lack of continuity of care, insufficient staffing levels, insufficient basic supplies, no physio provision, lack of assistance for personal care such as using the toilet and help with meals.

This has been fed back to the Winter Planning Group.

Cardiology Care

- The Mortality Council were requested to carry out a cardiology themed review looking at three deaths. Issues raised:
    - Ward 8 is not a formally recognised coronary care unit
    - resident doctors should be reviewing patient monitoring and alarms (they are often relying on nursing staff to highlight any abnormalities)
    - medical staffing cover on a weekend significantly depleted on average 130 patients to review plus any ad hoc referrals across the whole hospital
    - referral pathway to freeman – multiple different teams across cardiology within freeman, difficult to know which is the most appropriate for discussion
    - critical care/CPAP delay due to ongoing emergency within critical care
    - no capacity for nurse led initiation of CPAP
    - systemic medical staffing pressures on evenings and weekends
    - criteria for patient transferred from A&E to ward 8
    - diagnostic pathway delays – ECHO not performed within recommended 2 weeks
    - co-ordination of care between teams, when care spans more than one speciality
    - documentation – recording of fluid within the notes, however no evidence of fluid being given

Cardiology team have developed an induction booklet with expectations for their resident doctors and a contact list for cardiology services at Freeman Hospital, this is to be shared with A&E. Medical Business Unit to look a report to identify patients transferred to back of house without a senior medical review, discuss possibility of ward 8 trained nurses commencing CPAP service on the ward, discuss feasibility of a seven day cardiology rota/provision,

Services provided by tertiary centre / Service Level Agreements

- Identified that it is not well-known what service level agreements/standard operating procedures exist with tertiary centres, it would be helpful to make this information readily accessible. As well as a process to define what to do when the agreements are not being followed by either party.

Discussed with the Medical Director who confirmed that this will be picked up within regional discussions.

SALT assessment

- Continue to see a theme of SALT assessments not being performed within 48 hours particularly on a weekend. Challenges remain in relation to recruiting to current vacancies.

SALT staffing levels is recorded on the risk register: "*2244 Risk of decreased level of service to both in-patients and community patients requiring SALT services Due to current gap in staffing levels as result of staff leaving Trust. Also difficulty in recruiting and retaining level of appropriate staff to work on the wards to undertake necessary SLT assessments and reviews in a timely and safe manner. Resulting in pressure on other team members who have to backfill, stripping resource from the community service"*.

Mealtime support

- Current staffing gaps, particularly health care assistants is impacting on the support that can be provided to patients who need help with meals.

Healthcare assistant vacancies is recorded on the risk register: "*4770 Risk to patient safety and quality of care due to HCA vacancies across the medical business unit, which could lead to an increase in likelihood that adverse incidents will occur and an increase in complaints*".

Mouthcare

- Issues with sufficient mouthcare continues to be a recurring theme.

The Chief Matrons are working with the Practice Development Team to develop education following the publication of the Mouthcare Matters campaign.

Referral process across the organisation

- There are multiple ways to refer between teams across the organisation – ICE, nervecentre, verbally either over the telephone or face to face, electronic referral forms sent via email, paper referral forms.

Ability to speak directly to duty radiologist when making a referral

- A consultant having the ability to speak directly to the duty radiologist would be really helpful, this practice does happen in some pockets of the organisation, however, it is not widely known if this possible and if so, how to make contact

The duty radiologist is happy to speak with consultants regarding any referrals, this should be done via bleeping the duty radiology secretary. It is recognised that there

are barriers and challenges associated with using bleeps to communicate, discussions happening regarding moving from bleeps to vocera.

One of the deaths reviewed within the quarter was deemed to be Hogan 5 'Strong evidence of preventability'. Originally referred to Mortality Council due to concerns raised by the Medical Examiner, returning for second review with the postmortem findings. There is an ongoing PSII into this case. The main learning identified within the Mortality Council review was around blood tests being taken but not seen or acted on, transfer from EAU to base ward out hours without sufficient handover, staffing and workload for doctors covering wards at the weekend. The process for escalating concerns, and the interaction with nervecentre task allocation and escalation.

5 Addressing Mortality Council Backlog

At the start of Q2 there were 105 outstanding cases. We addressed these through the following extraordinary meetings and normal scheduled meetings.

Four extraordinary Mortality Council meetings, as well as three prescheduled meetings resulting in 40 cases being reviewed. 12 cases were added to the Mortality Council for review during Q2.

The impact of this was that by the end of Q2 there were 77 outstanding cases.

2024 - 35
2025 - 42

The plan for Q3 for has been set as follows:

14th October – normal scheduled meeting
28th October – additional meeting
11th November – normal meeting
25th November – additional meeting
2nd December - normal scheduled meeting

On average the Mortality Council review seven cases per meeting, however going forwards, to facilitate more timely reviews, the ward teams will be asked to carry out a more in-depth review and present the outcome to the Mortality Council, rather than have the in-depth ward level discussion within the Council. This has potential to allow more deaths to be reviewed within each meeting.

In Mortality and Morbidity Steering Group it was identified that the ward level reviews are not always being added to the mortality database. The teams have been reminded of the need to do this, and a report is being produced to look at the outstanding level 2 reviews by area on a quarterly basis to try and increase compliance with this.

Learning Disabilities deaths – update on backlog of cases for review

Three learning disabilities deaths still require a mortality council review; however, these have been reviewed by the learning disability lead nurse and any immediate learning actioned. These are scheduled for discussion at the November and December meeting.

Serious mental illness deaths – update on backlog of cases for review

Positive progress has been made with the backlog of serious mental illness deaths. 15 cases remain outstanding. A breakdown of the cases is below:

Under 65s	7 to review:	Four listed for Mortality Council in October 2025
Over 65s	8 to review: o 4 reviews remain outstanding.	Three listed for Mortality Council in October 2025

6 Triangulation of Mortality Data

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

Inphase

- Any potential patient safety incidents identified during the course of the medical examiner scrutiny are highlighted either to the treating team to report an incident via Inphase or the Inphase is completed by the Medical Examiner Office.

Patient Safety Team

- The Patient Safety Team is represented on the Mortality Council to ensure that any deaths deemed to be a Hogan 4 are managed appropriately in terms of deciding whether to commission a PSII.

Legal Services

- Deaths referred to the coroner which have the potential to progress to an inquest are shared with the Legal Team by the Medical Examiner Office.

Mortality Council

- For deaths reviewed by the Mortality Council, information is collated in advance of the meeting in relation to complaints/PALs, patient safety, legal and safeguarding, to ensure that the full picture is available for the discussion.
- Formal Complaints received from relatives/carers of the deceased are shared by the complaints team for discussion at the Mortality Council.
- Outcomes and learning from Inquests for individual patients are presented to the Mortality Council.
- A quarterly learning summary from the Mortality Council is developed and shared throughout the organisation.
- Learning from Mortality Council is also shared via Divisional SafeCare Meetings and the Safety Brief which is replacing the learning aspect of the Learning Panel.
- Deaths with significant learning/harm can also be discussed in the new formed Incident Learning Oversight Meeting.

7 Summary

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

Although four extraordinary Mortality Councils were held in quarter 2, it continues to be challenging to work through the existing backlog of cases to be reviewed and opportunities to identify learning and escalate any relevant cases into other governance processes e.g. patient safety and patient experience. Further extraordinary meetings will be required throughout at least the end of 2025.

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

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

8 Recommendation

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

Appendix 1.

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

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

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

   - Deaths of people with a learning disability - was autistic and was over 18 years old or had a learning disability and was over 4 years old.
   - Deaths of people with serious mental illness (SMI) - all inpatient, outpatient, and community patient deaths of people with serious mental illness (SMI) should be subject to case record review. In relation to this requirement, there is currently no single agreed definition in the Learning from Deaths framework which conditions/criteria would constitute SMI. The term is generally restricted to the psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis, and schizoaffective disorder. It is acknowledged that there is substantive criticism of this definition; personality disorders can be just as severe and disabling, as can severe forms of eating disorders, obsessive compulsive disorder, anxiety disorders and substance misuse problems. The purposes of this policy this apply to the psychoses.
   - Infant or child deaths – these deaths come to the Mortality Council to ensure that Trust have oversight of infant or child deaths, however, they are subject to the child death review process as per the Management of Sudden Unexpected Deaths in Neonates and Children Policy.
   - Stillbirths – are reviewed using the Perinatal Mortality Review Tool as per the Maternity Services Risk Management Operational Policy. A quarterly assurance/learning report is provided to the Mortality & Morbidity Steering Group.
   - Maternal deaths.
   - All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision –a significant concern is defined as a formal complaint or a concern raised via the Patient Advice and Liaison Services (PALS) Team.
   - All deaths in a service specialty, particular diagnosis or treatment group where an ‘alarm’ has been raised with the provider through whatever means (for example, via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the Care Quality Commission or another regulator).
   - All deaths in areas where people are not expected to die – for example, in certain elective procedures.

- Deaths where learning will inform the provider's existing or planned improvement work.

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

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

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

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

The quarterly Learning from Deaths report should be read in conjunction with the Mortality Data Report Quarter 4 2024/25.

This report includes learning from ward level reviews an update on the progress with the review of Learning Disability and Serious mental illness deaths and learning from Mortality Council review.

Appendix 2 – Mortality charts

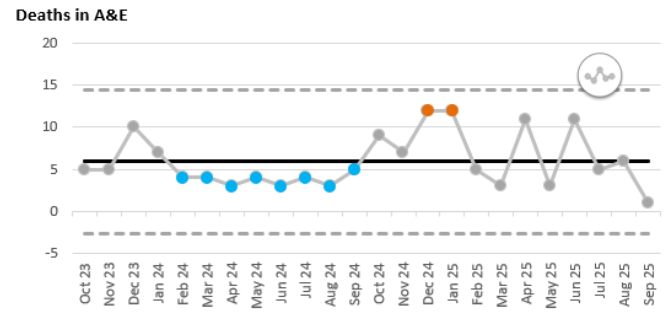


Figure 1: Deaths in A&E

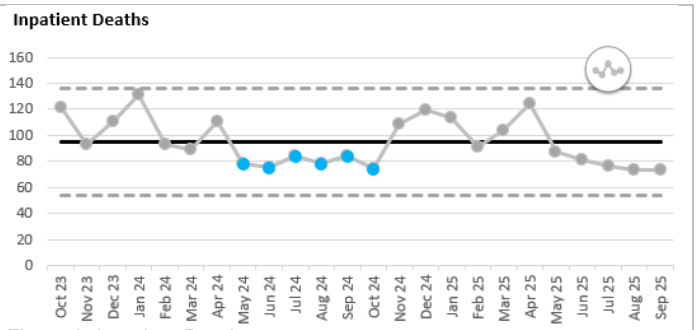


Figure 2: Inpatient Deaths

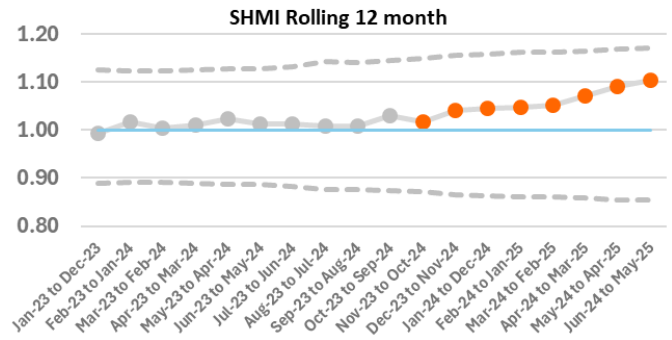


Figure 3: SHMI Rolling 12 months

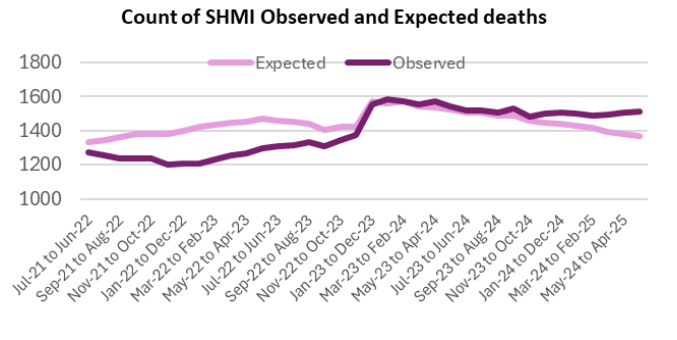


Figure 4: Observed and Expected Deaths

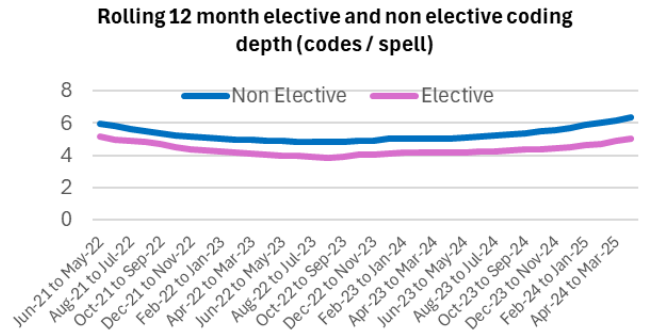


Figure 5: Elective and Non-Elective Coding Depth Rolling 12 months

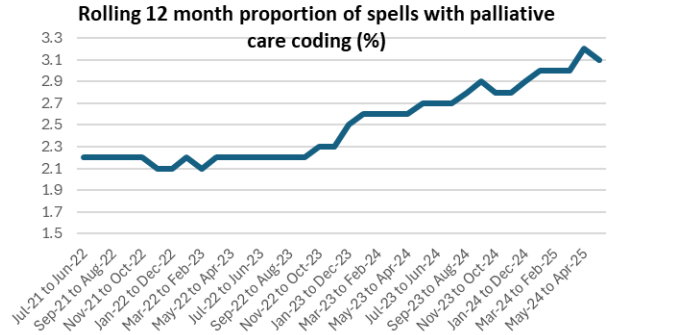


Figure 6: Proportion of spells with palliative care coding Rolling 12 months

	Alert	CCS Diagnostic Group	Period	Observed Deaths	Expected Deaths	Obs -Exp	SHMI	% of cases with scrutiny (where death within Trust Hospital)	% Definitely not preventable	% NCEPOD Good Practice
	SHMI	Cancer of prostate, Cancer of testis, Cancer of other male genital organs	Jul-24 to Jun-25	10 (8 in hospital)	3.5	6.5	287	100% 8 of 8	100%	100%
	SHMI	Peripheral and visceral atherosclerosis	Jul-24 to Jun-25	16 (15 in hospital)	7.3	8.7	218	100% 15 of 15	100%	100%

Table 1: Mortality Alerts from Healthcare Evaluation Data (HED) Jul-24 to Jun-25

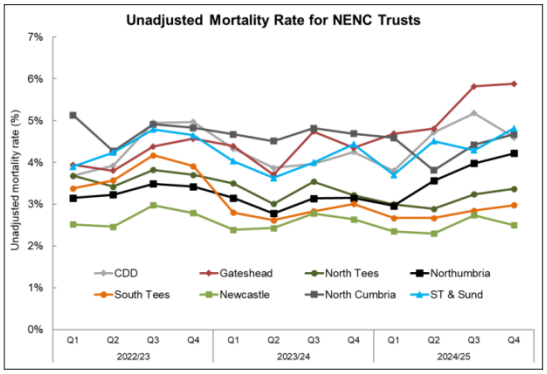


Figure 7 Unadjusted Mortality Rate NENC

Medical Examiner Scrutiny	
Deaths in period	1210
Deaths Scrutinised by Medical Examiner	1193
% of Deaths scrutinised by the Medical Examiner	98.6%

Hogan Scores		
Definitely not preventable	1148	94.9%
Some evidence of preventability	24	2.0%
Unable to score - Refer to Mortality Council	21	1.7%
Not scored by the Medical Examiner*	17	1.4%

NCEPOD Scores		
Good practice	1121	92.6%
Room for Improvement	53	4.4%
Unable to score - Refer to Mortality Council	19	1.6%
Not scored by the Medical Examiner*	17	1.4%

* Not scored by medical examiners office are cases referred directly to the coroner & non QE deaths (patients transferred, discharged, absconding who subsequently died shortly afterwards)

Table 2: Medical Examiner Scrutiny 12 months ending Q1 2025 Hogan and NCEPOD Scoring

Hogan Scoring		
1 Definitely Not Preventable	17	85.0%
2 Slight evidence of preventability	2	10.0%
3 Possibly Preventable (Less than 50:50)	1	5.0%
4 Probably preventable (more than 50:50)	0	0.0%
5 Strong Evidence Preventable	0	0.0%
6 Definitely Preventable	0	0.0%
Initial review but not yet scored	0	0.0%
Total	20	100%

NCEPOD Scoring		
1 Good practice	14	70.0%
2 Room for improvement - Clinical Care	1	5.0%
3 Room for Improvement - Organisational Care	2	10.0%
4 Room for improvement - Clinical and Organisational care	2	10.0%
5 Less Than Satisfactory	0	0.0%
6 Insufficient data	1	5.0%
Initial review but not yet scored	0	0.0%
Total	20	100.0%

Table 3: Ward team reviews in the quarter outcomes.

Hogan Scoring		
1 Definitely Not Preventable	1	100.0%
2 Slight evidence of preventability	0	0.0%
3 Possibly Preventable (Less than 50:50)	0	0.0%
4 Probably preventable (more than 50:50)	0	0.0%
5 Strong Evidence Preventable	0	0.0%
6 Definitely Preventable	0	0.0%
Initial review but not yet scored	0	0.0%
Total	1	100%

NCEPOD Scoring		
1 Good practice	1	100.0%
2 Room for improvement - Clinical Care	0	0.0%
3 Room for Improvement - Organisational Care	0	0.0%
4 Room for improvement - Clinical and Organisational care	0	0.0%
5 Less Than Satisfactory	0	0.0%
6 Insufficient data	0	0.0%
Initial review but not yet scored	0	0.0%
Total	1	100.0%

Table 4: Ward reviews in the quarter resulting from a Medical Examiner Referral

Hogan Scoring		
1 Definitely Not Preventable	28	82.4%
2 Slight evidence of preventability	2	5.9%
3 Possibly Preventable (Less than 50:50)	3	8.8%
4 Probably preventable (more than 50:50)	0	0.0%
5 Strong Evidence Preventable	1	2.9%
6 Definitely Preventable	0	0.0%
Initial review but not yet scored	0	0.0%
Total	34	100%

NCEPOD Scoring		
1 Good Practice	10	29.4%
2 Room for improvement - Clinical Care	0	0.0%
3 Room for Improvement - Organisational Care	13	38.2%
4 Room for improvement - Clinical and Organisational care	11	32.4%
5 Less Than Satisfactory	0	0.0%
6 Insuficient data	0	0.0%
Initial review but not yet scored	0	0.0%
Total	34	100.0%

Table 5: Mortality Council reviews in the quarter

Hogan Scoring		
1 Definitely Not Preventable	1	100.0%
2 Slight evidence of preventability	0	0.0%
3 Possibly Preventable (Less than 50:50)	0	0.0%
4 Probably preventable (more than 50:50)	0	0.0%
5 Strong Evidence Preventable	0	0.0%
6 Definitely Preventable	0	0.0%
Initial review but not yet scored	0	0.0%
Total	1	100%

NCEPOD Scoring		
1 Good Practice	1	100.0%
2 Room for improvement - Clinical Care	0	0.0%
3 Room for Improvement - Organisational Care	0	0.0%
4 Room for improvement - Clinical and Organisational care	0	0.0%
5 Less Than Satisfactory	0	0.0%
6 Insuficient data	0	0.0%
Initial review but not yet scored	0	0.0%
Total	1	100.0%

Table 6: Learning Disability Deaths

Hogan Scoring		
1 Definitely Not Preventable	2	100.0%
2 Slight evidence of preventability	0	0.0%
3 Possibly Preventable (Less than 50:50)	0	0.0%
4 Probably preventable (more than 50:50)	0	0.0%
5 Strong Evidence Preventable	0	0.0%
6 Definitely Preventable	0	0.0%
Initial review but not yet scored	0	0.0%
Total	2	100%

NCEPOD Scoring		
1 Good Practice	1	50.0%
2 Room for improvement - Clinical Care	0	0.0%
3 Room for Improvement - Organisational Care	1	50.0%
4 Room for improvement - Clinical and Organisational care	0	0.0%
5 Less Than Satisfactory	0	0.0%
6 Insuficient data	0	0.0%
Initial review but not yet scored	0	0.0%
Total	2	100.0%

Table 7: Severe Mental Illness Deaths

Hogan Scoring		
1 Definitely Not Preventable	1114	92.1%
2 Slight Evidence of Preventabiliy	3	0.2%
3 Possibly Preventable (Less than 50:50)	3	0.2%
4 Probably preventable (more than 50:50)	1	0.1%
5 Strong Evidence Preventable	0	0.0%
6 Definitely Preventable	0	0.0%
Awaiting Mortality Council Review	57	4.7%
Awaiting Ward Team Review	20	1.7%
Not reviewed / scored	12	1.0%
Total	1210	100%

NCEPOD Scoring		
1 Good Practice	1093	90.3%
2 Room for improvement - Clinical Care	3	0.2%
3 Room for Improvement - Organisational Care	9	0.7%
4 Room for Improvement Clinical and Organisational Care	13	1.1%
5 Less Than Satisfactory	0	0.0%
6 Insuficient data	0	0.0%
Awaiting Mortality Council review	57	4.7%
Awaiting Ward Team Review	20	1.7%
ME identified room for improvement but not referred	6	0.5%
Not reviewed / scored	9	0.7%
Total	1210	100.0%

Table 8: Scoring outcomes from all mortality review for deaths in the 12-month period ending Q2 2025-26.

15. Maternity Integrated Oversight Report presented by the Associate Director of Midwifery/SCBU

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 15

Report Title:	**Maternity Integrated Oversight Report October 2025**			
Name of Meeting:	Trust Board			
Date of Meeting:	5th December 2025			
Author:	Mrs Karen Parker Associate Director of Midwifery/SCBU			
Executive Sponsor:	Beth Swanson, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Karen Parker			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	This report presents an overview of maternity for October 2025			
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*	Obstetrics & Gynaecology Safecare 11/11/25 Division of Surgery, Women's Health and Children Operational Board 26/11/25			
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*	**Alert** • Infant abduction drill – full report & actions to flow via BRG **Advise** • Perinatal losses – 5 in Q2 2025/26 • 2024 NNAP report – full report & actions to flow via Audit committee • IG21 Risk - NENC Board response paper included as separate paper for information • National Coroner Reg 28 – full report & actions to flow via LMNS & Safecare **Assure** • Quarterly (Q2 2025/26) report for Saving Babies Lives Care Bundle • Quarterly (Q2 2025/26) patient feedback summary • Maternity dashboard:			

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	• October 2025 monthly data • ongoing PPH monitoring				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*					
Trust strategic priorities that the report relates to:	☒	Excellent patient care			
	☐	Great place to work			
	☒	Working together for healthier communities			
	☐	Fit for the future			
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	Centre of excellence for Women's Health				
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	3107 – Maternity Estate (separate building) 2456 – Infant Abduction 2369 – Maternity Theatres				
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

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Maternity Integrated Oversight Report

Maternity data from October 2025

Maternity IOR contents

- Maternity Dashboard 2025/26:
  - October 2025 data

- Maternity dashboard exceptions
  - PPH update following NMPA outlier status – positive SPC

- Exception reports:
  - Perinatal losses
  - 2024 NNAP report
  - IG21 Risk
  - Infant abduction drill
  - National Coroner Reg 28 - homebirth

- Items for information:
  - Saving Babies Lives Care Bundle – Q2 validated data
  - Patient feedback Summary – Q2

Maternity

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Maternity Oversight Report SPC Tool

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Births	Oct 25	149	-			161	127	195
Spontaneous vaginal deliveries	Oct 25	65	-			71	51	92
Assited births	Oct 25	84	-			90	65	115
Induction of Labour	Oct 25	46	-			54	23	84
Maternity Readmissions	Oct 25	3	-			3	-2	7
Neonatal Readmissions	Oct 25	5	-			4	-2	10
Smoking at time of booking	Oct 25	5.14%	15.00%		P	6.51%	0.85%	12.16%
Smoking at time of delivery	Oct 25	1.36%	6.00%			4.41%	-0.52%	9.34%
In area CO at booking	Oct 25	95.43%	90.00%	H		93.88%	82.81%	104.94%
In area CO at 36 weeks	Oct 25	85.62%	80.00%	H		83.71%	74.62%	92.81%
Admitted directly to NNU (SCBU) (>37 weeks)	Oct 25	6	4			7	-1	14
Percentage Admitted directly to NNU (SCBU) (>37 we	Oct 25	4.48%	6.00%			4.44%	-0.43%	9.32%
Preterm birth rate <=36+6 weeks at birth	Oct 25	9.46%	6.00%			5.10%	-1.01%	11.21%
Apgar < 7 (NMPA Definition)	Oct 25	2	-			4	-3	10
Apgar < 7 Percentage (NMPA Definition)	Oct 25	1.39%	-			2.49%	-1.71%	6.68%
Spontaneous Vaginal Births (%)	Oct 25	43.92%	-			44.29%	35.07%	53.52%
Induction Rate	Oct 25	31.29%	-			33.81%	18.14%	49.49%
Instrumental Delivery Rate	Oct 25	10.88%	-			11.63%	4.90%	18.36%
Elective C Section Rate	Oct 25	22.97%	-			20.39%	12.72%	28.06%
Emergency C Section Rate	Oct 25	22.30%	-			23.71%	16.59%	30.84%
C Section Rate	Oct 25	45.27%	-			44.10%	37.06%	51.15%
3rd or 4th degree tear (Total) Precentage	Oct 25	3.40%	3.00%			1.22%	-1.91%	4.35%
Massive PPH >=1.5L (All births)	Oct 25	2	2			6	-2	14
Breastfeeding: Percentage of Initiated Breasfeeding	Oct 25	80.82%	66.20%		P	80.07%	71.13%	89.01%
Breastfeeding: Breasfeeding at Discharge (Transfer to	Oct 25	65.71%	56.20%			64.06%	52.22%	75.89%

Safe

Responsive

Effective

Maternity Dashboard 2025/2026

Maternity Dashboard 2025/26

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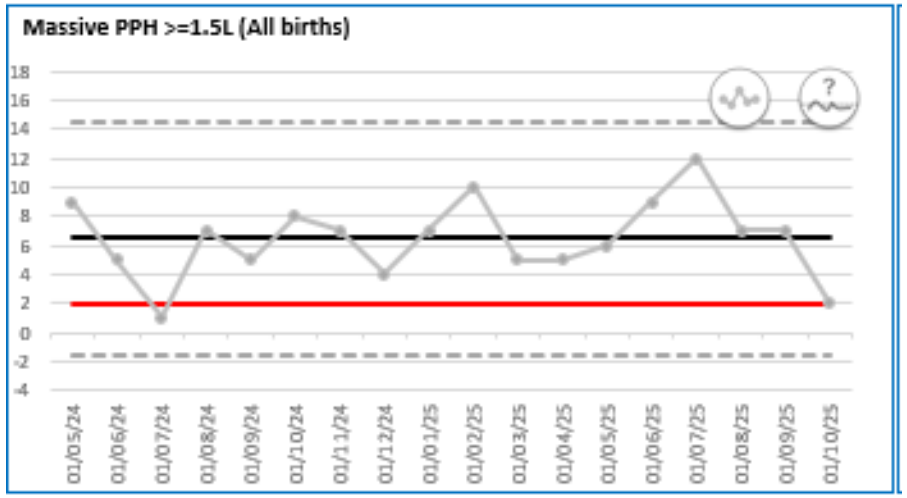
Safe

Responsive



- **Background**
  - PPH >1500mls is audited as part of NMPA
- **Assessment**
  - PPH rates of >1500mls saw an increase in July however returned to average in August and September but there has been a notable decrease in October.
- **Actions**
  - Continue to review as part of the maternity dashboard
  - All PPH's >1500mls to be reported via Inphase.
  - Continue yearly PPH audit.
- **Recommendations**
  - Implemented PPH risk assessment tool on Badgernet.

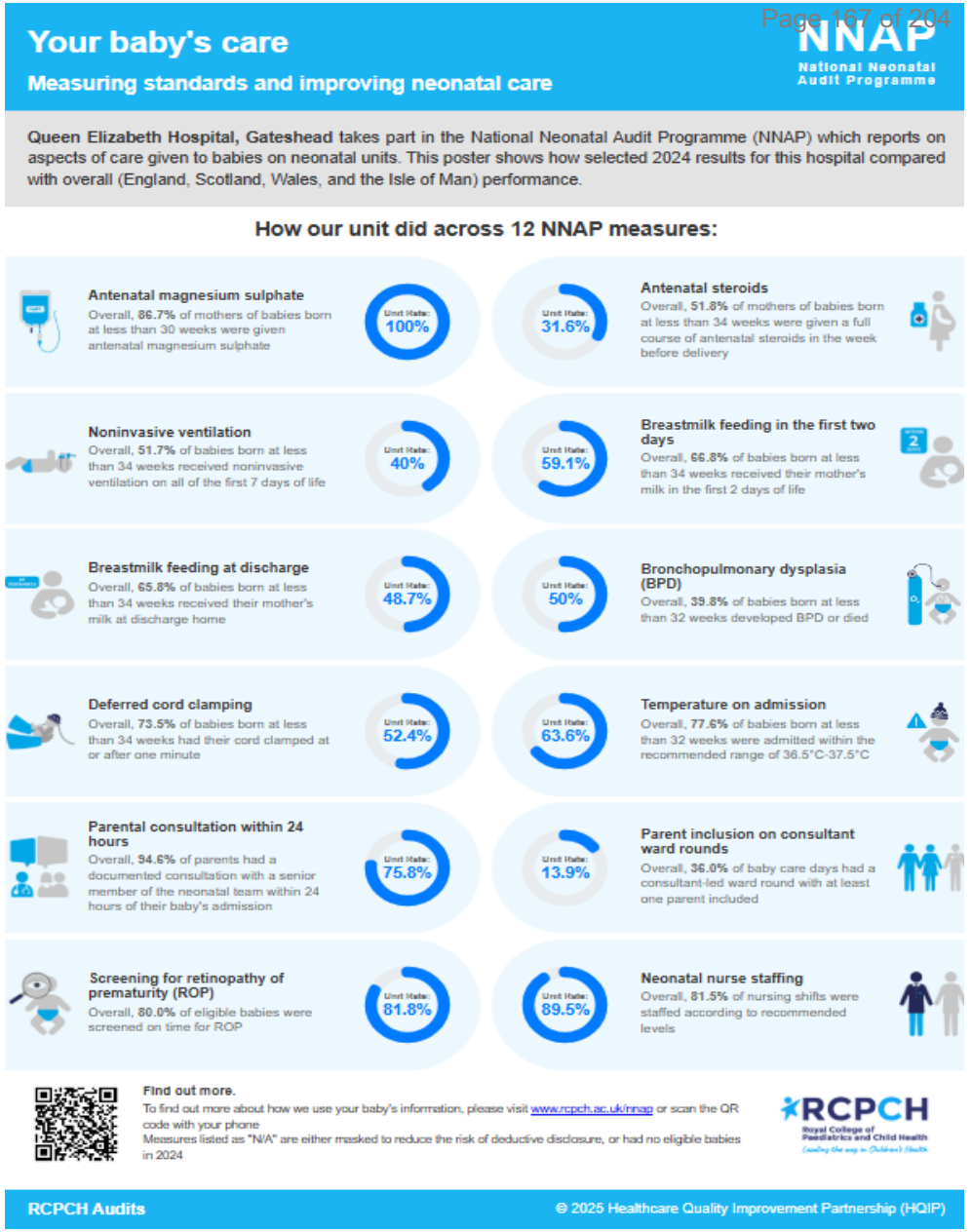
2025/26		April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Number of perinatal losses		0	0	0	0	1	1	3					
Number of MNSI cases		0	0	0	0	0	0	1					
Number of incidents logged as moderate harm or above		0	0	1	0	0	0	1					
Minimum obstetric safe staffing on labour ward		100%	100%	100%	100%	100%	100%	100%					
Minimum midwifery safe staffing including labour ward (average fill rates)	Day shift	80.2%	80.1%	85.4%	82.1%	72.9%	81.1%	89.1%					
	Night shift	97.8%	99.1%	99.3%	99.5%	98.8%	99.0%	99.1%					
Service user feedback	FFT "Overall how was your experience of our service" – total score for very good and good responses	100%	100%	100%	100%	Data not being received – escalated again to patient experience team							
	Complaints	2	2	2	1	2	0	1					
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust		0	0	0	0	0	0	0					
Coroner Reg 28 made directly to Trust		0	0	0	0	0	0	0					

*CHPPD overall care hours per patient per day

National Neonatal Audit Programme (NNAP)

- The NNAP reports on aspects of care given to babies on neonatal units
- NNAP report for 2024 babies was published October 2025
- [National Neonatal Audit Programme (NNAP) - Summary report on 2024 data | RCPCH]
- Deep dive review underway to produce action plan

NNAP measure
Better than national performance: • Antenatal magnesium sulphate • Development of bronchopulmonary dysplasia (BPD) • Neonatal nurse staffing • Screening for retinopathy of prematurity (ROP)
Below national performance: • Antenatal steroids • Non-invasive ventilation • Breastmilk – in first 2 days & at discharge • Deferred cord clamping • Temp on admission • Parental consultation <24 hours • Parent inclusion on ward rounds



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Regional IG21/Perinatal Institute alert

- Implementation of a new NENC regional guideline for the “Diagnosis & Management of Fetal Growth Disorders” was adopted in April 2024
- Part of this included changing the weight centile charts used, moving away from GROW customised charts & implementing IG21 charts
- Regional evaluation of the change is in progress 1 year post-implementation
- On 22/10/2025, the LMNS was sent a paper from the Perinatal Institute “NENC analysis of ONS stillbirth rates 2023-2024” which stated that SGA diagnosis rates had fallen from 8.5% to 4.6%, accompanied by an increase in stillbirth rates from 3.15/1000 in 2023 to 4.16/1000 in 2024 that was not seen in matched Trusts using GROW (reported as statistically significant)
- Contact was then received from NHSE National Clinical Director for Maternity to the NENC LMNS Obstetric Clinical Lead requesting clarification of the data & to discuss concern about the use of IG21
- Rapid analysis of data presented to LMNS Board meeting on 4/11/2025 (LMNS paper shared)

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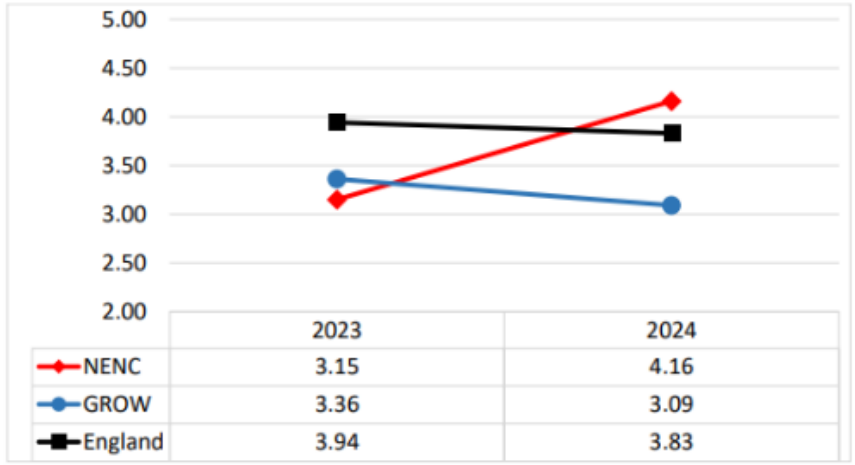
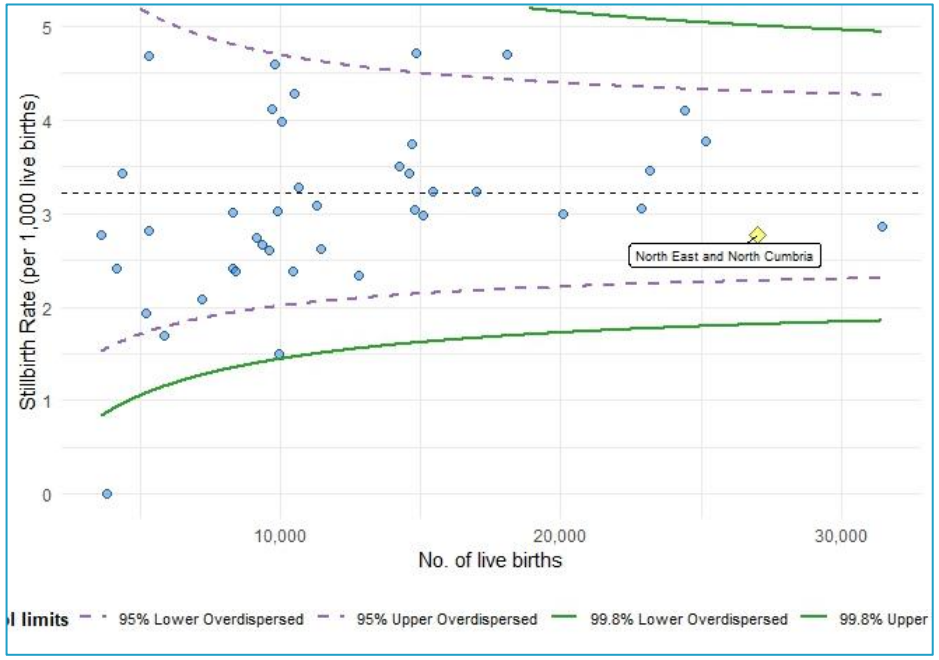
PI Report 22/10/25



	2023	2024
NENC	3.15	4.16
GROW	3.36	3.09
England	3.94	3.83

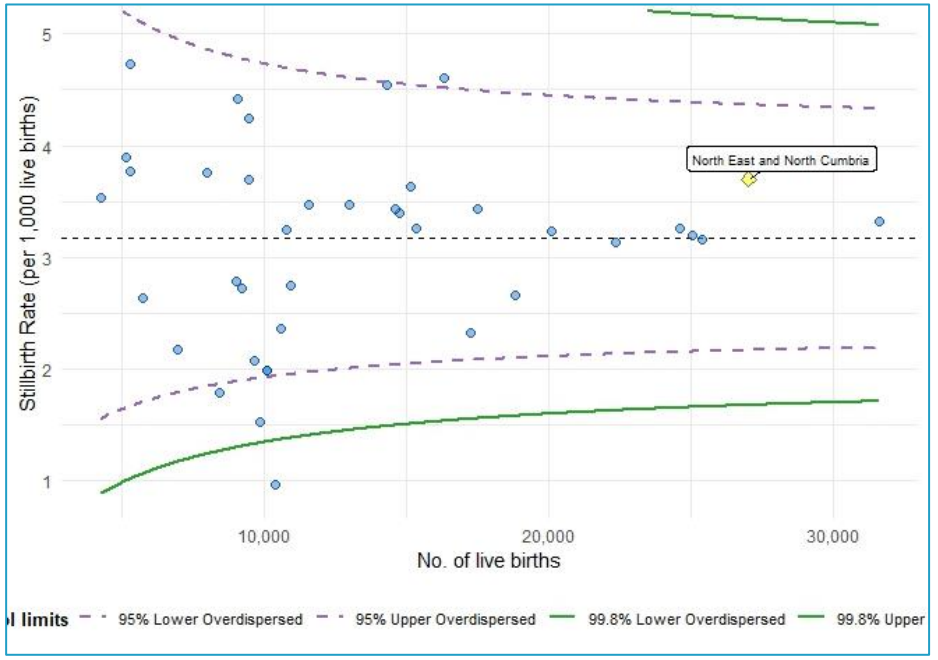
Data in PI report compares 2023 vs 2024

NENC agreed evaluation timeframe 1/4/23-31/3/24 vs 1/7/24-30/6/25 (allows for 3 month wash-out period)



NE&Y Analytics, Pre-implementation Apr 23-Mar 24

NE&Y Analytics, Post-implementation Jul 24-June 25



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Stillbirth rate by ICB – per 1000 births

NHS ICB	Year to March 24	Year to June 25	Difference
NHS DEVON INTEGRATED CARE BOARD	2.41	4.42	2.01
NHS GLOUCESTERSHIRE INTEGRATED CARE BOARD	2.82	4.73	1.91
NHS DORSET INTEGRATED CARE BOARD	1.93	3.77	1.84
NHS HUMBER AND NORTH YORKSHIRE INTEGRATED CARE BOARD	2.34	3.47	1.12
NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE INTEGRATED CARE BOARD	2.67	3.70	1.03
NHS HEREFORDSHIRE AND WORCESTERSHIRE INTEGRATED CARE BOARD	1.70	2.63	0.93
NHS NORTH EAST AND NORTH CUMBRIA INTEGRATED CARE BOARD	**2.77**	**3.70**	**0.93**
NHS SOUTH WEST LONDON INTEGRATED CARE BOARD	3.74	4.54	0.80
NHS NORFOLK AND WAVENEY INTEGRATED CARE BOARD	3.01	3.76	0.75
NHS LANCASHIRE AND SOUTH CUMBRIA INTEGRATED CARE BOARD	3.04	3.63	0.59
NHS SURREY HEARTLANDS INTEGRATED CARE BOARD	1.51	2.07	0.57
NHS GREATER MANCHESTER INTEGRATED CARE BOARD	2.86	3.32	0.46
NHS BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST INTEGRATED CARE BOARD	2.98	3.26	0.28
NHS KENT AND MEDWAY INTEGRATED CARE BOARD	2.99	3.24	0.25
NHS HAMPSHIRE AND ISLE OF WIGHT INTEGRATED CARE BOARD	3.24	3.39	0.15
NHS NORTH WEST LONDON INTEGRATED CARE BOARD	3.06	3.20	0.13
NHS BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE INTEGRATED CARE BOARD	2.61	2.72	0.11
NHS LINCOLNSHIRE INTEGRATED CARE BOARD	3.43	3.53	0.10
NHS NORTHAMPTONSHIRE INTEGRATED CARE BOARD	2.08	2.16	0.08
NHS FRIMLEY INTEGRATED CARE BOARD	2.74	2.78	0.04
NHS SOUTH YORKSHIRE INTEGRATED CARE BOARD	3.43	3.43	0.00
NHS SUSSEX INTEGRATED CARE BOARD	2.39	2.36	-0.03
NHS BIRMINGHAM AND SOLIHULL INTEGRATED CARE BOARD	4.72	4.60	-0.12
NHS CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD	3.46	3.13	-0.32
NHS MID AND SOUTH ESSEX INTEGRATED CARE BOARD	3.09	2.75	-0.34
NHS LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD	4.59	4.24	-0.35
NHS SUFFOLK AND NORTH EAST ESSEX INTEGRATED CARE BOARD	2.38	1.78	-0.60
NHS NORTH EAST LONDON INTEGRATED CARE BOARD	3.77	3.15	-0.62
NHS STAFFORDSHIRE AND STOKE-ON-TRENT INTEGRATED CARE BOARD	4.69	3.89	-0.80
NHS BEDFORDSHIRE, LUTON AND MILTON KEYNES INTEGRATED CARE BOARD	4.28	3.46	-0.82
NHS WEST YORKSHIRE INTEGRATED CARE BOARD	4.10	3.25	-0.85
NHS SOUTH EAST LONDON INTEGRATED CARE BOARD	3.51	2.66	-0.85
NHS NOTTINGHAM AND NOTTINGHAMSHIRE INTEGRATED CARE BOARD	4.12	3.24	-0.87
NHS NORTH CENTRAL LONDON INTEGRATED CARE BOARD	3.24	2.32	-0.92
NHS HERTFORDSHIRE AND WEST ESSEX INTEGRATED CARE BOARD	2.63	1.52	-1.10
NHS BLACK COUNTRY INTEGRATED CARE BOARD	4.70	3.43	-1.26
NHS COVENTRY AND WARWICKSHIRE INTEGRATED CARE BOARD	3.28	1.98	-1.30
NHS CAMBRIDGESHIRE AND PETERBOROUGH INTEGRATED CARE BOARD	3.98	1.98	-2.00
NHS DERBY AND DERBYSHIRE INTEGRATED CARE BOARD	3.03	0.96	-2.06

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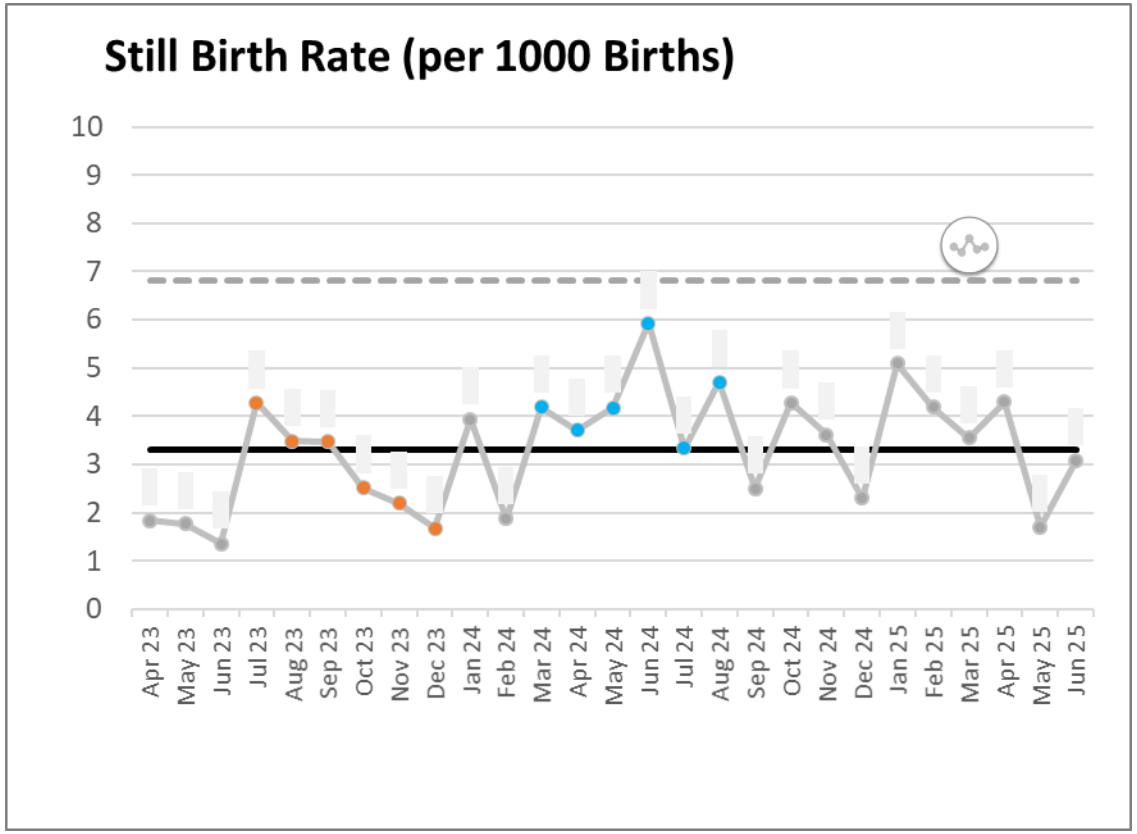
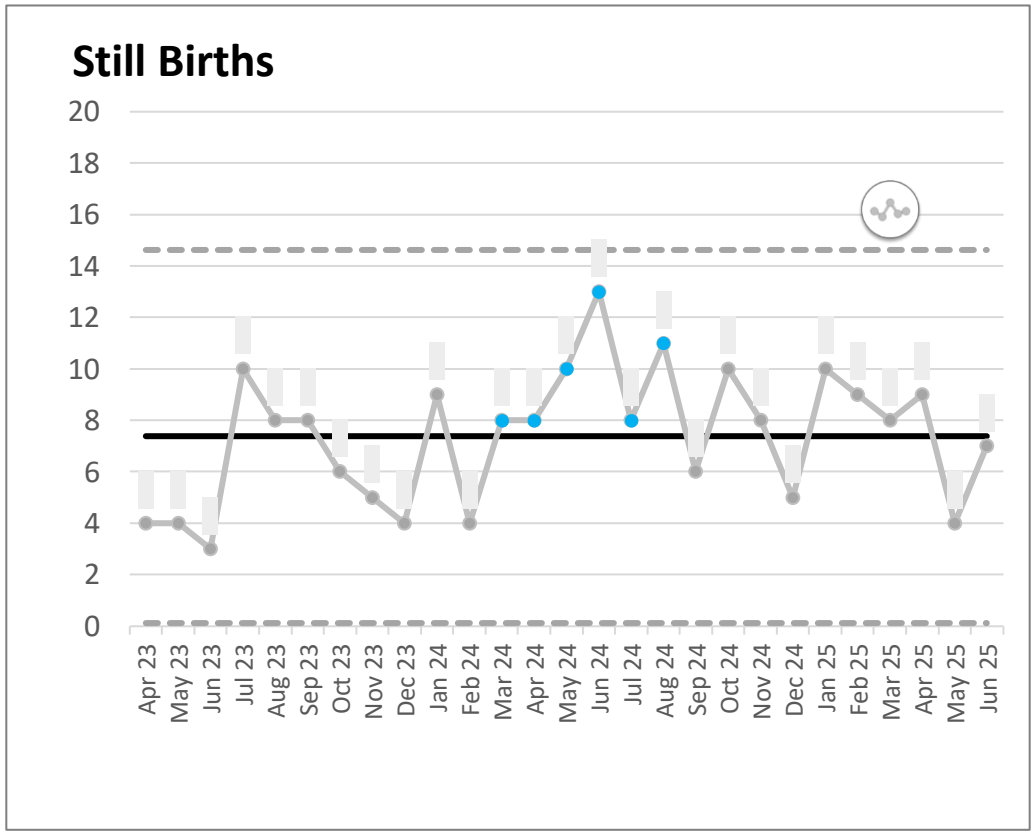
Stillbirth rate per 1000 births (SPC)





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Stillbirth rate per 1000 births in small & large babies

Based on 'agreed' definition (SGA <10th , LGA >95th						
	Apr 23- Mar 24			Jul 24- Jun 25		
	SGA (<10th) LGA (>95th)	10th-95th Centile	Overall	SGA (<10th) LGA (>95th)	10th-95th Centile	Overall
SB	47	26	73	51	45	96
TB	5457	21362	26819	5437	21369	26806
SB Rate	8.61	1.22	2.72	9.38	2.11	3.58

Based on 'conservative definition (SGA <25th, LGA >90th						
	Apr 23- Mar 24			Jul 24- Jun 25		
	SGA (<25th) LGA (>90th)	25th- 90th Centile	Overall	SGA (<25th) LGA (>90th)	25th- 90th Centile	Overall
SB	58	15	73	63	33	96
TB	11227	15592	26819	11166	15640	26806
SB Rate	5.17	0.96	2.72	5.64	2.11	3.58

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Conclusions & actions:

- Rapid data analysis completed using NENC agreed timeframe
- Results shared at LMNS Board 4/11/25

- Difference in SB rates is not statistically significant
- Although NENC has seen an increase in SB rates, NENC is not an outlier
- Changes in SB rate since April 23 are not out-with “normal variation” – there is no statistically significant trend or pattern

- LMNS Board acknowledges no current evidence that adoption of the NENC regional fetal growth disorder guidance in April 2024 has increased SB rates
- SB rates have increased & this requires regular (quarterly) review including statistical analysis
- Continue planned evaluation of the impact of the guidance change
- Share with all provider Trusts
- Work with NENC Maternity Engagement Group to prepare agreed comms in response to PI publication to reassure pregnant people across the NENC

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Conclusions & actions:

LMNS update (12/11/2025):

“Following on from the discussion at LMNS Board on Tuesday 4 November 2025, at the advice of ICB senior communication colleagues at this moment in time we are not issuing any press releases or comms messages on the LMNS website about the 8 NENC trusts using IG21 fetal growth chart. We will only respond to any particular queries if they arise or if we find that clinical colleagues are getting asked lots of questions from service users. Also, as there is potential for something to come out nationally in the coming weeks it would seem prudent to issue any statements that compliment national guidance if required.”

“Please do let the LMNS PMO team know by emailing nencicb-cu.lmns@nhs.net if you receive any questions or queries from service users or from other sources.”

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Infant abduction drill

- Live, no-notice infant abduction exercise conducted within the Maternity unit in October 2025
- Relevant guidance TCG707 Abduction & Unauthorised access procedure, Risk Register #2456
- Volunteer not known to maternity teams, dressed in scrubs/lanyard attempted to enter the unit, access all areas & remove a “baby”
- Hot debrief held with staff immediately following the exercise
- AAR completed with learning & actions

National Coroner Reg 28 re homebirth

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Reg 28 (for national action):

Planned “out of guidance” homebirth in NW, resulted in maternal & neonatal deaths

- No national homebirth guidance
- Increase in “high risk” women – inconsistent practice for out of guidance
- Homebirth not a specialist commissioned service
- Death, particularly maternal, not routinely discussed as a risk
- NICE intrapartum guidance only refers to risk of death to a baby
- Terminology around high or low risk
- Maintenance of skills – no set post-qualification requirement for midwives
- No bespoke training
- No national data re outcomes
- No national guidance on staffing model, training, experience

National Coroner Reg 28 re homebirth

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Gateshead immediate response:

- Share report with all staff
- MDT, regional, community meetings
- Add to risk register
- Audit – BBAs, planned homebirths, freebirths – outcomes, transfer rates
- Comms – work with comms team/MNVP/LMNS to reassure service users/FAQs
- Review local homebirth guidance & SOPs
- Review out of guidance process, request to LMNS for robust escalation process
- Explore reasons for out of guidance requests – birth trauma linked to maternal mental health service specification (in development)
- Clarity on commissioning/legal requirement to provide homebirth offer
- Develop homebirth champions to support birth planning/risk discussions
- Follow-up audit of risk assessment compliance (already monitored)
- Training – babylifeline Childbirth in the Community commissioned course, LMNS training faculty to develop local offer, skills drills
- Review of current workforce model including on-call options

Safe

Responsive

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Q2 Saving Babies Lives update

Elements	Validated Percentage
Element 1 – Smoking in Pregnancy	100%
Element 2 – Fetal growth restriction	68%
Element 3 – Reduced Fetal Movements	100%
Element 4 – Fetal monitoring in labour	85%
Element 5 – Preterm birth	100%
Element 6 – Diabetes	100%
Overall	92%

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Q2 patient feedback summary

Perinatal themes from women and families		
Themes from Birth Reflections / Debriefs /Family involvement in Incident reviews	**Themes from Patient Experience (via your Trust complaints process) and Friends and Family Test (FFT)**	**National Maternity Survey – Key Areas of Focus (2024 results)**
Request for parents to attend their baby's PMRT review – discussing with clinicians & family via bereavement midwife to ensure all adequately supported & aware of expectations whilst maintaining psychological safety	3 formal complaints received in Q2 Themes: • Request for copy of maternity notes • Interpreting issues - access to interpreter • Lack of acknowledgement from community midwife following miscarriage – booking appointment cancelled • Delays – to contact PAU via telephone, access to maternity unit out of hours, epidural, analgesia, discharge • Change of birthing partner on postnatal ward for support not allowed • Postnatal ward temperature • Information available via Badgerapp • Lack of availability of staff on post-natal ward to provide appropriate care	2024 CQC Survey action plan complete Awaiting publication of 2025 survey results

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Q2 patient feedback summary

Escalation and risks to take forward

- Gateshead MNVP remain unable to attend NENC Maternity Engagement Group due to timing of meetings

Surveys and listening events undertaken

- MNVP involved with QE Maternity website initial update planning meeting
- MNVP survey re website

Actions / Improvements undertaken / planned

MNVP attendance:

- Safety champions 11/7/25, 5/9/25
- Service user event 21/7/25
- ADoM meeting 5/9/25
- Neonatal meeting – Tiny Lives, neonatal self-assessment tool, Nothern neonatal Network call
- Social prescribing team
- Neonatal 15-steps October 25

Perinatal service user feedback themes

Women's Health Clinic:

- EOI submitted for charity legacy funded improvements to estate in WHC
- Customer Care course procured for front door staff
- Waiting times – clearer, visible information re expectations, variety of clinics, current wait times
- Maps, car parking advice – with appointment information

i) Maternity Safety Champion Report Presented by the Maternity Safety Champion

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Report Cover Sheet Agenda Item: 15i

Report Title:	**Maternity Safety Champion Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	5 December 2025			
Author:	Dr Gerry Morrow, Maternity Safety Champion and Non-Executive Director			
Sponsor:	Dr Gerry Morrow, Maternity Safety Champion and Non-Executive Director			
Report presented by:	Dr Gerry Morrow, Maternity Safety Champion and Non-Executive Director			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To provide additional assurance to support the Maternity Integrated Oversight Report based on regular discussion with our people, patients and maternal and neonatal voices partnership (MNVP) service users			
Proposed level of assurance *– 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 support the triangulation of information and intelligence from a variety of sources, providing a voice for our people and patients at Board through the Maternity Safety Champion. • Key issues will be presented and progress on these issues will be described in each report, which will be provided six times a year.			
Recommended actions for this meeting:	Board Members are requested to review the content of this report for assurance in conjunction with the Maternity			

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Outline what the meeting is expected to do with this paper	Integrated Oversight Report, noting that updates on the key issues will be provided in the next report.	
Trust strategic priorities that the report relates to:	☒	Excellent patient care
	☒	Great place to work
	☐	Working together for healthier communities
	☐	Fit for the future
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	1) We will be a clinically-led organisation focused on delivering safe, high-quality care and improving health outcomes for our patients 2) We will ensure our patients experience the best possible compassionate care and make every contact count 3) We will continually improve our services creating a restorative culture where learning, innovation and research can flourish	

Links to CQC Key Lines of Enquiry (KLOE):	Caring	Responsive	Well-led	Effective	Safe
	☒	☒	☒	☒	☒

Risks / implications from this report (positive or negative):			
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	3107 - Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings (15) 2341 - There is a risk to ongoing business continuity of service provision due to ageing trust estate (16) 4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (20) 4713 - The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis (16)		
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

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Maternity Non-Executive Director Safety Champion Report December 2025

1. Introduction

1.1. This is a narrative report which will complement the Integrated Oversight Report (IOR) report covering national metrics of maternal and neonatal safety.

1.2. This report seeks to provide an additional level of narrative assurance to board. It is based on my regular discussions with staff, patients, and maternal and neonatal voices partnership (MNVP) service users. It is not designed to be exhaustive but if board members would like more detail on any of the themes I would be happy to discuss further or provide more detail.

1.3. Key issues will be presented and progress on these issues will be described in each report, which will be provided six times a year.

2. Key issues

2.1. High quality of midwifery care provided continues despite challenges. Very positive feedback to community midwives recently regarding quality of care provided.

2.2. Sunderland Neonatal Intensive Care Unit restructured to Special Care Baby Unit. This may have a wider impact on neonatal care for the wider region. We await any fallout from this revision of Sunderland services.

2.3. Antenatal clinic booking and capacity. Near-miss recently woman with pre-eclampsia, picked up by community midwife. No harm resulted but concerns persist.

2.4. Maternity outcome signal system (MOSS) launches in November 2025. We have visibility of the process and triggers.

2.5. Local Maternity and Neonatal Services (LMNS) Q2 meeting – sitrep position declined. Action plan requested for next meeting.

3. Key issues

3.1. Ongoing concern regarding absence of obstetric clinical lead. Progress may be possible after the appointment of a substantive Service Line Manager in December. Safety Lead in place.

Gateshead Health NHS Foundation Trust

3.2. Dr Shilpa Ramesh, neonatal safety champion, now back in post. First maternity champion meeting 16 October 2025 and second meeting on 11 November 2025.

3.3. Challenges continue in the Women's Health Clinic (WHC). A paper has been discussed by Gateshead Health Leadership Group. Limited progress on the issues raised. Positive benefit of midwifery role in WHC discussed particularly vaginal birth after caesarean (VBAC).

3.4. Vacancies in the Advanced Neonatal Nurse Practitioner (ANNP) team. Approval given to use bank recruitment. Two interviews undertaken in October.

3.5. The Maternity Incentive Scheme (MIS). No concerns as all on track.

3.6. Saving babies lives metrics. No concerns as all on track.

3.7. Abduction simulation. Learning noted and material changes in training.

3.8. Neonatal 15 step visit. Informal feedback was very positive.

3.9. NEWTT2 updates (newborn early warning and trigger).

- Will be updated in the Badger system 13 November 2025 and will go live in January 2026
- Nursing, Midwifery and Allied Health Care Professional (NMAP) missing data as no direct compatibility with Neonatal Badger system. Digital colleagues informed and escalated via LMNS.

3.10. Enhanced recovery in place – all going well.

3.11. A recent regional concern raised on new intra-uterine growth charts and adverse outcomes. An analytical paper has been produced by Professor Steve Robson (LMNS Digital Obstetric Lead) demonstrating no association between use of these new charts and any adverse outcomes for neonates.

4. Summary

4.1. Board Members are requested to review the content of this report for assurance in conjunction with the Maternity Integrated Oversight Report, noting that updates on the key issues will be provided in the next report.

16. Nurse Staffing Exception Report Presented by the Chief Nurse/Deputy Chief Executive

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:	5th December 2025			
Author:	Helen Larkin, Clinical Lead for E-Rostering Drew Rayner Deputy Chief Nurse			
Executive Sponsor:	Beth Swanson, Interim Chief Nurse			
Report presented by:	Beth Swanson, Interim Chief Nurse			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	This report is to provide assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis to provide adequate staffing levels.			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by:				
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 provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls within the month of October 2025. October has demonstrated some areas with staffing challenges relating to ward 11 escalation area and continued periods of increased patient activity across the Trust. 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 documented. A staffing escalation protocol is now in operation across all areas within the organisation and assurance of this operating as expected, is provided by			

	the number of staffing incident reports raised through the incident reporting system.				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is asked to: • receive the report for assurance • note the work being undertaken to address the shortfalls in staffing				
Trust strategic priorities that the report relates to:	☒	Excellent patient care			
	☒	Great place to work			
	☐	Working together for healthier communities			
	☒	Fit for the future			
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	List strategic objective here				
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):	There were 9 nurse-staffing incidents raised via InPhase during the month of October from Ward 11, Maternity, Ward 21, Community, and Theatres. There was one low physical harm and one low psychological harm reported for an inphase related to Ward 11.				
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

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

1. Introduction

This report details the staffing exceptions for Gateshead Health NHS Foundation Trust during the month of October 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 October are presented in Table 1. Whole Trust wards staffing is 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 October 2025

Day	Day	Night	Night
Average fill rate - registered nurses/midwives (%)	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
84.9%	**78.9%**	**100.8%**	**103.9%**

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 daily challenges and operational pressures to maintain adequate staffing levels.

Exceptions:

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

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

The exceptions to report October are as below:

October 2025	
Registered Nurse Days	**%**
Cragside Court	69.0%
Critical Care	71.0%
SCBU	70.1%
Ward 14 Medicine	74.6%
Ward 28	65.1%
Ward 22	73.8%
Registered Nurse Nights	**%**
Cragside Court	71.0%
Sunniside	72.9%
Healthcare Assistant Days	**%**
Critical Care	72.6%
JASRU	65.7%
Ward 08	71.6%
Ward 09	69.1%
Ward 21	70.7%
Ward 28*	35.4%
Ward 24	62.2%
Ward 26	73.8%
Ward 27	58.5%
Healthcare Assistant Nights	**%**
Ward 28	45.2%

To note, Ward 11 escalation are not included in the above exception report as do not have a funded establishment.
Throughout October, 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 RN and HCA 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.

Contextual information and actions taken

Critical Care Department demonstrated fill rates below 75% for Registered Nurse (RN) Days and Healthcare Assistant (HCA) days due to lower occupancy rates, therefore able to support non-clinical time. There were also 73 redeployment episodes made to support other areas. In addition, two Registered Nurses were completing the supernumerary phase of the new starter pathway, which will be completed by November.

JASRU unregistered fill rates for days reported at 65.7% this is improved from 53.5% in September. Sickness absence was significant at 24.2%. No InPhase incidents were raised, however three Red Flags were escalated.

SCBU demonstrated a daytime RN fill rate of 70.1% with sickness absence levels of 12.8%. This is increased from 8.8% in September. No staffing incidents or red flags were raised.

Ward 22 report RN day fill rate as 73.8%. The ward report Maternity leave and sickness absence. No InPhase incidents were raised however there were six red flags.

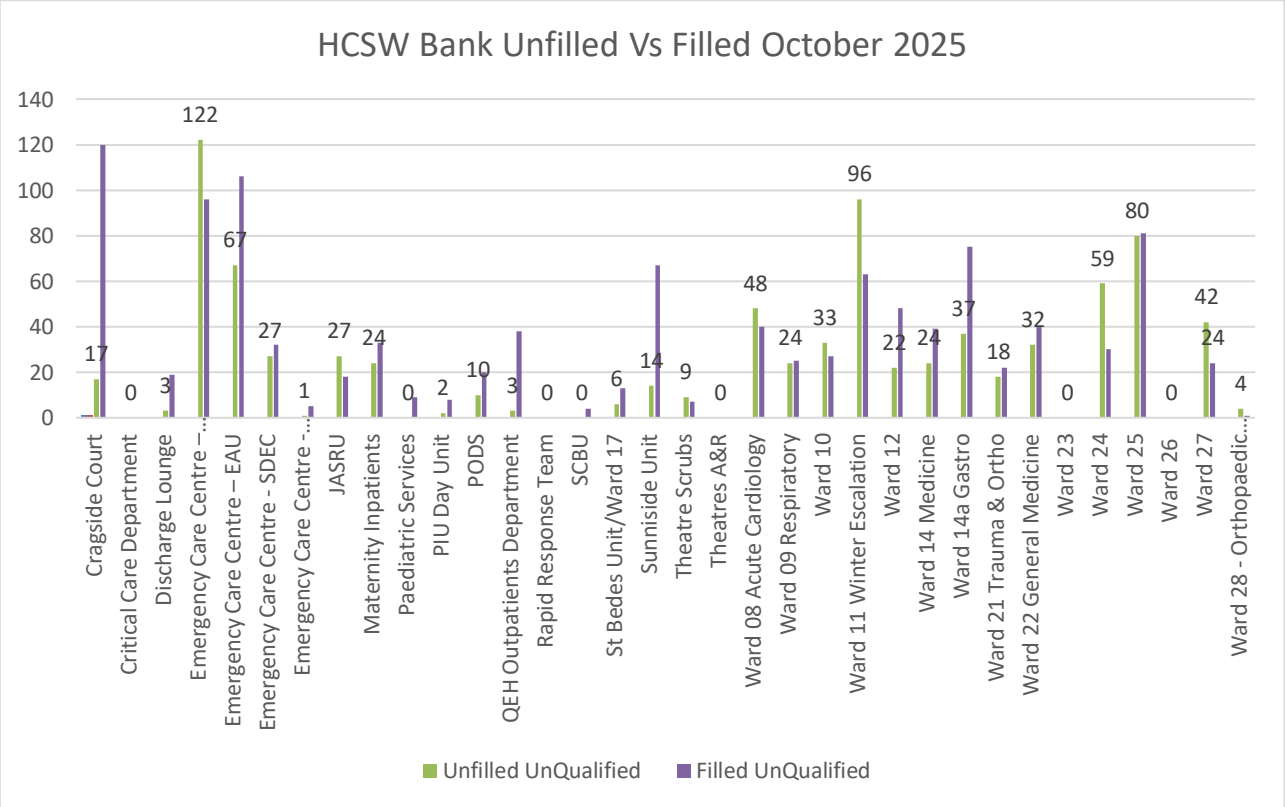
*Ward 28 continues to report a reduction in RN days and HCA for both days and nights. The ward manager assures staffing levels are safe for the continuation of reduced bed occupancy and acuity/dependency of the ward. There were no incidents or red flags reported.

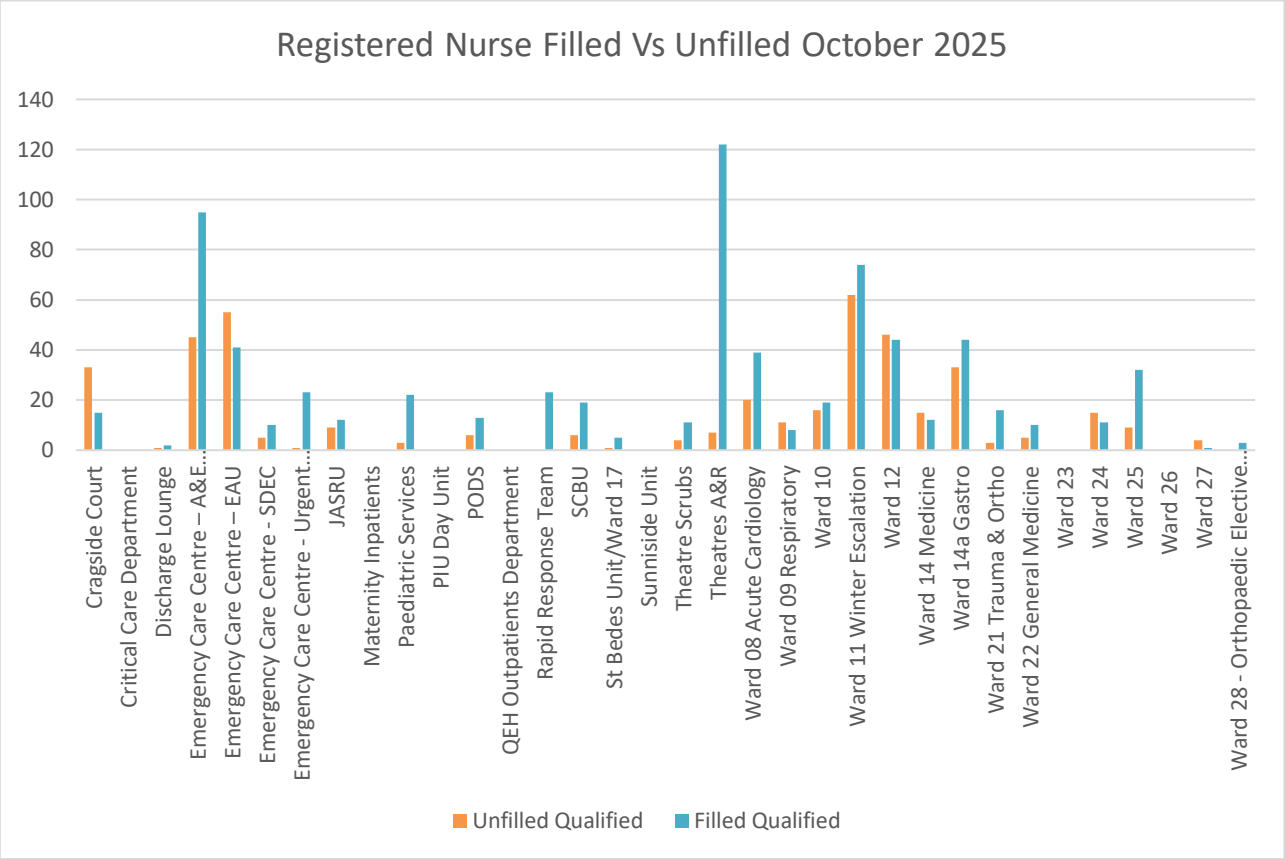
Cragside Court report 69% fill rates for Registered staff days and 71% for night. Both Cragside and Sunniside have been able to staff one Registrant per night however, there has been no cross-covering support available, affecting the overall fill rates. There was no registered nurse sickness in October. No red flags or InPhase incidents were raised by this area.

Wards 8, 9, 21, Ward 24, 26 and 27 have reduced HCA hours, due to the high number of vacancies recognised across all areas. Active monitoring and recruitment processes are in place. We are currently recruiting for Trustwide HCA positions which will be recruited into areas with those with the greatest shortfalls.

There is a live Rostering consultation process ongoing, which is due to close on the 24th December. This Consultation is under pinned by a full establishment review in general In-Patient areas across the RN and HCA workforce. A number of vacancies have been held to accommodate this work.

The graphs below highlight the number of bank shifts per clinical area for both workforce groups for October.





3. Care Hours Per Patient Day (CHPPD)

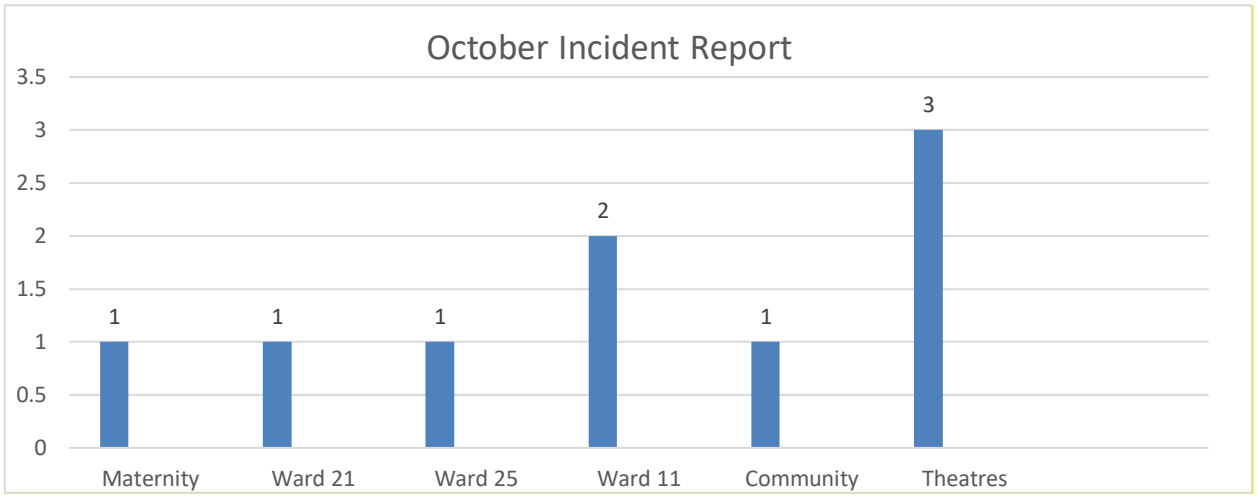
Following the Lord Carter Cole report, it was recommended that all trusts start to report on CHPPD this is to provide a single consistent way of recording and reporting deployment of staff working on inpatient wards/units. It is calculated by adding the hours of registered nurses to the hours of support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

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

Ward level CHPPD is outlined in Appendix 1. For the month of October, the Trust total CHPPD was 7.5. This compares well when benchmarked with other peer-reviewed hospitals.

4. Monitoring Nurse Staffing via Incident Reporting system

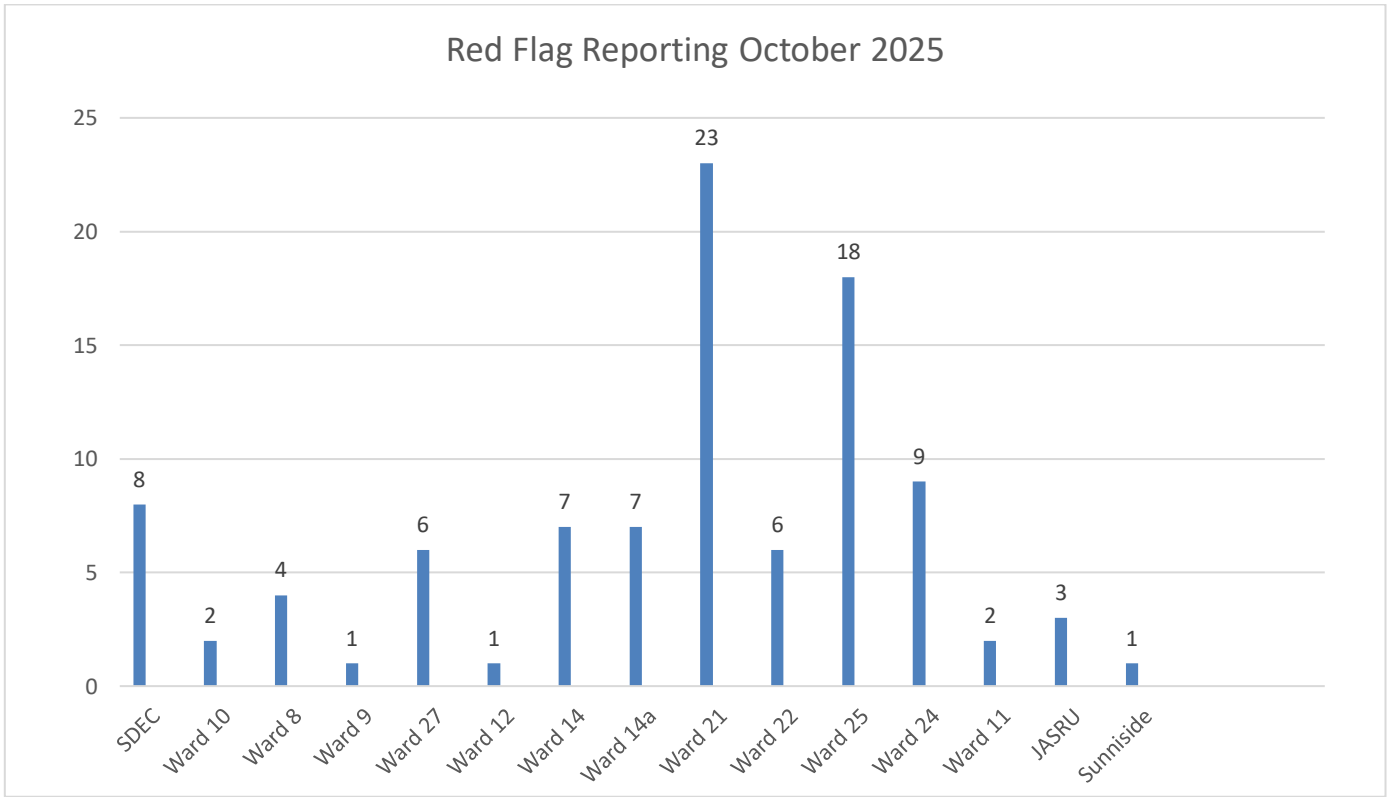
The Trust has an escalation process in place for addressing staffing shortages with identified actions to be taken. Further discussion is to take place to scope the potential for identifying thresholds that trigger when a staffing related incident should be submitted to provide reporting consistency.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



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 due to rostering practice/shortfall in staffing or by the nurse in charge if they identify a shortfall in staffing requirements. Throughout the month of October there were 98 nursing red flags reported. This has increased from the 75 reported in September. 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 action.

The graph below outlines the number of red flags raised per department for October.

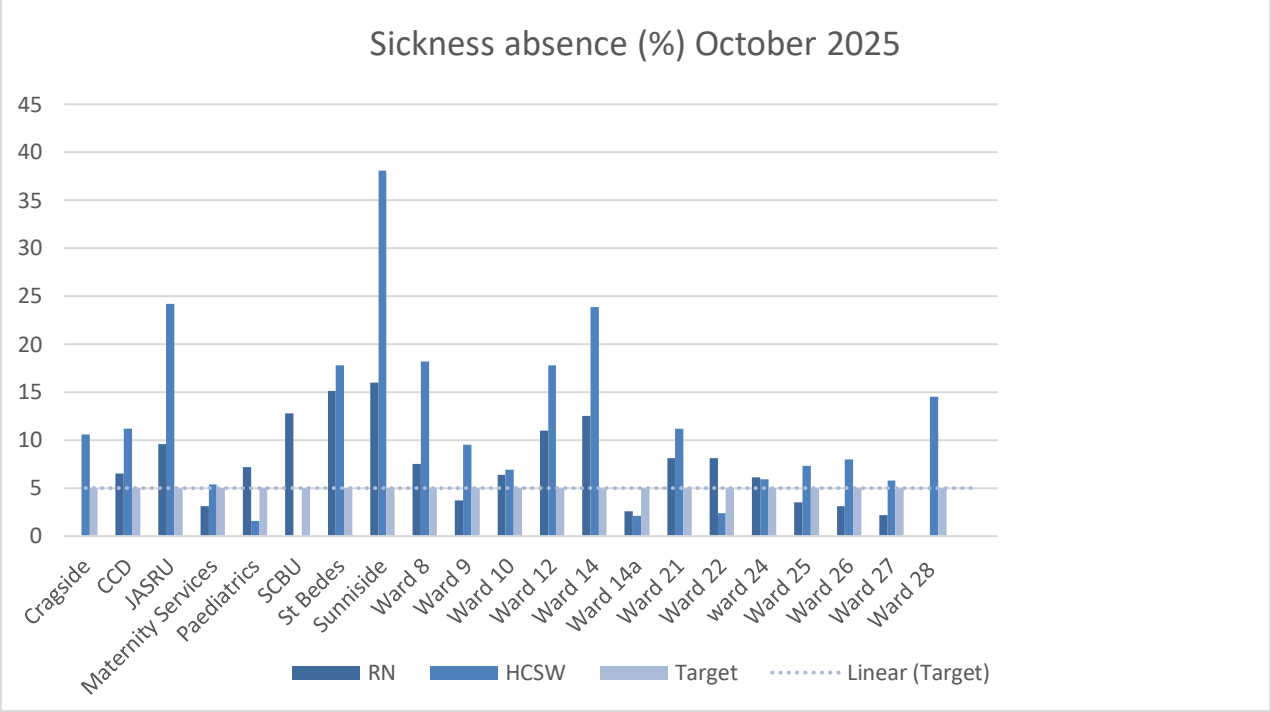


For Ward 21, all red flags were raised in relation to enhanced care requirements. For Ward 25, majority red flags were raised due to missed intentional rounding and increased levels of enhanced care.

5. Attendance

The below table displays the percentage of sickness absence per staff group for October.

Data extracted from Health Roster.



6. Governance

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

7. Conclusion

This paper provides an exception report for nursing and midwifery staffing for October 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.

Appendix 1- Table 3: Ward by Ward staffing October 2025

Decrease from previous month Increase form previous month

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative patient count over the month	Registered midwives / nurses	Care Staff	Overall
Cragside Court	69.0%	91.3%	71.0%	180.9%	161	8.4	16.3	24.7
Critical Care Dept	71.0%	72.6%	101.7%	78.7%	249	31.4	3.3	34.8
Emergency Care Centre - EAU	76.5%	88.2%	93.3%	84.3%	1418	5.1	3.7	8.8
JASRU	90.7%	65.7%	102.0%	102.6%	607	3.5	3.3	6.8
Maternity Unit	89.1%	122.1%	99.1%	118.8%	568	15.3	5.4	20.8
Special Care Baby Unit	70.1%	155.2%	107.6%	87.0%	130	14.1	4.1	18.2
St. Bedes	78.3%	82.7%	100.0%	93.7%	296	4.9	3.4	8.2
Sunniside Unit	97.3%	127.6%	72.9%	107.7%	189	8.7	7.2	15.9
Ward 08	100.1%	71.6%	101.8%	115.6%	632	4.5	2.6	7.1
Ward 09	101.6%	69.1%	103.3%	96.9%	855	2.7	1.8	4.5
Ward 10	82.2%	82.1%	101.7%	102.8%	792	2.5	2.2	4.7

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Ward 12	88.6%	86.5%	100.6%	102.0%	822	2.6	2.1	4.7
Ward 14 Medicine	74.6%	85.8%	78.0%	100.6%	780	2.9	2.2	5.2
Ward 14a Gastro	105.4%	109.6%	93.2%	126.4%	787	2.9	2.8	5.7
Ward 21 T&O	101.4%	70.7%	98.4%	98.0%	899	3.0	2.5	5.5
Ward 22	73.8%	75.3%	138.0%	101.5%	852	2.7	2.6	5.2
Ward 24	84.2%	62.2%	137.9%	106.7%	855	2.9	2.3	5.1
Ward 25	96.8%	75.9%	151.7%	123.4%	999	2.8	2.3	5.1
Ward 26	98.9%	73.8%	100.1%	97.3%	729	3.5	2.6	6.1
Ward 27	111.7%	58.5%	100.0%	109.6%	867	3.2	2.0	5.1
Ward 28	65.1%	35.4%	102.0%	45.2%	252	6.0	2.6	8.6
QUEEN ELIZABETH HOSPITAL - RR7EN	**84.9%**	**78.9%**	**100.8%**	**103.9%**	**13739**	4.6	2.9	7.5

ITEMS FOR INFORMATION / MEETING GOVERNANCE

17. Cycle of Business 2025/26

Presented by the Company Secretary

Meeting:	Trust Board
Chair:	Sir Paul Ennals
Financial year:	2025/26

	Lead	Type of item	Public/Private	May-25	25 June 25 (year end only)	Jul-25	Sep-25	Nov-25	Jan-26	Mar-26
Standing Items			Part 1 & Part 2							
Apologies	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√	√	√
Declaration of interests	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√	√	√
Minutes	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Action log	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Matters arising	Chair	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Chair's Report	Chair	Standing Item	Part 1	√		√	√	√	√	√
Chief Executive's Update Report	Chief Executive	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Cycle of Business	Company Secretary	Standing Item	Part 1 & Part 2	√		√	√	√	√	√
Patient & Staff Story	Company Secretary	Standing Item	Part 1	√		√	√	√	√	√
Questions from Governors	Chair	Standing Item	Part 1	√		√	√	√	√	√
Items for Decision			Part 1 & Part 2							
Annual Declarations of Interest	Company Secretary	Item for Decision	Part 1							√
Approval of new Strategic Objectives	Director of Strategy and Partnerships	Item for Decision	Part 1		√					√
Board Assurance Framework - approval of opening position	Company Secretary	Item for Decision	Part 1			√				
Board Assurance Framework - approval of closing position	Company Secretary	Item for Decision	Part 1			√				√
Standing Financial Instructions, Delegation of Powers, Constitution and Standing Orders - annual review	Company Secretary / Group Director of Finance	Item for Decision	Part 1				√			
Calendar of Board Meetings	Company Secretary	Item for Decision	Part 1				√			
Winter Plan	Chief Operating Officer	Item for Decision	Part 1			√				
Winter Plan	Chief Operating Officer	Item for Assurance	Part 1				√			
Responsible Officer Report	Medical Director	Item for Decision	Part 1				√			
Board Committee Annual Reviews of Effectiveness and Terms of Reference Update	Company Secretary	Item for Decision	Part 1							√
Green Plan	QEF Managing Director	Item for Decision	Part 1	deferred		deferred	√			
CQC Statement of Purpose and Registration	Chief Nurse	Item for Decision	Part 1							√
Items for Assurance			Part 1 & Part 2							
Board Committee Assurance Reports	Committee Chairs	Item for Assurance	Part 1	√		√	√	√	√	√
Board Assurance Framework - updates	Company Secretary	Item for Assurance	Part 1	√			√		√	
Organisational Risk Register	Chief Nurse	Item for Assurance	Part 1	√		√	√	√	√	√
Annual Staff Survey Results	Group Director of People & OD	Item for Assurance	Part 1 & Part 2						√	√
Finance Report	Group Director of Finance	Item for Assurance	Part 1	√		√	√	√	√	√
Strategic Objectives and Constitutional Standards Report	Group Director of Finance	Item for Assurance	Part 1	√		√	√	√	√	√
Maternity Integrated Oversight Report	Chief Nurse	Item for Assurance	Part 1	√		√	√	√	√	√
Maternity Staffing Report	Chief Nurse	Item for Assurance	Part 1	deferred		deferred	√			
Nurse Staffing Exception Report	Chief Nurse	Item for Assurance	Part 1	√		√	√	√	√	√
Bi-annual Inpatient Safer Nursing Care Staffing Report	Chief Nurse	Item for Assurance	Part 1	deferred		√			√	
Learning from Deaths (quarterly report)	Group Medical Director	Item for Assurance	Part 1	deferred		√	deferred	√		√
EPRR Core Standards Self-Assessment Report	Chief Operating Officer	Item for Assurance	Part 1				√		√	
CNST Maternity Compliance Report	Chief Nurse	Item for Assurance	Part 1						√	
Freedom to Speak Up Guardian Report	Group Director of People & OD	Item for Assurance	Part 1				deferred	√	√	
WRES and WDES Report	Group Director of People & OD	Item for Assurance	Part 1				√			
Board Walkabout Feedback	Chief Nurse	Item for Assurance	Part 1	√		none	none	√	√	√
Great North Healthcare Alliance Progress Report	Director of Strategy and Partnerships	Item for Assurance	Part 1 & Part 2	√		√	√	√	√	√
Items for Information			Part 1 & Part 2							
Register of Official Seal	Company Secretary	Item for Information	Part 1				√			
Ad Hoc Items (i.e. items emerging during the year)			Part 1 & Part 2							
Organisational Structure - Clinical Leadership GHLG Apr 2026	Group Medical Director	Item for Assurance	Part 1							

Cyber Assurance Framework report	Group Director of Finance	Item for Assurance	Part 1				?			
Premises Assurance Model	QEF Managing Director	Item for Decision	Part 1				√			
Charitable Funds Audited Financial Performance	Group Director of Finance	Item for Board of Trustees	Part 1						√	

18. Questions from Governors in Attendance

19. Any Other Business

20. Date and Time of Next Meeting - 09:30am Wednesday 28 January 2026

Meeting Closure and Exclusion of the Press and Public