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 9:30am on Wednesday 28th January 2026, in Room 3, Education Centre, Queen Elizabeth Hospital / via Microsoft Teams

AGENDA

No	Start time	Item	Purpose	Lead	Paper / Verbal
1.	09:30	Welcome	Information	Chair	Verbal
2.	09:33	Declarations of interest	Information	Chair	Verbal
3.	09:34	Apologies for absence	Information	Chair	Verbal
4.	09:35	Minutes of the last meeting held on 5 December 2025	Decision	Chair	Paper
5.	09:36	Action log and matters arising	Assurance / decision	Chair	Paper
6.	09:37	Top Organisational Risks	Information	Chair	Paper
7.	09:40	Patient and Staff Story	Assurance	Division	Presentation
ITEMS FOR DECISION					
8.	09:55	Board Committee Terms of Reference	Decision	Company Secretary	Paper
ITEMS FOR ASSURANCE					
9.	10:00	Chair's Report	Assurance	Chair	Paper
10.	10:05	Acting Chief Executive's Report	Assurance	Acting Chief Executive	Paper
11.	10:15	Governance Reports:			
		i) Board Assurance Framework	Assurance	Company Secretary	Paper
		ii) Organisational Risk Register	Assurance	Interim Chief Nurse	Paper
12.	10:25	Assurance from Board Committees:			
		i) Finance and Performance Committee – December 2025 and January 2026	Assurance/ Decision	Chair of the Committee	Paper
		ii) Quality Governance Committee – December 2025	Assurance	Chair of the Committee	Paper
		iii) Digital Committee – January 2026	Assurance	Chair of the Committee	Paper
		iv) People and Organisational Development Committee – January 2026	Assurance	Chair of the Committee	Paper
		v) Group Audit Committee – December 2025	Assurance	Chair of the Committee	Paper
		vi) Group Remuneration Committee – December 2025	Assurance	Chair of the Committee	Paper
13.	10:45	Finance Report	Assurance	Group Director of Finance	Paper
14.	10:55	Strategic Objectives and Constitutional Standards Report	Assurance	Group Director of Finance	Paper
15.	11:05	EPRR Core Standards Self-Assessment Report	Assurance	Group Chief Operating Officer	Paper

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No	Start time	Item	Purpose	Lead	Paper / Verbal
16.	11:10	Freedom to Speak Up Guardian Report	Assurance	FTSU Guardian	Paper
17.	11:20	Maternity Integrated Oversight Report	Assurance	Associate Director of Midwifery/SCBU	Paper
		i) Maternity Safety Champion Report	Assurance	Maternity Safety Champion	Paper
18.	11:30	Nurse Staff Exception Report	Assurance	Interim Chief Nurse	Paper
ITEMS FOR INFORMATION / MEETING GOVERNANCE					
19.	11:35	Cycle of Business 2025/26	Information	Company Secretary	Paper
20.	11:36	Questions from Governors in Attendance	Discussion	Chair	Verbal
21.	11:40	Any Other Business	Discussion	Chair	Verbal
22.	11:42	Date and Time of Next Meeting – 9:30am on Wednesday 25th March 2026	Information	Chair	Verbal
Exclusion of the Press and Public To resolve to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed					

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 5 December 2025

Presented by the Chair

Gateshead Health NHS Foundation Trust

Board of Directors (Part 1 – Public)

Minutes of a meeting of the Board of Directors (Part 1) held at 12.30pm on Friday 5th December 2025 in Room 3, Education Centre, Queen Elizabeth Hospital and via MS Teams.

Name	Position
Members present	
Sir Paul Ennals	Chair
Andrew Besford	Non-Executive Director
Gavin Evans	Managing Director for QE Facilities
Dr Sean Fenwick	Acting Chief Executive
Neil Halford	Medical Director of Strategic Relations
Joanne Halliwell	Group Chief Operating Officer
Robert Hughes	Non-Executive Director
Kris Mackenzie	Group Director of Finance
Dr Gerry Morrow	Vice Chair
Beth Swanson	Interim Chief Nurse
Amanda Venner	Group Director of People & Organisational Development
Attendees present	
Jennifer Boyle	Company Secretary
Helen Fox	Head of Communications and Engagement
Karen Parker	Associate Director of Midwifery and Special Care Baby Unit (Item 25/12/15)
Diane Waites	Corporate Services Assistant
Governors and Observers	
Helen Adams	Staff Governor
Steve Connolly	Lead Governor
Paul Johnson	Public Governor – Central & Eastern
	One member of the public
Apologies	
Adam Crampsie	Non-Executive Director
David Elliott	Chief Digital Officer
Martin Hedley	Non-Executive Director / Senior Independent Director
Dr Carmen Howey	Group Medical Director
Hilary Parker	Non-Executive Director
Maggie Pavlou	Non-Executive Director

Agenda Item No		Action Owner
25/12/01	**Chair's Business:** The meeting being quorate, Paul Ennals declared the meeting open at 12.30pm and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. He welcomed those present including the Trust Governors and observers. Paul Ennals highlighted that this is his first meeting as Chair and encouraged Board members to receive papers as read. There were no	

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Agenda Item No		Action Owner
	other advance items of business to be made aware of for consideration under the *Any Other Business* agenda item.	
25/12/02	**Declarations of Interest:** There were no declarations of interest.	
25/12/03	**Apologies for Absence:** Apologies were received from Adam Crampsie, David Elliott, Martin Hedley, Carmen Howey, Hilary Parker and Maggie Pavlou.	
25/12/04	**Minutes of the Previous Meeting:** The minutes of the meeting of the Board of Directors held on Thursday 25th September 2025 were approved as a correct record.	
25/12/05	**Action Log and Matters Arising from the Minutes:** The Board reviewed the action tracker as below: • 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 will be factored into the work the Chair, Acting Chief Executive and Company Secretary will undertake on a forward Board development plan. • Action 25/09/12 relating to providing a joint forward statement within the Green Plan from both Trudie Davies and Sean Fenwick. This has been actioned and the plan submitted therefore action agreed for closure. • Action 25/09/23 relating to arranging a future Board development session to discuss organisational plans around the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). This will be added to the forward plan for Board development which the Chair, Acting Chief Executive and Company Secretary are working on. 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. There were no further comments.	
25/12/06	**Top Organisational Risks:** The top organisational risks were noted as follows:	

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Agenda Item No		Action Owner
	• **Risk 4694 (Finance)**. Risk that the Trust will not achieve its revenue plan for 2025-26 and a deterioration from the 2024-25 planned deficit, resulting in a deterioration to the Trust's NHS Oversight Framework rating. (Risk Score 20) • **Risk 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). Sean Fenwick highlighted that discussions have taken place at the Executive Risk Management Group in relation to changing the approach to the governance process around top risk identification to be more focussed on composite risks. The outputs of the revised approach will be reflected at the next Board meeting under the *Top Organisational Risks* agenda item.	
25/12/07	**Chair's Report:** Paul Ennals gave an update to the Board on some current issues, events and engagement work taking place across the organisation. He highlighted that Hilary Parker will be leaving the Board on 31st December 2025 after five and a half years of service and formally recorded the Board's thanks for her dedication and commitment. The Trust will shortly be advertising for a Non-Executive Director with a legal qualification and significant legal experience to commence in early 2026. The Gateshead Health Star Awards 2025 took place on 7th November 2025 which celebrated the exceptional people who make a difference across our services every single day and the Board congratulated the winners and nominees. After consideration, it was: **RESOLVED:** to receive the report for assurance.	
25/12/08	**Chief Executive's Report:** Sean Fenwick gave an update to the Board on current issues which have been aligned to the Trust's new Strategic Aims. He drew attention to the key areas in relation to national policy, context and operating models and highlighted that the Medium Term Planning Framework 2026-29 was recently published, and work is taking place on the development of the plan. The draft Advanced Foundation Trust Framework is currently out for consultation and includes the assessment process for integrated health organisations (IHOs).	

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	In relation to national performance headlines, it was noted that flu cases are a lot higher than at this time last year and regional intervention work is taking place particularly around vaccination rates. The Trust has robust winter internal plans in place and collective support is in place within the North East and North Cumbria Integrated Care System with regular oversight group meetings taking place to monitor pressures, share learning, and coordinate responses across wards and departments. Sean Fenwick drew attention to the Trust's strategic objective for Excellent Patient Care and highlighted that robust plans were in place for the new period of industrial action from resident doctors, which ran from 7am on 14 November to 7am on 19 November 2025. 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. It was noted that a further ballot is due to take place. The Board noted that the Trust's Secondary Prevention Service won the prestigious Health Service Journal (HSJ) Award for Medicine, Pharmacy and Prescribing Initiative of the Year and thanked the team for their work. The service supports patients to manage potential risks (such as cholesterol, diabetes and blood pressure) following cardiovascular events. In relation to Great Place to Work, Sean Fenwick highlighted that in line with NHS England's 10 Point Plan to improve the working lives of our resident doctors, the Trust has appointed the 2 named leads for ensuring the resident doctor issues have appropriate visibility at Board. Carmen Howey is the named lead for resident doctor issues and Dr Ruby Hodges has been appointed as the resident doctor peer representative. Paul Ennals queried whether there was sufficient contingency winter planning in place recognising lessons from the recent national covid enquiry, and Jo Halliwell explained that national data is being reviewed on a regular basis via the System Winter Group and assurance can be provided that approaches are being adapted based on this including work to bring forward the timescales for the Acute Respiratory Intervention (ARI) hubs. After further discussion, it was: **RESOLVED:** to receive the report for assurance.	
25/12/09	**Great North Healthcare Alliance Progress Report:** Jennifer Boyle provided the Board with an update on the Great North Healthcare Alliance.	

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	The report demonstrates some of the progress in relation to the strategic objectives for 2025/26 and she highlighted that there are some proposed updates to the Alliance governance arrangements in relation to the Committees in Common and Joint Committee that were discussed at the Alliance Steering Group in October 2025. It was noted that this will require amendments to the Terms of Reference which will be brought back to Alliance Trust Boards for future approval. Discussion took place in relation to the RAG rating of some of the 2025/26 priorities particularly around progress in relation to improvements of digital services and Andrew Besford highlighted that there was still a lot of work to do to firm up plans but increased effective collaboration work was taking place and progress is being made. Board Members concurred that there was an appetite to move further and faster in respect of Alliance working. After further discussion, it was: **RESOLVED:** to receive the report for assurance and information.	Cycle of business
25/12/10	**Governance Reports:** **Organisational Risk Register (ORR):** Beth Swanson 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 17th September 2025 to 17th November 2025. As highlighted earlier in the meeting, Beth Swanson explained that work is being undertaken to review risk governance processes via the Executive Risk Management Group (ERMG) and there will be an opportunity to discuss further at a future Board Development Session. She reported that there are currently 16 risks on the ORR. Following the ERMG meetings in October and November 2025, there have been 2 risks added to the ORR relating to maternity estate and industrial action. There have been 2 escalations, 2 reductions, 3 closures and 2 de-escalations from the ORR. Gavin Evans highlighted that further discussion will take place at the next Board Development Session in relation to the maternity estate following a recent incident relating to pipework that necessitated the temporary closure of the maternity unit. Gerry Morrow assured the Board that no patient harm had taken place as a result of this and support was provided via mutual aid arrangements. Gavin Evans explained that the Board will be provided with the opportunity to discuss recommendations and next steps to address these issues.	

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	Discussion took place around the risk relating to industrial action and Jo Halliwel assured the Board that teams are working through the challenges however highlighted the potential increased risk around availability of staff over the festive period. It was confirmed that no new annual leave requested would be granted for the period of industrial action. The Board reviewed the organisational risks with no change to score in the last 6 months and Paul Ennals queried whether the right mitigations were in place for these. Beth Swanson explained this was part of the review work by the ERMG and will be updated for the next report. After consideration, it was: **RESOLVED:** to receive the report for assurance.	
25/12/11	**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:** Gerry Morrow provided a brief verbal overview to accompany the narrative reports from the October 2025 meeting and drew attention to the most recent meeting which took place on 25th November 2025. He highlighted that there was one issue requiring escalation to Board in relation to the number of patients awaiting a urology first outpatient appointment. This was deemed to be an escalation as at the time of the meeting there were no clear mitigations in place. Sean Fenwick reported that discussions were taking place to find a resolution with Alliance partners and provided assurance that no clinical risks have been raised. He felt that it was important to ensure that quality impact assessments are taking place and will be picked up as part of the review of constitutional standards. Paul Ennals highlighted that assurances will be provided via the Quality Governance Committee. Gerry Morrow reported that the Committee had received positive assurances in relation to the financial position and cost reduction plans. Kris Mackenzie will provide further details on the cash position and planning work as part of the Finance Report (Agenda Item 12). **Quality Governance Committee:** Gerry Morrow provided a brief verbal overview to accompany the narrative report following the November 2025 meeting. He reported that there were no alerts requiring escalation to the Board but there are some areas subject to ongoing monitoring including concerns raised in relation to the 28 and 62 day cancer standards and a	

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	detailed report has been requested for the next meeting to provide more assurance. Positive assurances were received by the Committee in relation to surgical site infections, but ongoing improvement work has been identified and is being taken forward. Sean Fenwick highlighted that a detailed investigation took place with no unified cause identified and the Trust continues to have an overarching low infection rate. Paul Ennals felt that it would be beneficial for the Committee to revisit this in due course for further assurance and Gerry Morrow highlighted that the Committee continues to receive updates at every meeting. **Digital Committee:** Andrew Besford provided a brief verbal overview to accompany the narrative report following the November 2025 meeting. He reported that that there were no alerts requiring escalation to the Board but there are some areas subject to ongoing monitoring including work around the Digital Records Programme and a business case is expected to be brought to Board in March 2026. This includes supporting digital nursing roles and an issue has been flagged by the Group Medical Director in relation to feedback from Foundation Doctors. Andrew Besford highlighted that the picture archiving and communication system (PACS) upgrade has taken place and Jo Halliwell explained that this involved moving to a new digital architecture which has eradicated previous risks to the system and positive clinical feedback has been received. The Board thanked the digital team for their work around this. Discussion took place at the Committee around the development of the digital chapter of the Trust Strategy and Neil Halford highlighted that this was discussed at the recent Clinical Strategy Group away day and there is an eagerness to provide engagement around this. **People and Organisational Development Committee:** Amanda Venner provided a brief verbal overview to accompany the narrative report following the September and November 2025 meetings. She highlighted that there were some alerts raised from the September meeting, although these items did have mitigations in place. Since this time the approach to the completion of the assurance reports has been adjusted to only include unmitigated issues in the alert section – as such there are no alerts on the November assurance report. Areas subject to ongoing monitoring from the November meeting included an update on industrial action and the Committee were assured that plans are in place to manage this with established systems and structures in place. The Committee identified a need for further work to take place in relation to Occupational Health to understand the reasons behind the high Did Not Attend (DNA) rates and how these can be addressed to support return to work processes.	

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	Amanda Venner reported that Dr Ruby Hodges, the new Resident Doctor Peer Lead attended the meeting to support the self-assessment work around the 10 Point Plan and an action plan is in place following the gap analysis work. Paul Ennals thanked the Committee Chairs for their reports. After consideration, it was: **RESOLVED**: to receive the reports for assurance	
25/12/12	**Finance Report:** Kris Mackenzie provided the Board with assurance against delivery of the approved 2025/26 revenue and capital plan as at 31st October 2025 (Month 7). She reported that the Trust has reported an actual deficit of £7m which is a favourable variance from plan of £0.185m. The Trust has achieved its current cost reduction programme target of £16.9m and is reporting an improvement in its underlying deficit of £19.3m comprising of recurring CRP totalling £14.8m. The organisational risk relating to the achievement of the revenue plan has been reduced from a risk score of 20 to 16. Kris Mackenzie highlighted that cash balances remain challenging and this risk has therefore been increased which indicates that the need for cash support / borrowing will be required. Following a query from Paul Ennals around whether cash support will be available from NHS England, Kris Mackenzie explained that the cash support application process for 2026/27 has not been released and whilst full assurance could not be given, there has been regular dialogue with NHS England on this matter throughout the year. The situation will continue to be monitored via the Finance and Performance Committee as part of the planning process. The Board acknowledged the achievement of the financial targets for 2025/26 but accepted that next year will be challenging. Paul Ennals queried when budgets for 2026/27 would be available to the Board and Kris Mackenzie explained that local discussions are still taking place with the Integrated Care Board as the contract mandate was only received in the previous week. Following a query assurance was provided that cash is being maximised across the Gateshead Health group on a daily basis. After consideration, it was: **RESOLVED:** to receive the Month 7 financial position and note partial assurance for the achievement of the 2025/26 planned financial targets.	

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Agenda Item No		Action Owner
25/12/13	**Strategic Objectives and Constitutional Standards Report:** Kris Mackenzie presented the progress, risks and assurance in relation to the Trust's strategic objectives and constitutional standards for Month 7 2025/26. She drew attention to some of the main headlines which includes an increase in length of stay primarily due to challenges with infection, prevention and control however there has been a reduction in 52 week waits. There are general pressures within urgent and emergency care including ambulance handovers and Jo Halliwell explained that this was due to increased demand following some diverts across the region. After action reviews continue to be conducted following each ambulance handover delay over 30 minutes, and no significant improvement actions have been identified. Standards continue to be monitored across the Board Committees. Following consideration, it was: **RESOLVED:** to receive the report for assurance and note the key areas of improvement and challenge.	
25/12/14	**Learning from Deaths Quarterly Report (Quarters 1 and 2):** Beth Swanson presented the reports for Quarter 1 and Quarter 2 which outlines the process for the 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. The report also 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 concern. Beth Swanson reported that extraordinary meetings have been taking place to address the backlog of cases awaiting review. Considerable progress has been made in the review of the deaths of patients with a Learning Disability and those with Serious Mental Illness with more scheduled to be reviewed in the coming weeks. It was noted that the SHMI (Summary Hospital-level Mortality Indicator) is showing an increase however deviation was expected as data from same day emergency care (SDEC) activity has been removed. Sean Fenwick explained that this was requested from NHS England however has been raised nationally via the regional Provider Collaborative due to the effect on the NHS Oversight Framework (NOF) ratings. He provided assurance to the Board that the SHMI was still below the expected range and there are no issues of concern based on continued analysis.	

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	Beth Swanson concluded in the 12 months preceding the end of Quarter 2, 94.9% of deaths were scrutinised by the Medical Examiner and deemed 'definitely not preventable'. There are some areas of learning and there is good evidence of improvements. Paul Ennals felt that it would be beneficial to highlight these within the executive summary to provide clear understanding and this will be taken forward. Following discussion, it was: **RESOLVED:** to receive the report for assurance and information.	BS
25/12/15	**Maternity Integrated Oversight Report:** Karen Parker presented a summary of the maternity indicators for the Trust for October 2025. She reported that the National Neonatal Audit Programme (NNAP) report for 2024 babies was published in October 2025 and a deep dive review has been undertaken to produce an action plan on target areas. Following this a regional alert was received from the NHS England National Clinical Director for Maternity in relation to stillbirth rates in the North East and North Cumbria following a change in weight centile charts. This resulted in a rapid analysis of data which was presented to the North East and North Cumbria Local Maternity and Neonatal System (LMNS) in November 2025 and will be presented to the Quality Governance Committee in January 2025. Assurance was received that the outlier status in relation to stillbirths in the region is a statistical artefact, i.e. it is not statistically significant and does not present patient safety concerns. Gerry Morrow confirmed that no concerns have been raised in current processes and there have been no increases in perinatal deaths. Karen Parker also provided an update on the Trust's recent infant abduction drill which highlighted some weaknesses in current processes. Some actions were being put in place following this which will be monitored via the Business Resilience Group. Gerry Morrow explained that a recent Executive walkabout had taken place to review some of the new processes and regular monthly exercises will continue to take place to provide further assurances to the Board and Quality Governance Committee. The report also highlights that a national coroner's Regulation 28 has been issued relating to homebirth and this has been shared with staff, and a taskforce is in place to review local guidance processes. Paul Ennals felt that it would be beneficial for the Board to receive a summary of key points to provide a clear understanding on areas of focus for assurance or further monitoring.	BS/KP

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Agenda Item No		Action Owner
	Following discussion, it was: **RESOLVED:** to receive the report for assurance. **Maternity Safety Champion Report:** Gerry Morrow presented his report which provides 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. He drew attention to some of the key issues and highlighted that Sunderland Neonatal Intensive Care Unit has recently restructured to Special Care Baby Unit which may have a wider impact on neonatal care for the wider region. The maternity and neonatal unit now has a Service Line Manager in place and Dr Shilpa Ramesh, Neonatal Safety Champion, is now back in post. Discussion also took place in relation to the maternity estate, and the Board were reminded that a presentation will be provided at the next Board Development Session. Sean Fenwick provided assurance that that there has been no day-to-day direct impact on patient care and further discussion will take place on short-term and long-term estates risk mitigations at the session. After consideration, it was: **RESOLVED:** to receive the report for assurance in conjunction with the Maternity Integrated Oversight Report.	
25/12/16	**Nurse Staffing Exception Report:** Beth Swanson presented the report for October 2025 which provides assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis to provide adequate staffing levels. She reported that 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 which has affected staffing resource. Continued focused work around the retention of staff and managing staff attendance remains. A live rostering consultation process is ongoing and Beth Swanson explained that this is underpinned by a full establishment review in general in-patient areas across the nursing and health care assistant workforce therefore a number of vacancies have been held to accommodate this work. The aim of the process is to improve establishments and provide dedicated supervisory time which will be beneficial to the whole organisation.	

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	The report highlights that there were 98 nursing red flags reported compared to 75 the previous month and continue to be escalated to the Matron or senior nurse for action. Following a query from Paul Ennals on safe staffing levels, Beth Swanson reported that these are manageable but will be further supported by the live rostering programme once it is fully in place. Paul Ennals also felt that it would be beneficial for the Board to receive some trends and key headlines within the summary and Beth Swanson explained that a review of the paper will be taking place to provide a clearer understanding of the information provided. Following discussion, it was: **RESOLVED:** to receive the report for information and assurance.	BS
25/12/17	**Cycle of Business 2025/26:** Jennifer 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.	
25/12/18	**Questions from Governors in Attendance:** There were no questions received from Governors in attendance however Paul Johnson felt that the approach from the Board was very positive and dealt with emerging issues in a proactive manner.	
25/12/19	**Any Other Business:** There was no other business raised.	
25/12/20	**Date and Time of Next Meeting:** The next meeting of the Board of Directors will be held at 9.30am on Wednesday 28th January 2026.	

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Agenda Item No		Action Owner
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

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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.**	
25/09/23	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. **Jan 26 – further discussion at POD Committee and agreement to incorporate a broader session into the Board development plan.**	
25/12/14 25/12/15	05/12/2025		To provide key highlights, trends, conclusions, etc within executive	28/01/2026	All		

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
25/12/16			summary to support Board in addressing key issues				

Closed Actions from last meeting

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
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 agreed for closure.**	

6. Top Organisational Risks

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Top Organisational Risks – January 2026

The top organisational risks as agreed by the Executive Risk Management Group on 6 January 2026 are as below. These are composite risks - the wording is currently draft subject to approval at the next meeting of the ERMG in February.

1. Financial Sustainability - Risk of inability to invest in staff and clinical services, including supporting financial collaboration with partners.

2. Estates - Risk to sustainability of core infrastructure and to invest in clinical advances and the working environment for our staff.

3. Digital - Risk of an inability to sustain and advance our digital offer impacting on the delivery of optimal clinical care, staff engagement and experience and our ability to deliver transformation.

7. Patient and Staff Story

ITEMS FOR DECISION

8. Board Committee Terms of Reference Presented by the Company Secretary

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Report Cover Sheet Agenda Item: 8

Report Title:	**Board Committee Terms of Reference**			
Name of Meeting:	Board of Directors			
Date of Meeting:	28 January 2026			
Author:	Jennifer Boyle, Company Secretary			
Sponsor:	Chairs and Executive Leads for the Board Committees			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To ratify the terms of reference for the Group Audit Committee and Digital Committee.			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Group Audit Committee – September 2025 Digital Committee – January 2026			
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*	**Group Audit Committee** The Group Audit Committee reviewed its terms of reference as part of its annual effectiveness review in September 2025. No changes were proposed (given that there had been extensive updates to align them with the Healthcare Financial Management Association Audit Committee Handbook in the previous year) and the Committee approved the terms of reference. The Committee recommends the terms of reference for ratification by the Board of Directors (Appendix 1). **Digital Committee** The Digital Committee reviewed its terms of reference in January 2026 under the leadership of the new Committee Chair and Alliance Chief Digital Officer. A number of updates were made to the membership and attendees, as			

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	well as to the role of the Committee in seeking assurance over the digital capital plan. The Committee recommends the terms of reference for ratification by the Board of Directors (Appendix 2).					
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board of Directors to recommended to ratify the terms of reference for the Group Audit Committee and the Digital Committee.					
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):	Collectively the Board Committees (Tier 1) support the Board in ensuring that there is effective assurance, accountability, risk management and decision-making in place. Well-governed Board committees ultimately support the achievement of the strategic objectives.					
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐	
Risks / implications from this report (positive or negative):						
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	-					
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒			

APPENDIX 1

Committee Terms of Reference

Group Audit Committee

Constitution and Purpose – The Group Audit Committee (thereafter referred to as the Audit Committee) is a formal committee of the Board with delegated responsibility to conclude upon the adequacy and effective operation of the organisation's overall internal control system including an effective system of integrated governance and risk management.

It provides a form of independent check upon the executive arm of the Board. The Audit Committee is a Group Audit Committee, overseeing the controls, governance and risk environment of Gateshead Health NHS Foundation Trust and QE Facilities.

In this document the use of the term 'Trust' shall mean Gateshead Health NHS Foundation Trust and QE Facilities.

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

Date Adopted / Reviewed	September 2025
Review Frequency	Annually
Review and approval	Group Audit Committee – September 2025
Adoption and ratification	Gateshead Health NHS Foundation Trust Board – January 2026 (to be confirmed)

Membership	The Committee shall be appointed by the Trust Board and shall consist of: • 4 Non-Executive Directors At least one Audit Committee member should have recent and relevant financial experience and this person should chair the Committee. A Non-Executive Director shall be nominated as Vice Chair for the Committee.
Attendance	The following are also invited and expected to attend all Audit Committee meetings: • Group Director of Finance and Digital • QEF Director of Finance • Chief Nurse • Company Secretary • Assistant Director of Finance • A representative of Internal Audit • A representative of External Audit • A representative of the Counter Fraud The Chair of the Trust shall not chair or be a member of the Committee, but can be invited to attend the Committee as required. The Accounting Officer (Chief Executive) should be invited to attend the meeting that considers the draft Annual Governance Statement and the Annual Report and Accounts and should discuss the process for assurance that supports the Governance Statement. All invited attendees, if they cannot attend, should ensure a deputy attends in their absence. Other Executive Directors and Senior Managers may be invited to attend meetings depending upon the issues under discussion.
Meeting frequency and quorum	Meetings shall be held **no less than five times per year** (including the meeting held to review and make recommendations relating to the Annual Report & Accounts) and as required by the national regulatory timetable. Meetings shall be held at such a time that supports the timely flow of

	assurance and items for escalation to the Gateshead Health NHS Foundation Board of Directors. To be quorate there should be at **least 2 Non-Executive Directors** present. The Committee reserves the right to pragmatically invite other Non-Executive Directors (excluding the Chair) to attend for a single meeting in order to achieve quoracy if the lack of quoracy is short term / short notice. The external and internal auditors shall be afforded the opportunity at least once per year to meet with the Audit Committee without Executive Directors present. Members of the Audit Committee shall meet at least once a year without Executive Directors present. Members of the Audit Committee will meet with the Chief Executive at least once a year.
Meeting organisation	The Committee shall be supported administratively by the Corporate Management Team secretarial body. In accordance with the Trust's Standing Orders, **papers will be circulated to members and attendees six days before the meeting.** Minutes of the Committee's meetings are held by the Corporate Management Team secretarial body and are circulated (alongside the agenda for the following meeting), to members and attendees.

Committee duties and responsibilities	
Internal control and risk management	To ensure the provision and maintenance of an effective system of **financial risk identification and associated controls, reporting and governance**. To maintain an **oversight of the Group's general risk management structures, processes and responsibilities**, including the production and issue of any risk and control-related disclosure statements. The Executive Risk

	Management Group will support the flow of risk management assurance to the Group Audit Committee. To **review processes to ensure appropriate information flows to the Group Audit Committee** from executive management, the Executive Risk Management Group and other board committees in relation to the trust's overall internal control and risk management position. To **review the adequacy of the policies and procedures in respect of all counter-fraud work**. The Committee must satisfy itself that adequate arrangements are in place to counter fraud and consider and agree the Annual Counter Fraud Plan and the results of counter fraud work. To review the **adequacy of the Trust's arrangements by which Trust staff may, in confidence, raise concerns** about possible improprieties in matters of financial reporting and control or any other matters of concern. To review the **adequacy of underlying assurance processes indicating the degree of achievement of corporate objectives** and the effectiveness of the management of principal risks via the Board Assurance Framework. To review the **adequacy of policies and procedures** for ensuring **compliance with relevant regulatory, legal and conduct requirements**.
Financial reporting	The Committee shall **review the Annual Report and Financial Statements** before submission to the Board in order to determine their completeness, objectivity, integrity and accuracy. The review should particularly focus on: • The contents of the Annual Report and Accounts and **Annual Governance Statement** and other year-end disclosures / reporting including the Corporate Governance Statement and self-certifications. • Changes in, and compliance with, the accounting policies and practices and estimation techniques. • Unadjusted mis-statements in the financial statements. • Major judgemental areas. • Significant adjustments resulting from the audit.

	• Letters of representation. • Explanations for any significant year on year movements. The Committee shall also ensure that the **systems and processes for financial reporting** to the Board, including those of budgetary control, are subject to review as to **completeness and accuracy** of the information provided to the Board. This includes seeking assurance that controls and processes are in place to enable the Trust to utilise the outputs of the annual reference cost exercise to identify efficiencies and promote value for money. The Committee shall review the **QE Facilities year-end accounts** in conjunction with the work and opinion of external audit. The Committee shall review the **Charitable Funds accounts** in conjunction with the work and opinion of external audit.
Internal Audit	To **review and approve the approach adopted by Internal Audit and the Internal Audit annual plan**, ensuring that it is consistent with the needs of the organisation. To oversee on an on-going basis the **effective operation of Internal Audit** in respect of: • Adequate resourcing and has appropriate standing within the Trust; • Its co-ordination with External Audit to optimise the use of audit resources; • Meeting relevant internal audit standards; • Providing adequate independence assurances; • Meeting the Public Sector Internal Audit Standards 2017; and • Meeting the internal audit needs of the Trust. To **consider the major findings of internal audits undertaken** and management's response and their implications and monitor progress of the implementation of agreed recommendations.

	To consider the **provision of the Internal Audit service and the cost** of the service. To conduct an **annual review** of the Internal Audit function, seeking feedback from Committee members / attendees, Internal Audit and other Trust personnel involved in audits during the year
External Audit	The Committee will **agree with the Council of Governors the criteria for appointing, reappointing and removing auditors**. The Audit Committee should make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the External Auditor alongside the remuneration and terms of engagement. The Committee shall review and monitor the external auditors' **independence and objectivity and the effectiveness** of the audit process. The Committee shall **review the work and findings of the External Auditor** appointed by the Governors and consider the implications and management's responses to their work and monitor progress of the implementation of agreed recommendations. Consider the performance of the External Auditor and **report at least annually to the Council of Governors on the continued adequacy or otherwise of the appointed auditors**, including recommendations for the tendering of External Audit services. A review of effectiveness will include seeking feedback from Committee members / attendees, External Audit and other Trust personnel involved in the audit during the year. The Audit Committee will **discuss and agree** with the External Auditor, before the audit commences, of **the nature and scope of the audit** as set out in their Annual Plan, and ensuring co-ordination, as appropriate, with other External Auditors in the local health economy. Discuss with the External Auditors of their **evaluation of audit risks** and assessment of the Trust in line with the tendered audit fee and agreement of any additional work and fees.

	Review all External Audit reports, including agreement of the annual audit letter before submission to the Gateshead Health NHS Foundation Trust Board or QE Facilities Board (as appropriate) any work undertaken outside of the annual audit plan, together with the appropriateness of the management responses. **Develop and implement a policy on the engagement of the external auditor to supply non-audit services**, taking into account relevant ethical guidance and National Audit Office requirements regarding the provision of non-audit services by the external audit firm (noting that assurance work on the Quality Report is classified as a non-audit service but excluded from non-audit service cap threshold set by the National Audit Office).
Counter Fraud (CF)	The Committee shall ensure that there is an **effective Counter Fraud function** established by management, which meets the standards of NHS Counter Fraud Authority. This will be achieved by: • The provision of the CF function. • Review and approval of the CF Annual Plan. • Consideration of the major findings of CF work and fraud investigations, management's response and progress of the implementation of agreed recommendations. • Ensuring that the CF function is adequately resourced. • Receiving a copy of the completed Counter Fraud Functional Standard Return (CFFSR) for awareness and to demonstrate consistency with counter fraud updates from throughout the year. • Annual review of the effectiveness of the CF function.
Regulatory and governance	Review on behalf of the Foundation Trust Board of Directors the operation of, and proposed changes to, the **Standing Orders** and **Standing Financial Instructions**, the **Constitution** and the **Scheme of Delegation**. The Committee will make recommendations to the Foundation Trust Board regarding the adoption of proposed amendments.

	To review reports outlining identified instances of non-compliance with these core documents, providing assurance over any corrective actions taken. To **review the findings of other significant assurance functions**, both internal and external to the organisation and consider the implications to the governance of the organisation, where the review is not covered by another Board Committee. The Committee shall receive and review the **schedules of losses and special payments** and authorise the Chief Executive and Group Director of Finance to approve any write-offs / special payments. On an annual basis the Committee shall receive and review a comprehensive **litigation register**, detailing cases and claims from across all subject areas (including for example patient / quality, people and health and safety). The Committee will seek to **satisfy itself that the Tier 1 Board Committees are operating effectively**, seeking and obtaining appropriate levels of assurance and identifying emerging risks from the business transacted. Assurance will be obtained via: • Review of the **Board Assurance Framework** on a bi-annual basis as part of the wider risk management reporting; • Review of the controls and processes for the development and delivery of the **clinical audit programme** (whose content and outputs are monitored by Quality Governance Committee); and • Access to the **Tier 1 Board committee effectiveness reviews** conducted annually, for information and assurance only (noting that they are also presented to the Board of Directors).

Reporting and monitoring	
Sub-groups	The following sub-groups report into the Committee:

	• Executive Risk Management Group (via the Gateshead Health Leadership Group) The summary of assurances and escalations document are received by the Committee as part of the flow of assurance through the Trust's governance structure.
Board reporting	An assurance report from the Committee will be presented by the Chair to the next meeting of the Foundation Trust Board of Directors. Where items considered at the Committee pertain to QE Facilities, a separate assurance report will be submitted to the QE Facilities Board of Directors for consideration (with the Non-Executive Director holding a dual role on Group Audit Committee and QE Facilities Board able to facilitate this).
Monitoring	Compliance with the terms of reference will be reviewed via an annual self-assessment. This will inform any proposed revisions to the terms of reference and the cycle of business. The outcome of the effectiveness and terms of reference review is presented to the Foundation Trust Board of Directors following considered by the Committee. This will also be shared with the QE Facilities Board of Directors. The Gateshead Health NHS Foundation Trust Annual Report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

NHS Gateshead Health NHS Foundation Trust

APPENDIX 2

Tier 1 Board Committee Terms of Reference

NHS Gateshead Health NHS Foundation Trust

Digital Committee

Constitution and Purpose – The Digital Committee is a formal Tier 1 committee of the Trust Board with delegated responsibility to oversee the development and seek assurance on the delivery of digital, data and technology aspects of the Trust's strategy. The Committee seeks assurance on behalf of the Board on the discharge of digital, data and technology functions, ensuring that the principle of clinically-led and management supported is embedded in digital strategy and delivery.

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

Date Adopted / Reviewed	January 2026 – Digital Committee January 2026 – Board of Directors (to be confirmed)
Review Frequency	Annually
Review and approval	Digital Committee
Adoption and ratification	Trust Board

Membership	The Committee shall be appointed by the Trust Board and shall consist of: • 2 Non-Executive Directors, one of whom shall chair the Committee • Chief Digital Officer • Medical Director • Group Director of Finance • Chief Executive • Associate Director of Digital

	A Non-Executive Director shall be nominated as Vice Chair for the Committee in the absence of the Chair.
Attendance	The following will be expected to attend the Committee on a routine basis: • Chief Nursing Information Officer • Head of Digital Transformation and Assurance • Director of Operations – CSS / Deputy Chief Operating Officer • Associate Director of Business Intelligence • Chief Nursing Information Officer – representing the Clinical Safety Officer • Chief Clinical Information Officer • Alliance Lead for Digital Executive Directors and senior managers should ensure that a deputy attends in their absence. Other Executive Directors and Senior Managers may be invited to attend meetings depending upon the issues under discussion. Two nominated Governors will be in attendance at the Committee as observers.
Meeting frequency and quorum	Meetings shall be held **bi-monthly**. Meetings shall be held prior to the Trust Board to support the timely flow of assurance and items for escalation. To be quorate there should be at **least 1 Non-Executive Director and 1 Director present**. The Committee reserves the right to pragmatically invite other Non-Executive Directors to attend for a single meeting in order to achieve quoracy if the lack of quoracy is short term / short notice. Members and regular attendees are expected to achieve **75% attendance** annually.
Meeting organisation	The Committee shall be supported administratively by the Corporate Governance Manager. In accordance with the Trust's Standing Orders, **papers will be circulated to members and attendees six days before the meeting** wherever possible, and no later than three clear days before the meeting, save in emergency.

Gateshead Health NHS Foundation Trust

	Minutes of the Committee's meetings are held by the Corporate Governance Manager and are circulated (alongside the agenda for the following meeting), to members and attendees.

Committee duties and responsibilities	
Strategy and planning	To **seek assurance over the delivery of the strategic objectives** mapped to the Committee for monitoring at the commencement of the financial year. To seek assurance over the development and delivery of the **digital element of the capital plan** via the Group Director of Finance. To seek assurance over the **delivery of national and local-level strategies** relating to the remit of the Committee, including the strategic intent outlined within the chapters of the main Trust Strategy relating to digital, data and technology.
Operational service delivery assurance	To seek assurance over the **responsiveness and effectiveness of the digital services** through the monitoring of KPIs covering core topics such as service effectiveness, clinical coding, cyber security, information risk management, information governance and records management. Seek assurance over the **completeness and accuracy of clinical coding**, recognising the importance of coding in respect of both its quality and financial implications. To seek assurances in relation to **digital clinical safety**. To seek assurances over the **performance of digital services managed outside of the Digital Team**, including pharmacy and pathology as needed.
Regulatory and governance	To seek assurance that the Trust has in place appropriate arrangements for ensuring that **technology is secure** and up-to-date and that IT systems are **protected from cyber threats** in accordance with national requirements. Seek assurance over the **effectiveness of the Trust's Information Asset Owners** and their roles in respect of key systems. This includes assurance over **data quality relating to the Trust's systems and processes**, the completion of Data Protection Impact Analyses where required and assurances regarding the clinical safety of systems.

	To seek assurance over **performance against key information governance standards and requirements**, including Freedom of Information requests, data breaches and information governance training. To provide assurance to the Trust Board that the Trust is compliant with the relevant **Data Security and Protection toolkit standards** and national requirements. To seek assurance over the **appropriate storage and processing of records** across the Trust including compliance with the General Data Protection Regulation requirements, local policy and subject access requests. To receive for information and assurance **Internal Audit reports** pertaining to the remit of the Committee, particularly in respect of audits completed by the Technology Risk and Assurance arm of AuditOne. To receive for information and assurance any **reports from external reviews** pertaining to the remit of the Committee. To review **feedback from regulators** and the **Information Commissioner** relating to digital technology and information governance. To review any material relating to **emerging regulatory guidance / requirements** with respect to digital and information governance matters on behalf of the Board.
Risk management	To **review the sections of the Board Assurance Framework (BAF)** mapped to the Committee for oversight and assurance, triangulating the control and assurance assertions on the BAF with the assurances and risks identified during each meeting. To **review the digital–related risks on the Organisational Risk Register**, seeking assurance over the effective management of these risks towards the achievement of their target scores. The Committee will triangulate the risk registers against the assurances and risks emerging from the meeting for completeness.

Reporting and monitoring

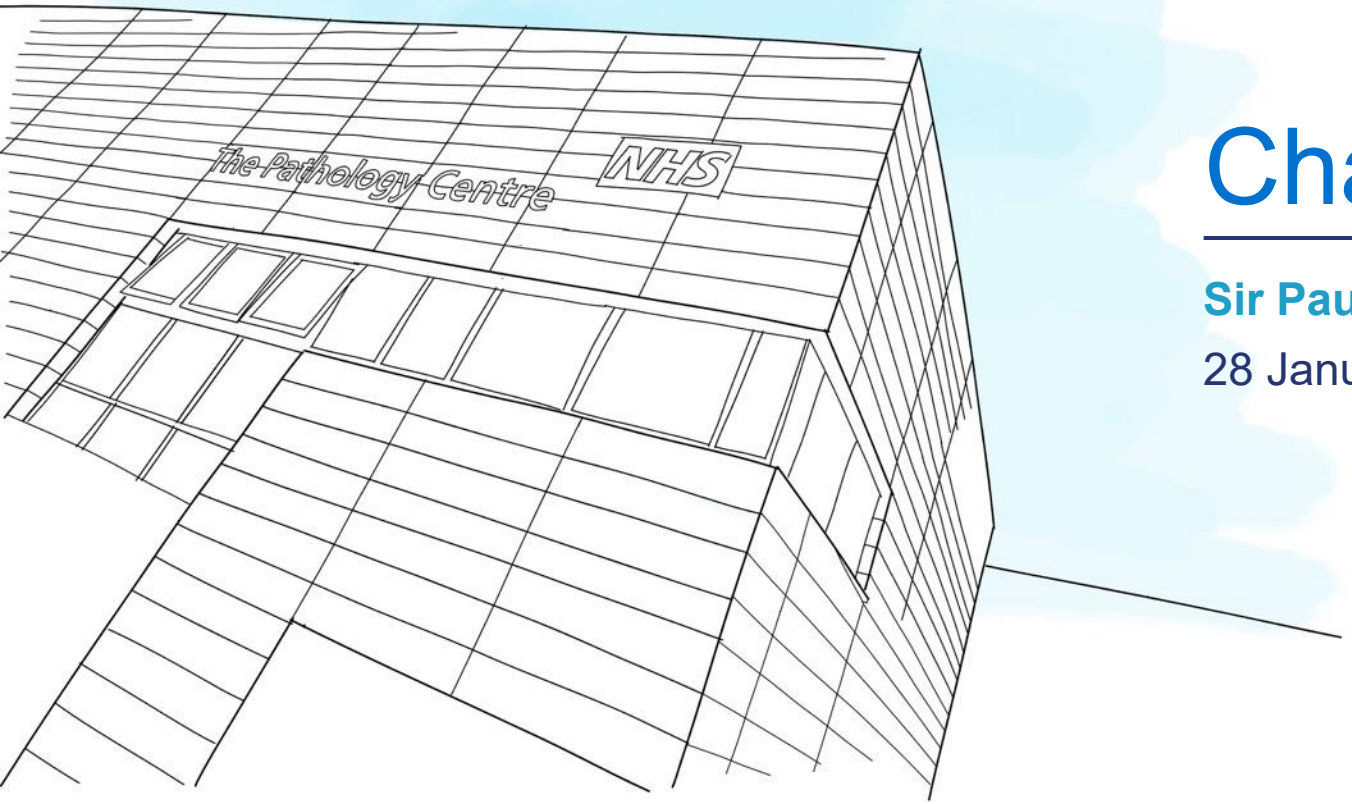
Sub-groups	The following sub-groups report into the Committee: • Digital, Data and Technology Steering Group • Senior Information Risk Officer (SIRO) Group *(name to be confirmed)* A summary of assurances and escalations document, in the format of a 3A (alert, advise, assure) report, is received by the Committee at every meeting as part of the flow of assurance through the Trust's governance structure.
Board reporting	An assurance report from the Committee will be presented by the Chair to the next meeting of the Board of Directors.
Monitoring	Compliance with the terms of reference will be reviewed via an annual self-assessment. This will inform any proposed revisions to the terms of reference and the cycle of business. The outcome of the effectiveness and terms of reference review is presented to the Board of Directors following considered by the Committee.

ITEMS FOR ASSURANCE

9. Chair's Report

Presented by the Chair

Gateshead Health NHS Foundation Trust



Chair's Report

Sir Paul Ennals, Chair of the Board of Directors

28 January 2026

Gateshead Health NHS Foundation Trust

Overview

- It has been a busy but rewarding first few months in post as Chair of Gateshead Health NHS Foundation Trust.
- Since the last Board meeting in early December I have undertaken a number of different activities to seek assurance and support our strategic development. This includes chairing Board development / workshops and extraordinary Board meetings, attending a range of different Board committees and meeting with Non-Executive Director colleagues.
- The development of the medium term plan has been a real focus for the Board throughout December and January. Earlier this month Sean Fenwick, Acting Chief Executive, and I met with NHS England as part of the planning assurance process, based on the initial submission.
- I also met with the Leader and Chief Executive of Gateshead Council as part of our commitment to work with partners to develop healthier communities.
- Prior to Christmas I had the opportunity to meet and thank a number of teams, including the catering teams at the QE, who were working hard to serve our colleagues and patients.

Sir Paul Ennals

Gateshead Health NHS Foundation Trust

Governor Updates

- Since the last Board meeting I have had a number of opportunities to engage with members of our Council of Governors.
- In early January 2026 I met with the Lead Governor as part of our routine monthly meetings to discuss any emerging issues and updates.
- Following this I attended the Membership, Governance and Development Committee, which provided a valuable opportunity for Governors to provide input into the consultation on the local authority's Health and Wellbeing Strategy.
- On 15 January I attended the Governor workshop, which was focussed on the medium term plan and the cost efficiency programme. Governors asked pertinent questions to seek assurance over the robustness of plans and how potential risks were being mitigated.
- I have also been working closely with the Governor Remuneration Committee on our plans to recruit a Non-Executive Director with a legal qualification and experience.
- I look forward to chairing the next Council of Governors meeting on 18 February.

10. Acting Chief Executive's Report

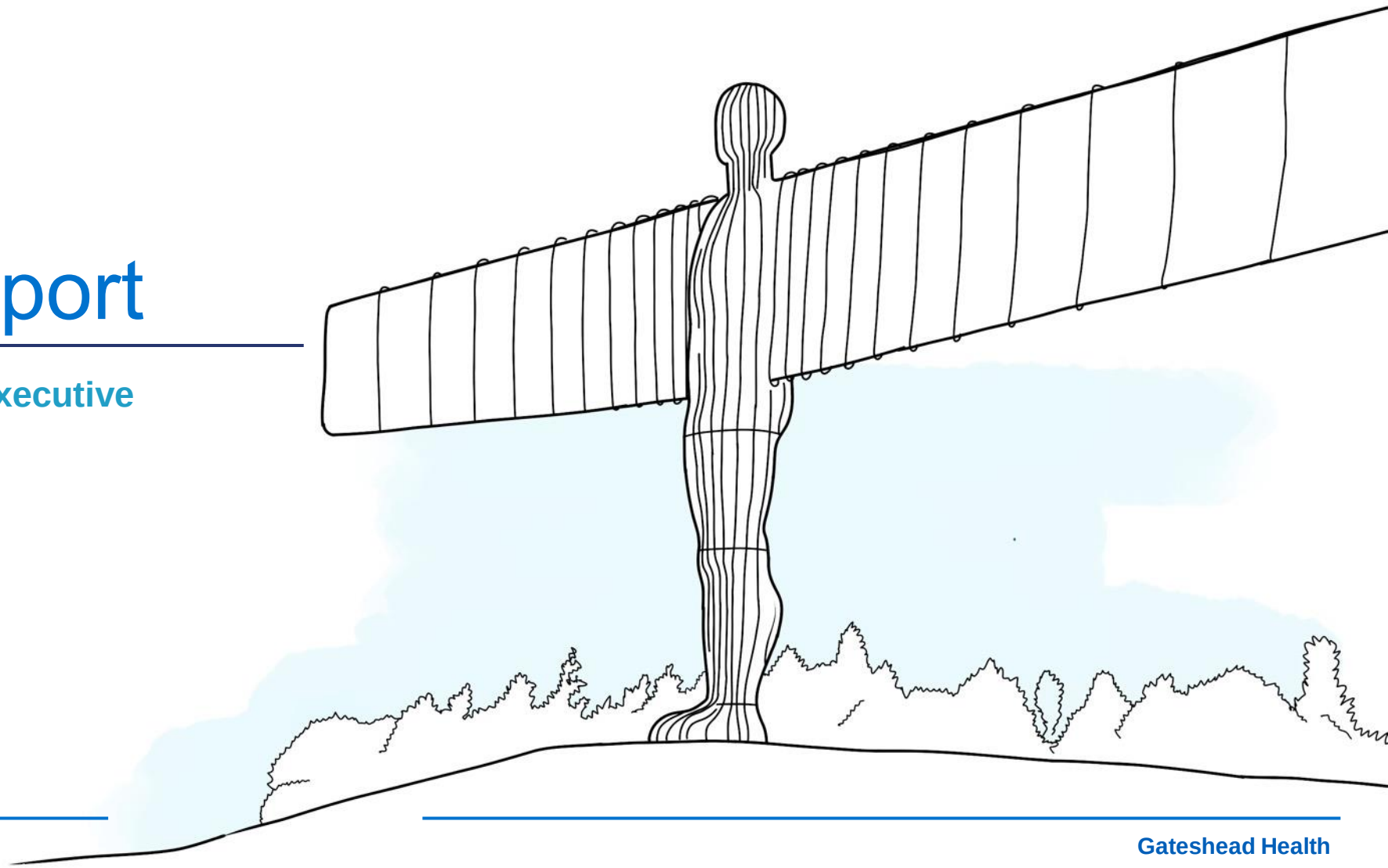
Presented by the Acting Chief Executive

Gateshead Health
NHS Foundation Trust

Acting Chief Executive's Report

Dr Sean Fenwick, Acting Chief Executive

28 January 2026



Gateshead Health NHS Foundation Trust

National statistics and context

National policy, context and operating models

Medium Term Planning underway nationally ahead of the full plan submissions in early February

NHS England and ICB holding check and challenge meetings with providers

NHS Oversight Framework Quarter 2 2025/26 ratings published in December 2025 – Gateshead ranked 62, an improvement on the previous quarter (83)

Merger of NHS Providers and NHS Confederation to form a new membership organisation

NHS Providers undertaking engagement work to gather views on the potential future changes in Foundation Trust governance (the removal of the requirement to have Councils of Governors)

Gateshead Health NHS Foundation Trust

National performance headlines

National performance – November and December 2025

At the start of winter flu was at record levels, but from 15 December onwards flu-related beds have been lower than in the past 2 years.

On average 58.1% of patients who no longer met the criteria to reside remained in hospital compared to 56.4% in December 2024.

73.4% of patients in A&E seen within 4 hours (Dec), an improvement on last year (71.1%), but below the 78% aim. For types 1 and 2 only 4 hour performance was 60.3%

10.5% of patients spent more than 12 hours in A&E in December, above the threshold of 10%

70.2% of referrals met the 62-day cancer standard in November, a slight improvement on last year.

In November 76.5% 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 (77.3%) and below the target of 80%.

In November 78.3% of patients were seen within 6 weeks for diagnostic tests, which is a slight deterioration from the previous month (78.7%), but far from the 99% constitutional standard

Waits over 18 weeks are equivalent to 61.8% of all waits (Nov), 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.

Winter Oversight Group
Internal & System

Board-approved Winter Plan

Clinically-led tactical plan

Ward 11 escalation area

Vaccinations

Information and adaptation

Excellent patient care

Great place to work

- Our maternity services have been ranked in the top five of all Trusts nationally in the Care Quality Commission's (CQC) 2025 National Maternity Survey, receiving an overall positive score of 92.5%. This is fantastic news for our patients and local community and testament to our colleagues' commitment to the delivery of high-quality compassionate care.
- **Our Breast Service has launched a unique set of children's books**, written by specialist breast care nurses Emily Turnbull and Rachel Lockerbie with illustrations from Kirsty Reilly. The books are designed to help explain cancer treatment to children whose parents have been diagnosed with breast cancer. The project was funded by the Women's Cancer Detection Society (WCDS) and has attracted media attention. The books are given to patients free of charge.

Working together for healthier communities

Gateshead Health NHS Foundation Trust

- The Gateshead Health Charity held its annual Light Up a Life event on 4 December bringing together families, colleagues and local residents to remember loved ones. The event gave people the chance to sponsor a star in someone's memory and come together for readings, music and the lighting of the memorial tree. More than 170 stars were dedicated this year. Actor Jill Halfpenny attended as the evening's special guest and switched on the lights. We are grateful to everyone who sponsored a star or supported the event, which raises vital money for the Charity.

Fit for the future

- There has been a significant focus on the **development of the medium term plan** ahead of the initial submission in December and the forthcoming submission in February. As part of the development of the plan we have been focussing on sustainability, with each division being asked to develop plans to support the identification of efficiencies. This process has been clinically-led to ensure that there is a strong clinical voice and patient focus through the development and implementation of plans. Assurance is provided that all efficiency projects are required to complete Equality and Quality Impact Assessments (EQIAs) to ensure that potential impacts on patient care and quality are identified.
- In December 2025 the North East and North Cumbria Pathology Network hosted a **visit to our pathology centre** by the Provider Collaborative and Lord Carter. The visit included an overview of the network and a tour of the centre. The critical role of data was recognised and the need to ensure that this is collected and used across providers in the most effective way. The pathology model is a powerful example of the value of working together at scale.

11. Governance Reports

i) Board Assurance Framework - presented by the Company Secretary

ii) Organisational Risk Register - presented by the Interim Chief Nurse

NHS Gateshead Health NHS Foundation Trust

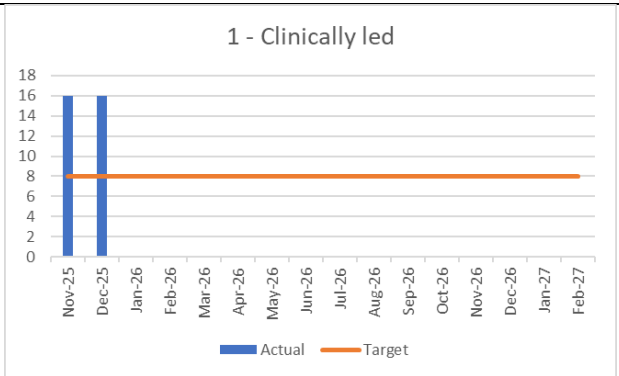
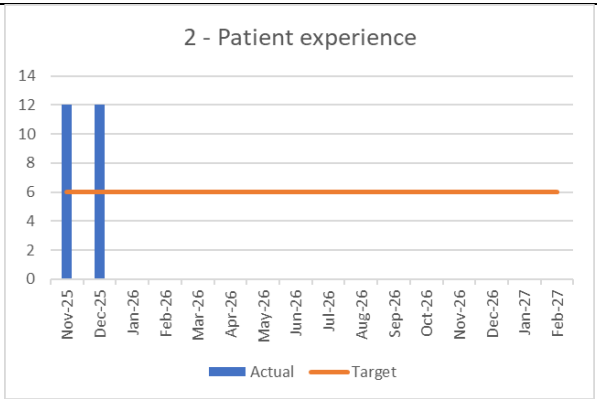
Report Cover Sheet Agenda Item: 11i

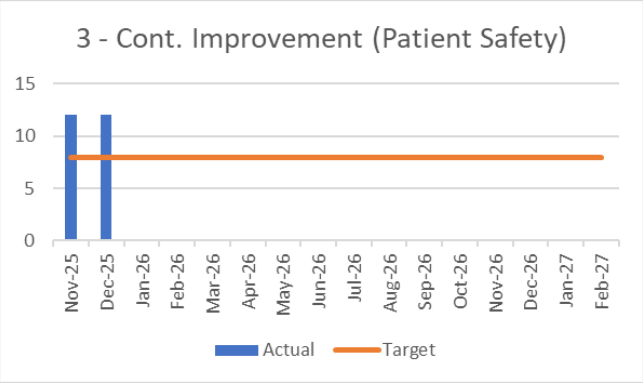
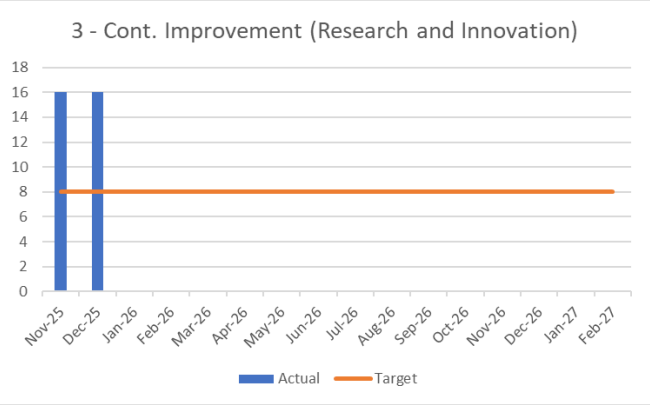
Report Title:	**Board Assurance Framework**			
Name of Meeting:	Board of Directors			
Date of Meeting:	28 November 2026			
Author:	Jennifer Boyle, Company Secretary Executive Directors			
Sponsor:	Executive Directors			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To review the Board Assurance Framework (BAF), triangulating its content against the items discussed on the agenda.			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *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*	BAF extracts have been presented to each of the Board committees, with a summary of the discussions outlined in this accompanying 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 BAF has been updated through the Board committees and the new top 3 composite risks added to the 'linkages to key risks' section on each BAF extract where relevant. • No summary risks have yet reached their target scores, but given that the objectives and risks were only confirmed in September 2025 with the aim of achieving target scores by March 2027, this is not considered to be a cause for concern at this time. • The BAF key is as follows:			

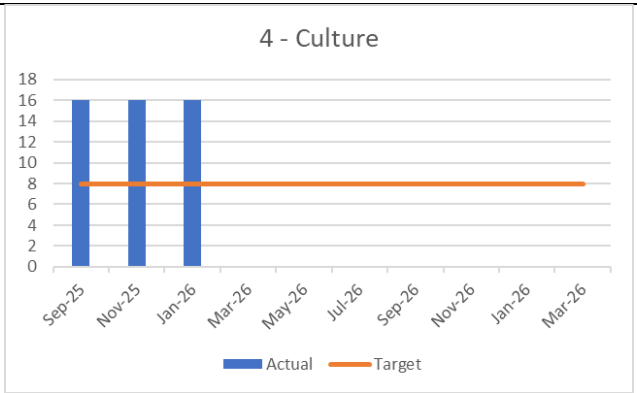
Key	Description
	Not yet started
	Started and on track no risks to delivery
	Plan in place with some risks to delivery
	Off track, risks to delivery and or no plan/timescales and or objective not achievable

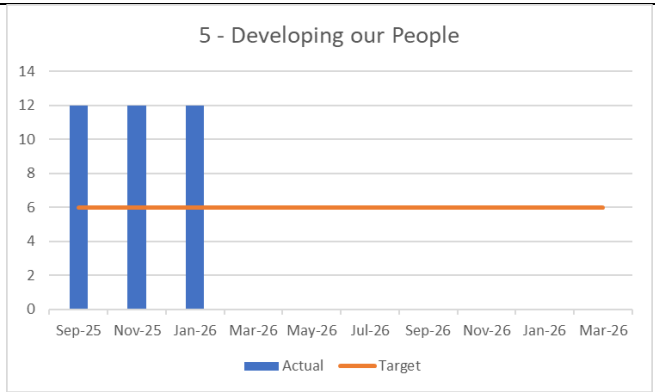
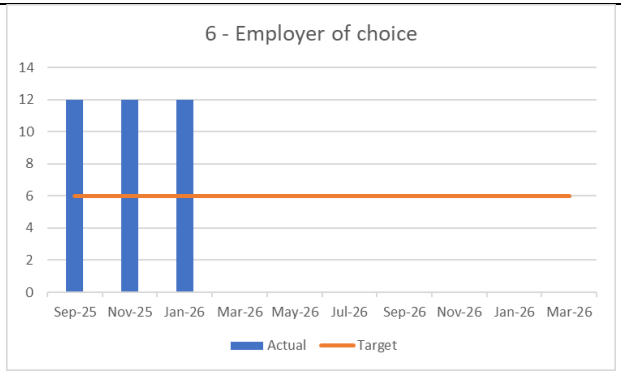
	Complete				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	To review the BAF for completeness, accuracy and triangulation against the assurances and risks discussed as part of the Board meeting, being assured that works continues to populate the controls, assurances and associated gaps.				
Trust strategic priorities that the report relates to:	☒	Excellent patient care			
	☒	Great place to work			
	☒	Working together for healthier communities			
	☒	Fit for the future			
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	All – as outlined on the BAF itself.				
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	Risks identified on the BAF				
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

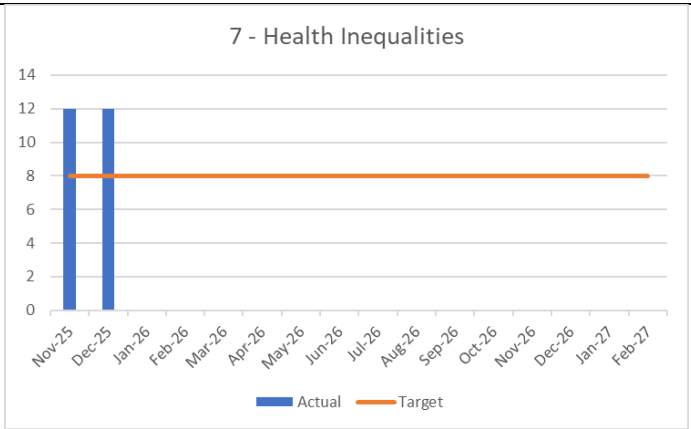
Board Assurance Framework – Summary from December 2025 / January 2026 Board Committee Meetings

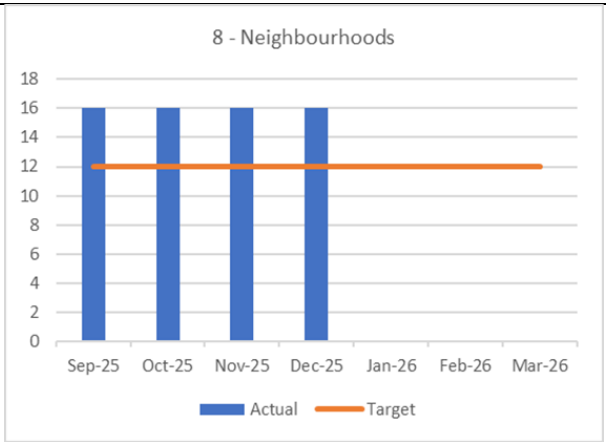
Strategic Objective	Summary risk	Risk scores	Overview
1) We will be a clinically-led organisation focused on delivering safe, high-quality care and improving health outcomes for our patients	There is a risk that decisions relating to the provision of care are made which are not reflective of the clinical voice. This may be due to the new model of clinical leadership not being fully embedded and therefore impacting upon the ability to inform strategic decision-making. This would result in a detrimental impact on patient care, safety and outcomes and disharmony amongst clinical leaders.		In November 2025 the Quality Governance Committee reviewed the BAF and reflected that more work was required to populate the controls and assurances. No change was proposed to the current score of 16. In December 2025 the Quality Governance Committee considered the BAF and noted that further controls, assurances and actions had been added following the previous meeting. The Committee noted the action to enhance clinical oversight of the Equality and Quality Impact Assessment (EQIA) process. No change was proposed to the current score of 16.
2) We will ensure our patients experience the best possible compassionate care and make every contact count	There is a risk that patients do not have the best possible experience due to a number of potential contributory factors. This would lead to patient dissatisfaction, poor reputation and poor staff morale.		In November 2025 the Quality Governance Committee reviewed the BAF and reflected that more work was required to populate the controls and assurances. No change was proposed to the current score of 12. In December 2025 the Quality Governance Committee considered the BAF and noted that further controls, assurances and actions had been added following the previous meeting. The Committee noted the action to enhance clinical oversight of the Equality and Quality Impact Assessment (EQIA) process. No change was proposed to the current score of 12.

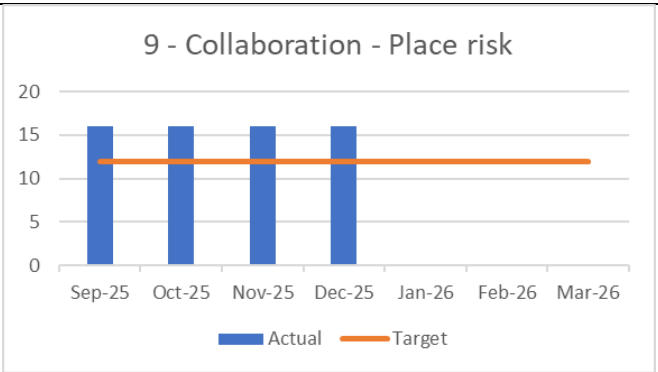
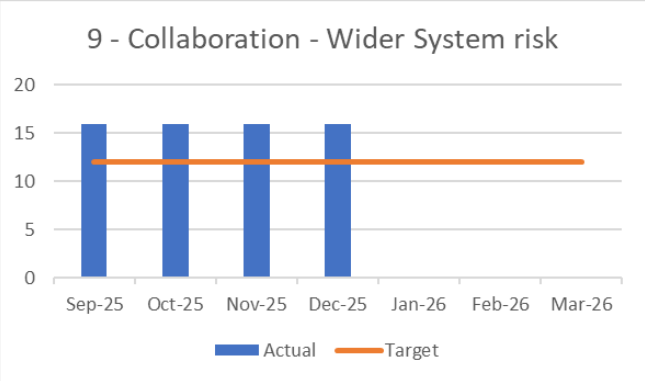
Strategic Objective	Summary risk	Risk scores	Overview
3) We will continually improve our services creating a restorative culture where learning, innovation and research can flourish	There is a risk that we do not achieve continuous improvement in the quality and safety of our services. This could be caused by poor organisational culture and a poor adoption / embedding of learning, research and development. This would impact on patient safety and our credibility and reputation as an innovative and quality-driven organisation.	 	In November 2025 the Quality Governance Committee reviewed the BAF and reflected that more work was required to populate the controls and assurances. No change was proposed to the current scores of 12 for the patient safety element of the risk and 16 for the research and innovation element of the risk. In December 2025 the Quality Governance Committee considered the BAF and noted that further controls, assurances and actions had been added following the previous meeting. No change was proposed to current risk scores of 12 for the patient safety element of the risk and 16 for the research and innovation element of the risk.

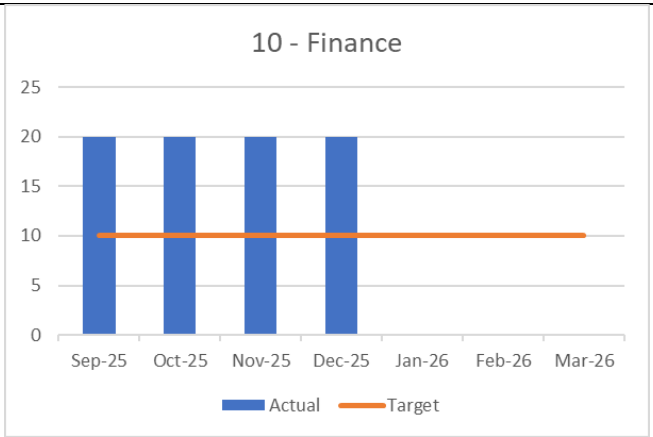
Strategic Objective	Summary risk	Risk scores	Overview
4) We will care for our people, creating a fair, inclusive and respectful environment where everyone can thrive in their role	There is a risk that the Trust's culture does not reflect the organisational values. This may be caused by poor behaviours which are not appropriately addressed and a lack of confidence that issues raised will be listened to and acted on. This could lead to low morale, high sickness absence, an inability to attract and retain staff and poorer patient outcomes.		At the September 2025 meeting the People and OD Committee members concurred with the current score of 16, which was reflective of some of the issues which had been raised as part of the agenda items. It was noted that further information could be added to the BAF for completeness following the discussions. At the November 2025 meeting the discussed the change to the incivility and disrespectful behaviours risk on the Organisational Risk Register (ORR), which had been reframed and de-escalated from the ORR. A discussion was held regarding the impact of this on the summary risk score of 16. Upon reflection it was agreed to retain the current score at 16, which reflected that the summary risk includes broader considerations around inclusivity. At the January 2026 meeting the Committee reflected on the significant amount of work undertaken in relation to the 10 Point Plan for resident doctors, sickness absence and violence and aggression. A number of updates were made to controls and assurances to reflect this. The Committee referred to the emerging staff survey results and the need to develop action plans following the full analysis. It was noted that whilst a risk relating to raising concerns had been de-escalated the Organisational Risk Register, there may be a need to reflect on this and re-articulate the risk at the next Executive Risk Management Group. The Committee agreed to retain the current score of 16.

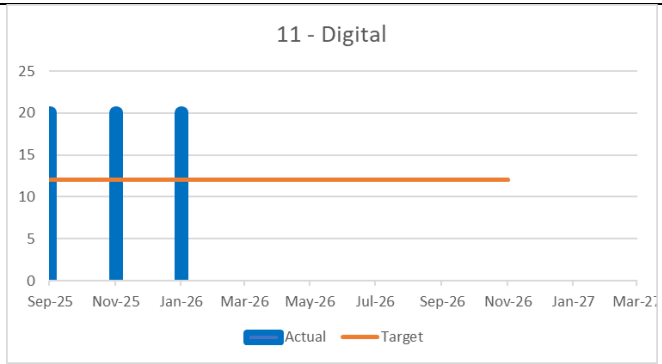
Strategic Objective	Summary risk	Risk scores	Overview
5) We will grow and develop our people with a focus on celebrating achievements and creating a culture of high performance and innovation	There is a risk that there is a failure to deliver equity in access to staff experience and career development opportunities. This may be caused by inequalities, financial constraints and other operational pressures to deliver performance. This could lead to a lack of capable and diverse talent pipelines and a failure to build sustainable leadership capacity at all levels and into the place, alliance and system.		At the September 2025 meeting the People and OD Committee members concurred with the current score of 12. At the meeting in November 2025 the POD Committee members agreed to retain the score of 12. At the meeting in January 2026 the Committee sought further assurance in relation to the apprenticeship levy position. The Committee agreed to retain the current risk score of 12.
6) We will be an employer and training provider of choice within the local community recognising our role as an anchor institution	There is a risk that the Trust is not seen as an employer or training provider of choice within the local community. This may be due to limited ability and reduced capacity to work with system partners. This may result in an inability to attract and retain talent from diverse backgrounds that reflect our community and could have a negative impact on patient outcomes.		At the September 2025 meeting the People and OD Committee members concurred with the current score of 12 and noted that further level 3 assurance could be added to reflect the Annual Dean's Quality Monitoring report which had been considered as part of the papers. At the meeting in November 2025 a number of updates were made to this BAF extract, including reflecting the work undertaken in relation to the Resident Doctors' 10 Point Plan. It was agreed to retain the score of 12. At the meeting in January 2026 the Committee noted the commitment to go beyond the requirements of the 10 Point Plan and deliver

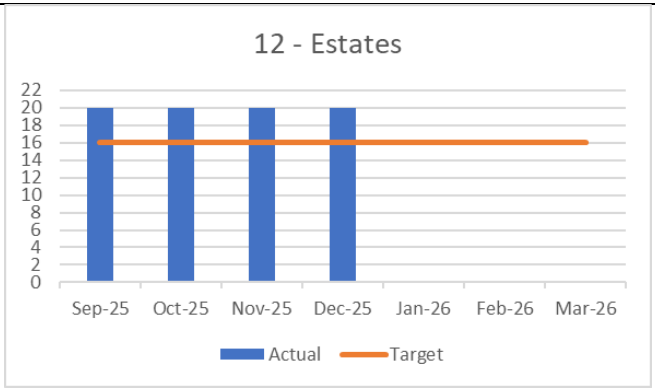
Strategic Objective	Summary risk	Risk scores	Overview
			improvements for wider cohorts of colleagues. Additional assurances were noted regarding the Guardian of Safe Working exception report and GMC (General Medical Council) survey. It was agreed to retain the current score of 12.
7) We will work in collaboration with our partners to improve the health of our population and reduce health inequalities	There is a risk that the Trust does not effectively collaborate with partners to maximise impact on health improvement in a way which reduces health inequalities for our Gateshead population. This may be caused by a lack of enabling access to data and resource due to historical and organisational barriers, cultural resistance, capacity and ability or appetite to make difficult decisions. This results in poor patient outcomes and an inability to deliver against the NHS 10 Year Plan sickness to prevention shifts		In November 2025 the Quality Governance Committee reviewed the BAF and reflected that more work was required to populate the controls and assurances. No change was proposed to the current score of 12. In December 2025 the Quality Governance Committee considered the BAF and noted that further controls, assurances and actions had been added following the previous meeting. No change was proposed to the current score of 12.

Strategic Objective	Summary risk	Risk scores	Overview
8) We will develop our neighbourhoods in line with the NHS 10 year plan	There is a risk that the ability to deliver care and prevention at neighbourhood and place level is not fully maximised. This may be caused by a lack of internal strategic resource to engage at this level or a lack of internal understanding of the neighbourhood concept resulting in a failure to co-create Neighbourhood health services. This results in poor patient outcomes and an inability to deliver against the NHS 10 Year Plan hospital to community shift		At the September 2025 meeting Finance and Performance Committee members noted the current score of 16, reflecting on the recent Board development session which set out the strategic landscape for neighbourhood working. No changes to the score of 16 were proposed. At the October 2025 meeting F&P members noted the importance of gaining traction on the neighbourhood agenda to fully deliver in this area. It was agreed to retain the score of 16. At the November 2025 meeting F&P members reflected that the neighbourhood framework and commissioning arrangements had not yet been published. It was noted that this is impacting upon the ability to make progress and driving the risk (the ambition and commitment of the Trust in relation to neighbourhoods is clear). No changes to the score of 16 were proposed. Since the meeting work has been undertaken by the Medical Director, Medical Director of Strategic Relations and Company Secretary to further populate this BAF area. At the December 2025 meeting the BAF was reviewed and no changes proposed to the score.

Strategic Objective	Summary risk	Risk scores	Overview
9) We will collaborate with system partners with an emphasis on maximising the efficient use of collective resources across health and care services	There is a risk that we are unable to utilise our collective resources across health and care services in a way that delivers value for money and the best outcomes for patients. This may be caused by a lack of effective engagement and collaboration within the Great North Healthcare Alliance, Place arrangements and wider partnerships. Contributing factors may include unclear governance arrangements, lack of clarity on leadership, differing organisational priorities and operational complexity in aligning resources and decision-making. This may result in missed opportunities to optimise service delivery, reduced ability to attract future funding and potential reputational impact if collaborative ambitions are not realised	 	In September 2025 Finance and Performance Committee members reflected that meeting discussions had identified several areas where Alliance and partnership working would be critical to maximising the efficient use of collective resources. It was noted that the BAF could be populated further to more accurately reflect the controls and assurance in place around both the Alliance and wider partnership working. In relation to the Alliance there was a discussion about the need to be clear on the memorandum of understanding and how this can drive improvement. A review of the governance of the Alliance is underway and the BAF has been updated to reflect this action. It was agreed to maintain the current score of 16. At the October 2025 meeting F&P members agreed to retain the current score of 16. At the November 2025 meeting F&P members reflected the impact of the change in ICB commissioning arrangements and the need to assess the impact on service funding. It was agreed to maintain the current score of 16 for both risks. Since the meeting work has been undertaken by the Medical Director, Medical Director of Strategic Relations and Company Secretary to further populate this BAF area.

Strategic Objective	Summary risk	Risk scores	Overview
			At the December 2025 meeting the BAF was reviewed and no changes proposed to the score.
10) We will ensure effective and efficient use of our resources identifying opportunities to improve productivity and ensure best use of public money	There is a risk that the Trust does not improve its financial sustainability and therefore fails to utilise public money to best effect. This may be caused by limited access to, or inconsistent understanding of, data, trends, forecasts, and improvement methodologies or lack of improvement culture / financial governance & accountability. This would result in reduced responsiveness to patient needs, an inability to meet financial targets and a loss of reputation and organisational autonomy.		In September 2025 Finance and Performance Committee members noted the assurances provided regarding achieving the financial plan for month 5. It was noted that additional controls and assurances could be added to the BAF for completeness. Discussions were held regarding what the Committee would expect to see to enable the current score to be reduced. The potential for reducing the likelihood to 3 (and therefore the overall score to 15) were debated, although no changes were agreed at that time. The Committee reflected that it would be beneficial for Executive Risk Management Group to review the underlying financial risks on the Organisational Risk Register and make a recommendation as to whether their risk scores should be lowered. This would then support the Committee in making decisions regarding the summary risk score. It was agreed to maintain the current score of 20. At the October 2025 meeting F&P members agreed to retain the current score of 20. It was noted that the planning information had been published earlier than usual, but the detailed documents to support this were still awaited. At the November 2025 meeting it was agreed to maintain the current score of 20.

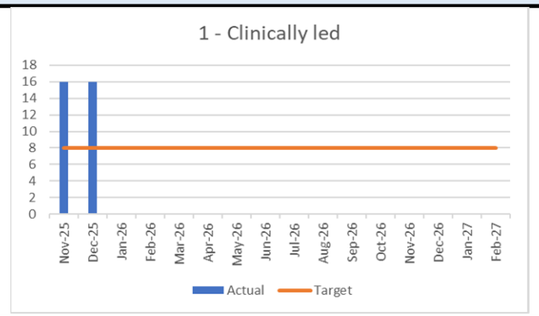
Strategic Objective	Summary risk	Risk scores	Overview
			At the December 2025 meeting the BAF was reviewed and no changes proposed to the score.
11) We will be a data informed, digitally enabled organisation using technology to transform the way we plan and deliver care	There is a risk that the Trust does not utilise digital technology effectively. This may be caused by a lack of a clear digital strategy, a lack of effective business continuity a lack of resource (e.g. financial, skilled people) and a lack of appropriate clinical input into decision-making. This may result in a lack of ability to utilise digital technology to support cultural transformation, productivity, efficiency, clinical safety and patient experience.		In November 2025 the Digital Committee noted that updates which had been made to the BAF regarding the confirmation of the SIRO role, the launch of the new strategy with its digital chapter and the remaining gaps in assurance relating to the Digital Records Programme. Sub-objectives may be needed to achieve the 5-year strategic goal. It was noted that the summary risk had linkages to People and OD and that whilst the Digital Committee would lead on this, there may be a need to obtain some input from the People and OD Committee from time to time. It was agreed to retain the current risk score of 20. In January 2026 the Committee discussed whether the implementation of the digital strategy would impact on the current risk score. It was agreed to retain the current score of 20 for now, pending evidence of impact of strategic delivery. A gap in control was added in relation to Clinical Safety Officer capacity and wider digital team skills. An additional gap was noted in relation to digital transformation assurance flowing to the Committee.

Strategic Objective	Summary risk	Risk scores	Overview
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	There is a risk that the Group will be unable to develop its estate in line with changing clinical requirements and may experience failure of critical infrastructure, as a result of insufficient capital investment, This could result in compromised patient safety, disruption to business continuity, reduced staff morale, non-compliance with statutory obligations, and failure to deliver on environmental sustainability commitments.		In September 2025 the Finance and Performance Committee discussed that the lack of an agreed estates strategy impacts on the ability to forward plan for 2026/27. It was recognised that there will be limited capital for 2026/27 and there would be a need to develop a realistic plan. The Committee felt the target risk score of 16 may not be ambitious enough and further reflection on this was required. It was agreed to maintain the current score of 20. At the October 2025 meeting F&P members agreed to retain the current score of 20. At the November 2025 meeting F&P members agreed to retain the current score of 20. At the December 2025 meeting the BAF was reviewed and no changes proposed to the score.

EXCELLENT PATIENT CARE

Strategic objective:	1) We will be a clinically-led organisation focused on delivering safe, high-quality care and improving health outcomes for our patients
Executive Owner:	Chief Nurse & Medical Director
Board Committee Oversight:	Quality Governance Committee
Date of Last Review:	Dec-25
Summary risk	

There is a risk that decisions relating to the provision of care are made which are not reflective of the clinical voice. This may be due to the new model of clinical leadership not being fully embedded and therefore impacting upon the ability to inform strategic decision-making. This would result in a detrimental impact on patient care, safety and outcomes and disharmony amongst clinical leaders.



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

Links to risks on the ORR:

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

4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (15)

~~4705 - Risk of considerable clinical and operational impact to patient care due to failure of PACS environment (15)~~ Risk agreed as closed at Executive Risk Management Group in Jan 26

4768 - Risk of demand overwhelming capacity over the 25-26 Winter period (16)

4525 - Risk of Lack of a strategic workforce planning (9)

NEW composite risk - Financial Sustainability - Risk of inability to invest in staff and clinical services, including supporting financial collaboration with partners.

NEW composite risk - Digital - Risk of an inability to sustain and advance our digital offer impacting on the delivery of optimal clinical care, staff engagement and experience and our ability to deliver transformation

NEW composite risk - Estates - Risk to sustainability of core infrastructure and to invest in clinical advances and the working environment for our staff

2341 - There is a risk to ongoing business continuity of service provision due to ageing trust estate (16)

Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
A Trust-wide definition of 'clinically led' is agreed, approved at Board and embedded into governance structures.	No formally agreed organisational definition of clinically led. Action - Develop and approve a standardised definition and embed within governance structures and job descriptions.	CEO	Jan-26	23/11/25 GHLG - TOR being reviewed by CEO	
Highlight clinical leaders and influencers working within GH.	Limited visibility of clinical opinion leaders and those contributing to external bodies. Action- Develop and maintain a register of clinical opinion leaders including external roles (NHSE, NICE, GIRFT, Royal Colleges).	MD/CN	Mar-26		
Minimum required clinical representation established for all decision-making forums	Clinical representation and contribution is inconsistent across some governance groups. Action- Implement minimum representation standards via TOR; monitor attendance of all TIER 2 groups; clinical representation report to GHLG for assurance.	MD/CN	Mar-26		

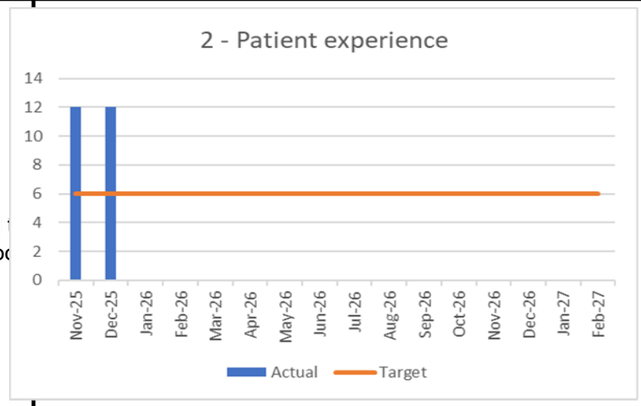
Effective triumvirate leadership model with defined roles, responsibilities and delegated authority in place.	Triumvirate roles, contribution and evidence of decision making variable by division. Action - Develop and implement a Trust-wide triumvirate accountability and decision-rights framework with linked governance.	MD	Mar-26		
Leadership capability: leadership development pathway for clinical leaders.	Leadership capability varies across triumvirates. Actions- Launch Leading Forward programme; scope wrap-around coaching and mentoring.	MD/CN	Dec-25	23/11/2025 - Program launched. Action recommended for closure	
A clinically led EQIA process requiring divisional sign-off before CN/MD approval.	EQIA clinical oversight inconsistent and not evidenced. Action -Review EQIA process; implement divisional clinical sign-off; establish EQIA assurance reporting to QGC.	MD/CN	Mar-26		
Strengthen NMAHP engagement and participation in key decision-making forums.	No NMAHP forum currently influencing decision making and workforce planning. Action- Re-establish NMAHP Professional Forum; embed structured reporting into GHLG. - Confirm numbers of NM&AHP staff working at enhanced, advanced and consultant level to ensure all have appropriate governance, supervision and forums for support and development	CN	Mar-26	23/11/25 NM&AHP forum being re-established from Jan 26 with TOR and reporting governance line Report commissioned by CN in relation to levels of advanced practice, location and banding. Feeding into GHLD & execs.	
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
Chief Nurse and Medical Director have operational oversight and sign-off of all EQIAs	EQIAs assurance reporting to be established to QGC - to outline provide assurance on process and decision making.	MD / CN	Feb-26		
Evidence of triumvirate decision-making within divisional governance reporting	Incorporate attendance matrix to all Tier 2 meetings. This can then be monitored and audited.	COO/ MD/ CN	Mar-26		
Attendance monitoring of clinical representatives at governance groups	Establish a standardised reporting framework for all senior professional forums (Medical, Nursing/Midwifery/AHP), ensuring that key themes, risks, decisions and escalation points are formally captured and submitted to GHLG	CN	Mar-26		
Senior professional forums (Medical Forum, Nursing/Midwifery/AHP Forum) providing direct operational feedback into governance structure	Conduct an annual well led review to provide assurance to board that all appropriate reports are feeding appropriately through the governance structure	CN / MD / Company secretary	Mar-26		
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
OOG & CSG 3A reporting to GHLG					
Maternity IOR report presented to the Board by the Associate Director of Midwifery/SCBU					
Monthly Executive Risk Management Group oversight of divisional and corporate clinical risks					

Quality Governance Committee oversight of PSII actions, EQIAs, clinical standards and divisional governance outputs	[redacted]					
POD Committee oversight of leadership development, workforce sustainability and succession planning	[redacted]					
Structured reporting from professional forums (medical, nursing, AHP) into GHLG	[redacted]					
Assurance (Level 3 – external)	[redacted]					
	[redacted]					
	[redacted]					
	[redacted]					
	[redacted]					

EXCELLENT PATIENT CARE

Strategic objective:	2) We will ensure our patients experience the best possible compassionate care and make every contact count
Executive Owner:	Chief Nurse, Medical Director and Chief Operating Officer
Board Committee Oversight:	Quality Governance Committee
Date of Last Review:	Dec-25
Summary risk	

There is a risk that patients do not have the best possible experience due to a number of potential contributory factors. This would lead t patient dissatisfaction, poor reputation and poo staff morale.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
4	3	12	2	3	6

Links to risks on the ORR:

~~4705 - Risk of considerable clinical and operational impact to patient care due to failure of PACS environment (15)~~ Risk agreed as closed at Executive Risk Management Group in Jan 26

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

2341 - There is a risk to ongoing business continuity of service provision due to ageing trust estate (16)

4734 - Risk of patient harm due to variability in meeting 4 hour ED Emergency Care standard (increased from 8 to 12)

2984 - There is a risk to our ability to continue to run maternity services from the designated building due to a catastrophic failure of the steam supply, resulting in enactment of a business continuity plan (20)

4768 - Risk of demand overwhelming capacity over the 25-26 Winter period (16)

NEW composite risk - Financial Sustainability - Risk of inability to invest in staff and clinical services, including supporting financial collaboration with partners.

NEW composite risk - Digital - Risk of an inability to sustain and advance our digital offer impacting on the delivery of optimal clinical care, staff engagement and experience and our ability to deliver transformation

NEW composite risk - Estates - Risk to sustainability of core infrastructure and to invest in clinical advances and the working environment for our staff

4704 - Risk of failure to review appropriate clinical information due to multiple sources of data stored across a variety of digital systems (16)

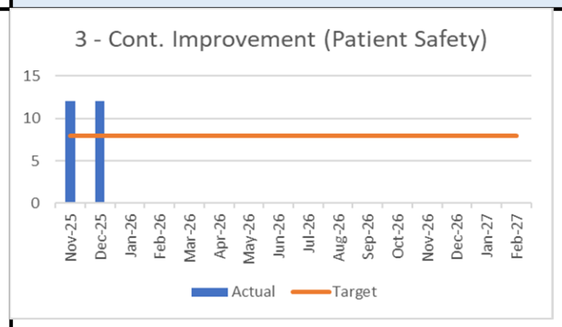
Controls		Gap in controls and corrective action	Owner	Timescale	Update	Action status
PSIRF policy and plan in place		EQIA clinical oversight inconsistent and not evidenced. Action -Review EQIA process; implement divisional clinical sign-off; establish EQIA assurance reporting to QGC.	MD/CN	Mar-26		

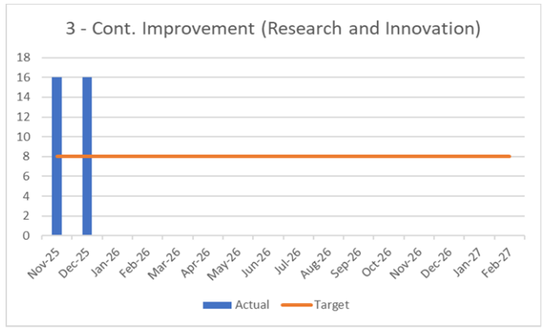
Quality priorities in place with 2 specific priorities focussed on patient experience (timeliness of complaints and strengthening voluntary workforce) and 2 on patient safety (eliminating unnecessary waits and implementing the Maternity 3 Year Delivery Plan)	Learning Disability, Mental Health and Autism Group in development	Chief Nurse	Mar-26		
Falls workstream in place with a focus on improving patient safety and experience	Quality Improvement Plan in development which will align with the CQC Fundamental Standards	Chief Nurse	Mar-26		
New learning forum in place - Safety Huddle	Limited triangulation of patient experience data. Action to review the terms of reference of the Patient Experience Group to further support triangulation and enable reporting to SafeCare	Chief Nurse	Mar-26		
Patient experience team and PALS team in place	A need to revise the terms of reference of SafeCare Steering Group to ensure there is appropriate time allocated for a focus on patient stories and patient feedback	Chief Nurse	Mar-26		
Cancer Lead Nurse in post					
Process in place for tracking quality priorities					
Volunteer service in place					
EQIA process					
MVP in place					
Maternity Safety Champion in place					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
Oversight of key metrics through the Patient Experience Group	Surgical Site Infections - consolidated action plan developed and a formal report to be presented to the Quality Governance Committee	Chief Nurse	Oct-25		
Oversight of key metrics through the Safecare Steering Group	Learning Disability, Mental Health and Autism Group meeting but 3A assurance reporting not flowing into GHLG	Chief Nurse	Dec 25		
Quality priorities tracked	SafeCare currently doesn't hear directly about the experiences of patients. This will be addressed through addition of an enhanced report / agenda item which will include a patient story to the Group	Chief Nurse	Mar-26		
New Safety Huddle meeting every two months to share learning across the organisation	Feedback from Board walkabouts no longer being formally documented and therefore no reported to Board. Action - review process and reporting	Chief Nurse	Mar-26		
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					

Patient experience metrics reported to Quality Governance Committee					
Patient experience metrics reported to the Board as part of the performance report					
Safecare Steering Group reports to Gateshead Health Leadership Group through the 3A report with opportunity to escalate any significant patient experience issues					
PLACE visits conducted weekly with representation from volunteers and Governors					
15 Step programme in place					
New Maternity Safety Board report captures feedback from Maternity and Neonatal Voices Partnership					
Quality priorities and progress against these formally reported to the Quality Governance Committee, SafeCare Steering Group					
Quality priorities and their progress formally reported to ICB and the local authority					
Volunteer representatives formally attend the Patient Experience Group					
Falls workstream reports into SafeCare					
Cancer Group reports to GHLG					
Walkabout Wednesdays in place provide protected time for the Board to visit services and speak with patients and colleagues					
Patient stories featured at Board					
Assurance (Level 3 – external)					
Cancer Patient Experience Survey - 9.2 out of 10					
CQC Maternity patient survey - top performing trust					
Adult Inpatient Survey - 12th of out 61 organisations					
Children's Bladder and Bowel Service awarded Gold Standard for Autism					

EXCELLENT PATIENT CARE	
Strategic objective:	3) We will continually improve our services creating a restorative culture where learning, innovation and research can flourish
Executive Owner:	Medical Director
Board Committee Oversight:	Quality Governance Committee
Date of Last Review:	Dec-25
Summary risk	

There is a risk that we do not achieve continuous improvement in the quality and safety of our services. This could be caused by poor organisational culture and a poor adoption / embedding of learning, research and development. This would impact on patient safety and our credibility and reputation as an innovative and quality-driven organisation.





	CURRENT RISK SCORE			TARGET RISK SCORE		
	Likelihood	Impact	Score	Likelihood	Impact	Score
Patient safety risk:	3	4	12	2	4	8
Risk of not embedding R&D and innovation	4	4	16	2	4	8

Links to risks on the ORR:

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

4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (15)

~~4772 - Risk of Potential instability of the Board of Directors due to secondment of Chief Executive Officer.(12)~~ Risk closed

NEW composite risk - Financial Sustainability - Risk of inability to invest in staff and clinical services, including supporting financial collaboration with partners.

NEW composite risk - Digital - Risk of an inability to sustain and advance our digital offer impacting on the delivery of optimal clinical care, staff engagement and experience and our ability to deliver transformation

NEW composite risk - Estates - Risk to sustainability of core infrastructure and to invest in clinical advances and the working environment for our staff

Controls		Gap in controls and corrective action	Owner	Timescale	Update	Action status
EQIA process in place for all policies and major service changes						
Innovation Manager is a dedicated post in the Trust						
New learning forum in place						
Research and development team in place						
Clinical audit programme in place						

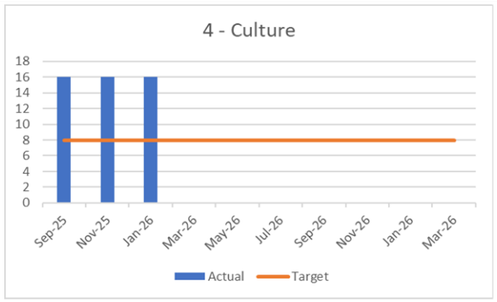
Clinical audit processes revised to include new escalation process and increased resource					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
Audit and Effectiveness Group reports to Safecare Steering Group					
Research and Development tier 3 meeting reporting to CSG					
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Clinical audit reporting to Quality Governance Committee on outcomes, learnings and improvements					
Clinical audit reporting to Group Audit Committee on the processes and controls for the development and delivery of the clinical audit plan					
Safecare Steering Group reports to Gateshead Health Leadership Group through the 3A report with opportunity to escalate any significant issues relating to this remit					
Assurance (Level 3 – external)					
Children's Bladder and Bowel Service awarded Gold Standard for Autism					

GREAT PLACE TO WORK

Strategic objective:	4) We will care for our people, creating a fair, inclusive and respectful environment where everyone can thrive in their role
Executive Owner:	Executive Director of People & OD
Board Committee Oversight:	People and OD Committee
Date of Last Review:	Jan-26
Summary risk	

There is a risk that the Trust's culture does not reflect the organisational values.

This may be caused by poor behaviours which are not appropriately addressed and a lack of confidence that issues raised will be listened to and acted on. This could lead to low morale, high sickness absence, an inability to attract and retain staff and poorer patient outcomes.



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

Links to risks on the ORR:

3132 - Exposure to incidents of violence and aggression (16). Agreed via ERMG on 06/01 to reduce to 12.

NEW composite risk - Financial Sustainability - Risk of inability to invest in staff and clinical services, including supporting financial collaboration with partners.

NEW composite risk - Digital - Risk of an inability to sustain and advance our digital offer impacting on the delivery of optimal clinical care, staff engagement and experience and our ability to deliver transformation

Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Health and wellbeing offer in place	FTSU Guardian temporarily absent - recruitment of an interim Guardian underway	Executive Director of POD	Sep-25	Complete - Interim appointed	
Zero tolerance campaign continues to be delivered	Instances of poor behaviours - incivility, discrimination, harassment still taking place. Continue to promote culture of speaking out, hold people to account and take appropriate action	Executive Director of POD	Ongoing	Ongoing action - mark as complete, but retain on the BAF	
FTSU Champions in place	Triangulation of lessons learned from POD with the Trust Learning panel	Head of People Advisory	Feb-26		
Absence taskforce in place	Continued instances of Violence and Aggression towards staff. Action to ensure that training targeted at the right cohort of staff	Executive Director of POD	Mar-26		
New prevention of violence at work policy developed	To develop an action plan to address the emerging findings of the staff survey	Executive Director of POD	Mar-26		
Staff networks in place					
EQIA process in place for all policies and major service changes					
Interim FTSU Guardian in place					
Annual staff survey and quarterly staff survey takes place					

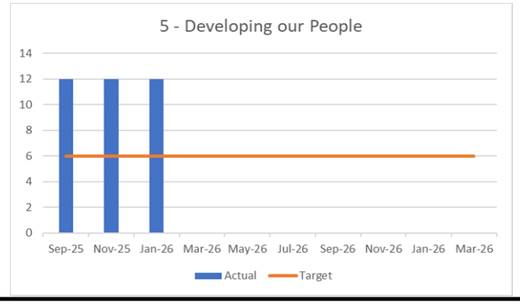
EDI Policy being updated					
Engagement with the staff network chairs					
Sexual Safety Policy in place					
Bullying and Harassment policy in place					
Culture Insight and triangulation meeting in place					
People policies in place re: absence and leave provisions					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
Staff Experience and EDI Group to seek assurance over culture at Tier 3 level - new group triangulating information on culture	Some gaps in assurance around the triangulation of data and themes specifically with staff experience and EDI, which the merged Tier 3 Group seeks to address.	Executive Director of POD	Oct-25	New group met with engaged membership and TOR agreed. Agreed to close	
POD team meetings to review metrics and indicators	Some gaps identified on assurance of staff survey actions being taken by the business units to demonstrate changes made. Corrective action to refresh the approach for next year, aligned to the medium term planning framework. Going to Staff Experience and Inclusion group in December	Head of Staff Experience	01/01/2026		
POD Steering group well embedded with engaged membership. Reviews metrics and decision making enabled					
Staff survey action plans in place					
Positive reduction noted in long term sickness absence data.					
Violence and aggression 3A report presented to the POD Steering Group					
Regular Review of Lesson Learnt take place					
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Assurance reports to POD Committee re: staff survey outcomes and action plans					
POD Committee receives deep dive assurance reports on sickness absence					
POD Committee receives assurance reports on the actions as a result of recent cultural reviews					
Sick absence report provides assurance over progress (including regional position for context) and confirmed closure of the absence task force					
Progress reported to Committee re: the progress with the 10 Point Plan for resident doctors					

EDI reporting to POD Committee including progress against the EDI strategy						
Assurance (Level 3 – external)						
Occupational Health SEQOSH accredited						

GREAT PLACE TO WORK

Strategic objective:	5) We will grow and develop our people with a focus on celebrating achievements and creating a culture of high performance and innovation
Executive Owner:	Executive Director of People & OD
Board Committee Oversight:	People and OD Committee
Date of Last Review:	Jan-26
Summary risk	

There is a risk that there is a failure to deliver equity in access to staff experience and career development opportunities. This may be caused by inequalities, financial constraints and other operational pressures to deliver performance. This could lead to a lack of capable and diverse talent pipelines and a failure to build sustainable leadership capacity at all levels and into the place, alliance and system.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
3	**4**	**12**	**2**	**3**	**6**

Links to risks on the ORR:

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

4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (15)

4525 - Risk of Lack of a strategic workforce planning (9)

NEW composite risk - Financial Sustainability - Risk of inability to invest in staff and clinical services, including supporting financial collaboration with partners.

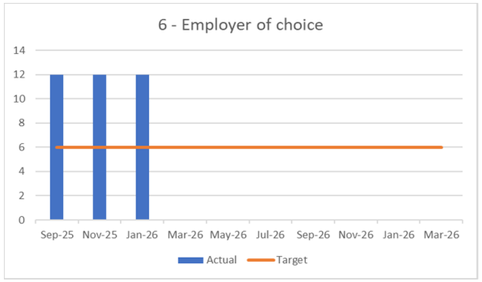
Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
New leadership and management programme - Leading Forward - launched	Level 7 apprenticeship funding changes will create a gap in leadership development opportunities.	Head of Staff Experience	Jan-26		
People plan in place as part of annual planning	Lack of 10 year workforce plan to support the NHS 10 yr plan - delayed. Once received will need reviewed and implemented in a planed and achievable way.	Executive Director of POD	Mar-26		
Medical staffing function strengthened	Clinical Placement capacity remains a challenge for students, trainees and apprentices. To be reviewed via the E&T group and any proposals scoped and shared.	Head of Staff Experience	Mar-26		
Controls in place to prevent unintentional workforce growth					
Reinvigoration of Star Awards to celebrate success					
Monthly You're a Star award presented by the Chair					
Recruitment process ensures appropriate focus on minimising bias					
Mid-year planning submission completed					

Education and Training group established containing Professional Leads, corporate reps and operational colleagues					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
POD team meetings to review metrics and indicators	Apprenticeship levy underutilisation risk due to funding changes; need for a clear plan to maximise use and align with workforce strategy.	Head of Staff Experience	Jan-26	Jan 26 - There is a need for further analysis on the apprenticeship levy position and the likely impact	
POD Steering Group and supporting groups in place					
Q1 EDI dashboard					
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
POD Committee receives assurance updates on key workforce and employment metrics through the People Metrics report					
WRES and WDES Metrics and Reports reviewed at POD Committee and Board					
Assurance (Level 3 – external)					
ADQM Outcome Report					
CPD submission shared with NHS England					

GREAT PLACE TO WORK

Strategic objective:	6) We will be an employer and training provider of choice within the local community recognising our role as an anchor institution
Executive Owner:	Executive Director of People & OD
Board Committee Oversight:	People and OD Committee
Date of Last Review:	Nov-25
Summary risk	

There is a risk that the Trust is not seen as an employer or training provider of choice within the local community. This may be due to limited ability and reduced capacity to work with system partners. This may result in an inability to attract and retain talent from diverse backgrounds that reflect our community and could have a negative impact on patient outcomes.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
4	**3**	**12**	**2**	**3**	**6**

Links to risks on the ORR:

4525 - Risk of Lack of a strategic workforce planning (9)

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

4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (15)

2341 - There is a risk to ongoing business continuity of service provision due to ageing trust estate (16)

NEW composite risk - Financial Sustainability - Risk of inability to invest in staff and clinical services, including supporting financial collaboration with partners.

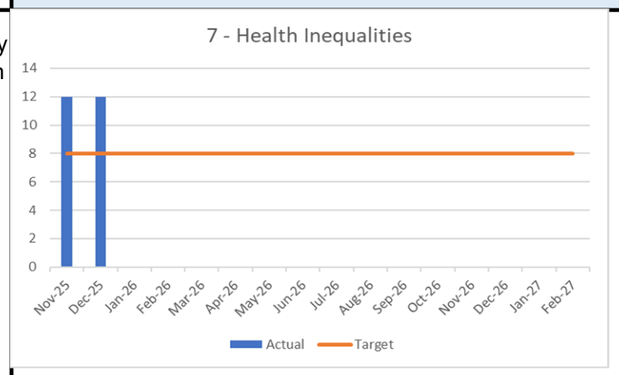
Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
New leadership and management programme - Leading Forward - launching imminently	Ongoing need to improve communication and clarity around consultation vs. engagement in change process	Deputy Director of POD	Nov-26	Complete - updated consultation template, using for all consultations	
People plan in place as part of annual planning	Sexual safety/harassment training not mandatory. Discussion with the RDPL to develop awareness session in the Resident Doctor induction.	Head of Staff Experience	Feb-26		
Medical staffing function strengthened	Resident doctors are still required to complete some local training at induction, despite national agreements to accept prior training. Blood Transfusion training is under review.	Head of Staff Experience	Mar-26		
Festive meal vouchers to be used as a thank you initiative	Limiting numbers of places being made available for T Level students, schools outreach and work experience students due to capacity. To be reviewed on an ongoing basis to assess impact	Head of Staff Experience	Nov-27		
Actions plans in place for any areas of the 10 Point Plan for Resident Junior Doctors that are not yet currently met.					

Appointment of the Senior Lead for Resident Doctor Experience and appointment of the Resident Doctor Peer Lead for resident doctor experience.					
Increased OD support for organisational change, including documentation and frameworks for managers					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
POD team meetings to review metrics and indicators	Delay in launching Learning Disability pledge	EDI Manager	Dec-26		
POD Steering Group and supporting groups in place	Resident doctors should never experience payroll errors due to rotations - with board-level governance framework to monitor and report payroll accuracy. To form part of the standard Medical Workforce Metrics to report via AAA to PSG and PODC.	Head of Staff Experience	Mar-26		
Experience and Inclusion group established with broad engaged membership					
Initial self-assessment against 10 Point Plan for Resident Junior Doctors highlighted the Trust meets (or partially) meets the majority of points in the plan.					
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
POD Committee receives quarterly assurance from the Guardian of Safe Working					
GMC survey results reviewed by POD Committee for assurance					
Reporting of the Resident Doctor 10 Point Plan to POD Committee					
Committee assured plans are in place to go beyond the requirements of the 10 Point Plan for resident doctors to apply the principles to for other cohorts of colleagues					
Committee receives Guardian of Safe Working Exception report					
Assurance (Level 3 – external)					
ADQM report provides external assurance - Sept 25					
GMC report received					

EXCELLENT PATIENT CARE

Strategic objective:	7) We will work in collaboration with our partners to improve the health of our population and reduce health inequalities
Executive Owner:	Medical Director (& Medical Director of Strategic Relations)
Board Committee Oversight:	Quality Governance Committee
Date of Last Review:	Dec-25
Summary risk	

There is a risk that the Trust does not effectively collaborate with partners to maximise impact on health improvement in a way which reduces health inequalities for our Gateshead population. This may be caused by a lack of enabling access to data and resource due to historical and organisational barriers, cultural resistance, capacity and ability or appetite to make difficult decisions. This results in poor patient outcomes and an inability to deliver against the NHS 10 Year Plan sickness to prevention shifts



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

Links to risks on the ORR:

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

4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (15)

4704 - Risk of failure to review appropriate clinical information due to multiple sources of data stored across a variety of digital systems (16)

~~4772 - Risk of Potential instability of the Board of Directors due to secondment of Chief Executive Officer.~~(12) Risk closed

NEW composite risk - Financial Sustainability - Risk of inability to invest in staff and clinical services, including supporting financial collaboration with partners.

NEW composite risk - Digital - Risk of an inability to sustain and advance our digital offer impacting on the delivery of optimal clinical care, staff engagement and experience and our ability to deliver transformation

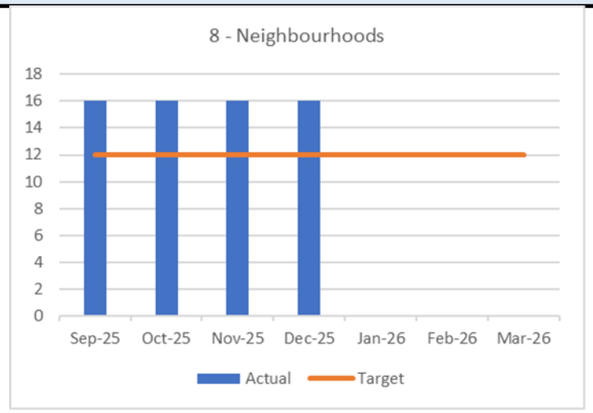
Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Health Inequalities Group in place	Lack of operational engagement in the Health Inequalities Group and Equitable Elective Recovery workstream - in terms of representation and data.	MD	Feb-26		
Public Health engagement and involvement in health inequalities within the Trust	Health Inequalities Ambassadors not yet in place	MD	Mar-26		
Health inequalities workplan in place	Lack of visibility of health inequalities through Trust comms channels	MD	Mar-26		
Board Development session held to commence discussions on strategic positioning re: health inequalities and neighbourhood health	Lack of embedding of health inequalities throughout the Trust - not captured as part of the decision-making process. Review of EQIA process and business case template to incorporate consideration of HE	MD & CN	Mar-26		

Key priorities identified following a review by the Specialty Registrar in Public Health Medicine					
Significant engagement at Place including the CEO chairing the Gateshead Place Committee					
Engagement in the Community Promise at Alliance level					
Practitioners recruited into the HIVE programme to address health inequalities in the lung cancer pathway					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Health Inequalities Group reports to Gateshead Health Leadership Group (GHLG) via 3A reporting					
Health inequalities assurance reporting to Quality Governance Committee					
Assurance reports on Place engagement presented to Quality Governance Committee					
Assurance (Level 3 – external)					

WORKING TOGETHER FOR HEALTHIER COMMUNITIES

Strategic objective:	8) We will develop our neighbourhoods in line with the NHS 10 year plan
Executive Owner:	Medical Director (& Medical Director of Strategic Relations)
Board Committee Oversight:	Finance and Performance Committee
Date of Last Review:	Dec-25
Summary risk	

There is a risk that the ability to deliver care and prevention at neighbourhood and place level is not fully maximised. This may be caused by a lack of internal strategic resource to engage at this level or a lack of internal understanding of the neighbourhood concept resulting in a failure to co-create Neighbourhood health services . This results in poor patient outcomes and an inability to deliver against the NHS 10 Year Plan hospital to community shift



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

Links to risks on the ORR:

4713 - Risk of not delivering our sustainable future CRP on a recurring basis (16)

4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (15)

NEW composite risk - Financial Sustainability - Risk of inability to invest in staff and clinical services, including supporting financial collaboration with partners.

Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Medical Director of Strategic Relation and Director of Strategy in place to provide senior leadership	Neighbourhood Health Planning Framework and Model Neighbourhood Framework not yet published nationally. Due to be published in November 2025 by NHS England - once published they will assist in developing the next steps	Medical Director	Jan-26	National guidance documents awaited	
Board Development session held to commence discussions on strategic positioning re: neighbourhood health	Governance not yet clear on neighbour and place-based structures at present. Action - active dialogue between Trust Executives, Local Authority and partner organisations to develop the governance and reporting	CEO and MD of Strategic Relations	Mar-26		
Appropriate director level attendance at Gateshead Overview and Scrutiny and Health and Wellbeing Boards	National information regarding specifics of 'how' to deliver is not yet clear - awaiting NHSE framework for neighbourhoods. Note gap - not within our control, but important to note	N/a	N/a	N/a	
Trust Strategy and Clinical Strategy feature 3 shifts, 10 Year Plan prominently - i.e. alignment of clinical plans, including focus on neighbourhood	Succession plan required for leading neighbourhood work following planned retirement of Medical Director of Strategic Relations	CEO and MD of Strategic Relations	Mar-26		
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**

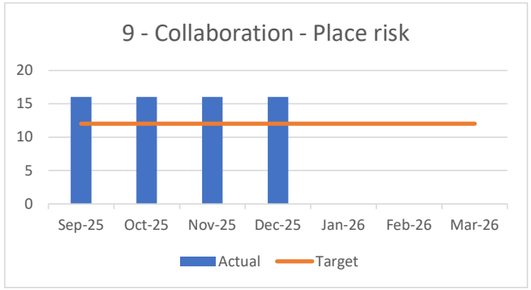
	[redacted]	Workplans in their infancy against draft strategies.	MD of Strategic Relations	Apr-26	Clinical strategy to be signed off at Jan Board with workplans then to follow	
		Currently neighbourhood work does not flow through the governance structure and there is a need to define this and ensure it is clear from Tier 3 through to Board committee assurance. To address through the governance structure review led by the CEO	CEO / MD / MD Strategic Relations / Co Sec	Mar-26		
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Alliance plan progress report (Oct 25) provides assurance over 2 workstreams linked to neighbours - milestones re: primary / secondary care compact and co-design of neighbourhood work marked as 'green'						
Assurance (Level 3 – external)						

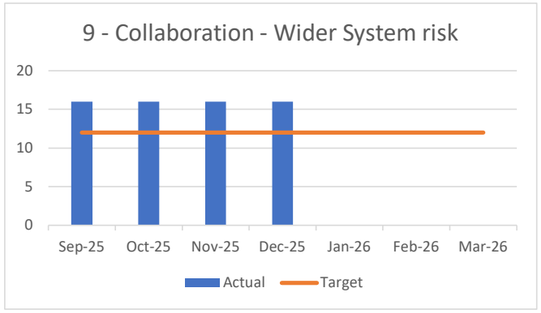
WORKING TOGETHER FOR HEALTHIER COMMUNITIES

Strategic objective:	9) We will collaborate with system partners with an emphasis on maximising the efficient use of collective resources across health and care services
Executive Owner:	Group Director of Finance (& Medical Director of Strategic Relations)
Board Committee Oversight:	Finance and Performance Committee
Date of Last Review:	Dec-25
Summary risk	

There is a risk that we are unable to utilise our collective resources across health and care services in a way that delivers value for money and the best outcomes for patients. This may be caused by a lack of effective engagement and collaboration within the Great North Healthcare Alliance, Place arrangements and wider partnerships. Contributing factors may include unclear governance arrangements, lack of clarity on leadership, differing organisational priorities and operational complexity in aligning resources and decision-making.

This may result in missed opportunities to optimise service delivery, reduced ability to attract future funding and potential reputational impact if collaborative ambitions are not realised





	CURRENT RISK SCORE			TARGET RISK SCORE		
	Likelihood	Impact	Score	Likelihood	Impact	Score
Place aspect of risk:	4	4	16	3	4	12
Wider system aspect of risk:	4	4	16	3	4	12

Links to risks on the ORR:	4713 - Risk of not delivering our sustainable future CRP on a recurring basis (16) 4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (15) 4734 - Risk of patient harm due to variability in meeting 4 hour ED Emergency Care standard (increased from 8 to 12) NEW composite risk - Financial Sustainability - Risk of inability to invest in staff and clinical services, including supporting financial collaboration with partners.

Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Appropriate director level attendance at Gateshead Overview and Scrutiny and Health and Wellbeing Boards	Work is underway to align constitutions around Chair provisions	Company Secretary	Jan-26	Sept 25 - collaborative working with NUTH and NHCT supported with legal advice	
Senior engagement in Gateshead Cares meetings	Work is underway via the Alliance Formation Team to review and revise the terms of reference for the Committee in Common and Joint Committee. This will be presented to Board for approval in December 2025	Company Secretary	~~01/12/2025~~ Jan 26	December Alliance meetings cancelled and therefore to be reconsidered in January 2026. Timescale amended accordingly	
	Governance not yet clear on neighbour and place-based structures at present. Action - active dialogue between Trust Executives, Local Authority and partner organisations to develop the governance and reporting	CEO and MD of Strategic Relations	Mar-26		
Direct engagement with GPs and PCNs through PCN Lead meetings	ICB commissioning function changing - to understand the impact on services from the cessation of funding	COO / Director of Finance	Mar-26		

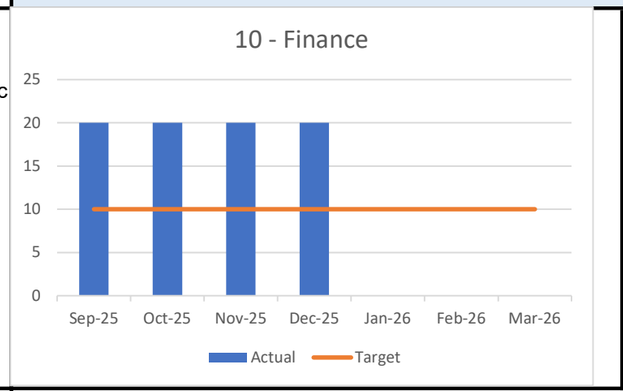
Systems approach taken to winter planning	[redacted]					
Strong representation at the Alliance for GHFT - Committee in Common, Joint Committee, Alliance Formation Team						
Weekly meetings of Alliance CEOs						
Shared Chair in place from 1/10/25						
Governor events held across the Alliance						
Alliance risk management framework in place						
Governor engagement across the Alliance through Lead Governors						
Jointly funded Quality Assurance Manager role in place with NUTH to support larger scale collaborative research and commercial opportunities						
Strong engagement and representation at the Primary Care and Secondary Care Interface meetings to support shift to care in the community						
Regular Executive Director meetings across Alliance on specific pieces of work e.g. financial plan development						
Collaboration with other providers and Provider Collab re MMC						
Collaborative approach to capital in place with Alliance and Provider Collaborative partners						
Second Alliance Governor event held 24 October						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
Regular updates to internal leadership forums on place, Alliance and system working - e.g. via Gateshead Health Leadership Group		Currently neighbourhood work does not flow through the governance structure and there is a need to define this and ensure it is clear from Tier 3 through to Board committee assurance. To address through the governance structure review led by the CEO	CEO / MD / MD Strategic Relations / Co Sec	Mar-26		
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Alliance updates shared at Board						
Committee in Common and Joint Committee minutes and 3A reports presented at Trust Board						
Considered approach taken to pause CDC Phase 2 with NUTH to ensure the Trusts are able to utilise the facility effectively and efficiently - approved at Board Sept 25						
MMC reporting to Board - decision-making, risk sharing, finance						
Assurance (Level 3 – external)						

FIT FOR THE FUTURE

Strategic objective:	10) We will ensure effective and efficient use of our resources identifying opportunities to improve productivity and ensure best use of public money
Executive Owner:	Group Director of Finance / Chief Operating Officer
Board Committee Oversight:	Finance and Performance Committee
Date of Last Review:	Dec-25
Summary risk	

There is a risk that the Trust does not improve its financial sustainability and therefore fails to utilise public money to best effect. This may be caused by limited access to, or inconsistent understanding of, data, trends, forecasts, and improvement methodologies or lack of improvement culture / financial governance & accountability.

This would result in reduced responsiveness to patient needs, an inability to meet financial targets and a loss of reputation and organisational autonomy.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	2	5	10

Links to risks on the ORR:

4713 - Risk of not delivering our sustainable future CRP on a recurring basis (16)

4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (15)

~~4714 - 2025-26 planned activity is not achieved resulting in the Trust not achieving planned income targets (9)~~ Risk removed from the ORR

4704 - Risk of failure to review appropriate clinical information due to multiple sources of data stored across a variety of digital systems (16)

NEW composite risk - Financial Sustainability - Risk of inability to invest in staff and clinical services, including supporting financial collaboration with partners.

NEW composite risk - Estates - Risk to sustainability of core infrastructure and to invest in clinical advances and the working environment for our staff

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

4702 - Reducing cash balance increases the risk of the Group having to access revenue cash support during 2025-26 (16)

Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Annual plan developed and in place	Medium term financial plan in development with Alliance partners as part of the Joint Committee working	DoF	Dec-25	Regular Alliance DoF meetings in place - frequency increased in planning round	
Agreed budgets in place for each division and corporate area	High level of vacancies within the finance team - this is being addressed through the implementation of a new operating model.	DoF	Mar-26	Recruitment underway alongside a supporting development plan for the whole team	
Corporate Governance Manual updated and approved at the Sept 25 Board meeting (SFIs, Standing Orders and Scheme of Delegation)	Target operating models for all corporate functions not yet signed off - to be presented through CRP Steering Group	DoF	Oct-25	Dedicated GHLG meetings held during Jan 26 to develop CRP 10% plans for each corporate and operational division. Work is ongoing to develop 25-27 plan, but this related to 25-26 and therefore action recommended for closure	
Securing Our Sustainable Future work programme developed					
Post recruited to lead the Sustainable Future work					
Financial accountability framework in place					

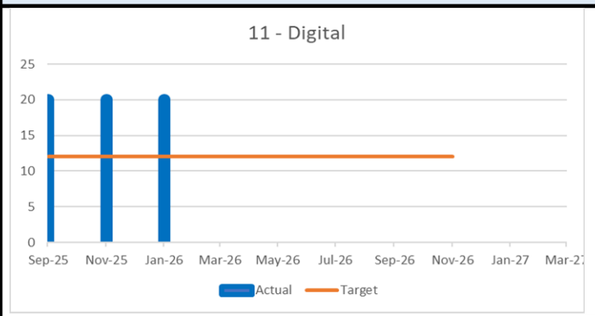
Internal planning framework in place with clear roles and responsibilities and agreed timetable (in absence of detailed guidance from NHSE) - planning to proceed with clearly defined internal assumptions to ensure no internal delay					
Internal audit plan agreed for 25-26					
There is a risk that the Trust does not improve its financial sustainability and therefore fails to utilise public money to best effect. This may be caused by limited access to, or inconsistent understanding of, data, trends, forecasts, and improvement me					
Model Hospital Data and corporate benchmarking used to support productivity and efficiency plans					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
New Key Indicators report circulated to leadership team on a weekly data to provide timely insight into performance	Performance reporting to be realigned to the new strategic priorities and objectives to maximise productivity and efficiency	DoF / COO	Mar-26	Year end timescale set to reflect capacity constraints and prioritisation of planning and statutory obligations	
CRP Steering Group in place to seek assurance over plans and their delivery					
Peer benchmarking e.g. corporate services benchmarking across Alliance reported to Tier 2 groups					
Cash monitoring and scenario modelling in place with options appraisal to manage risk - reported to FFPAG					
Strategic planning group meets weekly with agreed terms of reference/ purpose to seek assurance that planning is on track					
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Monthly finance and CRP reporting to Finance and Performance Committee and Board which report on the underlying financial position					
Quarterly reporting to the Council of Governors on finance and wider performance, including updates on the Sustainable Future work					
Reporting to Board on financial, operational, quality and people performance against plan					
QEF financial performance reported to F&P Committee					
Update on CRP delivered to the Council of Governors workshop - Oct 25					
Improved reporting to F&P Committee re: cash modelling and scenario forecasting					
Initial submission of the medium term plan approved by Board in December 25					

Workshops held with the Board and Council of Governors in respect of the medium term plan	[redacted]					
Assurance (Level 3 – external)						
NHS Oversight Framework ratings and league tables now published & provide benchmarking information						
Clean external audit opinion for 24/25						
NHSE and ICB financial deep dive - assurance provided over efficiency plans and leadership						

FIT FOR THE FUTURE

Strategic objective:	11) We will be a data informed, digitally enabled organisation using technology to transform the way we plan and deliver care
Executive Owner:	Chief Digital Officer
Board Committee Oversight:	Digital Committee
Date of Last Review:	Jan-26
Summary risk	

There is a risk that the Trust does not utilise digital technology effectively. This may be caused by a lack of a clear digital strategy, a lack of effective business continuity a lack of resource (e.g. financial, skilled people) and a lack of appropriate clinical input into decision-making. This may result in a lack of ability to utilise digital technology to support cultural transformation, productivity, efficiency, clinical safety and patient experience.

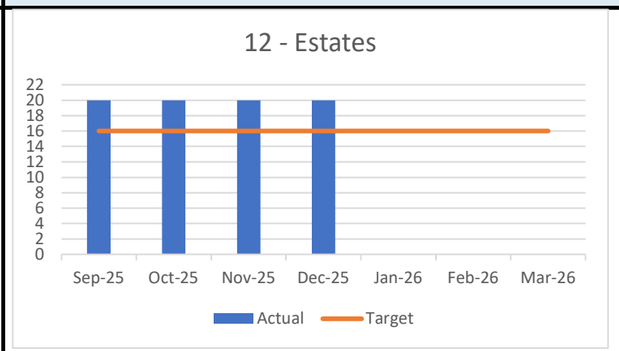


CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
5	**4**	**20**	**3**	**4**	**12**

Links to risks on the ORR:	4402 - Inability to support legislation and best practice associated with records management (16) 4405 - Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure (8) 4704 - Risk of failure to review appropriate clinical information due to multiple sources of data stored across a variety of digital systems (was 15 now 16) NEW composite risk - Digital - Risk of an inability to sustain and advance our digital offer impacting on the delivery of optimal clinical care, staff engagement and experience and our ability to deliver transformation NEW composite risk - Financial Sustainability - Risk of inability to invest in staff and clinical services, including supporting financial collaboration with partners. 4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (15) 4554 - Cyber threats and vulnerabilities (10)

Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Chief Digital Officer in place across the Alliance	Digital Committee membership, scope and terms of reference to be revisited in light of recent new appointments (including a new Chair of the Committee)	Chief Digital Officer / Chair of the Committee	Oct-25	Discussions to be held in advance of the next Digital Committee meeting in Jan 26	
Associate Director of Digital appointment made	Digital chapter to be developed to provide a clear digital strategy as part of the Trust's new 5 year strategy - for sign off at September Board	Chief Digital Officer	Sep-25	Strategy signed off at the Board in September with a chapter on digital to align to the priority and therefore action recommended for closure. Action agreed as closed in Nov 25.	
Digital Committee in place with supporting groups at Tier 2 and Tier 3	IRM / SIRO meeting has not taken place for a period of time - resulting in a gap in reporting and assurance. In addition, the SIRO requires role-specific training	Chief Digital Officer	Jan-26	SIRO training arranged for Dec 25 and the IRM / SIRO meeting will be recommenced shortly after this time	
SIRO role confirmed as the Group Director of Finance	Costed model for digital strategy delivery not in place - to be developed as part of the detail sitting behind the digital chapter of the new corporate strategy	Chief Digital Officer	Mar-26	Currently being developed with the aim to be in place for the start of the new financial year	

New 5 year corporate strategy launched with the digital chapter included	Direction of travel for the digital records programme not yet agreed	Chief Digital Officer	Mar-26	A costed case for consideration is being developed in line with the costed model for the digital strategy delivery	
PACS upgrade successfully completed to provide enhanced level of stability for the system	There is a gap in control in relation to Clinical Safety Officer capacity within the organisation to support the digital work, alongside a wider a broader skills gap within the digital team. Actions underway to address this	Chief Digital Officer	Mar-26		
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
	Following discussion at the June Digital Committee further work is needed to develop a recommended position on the Digital Records Programme and provide assurance over resource allocation and prioritisation	Chief Digital Officer	Sep-25	Nov 25 - Committee concluded that gaps remain re: the digital records programme	
	To enhance assurance reporting to the Digital Committee to ensure that the patient care impact on developments, risks and proposals is clearly articulated in papers to the Committee	Chief Digital Officer	31/03/2026		
	As outlined above, assurance over IRM / SIRO areas not being received as the meeting has not taken place for some time. A plan to restart this is in place.	Chief Digital Officer	Jan-26	SIRO training arranged for Dec 25 and the IRM / SIRO meeting will be recommenced shortly after this time	
	The Committee is not currently sighted on digital transformation assurance. To identify ways in which assurance flows can be strengthened	Chief Digital Officer	31/03/2026		
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Digital service KPIs reviewed at every Digital Committee					
Following the audit the Digital Co now receives clinical safety activity reporting to provide greater oversight and assurance in this area					
Assurance (Level 3 – external)					
Internal Audit: Cyber Assurance Framework (CAF) Aligned Data Security Protection Toolkit (DSTP) Independent Assessment - outcome High / Low assessment rating.					
Internal Audit: Clinical Safety System Changes - Reasonable Assurance rating					

FIT FOR THE FUTURE								
Strategic objective:	12) We will focus on productive utilisation of our estate to facilitate care in the right setting and providing our services in an environmentally sustainable way							
Executive Owner:	QEF Managing Director and Group Director of Finance							
Board Committee Oversight:	Finance and Performance Committee							
Date of Last Review:	Dec-25							
Summary risk								
There is a risk that the Group will be unable to develop its estate in line with changing clinical requirements and may experience failure of critical infrastructure, as a result of insufficient capital investment, This could result in compromised patient safety, disruption to business continuity, reduced staff morale, non-compliance with statutory obligations, and failure to deliver on environmental sustainability commitments.		**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		4	**5**	**20**	**4**	**4**	**16**
Links to risks on the ORR:	2341 - There is a risk to ongoing business continuity of service provision due to ageing trust estate (16) 4713 - Risk of not delivering our sustainable future CRP on a recurring basis (16) 4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (15) 4702 - Reducing cash balance increases the risk of the Group having to access revenue cash support during 2025-26 (16) 4839 - Risk of non-compliance with statutory fire safety legislation (20) NEW composite risk - Financial Sustainability - Risk of inability to invest in staff and clinical services, including supporting financial collaboration with partners. NEW composite risk - Estates - Risk to sustainability of core infrastructure and to invest in clinical advances and the working environment for our staff 2984 - There is a risk to our ability to continue to run maternity services from the designated building due to a catastrophic failure of the steam supply, resulting in enactment of a business continuity plan (20)							

Controls		**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Capital plan in place for 25/26		Outline capital plan in place for 26-27 but not yet fully approved	QEF MD	Jan-26	Jan 26 - action recommended for closure. Approved capital plan has been in place for this financial year	
Governance structure includes strengthened focus on capital and estates through 1 single Capital Oversight Group at Tier 3 and the accommodation group		Estates strategy not yet in place - impacts on ability to develop the outline capital plan	QEF MD	Jun-26	Jan 26 - due date updated as per Board workshop discussions	
Corporate Governance Manual updated and approved at the Sept 25 Board meeting - strengthened capital provisions		Fire safety survey to be conducted to inform risk assessment	QEF MD	Timescale to be agreed	Jan 26 - Board supported the need for the survey at its workshop in December 25	

New Green Plan approved at Board Sept 25		Electrical distribution assessment to be undertaken to inform site risk assessment	QEF MD	Timescale to be agreed	Jan 26 - Board supported the need for the assessment at its workshop in December 25	
Collaborative approach to capital in place with Alliance and Provider Collaborative partners						
Engagement in the Alliance Construction Programme with market engagement undertaken						
New Greener NHS Group established						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
Capital Oversight Group meets monthly to review capital plans, spend and reprioritisation						
Capital Oversight Group reports to the Operational Oversight Group via 3A reporting						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Capital reporting and monitoring to F&P Committee and Board of Directors via finance reports						
Board development session held on the estates position- Dec 25						
Assurance (Level 3 – external)						

NHS Gateshead Health NHS Foundation Trust

Board of Directors Agenda Item: 11ii

Report Title:	**Organisational Risk Register (ORR)**			
Name of Meeting:	Board of Directors			
Date of Meeting:	28th January 2026			
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, 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 full ORR is received into the Gateshead Health Leadership Group (GHLG) Meeting, the Executive Risk Management Group meeting every month, as well extracts into relevant Tier 1 and Tier 2 committees.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format*	Risks on the ORR were comprehensively discussed at previous ERMG meetings in December 2025 and January 2026. The following updates and movements were undertaken:			

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Consider key implications e.g. • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• In the period of 17th November 2025-17th January 2026, there were 2 risks added to the ORR, 2 escalations, 3 reductions, 2 closures, and 1 risk removed from the ORR. • 14 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 100% for risks and 96% for associated actions. (This is in comparison to 93% for risks and 90% 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. • Acknowledge 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 new composite risk approach as outlined in the 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):	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	

Gateshead Health NHS Foundation Trust

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

Gateshead Health NHS Foundation Trust

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 GHLG, 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, details of risk movements over the previous 12-month period, review compliance, and top composite organisational risks.

This report covers the period 17th November 2025 -17th January 2026 (extraction date for this report, Via Inphase).

Organisational Risk Register

2. Movements in period

Following ERMG meetings in December and January, 2 risks has been added to the ORR.

There have been 2 escalations, 3 reductions, 2 closures and 1 de-escalation from the ORR.

There are currently 14 risks on the ORR, agreed by the Executive Risk Management Group as per enclosed report.

Risks added to the Organisational risk register:
2 risks have been added in period, including one escalation:

- **4839 (QEF)** There is a risk that the Trust may be unable to provide full independent assurance of compliance with statutory fire safety legislation. This is due to potential gaps in passive fire protection (such as compromised fire compartmentation), an ageing fire alarm system that does not provide full L1 coverage, incomplete assurance data, and other vulnerabilities identified through internal audits and inspections. Failure to achieve and evidence full compliance may result in:

Increased risk to the safety of patients, staff, and visitors due to undetected or uncontrolled fire spread and delayed emergency response.
Potential for extensive property damage and disruption to critical healthcare services. Regulatory enforcement action, legal and financial penalties, and reputational damage. (20)

- Fire risk assessments in place, training, fire wardens in place and drills undertaken.
- Significant gaps in control include outdated fire detection systems and gaps in independent assurance in relation to compartmentalisation and passive fire protection.

- **4768 (COO)** Risk of demand overwhelming organisational capacity over the 25-26 Winter period due to an increase in respiratory illness, other infections, injury and changes to the availability of services due to staff / other resource limitations. This could result in increased risk of clinical harm, adversely impacted patient outcomes and poor experiences for staff, patients and their carers (16)
  - Increased from 12 to 16
  - Activity levels high with significant sustained demand on services evident

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

- **4734 (Medicine)** Risk of patient harm due to extended lengths of stay within the Emergency Department resulting in poor patient outcomes and an increase in clinical risk. Monitored and evidenced by variable compliance with the national four-hour emergency care standard. (12)
  - Increased from 8 to 12
  - Decline in performance evidenced.

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

- **3132 (POD)** Risk of harm to staff (psychological and physical) due to exposure to violence and aggression from patients and visitors who exhibit challenging behaviours. This could result in injury, increased absence from work, staff morale and confidence and potentially effect recruitment and retention. (12)
  - Reduced from 16 to 12
  - Monthly review at violence reduction group undertaken with analysis of number of incidents reported and level of harm incurred.
  - Significant controls are now in place including a dashboard which breakdown intentional incidents vs specific cohort of cognitive patients

- **4702 (Finance)** The Group's cash balance is reducing due to the Organisation operating with an underlying deficit. Reducing cash balance increases the risk of the Group having to access revenue cash support during 2025-26. (16)
    - Reduced from 20 to 16
    - Cash modelling has provided more accuracy with improved position forecast

- **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. (15)
    - Reduced from 20 to 15
    - Reduced likelihood based on current delivery and forecasting

Risks removed from the Organisational Risk register:
1 risk have been de-escalated from the ORR:

- **4714 (COO)** Risk of inability to secure funding in the 25-26 financial plans due to the elective care financial arrangements (elective cap) resulting in a deterioration in the Trusts financial position and non-achievement of the agreed plan. (9)
    - Evidenced improvement in position noted.

Risks closed:
2 Risks have been closed in period:

- **4820 (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, and well as financial implications.
    - At time of closure, no further balloting has been announced
    - Assurance provided that no significant clinical incidents were reported during period.

- **4705 (Digital)** Risk of considerable clinical and operational impact to patient care due to system failure of PACS environment. This is resulting in delayed diagnosis and treatment plans across services, as well as delayed discharges, resulting in significant disruption to patient pathways throughout the Organisation.
    - PACS upgrade has now taken place which supports reduction in likelihood of failure
    - Weekly maintenance schedule in place

Gateshead Health NHS Foundation Trust

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

There are 6 risks on the ORR with no movement in the past 6 months (August 2025-January 2026) as displayed below.
The board of Directors are asked to be fully cognisant of these risks, acknowledging that lack of risk movement could pose threat to the trust achieving its strategic priorities. However, it should also be acknowledged that this is an improvement from the last reporting period (where 10 risks had not changed in score), thereby demonstrating that ORR risks continue to be monitored and mitigated.

Risk ID	Risk Title	Owner	Business Unit	Service	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026
2341	There is a risk to ongoing business continuity of service provision due to ageing trust estate	Anthony Pratt	QE Facilities	Estates	16	16	16	16	16	16
4402	Inability to support legislation and best practice associated with records management	Catherine Bright	Digital	Health Records	16	16	16	16	16	16
4704	Risk of failure to review appropriate clinical information due to multiple sources used across a variety of digital systems.	David Thompson	Digital	Systems	16	16	16	16	16	16
4713	Risk of not delivering our sustainable future CRP on a recurring basis	Kris Mackenzie	Finance	Finance	16	16	16	16	16	16
4525	Risk of Lack of a strategic workforce planning	Natasha Botto	People & OD	People Services	9	9	9	9	9	9
4405	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 Board of Directors are asked to acknowledge a change in approach to the governance processes around top risk identification to be more focussed on composite risks.

A composite or “cumulative” risk approach will now formally be undertaken at each ERMG meeting.

Whilst the following 3 composite risks were agreed as top risks in January’s meeting, the Board are asked to note that this wording remains in draft format, subject to approval at Executive Risk Management Group in February.

1. **Financial Sustainability** - Risk of inability to invest in staff and clinical services, including supporting financial collaboration with partners.
2. **Estates** - Risk to sustainability of core infrastructure and to invest in clinical advances and the working environment for our staff
3. **Digital** - Risk of an inability to sustain and advance our digital offer impacting on the delivery of optimal clinical care, staff engagement and experience and our ability to deliver transformation

5. Current compliance with Risk reviews:

Risk review compliance in January sits at 100%. Action review compliance is 96%.

This is a sustained improvement, with compliance for the previous reporting period being 93% for risks and 90% associated actions.)

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

6. Recommendations

The Board of Directors are asked to:

- Review the risks and discuss and seek further information relating to risks as appropriate.
- Note positive movement and mitigation of ORR risks in the 6-month period
- Acknowledge the new approach to articulating composite Top Organisational risks.
- Take assurance over the development and review of the Organisational Risk Register as per risk governance framework.

Organisational Risk Report- January 2026.

Total Risks (Current/Managed)

14

People

2

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Staff Safety	People & OD	3132	Exposure to incidents of violence and aggression	12
Resources	People & OD	4525	Risk of Lack of a strategic workforce planning	9

Quality

5

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Safety	Surgical Services	2984	Inability to run service from current building due to the age and condition of the maternity estate and infrastructure.	20
Safety	Surgical Services	3107	There is a risk of delayed treatment due to maternity estate being a separate building	15
Safety	Chief Operating Officer	4768	Risk of demand overwhelming organisational capacity over the 25-26 Winter period	16
Safety	Digital	4704	Risk of failure to review appropriate clinical information due to multiple sources used across a variety of digital systems.	16
Safety	Medicine and Community Services	4734	Risk of patient harm due to variability in meeting 4 hour ED Emergency Care standard	12

Finance

4

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Business Continuity	QE Facilities	2341	There is a risk to ongoing business continuity of service provision due to ageing trust estate	16
Finance	Finance	4702	Reducing Cash Balances	16
Finance	Finance	4713	Risk of not delivering our sustainable future CRP on a recurring basis	16
Finance	Finance	4694	Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m	15

Regulation

3

Risk Sub Type	Business Unit	Risk Id	Risk Title	Rating
Compliance	QE Facilities	4839	Risk of Non-Compliance with Statutory Fire Safety Legislation	20
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

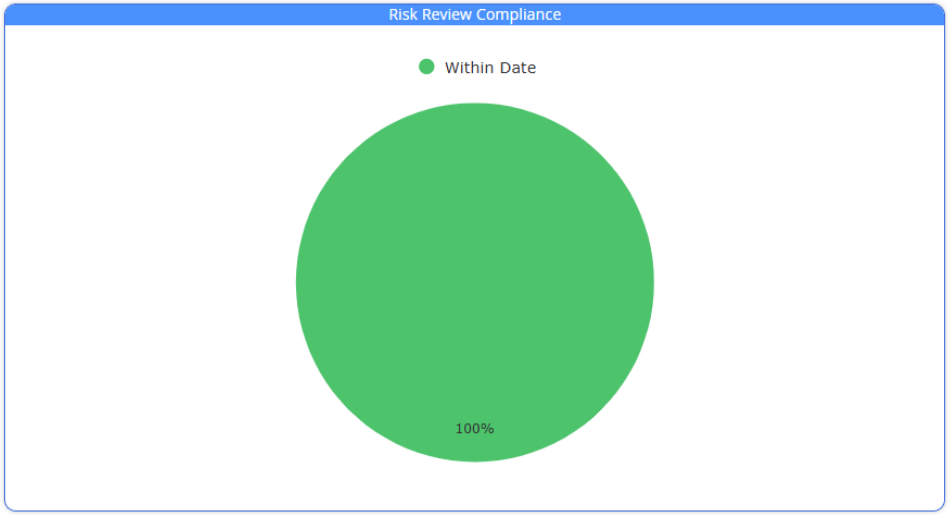
This report does not contain any data

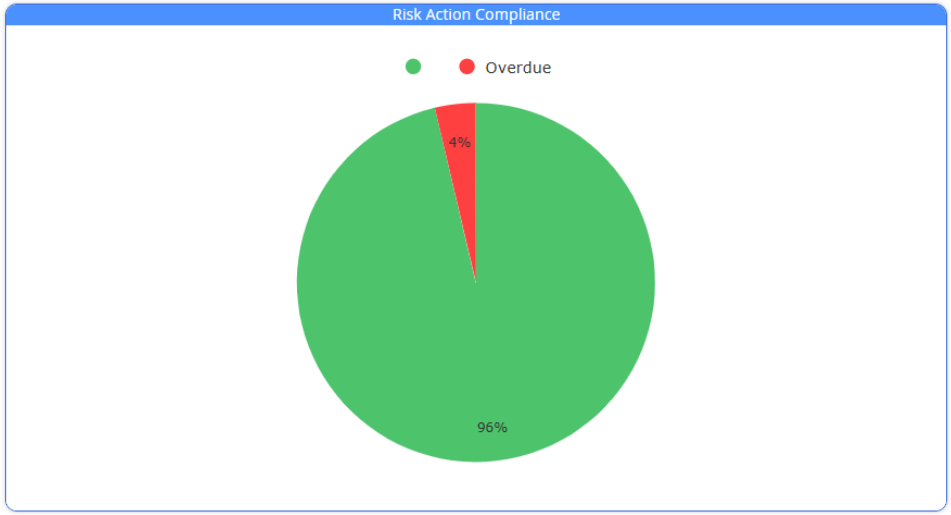
All Organisational Risks- Movements in Scores over 12 Months. February 2025 - January 2026

Changes to Current Score over 12 Months

Risk ID	Risk Title	Owner	Business Unit	Service	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026
2984	Inability to run service from current building 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	20	20	20	20
4839	Risk of Non-Compliance with Statutory Fire Safety Legislation	Genna Bulley	QE Facilities	Estates											20	20
2341	There is a risk to ongoing business continuity of service provision due to ageing trust estate	Anthony Pratt	QE Facilities	Estates	16	16	16	16	16	16	16	16	16	16	16	16
4402	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
4702	Reducing Cash Balances	Kris Mackenzie	Finance	Finance	16	16	16	16	12	16	16	16	20	20	16	16
4704	Risk of failure to review appropriate clinical information due to multiple sources used across a variety of digital systems.	David Thompson	Digital	Systems	16	16	16	16	16	16	16	16	16	16	16	16
4713	Risk of not delivering our sustainable future CRP on a recurring basis	Kris Mackenzie	Finance	Finance		16	16	16	16	16	16	16	16	16	16	16
4768	Risk of demand overwhelming organisational capacity over the 25-26 Winter period	Jo Halliwell	Chief Operating Officer	Winter Escalation						12	12	12	12	12	16	16
3107	There is a risk of delayed treatment due to maternity estate being a separate building	Karen Parker	Surgical Services	Obstetrics	15	15	15	15	15	15	15	15	15	15	15	15
4694	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	15	15
3132	Exposure to incidents of violence and aggression	Kate Clark	People & OD	People Services	12	12	12	12	16	16	16	16	16	16	16	12
4734	Risk of patient harm due to variability in meeting 4 hour ED Emergency Care standard	Jo Halliwell	Medicine and Community Services	Med 1				16	16	16	12	12	8	8	8	12
4525	Risk of Lack of a strategic workforce planning	Natasha Botto	People & OD	People Services	12	9	9	9	9	9	9	9	9	9	9	9
4405	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

Risk review and action review compliance- January 2026





Top Composite Organisational Risks- January 2026 (wording to be finalised at the next Executive Risk Management Group meeting)

1. **Financial Sustainability** - Risk of inability to invest in staff and clinical services, including supporting financial collaboration with partners.
2. **Estates** - Risk to sustainability of core infrastructure and to invest in clinical advances and the working environment for our staff
3. **Digital -** Risk of an inability to sustain and advance our digital offer impacting on the delivery of optimal clinical care, staff engagement and experience and our ability to deliver transformation

12. Assurance from Board Committees

i) Finance and Performance Committee - December 2025 and January 2026 - presented by the Chair of the Committee

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

iii) Digital Committee - January 2026 - presented by the Chair of the Committee

iv) People and Organisational Development Committee - January 2026 - presented by the Chair of the Committee

v) Group Audit committee - December 2025 - present 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:	16 December 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:

- **Increased UEC Demand** – increased demand has been seen across the region and work is ongoing at a regional level to look at the reasons, but no mitigations are currently in place.
- **Urology** – The issues with the Urology service are likely to impact the Trust's 52 week 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:

- **Draft Planning Submission –** the Committee considered the draft plan for the financial years 2026/27 and 2027/28 and agreed to recommend support for the submission of the draft plan in its current form to the Trust Board.
- **Paediatric Transfer Delays –** to highlight this issue to the Board.

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

The Committee received assurances in relation to the following:

- CDC Phase 2 – the Trust has adhered to the agreed governance principle of not moving forward with a proposal that would have a detrimental impact on the financial position of either Trust.
- Finance – Month 8 position is on plan.
- NOF – The Trust's ranking level has improved but remains in Segment 3.

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

- There were no new risks identified.

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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:	19 December 2025
Chair of Board Committee:	Dr 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)

- Urology – the Committee noted that this has been raised as an issue for a considerable length of time – conversations are ongoing with Newcastle but concern that there are currently no solutions.

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:

- Safecare – an update was provided on the Inphase backlog for Clinical Support and Screening.
- Paediatric Delays in Transfer – an issue has been identified, and actions are being taken forward to address this.
- Breast Cancer – the increase in referrals is impacting on the Trust's performance standards.
- PMVA (Prevention and Management of Violence and Aggression) Training Attendance – it was noted that attendance levels for PMVA training were low at 28% and the reasons for this need to be understood so this can be addressed.
- Intrauterine Growth Chart issue has been identified. No risk or adverse outcomes for the trust but alternative tools are being evaluated before a move from the current growth chart.

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

Positive assurances were agreed in relation to:

- County Durham and Darlington NHS Foundation Trust – Aubrey Report – self assessment and action plan being developed but no issues to highlight.
- Improvement in meeting governance for tier 3 meetings.
- BAF – The BAF has been reviewed with the Company Secretary and populated with greater clinical engagement.
- 2025 CQC Maternity Survey – Gateshead rated in top 5 overall, 1st place in the Picker survey group and 1st place for 'staff caring'. Thanks were recorded to staff.

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• Health Inequalities – progress was noted. • Patient Safety – progress made in reducing both legacy and transitional incidents. • DM01 – there has been an improvement in performance. • Freedom To Speak Up (FTSU) – Update from the interim FTSU Guardian was provided. • Research and Development – progress for this year will be reported through the next report.
Risks (any new risks / proposed changes to risk scores)
• There were no new risks identified.
Cross-referrals (by exception only)
• Responsibility for action 42a – issues with interoperability of the Badgernet system to be referred to the Digital Committee to take forward.

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3A Escalation and Assurance Report

Name of Committee	Digital Committee
Date of Committee	14 January 2026
Chair of Committee	Mr Andrew Besford

Alert
(matters of significant concern requiring escalation for further action)

- **Data and Business Intelligence Strategy Update** – the Committee has not received a recent written update on progress and requested a report to the next meeting of the Committee.

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)

- **Badgernet Cross Referral** – this is a national issue. The Committee received assurances on safety and there is an Alliance approach in raising the issue with the supplier, but will also be taken forward locally.
- **Clinical Communication Strategy** – The Medical Director is the lead for this work which falls under the remit of the Digital Committee. An update will be provided to the next meeting.
- **Digital Strategic Plan** – the Committee considered the draft Digital Strategic Plan which is the enabling digital plan to the Trust Corporate Strategy. The Committee provided positive feedback on the plan. There is a need for some revision to refine the language to meet the target audience and a revised version will be provided for consideration at the next meeting of the Committee.
- **Hybrid Mail** – Committee noted that the Hybrid Mail project has been temporarily paused in order to allow the internal transfer of delegated budgets to take place. Decision being taken up internally by the operational director in charge of CSS.
- **Acute Clinical EPR** – the business case is underway with a view to submission to the Trust Board in March. This is a need is a need for executive input prior to submission to the Board.
- **Projects Update** – There is a need to review the level of detail included in this report to allow assurance to be provided to the Committee – this will be reviewed with the Chair ahead of the next meeting.
- **Medium Term Planning** – work is ongoing with the Finance Team and we are building a plan.
- **Target Operating Model** – this is focussed on a paper records plan. It was noted that paper record costs are significantly higher than peer Trusts, and there are benefits to be achieved in freeing up space. This links in to the Digital Plan.
- **Digital Front Door** – this is a new way of working and will require support to implement across the organisation.

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- **BAF** – there are some gaps to be filled. There is a need to clarify the ownership of the data element of the objective.

Assure
(key assurances received and any highlights of note)

- **Digital Procurement** – Joint procurement principles from an Alliance perspective have been reviewed. There are some practical issues with joint procurement, but some areas have been identified where there may be benefits and these are being considered first. These are around hardware/commodities/printers.
- **Audit** – no outstanding actions. There are two reports due and unused audit days have been allocated to Pathology IT.
- **No critical IT incidents**, although some issues have been noted in relation to Great North Health Record and this is being picked up by the Chief Digital Officer.
- **Clinical Safety** – there have been no major incidents. A CSO training plan is being developed with an aim to increase the number of CSOs to 20 in the next 12 months.
- **Risk Register** – work is ongoing with QEF in relation to data centres.
- **Terms of Reference for the Committee** – the revised terms of reference were agreed for ratification by the Board.

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

- There were no new risks identified.

Cross-referrals to other Committees / Groups / Executive Director Leads

- There were no cross referrals.

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Committee Escalation and Assurance Report

Name of Board Committee	Group Audit Committee
Date of Board Committee:	2 December 2025
Chair of Board Committee:	Mr R Hughes

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

- No alert items identified

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

- **Board Assurance Framework (BAF)** – The Committee noted some assurance around the process for the development of the BAF but recognised there is more work to do around controls and assurance to ensure it is robust.
- **Failure to Prevent Fraud** – The Committee received an outline of next steps to support compliance, but this is still to be delivered. The risk assessment to be reported through to the Committee in March 2026.
- **Litigation Register** – The Committee received an outline report and there was a good discussion around how to reframe this for the Committee around process, with reporting on the details and themes to be reported through to the Quality Governance Committee.
- **Internal Audit Progress Report** – there are some challenges in delivery, but assurance provided on the allocation of audits to individuals. The new audits for contingency need to be included in the plan towards the end of the year. Positive assurance was provided that engagement with the Trust is going well. The Committee approved the re-scheduling of the Occupational Health Audit.

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

- **Executive Risk Management Group (ERMG)** – Evidence of good dynamic review of risks via the ERMG. Some compliance rates have dipped but assurance given via ERMG that this is improving.

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- **Freedom to Speak Up (FTSU)** – good assurance provided around the control environment.
- **QEF Accounts** – Clean audit opinion provided with only one control deficiency noted. The Audit has been completed earlier than in previous years. The Audit Committee recommended approval to QEF Board.
- **Audit Plan for 2026-27** – A comprehensive process for development is in place with the aim for the plan to be developed and approved earlier with a target of March 2026.
- **Charitable Funds** – Clean audit and minimal level of error. The Committee recommended approval to the Board of Trustees.
- **Counter Fraud Annual Report** – Assurance provided on all areas other than conflicts of interest which is rated amber.

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

There were no new risks.

Cross-referrals to Tier 1 Board Committees

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 13 January 2026
Chair of Committee / Group:	Mrs Maggie Pavlou

Alert
(matters of significant concern requiring escalation for further action)

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. **GMC Survey** – there are some areas of improvement since last year and other areas where ratings have deteriorated. Where there has been a deterioration this was already known to us, so was expected and work is already underway in these areas.
2. **Job Evaluation** – item deferred as progress has been paused due to regional work, but a report to be provided to the next meeting to include a progress report and milestones for the future.
3. **Apprenticeship Levy** – Apprenticeship Levy Funds have reached £2m but there are challenges in utilizing the funds effectively – this is being reviewed by the People & OD Team and options are being considered.
4. **Anti Racism Charter** – consideration of the role the Trust has to play as an anchor institution and agreement this should be considered as an item for a future Board Development session.
5. **Internal Audit** – outstanding action in relation to Job Plans over 12 PA's. Commitment for this to be completed by end March 2026.

Assure
(key assurances received and any highlights of note)

Positive assurances were agreed in relation to:

1. **Corporate Strategy People Chapter** - received with a final sense check needed re volume of actions and strategic ambition v's business as usual.
2. **Guardian of Safe Working Reforms** – assured on changes, the projected costings and comms and engagement re implementation.
3. **Sickness Absence** – the Committee commended the data led report and the positive work which had taken place between People & OD and operational

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teams. Sickness remain amongst the lowest in the region and the work of the absence task force are being incorporated into business as usual. 4. **Internal Audit Actions** –Of 8 audit actions, 6 are complete, 1 is not yet due and one remains overdue (See pt 5. In Advise re Job Plans) 5. **Resident Doctor 10 Point Plan** – the report set out where we are currently and the aspiration to go above and beyond the minimum requirements set out to become compliant. Recognition of the importance of communicating the nuance of this. 6. **Fit and Proper Persons Audit** – Good level of assurance via the audit and plans in place to address the 2 recommendations that are not yet overdue. 7. **Freedom to Speak Up Report** – assurance provided on the role of the FTSU Guardian but more work to do to improve the report and to consider governance around the disbanding of the National Governors Office. 8. **Staff Spaces** – action raised by the Council of Governors has been addressed and closed with spaces available for staff now available to view on the Trust website. 9. **Violence Reduction Group** – Triple A report to now flow into POD Steering group to ensure more robust management of the V&A risk on the risk register. 10. **Staff Network Reset** – follow-up from the meeting with the CEO in December has confirmed the networks primary function is per support. Committee acknowledged that wider engagement will be needed to hear voices with lived experience and ensure our work is led by need. 11. **Flu Vaccination Rates –** uptake among frontline healthcare workers has exceeded the regional target, while vaccinations continue.
Risks (any new risks / proposed changes to risk scores)
Risk 4525 –to consider rewording the risk to provide clarity and to focus on what is within our control.
Cross-referrals to Committees/Groups/Executive Director Leads
There were no cross-referrals.

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3A Escalation and Assurance Report

Name of Committee / Group:	Group Remuneration Committee
Date of Committee / Group:	10 December 2025
Chair of Committee / Group:	Dr Gerry Morrow, Vice Chair

Alert ***(matters of significant concern requiring escalation for further action)***
• There were no matters to alert to the Board.
Advise ***(areas subject to ongoing monitoring where some assurance has been noted / further assurance sought or emerging developments that the Committee / Group is seeking assurance over)***
• There were no matters to advise to the Board.
Assure ***(key assurances received and any highlights of note)***
• This was a single agenda item extraordinary Group Remuneration Committee meeting to formally approve the extension of the secondment for the Acting Chief Executive, Sean Fenwick, for an additional three months until 30th April 2026. The Committee formally approved the extension.
Risks (any new risks / proposed changes to risk scores)
• No new risks identified.
Cross-referrals to other Committees / Groups / Executive Director Leads
• None

13. Finance Report

Presented by the Group Director of Finance

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 13

Report Title:	**Consolidated Finance Report – Part 1**			
Name of Meeting:	Board of Directors			
Date of Meeting:	28th January 2026			
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 December 2025, the Trust has reported an actual deficit of £8.175m after adjustments for donated asset depreciation. This is a favourable variance of £0.007m 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 December 2025, the Trust has capital spend on schemes totalling £9.537m. Cash balances are £19.826m at 31st December 2025 and £15.326m 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 November 2025 is detailed in Table 1.

Finance KPIs	Month 09 - Dec-25 Budget £ '000	Actual £ '000	Variance £ '000	RAG	YTD Budget £ '000	Actual £ '000	Variance £ '000	RAG
I&E (Surplus) / Deficit (adjusted perf.)	490	516	25		8,182	8,175	(7)	
Operating Income	-36,089	-36,065	23		-324,601	-321,438	3,163	
Pay Expenditure	24,375	24,710	334		220,792	216,530	(4,262)	
Non Pay Expenditure	11,764	11,780	16		107,424	109,091	1,667	
Non Operating Income	-56	-86	(30)		-500	-1,056	(556)	
Non Operating Expenditure	600	212	(389)		5,402	5,343	(59)	
Remove capital donations / grant I&E Impact	-34	-34	0		-305	-295	10	
Balancing adj to NHSE Plan	-71	0	71		-30	0	30	
Agency Expenditure	97	100	3		704	847	143	
CRP Delivery	2,859	2,859	0		22,582	22,582	0	
Capital Expenditure	1,078	1,628	550		15,106	9,537	(5,569)	
Cash position	-170	1,584	1,754		4,500	19,826	15,326	
Liquidity (days)	20	14	(6.7)		20	14	(6.7)	
Better Payment Practice Code (BPPC)								
NHS	95.0%	92.7%	-2.3%		95.0%	75.8%	-19.2%	
Non NHS	95.0%	98.1%	3.1%		95.0%	96.8%	1.8%	
Aged Debt								
Receivables over 90 days NHS	10.0%	36.8%	26.8%		10.0%	36.8%	26.8%	
Receivables over 90 days non NHS	10.0%	37.3%	27.3%		10.0%	37.3%	27.3%	

Table 1: Finance KPIs

2.2 The Trust has reported a **£0.516m** deficit for the month of December; which is an adverse variance of **£0.025m** against plan.

2.3 Year-to-date the trust position is **£8.175m** deficit, a favourable variance from plan of **£0.07m.** 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 as well as high postage costs across the trust and the overspending on unfunded insulin pumps.

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2.4 As at M9 the key risks to the delivery of the plan are summarised as non-delivery of the remaining 2025-26 forecast cost reduction schemes resulting in slippage against the cost reduction target as well as medical pay overspends within Medicine and Community. December saw a significant increase in pay costs across all staff groups due to the impact of winter site pressures.

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 **£22.582m** and is summarised in Table 2 by Division.

					Annual Achieved		
Division	Target as at M9 Dec 25 £000	Actual as at M9 Dec 25 £000	Variance as at M9 Dec 25 £000	Annual Achieved as at M9 Dec 25 £000	Recurring £000	Non Recurring £000	Total £000
Chief Executive	151	0	151	0	0	0	0
Chief Operating Officer	251	191	60	267	213	54	267
Clinical Support & Screening Services	3,649	446	3,203	594	594	0	594
Estates & Facilities	300	225	75	300	300	0	300
Medical Director	168	156	12	210	196	14	210
Nursing & Midwifery	324	295	30	419	363	56	419
People & Organisational Development	288	204	84	272	272	0	272
Surgical Services	3,760	1,835	1,925	2,234	501	1,733	2,234
Trust Financing	6,809	15,462	(8,653)	17,310	3,749	13,562	17,310
Medicine & Community	4,391	1,350	3,041	2,103	1,986	117	2,103
Finance & Performance	296	227	69	294	294	0	294
Digital	826	372	454	497	152	344	497
QEF	1,365	1,820	(455)	1,820	1,820	0	1,820
Total	**22,578**	**22,582**	**-4**	**26,321**	**10,440**	**15,880**	**26,321**

Table 2 Cost Reduction Performance

3.2 To date the Trust has achieved annually **£26.321** of the £32.871m cost reduction target of which **£10.440m** (32%) is achieved on a recurring basis.

3.3 On a recurring full year effect basis £14.744m is forecast, carrying forward a shortfall of £18.127m against the £32.8m target.

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.

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4.0 Underlying Trust Financial Position

4.1 The Trust internal objective is to improve its underlying deficit by the end of March 2026 to £26.4m as summarised in Table 3, informed by achieving savings totalling £32.8m as it exits 25-26. The Trust is currently forecasting an exit underlying deficit of £43.07m. Whilst the delivery of £14.744m recurring CRP savings is higher than any other financial year it remains £18.115m short of the internal target of £32.8m and is the reason why the exit underlying deficit target has not been achieved, as summarised in Table 3.

	25-26 Internal Objetive		Annual Plan	Forecast	
	25-26 £m	Underlying £m	As per 25-26 Annual Plan £m	M9 Forecast £m	As per 25-26 Annual Plan £m
Opening Deficit	(61.20)	(61.20)	(61.20)	(61.20)	(61.20)
Recurring FFYE CRP Achieved	32.80	32.80	20.10	14.66	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)
Excess Depreciation				(0.50)	(0.50)
Deleged Budget Control Total Corrections				(0.55)	0.00
Total Exit Deficit	**(8.20)**	**(26.40)**	**(35.20)**	**(43.07)**	**(37.07)**

Table 3: Underlying Deficit

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 The Trust has reported capital spend totalling £9.537m as at December 2025, mainly against the Colposcopy and Paediatrics schemes, £0.697m of IT hardware and £3.280m of Backlog Maintenance as summarised in Table 4.

5.3 The timeline for the CDC Phase 2 business case is to be presented to Trust Board and NHS England in January 2026. In recognition of the delay in the scheme the Trust has accessed the national facility to convert PDC cash funded schemes to operating CDEL. Via this facility the Trust has converted £4.5m PDC capital to operating capital and released this to the system to broker with other system Organisations. If the CDC business case is approved this brokerage will be returned to the Trust in 2026-27 as

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operating CDEL. The £4.5m brokerage is now reflected in the Trusts external financial return.

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

Capital Scheme	2025/2026 Annual Plan £000's	2025/2026 Revised Plan £000's	Spend to Dec 25 £000's
CDC Phase 2 - PDC	5,468	5,468	272
Physiological Sciences	106	106	107
Day Care Service Improvements	50	50	0
UEC Creation of a Surgical Assessment Area	562	562	83
EPAC Expansion	700	700	127
Same Day Emergency Care (SDEC)	585	585	55
Sub-total Constitutional Standards	**7,471**	**7,471**	**645**
Sub-total Estates Safety - Backlog Maintenance	**5,000**	**5,000**	**3,116**
Sub-total Medical Equipment Replacement	**941**	**941**	**19**
Sub-total Digital	**800**	**800**	**697**
Colposcopy	2,319	2,319	2,212
Paediatrics	2,945	2,945	1,524
X-Ray Room 5	600	600	0
Sub-total Strategic Schemes	**5,864**	**5,864**	**3,736**
IFRS16	**0**	**0**	**1,160**
Backlog Maintenance - Internally Funded			**164**
Accelerator Charge Point		**134**	**0**
CDC Phase 1 Liver Pathway		**129**	**0**
Total Capital Programme	**20,076**	**20,339**	**9,537**
Funded By:			
Depreciation	11,004	11,004	5,776
Cash	64	64	0
Public Dividend Capital	9,008	9,271	3,761
Charitable Funds	0	0	0
Total Funding	**20,076**	**20,339**	**9,537**
CDC Phase 2 Conversion to operating CDEL and Broker		(4,500)	0
Amended Capital Plan	**20,076**	**15,839**	**9,537**

Table 4: Capital Programme Spend

6.0 Cash Balances

6.1 Group cash as of 31st December 2025 totalled £19.826m, £15.326m more than planned. This favourable variance is due to improvements on working capital balances specifically an increase in trade / other payables of £8.831m and £6.521m of slippage against the capital programme. This is offset by an increase in receivables of £2.029m.

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

Gateshead Health NHS Foundation Trust

7.0 Conclusion

7.1 The Trust has reported an adjusted deficit of **£0.516m** for the period ending 31st December 2025 against a plan of £0.490m resulting in an adverse variance of **£0.025m**. Year-to-date the Trust reported an adjusted deficit of **£8.175m** against a plan of £8.182m resulting in a favourable variance of **£0.007m**.

7.2 The Trust has reported total capital spend of **£9.537m**, equating to 60% of its revised plan, after the conversion of £4.500m CDC Phase 2 funding to operating capital which has then been brokered across the North East & North Cumbria System.

7.3 The Trust has reported achievement of £22.582m cost reduction, which is on target for the year to date. On an annual basis, £26.321m (75%) has been achieved against the target of £32.871m, of which **£10.440m (32%)** has been achieved on a full year effect recurring basis. The Trust is forecasting **£14.744m (45%)** on an annual recurring

7.5 As this stage in the financial year, the Trust is forecasting achievement of both its revenue and capital plan, with no unmitigated risk included its external financial returns.

7.6 Cash balances at the end of December total **£19.826m**, however current liabilities are above £60m which when realised, alongside catch up of the capital programme and repayment of PDC and loans will reduce cash balances throughout the remainder of 2025-26. The Trust is not planning to access revenue cash support in 2025-26.

7.7 The Trust underlying deficit is forecast to improve by **£18m** resulting in a forecast underlying exit deficit totalling **£43.07m**, which is less than Trust external plan and internal stretch target.

Kris Mackenzie, Group Director of Finance
January 2026

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Appendix A – Statement of Comprehensive Income (SOCI)

Statement of Comprehensive Income	Month 09 - Dec-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	-32,852	-33,043	(191)	-295,586	-292,376	3,210
Income From Local Authority Care Contracts	-30	-30	0	-269	-284	(15)
Private Patient Revenue	-66	-94	(29)	-593	-727	(134)
Injury Cost Recovery	-42	-34	8	-375	-416	(41)
Other non-NHS clinical revenue	-14	-13	1	-130	-128	3
Total Operating Income From Patient Care activities	-33,004	-33,214	**(210)**	-296,953	-293,931	**3,022**
Other Operating Income						
Education and Training Income	-1,054	-1,079	(25)	-9,308	-9,528	(220)
R&D Income	-92	-103	(11)	-829	-824	5
Funding outside of System Envelope	0	0	0	0	0	0
Other Income	-1,939	-1,670	269	-17,511	-17,154	357
Donations & Grants Received	0	0	0	0	0	0
Cost Improvement Programme - Income	0	0	0	0	0	0
Total Other Operating Income	-3,085	-2,852	**233**	-27,648	-27,507	**142**
Total Operating Income	-36,089	-36,065	**23**	-324,601	-321,438	**3,163**
Operating Expenses						
Employee Expenses - Substantive	23,598	23,326	(272)	213,623	207,089	(6,533)
Employee Expenses - Bank	563	1,176	613	5,398	7,559	2,161
Employee Expenses - Agency	97	100	3	704	847	143
Employee Expenses - Other	118	108	(10)	1,068	1,035	(33)
Cost Improvement Programme - Pay	0	0	0	0	0	0
Total Employee Expenses	**24,375**	**24,710**	**334**	**220,792**	**216,530**	**(4,262)**
Purchase of Healthcare - NHS bodies	781	952	171	6,189	7,895	1,706
Purchase of Healthcare - Non NHS bodies	145	167	22	1,379	1,583	204
Purchase of Social Care	0	0	0	0	0	0
NED's	15	15	(1)	137	141	4
Supplies & Services - Clinical	3,389	3,804	414	33,522	34,104	583
Supplies & Services - General	253	273	21	2,313	2,275	(38)
Drugs	2,062	2,126	64	18,657	19,410	753
Research & Development expenses	0	7	6	5	17	12
Education & Training expenses	215	148	(68)	1,886	1,102	(784)
Consultancy costs	60	53	(7)	438	141	(298)
Establishment expenses	359	418	60	3,210	3,446	236
Premises	1,609	1,398	(211)	14,461	14,070	(391)
Transport	169	164	(5)	1,540	1,187	(353)
Clinical Negligence	783	813	30	7,045	6,923	(123)
Operating Leases	246	-61	(307)	2,154	1,146	(1,008)
Other Operating expenses	509	387	(122)	4,146	5,482	1,337
Cost Improvement Programme - Non Pay	0	0	0	0	0	0
Reserves	0	0	0	0	0	0
Operating Expenses included in EBITDA	**10,596**	**10,663**	**68**	**97,082**	**98,923**	**1,840**
Depreciation & Amortisation - Purchased / Constructed	951	941	(10)	8,555	8,550	(5)
Depreciation & Amortisation - Donated / Granted	34	34	(0)	305	295	(10)
Depreciation & Amortisation - Finance Leases	253	165	(88)	2,275	2,171	(103)
Impairment & Revaluation	-69	-23	46	-793	-849	(56)
Operating Expenses excluded from EBITDA	**1,168**	**1,116**	**(52)**	**10,342**	**10,168**	**(173)**
Total Operating Expenses	**36,139**	**36,489**	**350**	**328,216**	**325,621**	**(2,595)**
(Profit)/Loss from Operations	**51**	**424**	**373**	**3,615**	**4,183**	**568**
Non-Operating Income						
Finance Income	-56	-86	(30)	-500	-1,056	(556)
Total Non-Operating Income	-56	-86	**(30)**	-500	-1,056	**(556)**
Non-Operating Expenses						
Finance Expense	70	100	30	632	997	365
Gains / (Losses) on Disposal of Assets	0	0	0	0	0	0
PDC dividend expense	426	8	(418)	3,833	3,416	(417)
Total Finance Costs (for non-financial activities)	**496**	**107**	**(389)**	**4,465**	**4,412**	**(52)**
Other Non-Operating Expenses						
Misc. Other Non-Operating expenses	0	0	0	0	0	0
Total Non-Operating Expenses	**496**	**107**	**(389)**	**4,465**	**4,412**	**(52)**
(Surplus) / Deficit Before Tax	**491**	**445**	**(46)**	**7,580**	**7,539**	**(40)**
Corporation Tax	104	104	(0)	938	931	(7)
(Surplus) / Deficit After Tax	**595**	**550**	**(46)**	**8,517**	**8,470**	**(47)**
Balancing Adjustment to NHSE Plan	(71)		71	(30)		30
(Surplus) / Deficit After Tax from Continuing Operations	**524**	**550**	**25**	**8,487**	**8,470**	**(17)**
Remove capital donations / grants I&E impact	-34	-34	0	-305	-295	10
Adjusted Financial Performance (Surplus) / Deficit	**490**	**516**	**25**	**8,182**	**8,175**	**(7)**

Appendix B Statement of Financial Position

NHS Gateshead Health NHS Foundation Trust

Statement of Position - December 2025

	2025/2026 December 2025 Group Plan	2025/2026 December 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	177,499	169,289	(8,210)
Right of Use Assets	10,419	12,813	2,395
Trade and Other Receivables, Net	2,272	1,585	(687)
Finance Lease - Intragroup			
Trade and Other Receivables - Intragroup Loan	0	0	0
Total Non Current Assets	190,270	183,767	(6,502)
Current Assets			
Inventories	5,110	4,404	(706)
Trade and Other Receivables - NHS	6,161	5,089	(1,072)
Trade and Other Receivables - Non NHS	15,067	18,168	3,101
Trade and Other Receivables - Intragroup			
Trade and Other Receivables - Other	0	0	0
Cash and Cash Equivalents	4,500	19,820	15,320
Total Current Assets	30,838	47,481	16,643
Liabilities			
Current Liabilites			
Deferred Income	2,310	3,376	1,066
Provisions	1,564	1,784	220
Trade and Other Payables	43,951	51,669	7,718
Lease Liabilities	1,584	1,948	364
Trade and Other Payables - Capital	250	1,362	1,112
Other Financial Liabilities - Borrowings FTFF	999	499	(499)
Other Financial Liabilities - Borrowings Other (Non-DHS	0	12	12
Total Current Liabilities	50,658	60,652	9,994
NET CURRENT ASSETS (LIABILITIES)	(15,155)	(13,171)	6,649
Non-Current Liabilities			
Deferred Income	1,983	1,647	(336)
Provisions	2,445	2,143	(302)
Trade and Other Payables - Other	-	0	0
Lease Liabilities	9,943	11,746	1,803
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	23,884	25,646	1,762
TOTAL ASSETS EMPLOYED	**146,567**	**144,950**	(1,614)
Tax Payers' and Others' Equity			
PDC	170,250	169,238	(1,012)
Taxpayers Equity	0	0	0
Share Capital	0	0	0
Retained Earnings (Accumulated Losses)	(36,962)	(37,058)	(96)
Other Reserves	0	0	0
Revaluation Reserve	13,180	12,671	(509)
Misc Reserve	99	99	0
TOTAL TAXPAYERS EQUITY	146,567	144,950	(1,617)
TOTAL ASSETS EMPLOYED	**146,567**	**144,950**	(1,617)

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

NHS Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 14

Report Title:	Strategic Objectives & Constitutional Standards			
Name of Meeting:	Board of Directors			
Date of Meeting:	Wednesday 28th January 2026			
Author:	Deborah Renwick: Associate Director of Planning & Performance (Liz Graham: Principal Analyst)			
Executive Sponsor:	Kris Mackenzie: Group Director of Finance & Digital			
Report presented by:	Kris Mackenzie: Group Director of Finance & Digital Joanne Halliwell: Chief Operating Officer			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☐	**Information:** ☐
	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*				
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*	**Excellent patient care** **Quality Improvement Plan:** December 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 December, the falls steering group continue to meet and progress the current action plan. In support of identification and prevention of Venous Thromboembolisms (VTE) 99.2% of all patients admitted in December were risk assessed (in accordance with NICE guidance criteria). Exceeding the national standard of 95%. **QA**: The Trust reported two cases of C. difficile in December. The Trust's annual threshold has been set at 36, YTD cases stand at 30. In-month rates per 100k bed days were 14. A ten point action plan is in place.			

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Performance against learning disability and autism training has increased to 84.48% 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 82%, 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.

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 December, a total of 22 estate risks with a combined critical infrastructure risk score of 244. Representing no new risks, one closed risk and a reduction in the score of a further one risk.
- There were five patient safety incidents reported linked to estate issues, three incidents relate to patient falls and two related to lighting.
- In December PLACE inspection visits took place in the New Paediatrics area, St Bedes and Medical Physics. No concerns were raised.

Great place to work

- Vacancy rates in December increased 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.
- Turnover decreased to 12.1% in December. Promotion as a voluntary leaving reason has shown an increasing trend since March indicating possible lack of opportunities / career advancement in the Trust.
- Sickness absence rates reduced slightly to 5.4% but is still above the target level of 4.9%.
- Temporary staffing spend as a proportion of pay bill remains under target at 0.4% and has been consistently under target in the past 12 months.

Fit for the future

Improve the quality-of-care delivery and accessibility for patients by meeting locally agreed stretch targets.

Gateshead Health NHS Foundation Trust

- The ED 4-hr standard decreased in December with performance at 73%, below the 78% standard.
- Reducing time in department deteriorated with 240 patients, 3.85% of our Type 1 patients spending more than 12 hours in ED. Below the national tolerance of <2% and the planned target of 0.2%.
- There was a reduction in the reportable 12-hr delays for admission to two.
- The Trust remains a top performer in Ambulance Handover times with average hand-over time of 14 mins 51 seconds in December against the national standard of <15mins. 32 handovers exceeded 30 mins in December, 15 was more than 45minutes with nine 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 December increased to 7.59 days, 1.28 days higher than planned levels primarily due to challenges with social care discharges.
- 52.3% of patients were discharged on their discharge ready date.
- A daily average of 48 patients no longer meet the criteria to reside actions to improve this will be incorporated into the discharge program work.
- In December there were 453 beds open, 35 beds more than planned.

The waiting list reduced by 234 patients to 12,521.

- Current waiting list is 2,174 (21%) above planned trajectory.
- Key Waiting list pressures remain in all services but particularly in Urology.

December RTT performance is 70.1%.
There were 25 52+ week waiter at the end of the month, 17 in T&O and 8 in Urology.

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

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	this tumour site fails the target, it has a significant impact on the Trust overall performance. The unvalidated 28 Day Faster Diagnosis performance in December dropped to 73.3%, below the expected national position of 80% by the end of March 2026. The unvalidated 62 day performance was 54.7% in November. Challenges in the breast tumour site and those pathways which are shared with other providers are ongoing. The unvalidated 31 day performance for November was 97.2%, initial data for December and January shows this position significantly deteriorating to below the 96% standard. Diagnostics: Waiting List at the end of December was 4,814 representing a decrease of 474 waiters. DM01 performance has increased to 95.87%, but remains below the constitutional standard of 99%. Challenges remain in the following modalities: Cystoscopy performance at 77.3% and Audiology performance at 81.54%. **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 M9 of £8.182 and actual performance of £8.175m deficit which is a favourable variance of £0.0.07m. 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 M9 is £22.582m and actual performance of £22.582m; of which £14.744m 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 3 months, is challenging. **Working together for healthier communities.** The Group continues to be an effective partner in the Great North Care Alliance: highlights include collaboration to maintain a system wide balanced financial plan. The appointment of a shared Digital Director to support standardised technical infrastructure, and collaboration across

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	clinical services networks to improve patient access and clinical outcomes. Gynaecology outpatient median waiting times reduced to 29 weeks. Service plans to support recovery are in development to improve waiting times. Paediatric autism assessments and diagnosis waiting times have slightly decreased to a median wait of 58 weeks. Work is ongoing to increase external income as part of business efficiency plans. QEF generated income is down in December from the previous 12 months.					
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The recommendations to the Committee are to receive this report, discuss the potential implications and note the improvement or challenge in key areas					
Trust strategic priorities that the report relates to:	☒	Excellent patient care				
	☒	Great place to work				
	☒	Working together for healthier communities				
	☒	Fit for the future				
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	All strategic objectives					
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒	
Risks / implications from this report (positive or negative):						
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	Areas requiring attention: **Quality & Safety:** • Quality Improvement Plans • Disability & Autism Training • Mental Health Act training • Estates risks and incidents • Harm falls rates • C-difficile rates **Workforce:** Staff engagement, turnover rates, vacancy & sickness absence rates. **Fit for the future risks:**					

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	• All cancer standards now at risk, having been impacted by increase in Breast referrals • Higher than planned waiting lists • Staffing gaps in key operational areas • Maintaining financial sustainability, reducing expenditure, and achieving CRP.		
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

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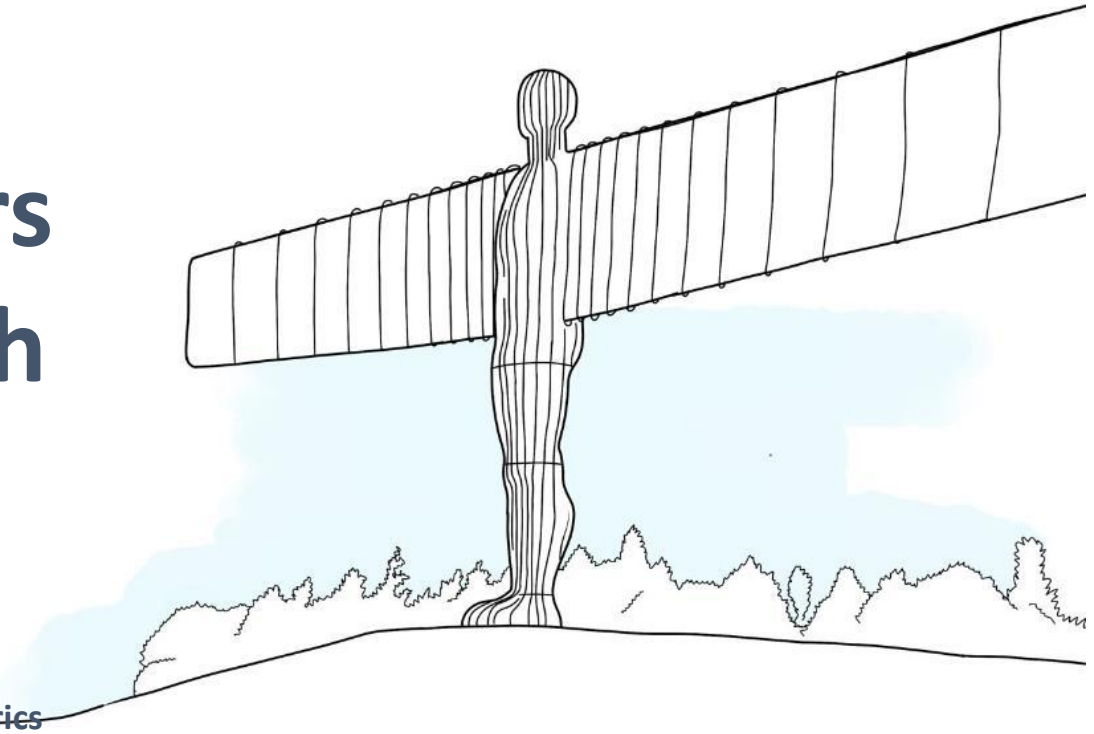
Strategic Objectives 2025/26

Leading Indicators and Breakthrough Objectives



Including Constitutional standards monitoring metrics

Reporting Period: December 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		
Venous thromboembolism (VTE) risk assessment	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
		Harm rate from falls
		Mental Health Act Training for all registered staff
		Severity of risk scores linked to estates
We will be a great organisation with a highly engaged workforce		
	Reduction in temporary staffing spend 0.5% of pay bill	Achievement of the internal turnover standard
		Improve the staff engagement score
		Internal sickness absence standard
		Maintain the vacancy rate at <=2.5%
We will enhance our productivity and efficiency to make the best use of our resources		
	Review and revise Green Plans	Average non-elective length of Stay < 4 Days
		Reduce the number of patients with no Criteria to Reside
		Achievement of 4-hr A&E target
		Reduce New & Follow up non value added activity to 67%
		Achievement of the trajectory to achieve 60% RTA to Bed within 1 hour
		Achievement of Zero 52 weeks.
		Reduce >12 hour total time in Emergency Department
		Risk in achievement of financial plans including CRP
We will be an effective partner and be ambitious in our commitment to improving health outcomes		
	Evidence a reduction in the number of 'fragile' and 'vulnerable' services as a direct outcome of Alliance working	Reduction in the wait for gynaecology outpatients to no more than 26 weeks
	Evidence in an improvement in health inequalities in the key focus areas linked to the determinants of Health for Gateshead	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	Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 weeks
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

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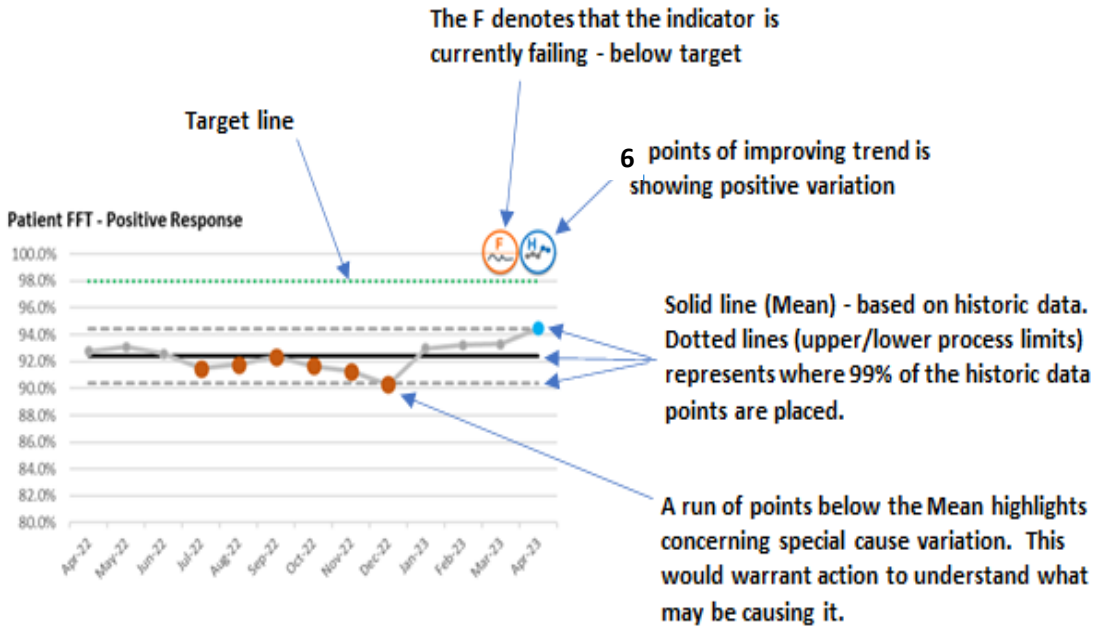
The Trust has adopted the NHSEI 'Making Data Count' methodology and standard templates which demonstrates where historic performance/activity is subject to natural variation or where action may need to be taken where there may be cause for concern.

What are Statistical Process Control (SPC) charts

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



SPC Rules

Assurance		Variation	
?	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

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	P	?	F	
Improving		Maternity Incentive schemes % compliance with Total Recommendations Ockenden Recommendations % 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	Achievement of the 52 week RTT standard 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 90% of staff to complete Mental Health Act training Reduction in severity of risk score linked to estates Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 by March 2025 C.Diff Healthcare associated rate per 100,000 occupied bed days Reduction in patient safety incidents related to estates issues	Achievement of the internal turnover standard of 9.7% Average Length of Stay Non-Elective <4 days Reduce the number of patients with no Criteria to Reside Achievement of the trajectory to achieve RTA to Bed within 1 hour Increase in the number of digital devices repurposed to the local community Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients by March 2025	
Deteriorating		Harm falls rate per 1000 bed days	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**	

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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	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Ass/Var	Trend
LEADING INDICATORS																	
Ockenden Recommendations % compliance with Total Recommendations	100%	97.4%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Maternity Incentive Schemes % compliance with Total Recommendations	100%	89.0%	96.0%	96.0%	100.0%	100.0%	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	5	5	7	5	2	9	5	6	2	2	6	8	6	5		
Compliance with the quality improvement plan indicated by the % of actions on track	100%	68%	56%	68%	64%	68%	76%	80%	80%	76%	84%	84%	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	280	272	256	252	256	244	260	276	266	234	246	240	256	244		
Harm falls rate per 1000 bed days (5% reduction)	3.2	4.38	4.43	3.11	3.81	4.27	3.49	4.27	3.93	4.61	4.78	4.12	3.96	4.59	6.03		
C.Diff Healthcare associated rate per 100,000 occupied bed days	<=3.20	28.6	13.2	26.7	31.4	70.1	28.7	7.1	28.3	28.9	0.0	46.1	42.8	22.2	14.0		
90% of staff to complete Mental Health Act training.	90%	84.2%	84.2%	84.0%	83.0%	85.0%	86.0%	88.0%	86.0%	88.0%	86.0%	91.0%	89.0%	87.0%	82.0%		
Venous thromboembolism (VTE) risk assessment	95%	99.0%	98.9%	99.2%	99.2%	99.0%	99.0%	99.5%	98.9%	99.1%	99.0%	99.3%	98.9%	99.0%	99.2%		
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%	57.36%	59.97%	61.80%	64.21%	68.31%	68.31%	75.74%	76.83%	79.39%	80.86%	81.76%	83.00%	83.72%	84.48%		

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 December 2025 with 84% of the Improvement Plan actions delivered, this 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 0.52% below the compliance level. Learning disabilities training has been replaced with The Oliver McGowan Mandatory Training on Learning Disability and Autism Part 1 eLearning as of the 1st January 2026. Compliance from the learning disability has been transferred over to the new e-learning. New Tier's for Oliver McGowan training are currently being rolled out on a phased basis
	Improve Mental Health Act Policy Training Compliance to 90% for all *registered* staff via training and audit.	Mental health staff trained is 82% which is a decrease of 5% from November. Compliance for qualified staff has dropped to 86%. Compliance for HCAs & support workers has dropped to 74% from 85% as a result of several new staff in post who require training. Cragside are 70% compliant with training; an increase from the previous month which was 62%. This drop is largely due to new staff in post who require training. Sunniside decreased to 67% compliant, additional training sessions have been carried out for staff on inpatient wards to support with improving compliance. The CPN team performance is 100%, the Younger Persons Memory Service, memory hub, mental health liaison team and OT team all remain compliant at 100%. Bespoke training is arranged for all new staff members rotating into the team. 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. 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 14.0. 2 cases recorded in December, 30 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 December performance reported at 99.2%.
	Harm related falls will reduce by 5%.	89 harm falls were reported in December 2025, 2 of these were reported as severe harm. The falls steering group continue to meet and progress the current action plan. There was a discussion around the way the data is collated, which may be out of line with national reporting. A paper with a suggested change is being produced by the group to highlight the proposed changes, and will assist in determining new targets for falls prevention.
3	Evidence an agreed strategic approach to the development of an EPR supported by a documented and timed implementation plan.	Outline Business Case was presented 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	December position, 22 Risks with combined critical infrastructure risk score of 244 (decreased from 256 in November). No new risks identified, 1 risk reduced[ref 4805, legionella counts] and 1 risk closed [ref 3643, paediatric estate]
	Reduction in patient safety incidents linked to estate issues	5 patient safety incidents related to estates issues in December 2025. 3 incidents relate to patient falls. 2 incidents relate to lighting (one lights not working, the other the broken light fitting in Theatres) 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 December visits took place in New Paediatrics, Medical Physics and St Bedes, no issues were raised, all areas were fine across all elements.
	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

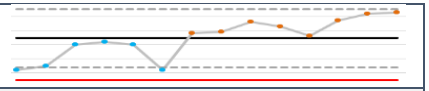
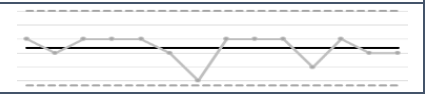
We will be a great organisation with a highly engaged workforce

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	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Ass/Var	Trend
LEADING INDICATORS																	
Maintain the vacancy rate at <=2.5%	<=2.5%	3.2%	3.5%	5.0%	5.2%	5.0%	3.2%	5.8%	5.9%	6.6%	6.3%	5.6%	6.7%	7.2%	7.3%	H, F	
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%	11.4%	11.5%	11.7%	11.3%	11.5%	11.8%	11.9%	11.9%	12.0%	11.7%	12.1%	12.6%	12.4%	12.1%	F	
Achievement of the internal sickness absence standard of 4.9%	4.90%	5.6%	5.7%	5.7%	5.7%	5.7%	5.7%	5.6%	5.6%	5.6%	5.6%	5.6%	5.5%	5.5%	5.5%	L, F	
Reduction in temporary staffing spend of pay bill evidenced month on month	<=2.3%	0.5%	0.4%	0.5%	0.5%	0.5%	0.4%	0.2%	0.5%	0.5%	0.5%	0.3%	0.5%	0.4%	0.4%	P	

Measures requiring focus this month

Measure	Summary
Maintain the vacancy rate at <=2.5%	Vacancy rate stands at 7.3% in December 2025, a 0.1% increase compared to November 25. Only nominal changes observed in both substantive WTE and budgeted establishment.
Improve the staff engagement score to 7.3	The annual staff survey results had a 42% completion rate, and an overall engagement score of 6.5. This is an increase of 0.87% compared to the July People Pulse, but an overall decline of 0.3 compared to the 2024 Staff Survey Results. There are various factors leading to this decline but areas with the largest in year change are career development and learning, advocacy and organisational confidence, and feeling valued. The results will cascade throughout in January/February, and the Board will agree the top 3 priority areas to address the greatest areas of dissatisfaction within the Trust, with an aim to improve the engagement score.
Achievement of the internal turnover standard of 9.7%	Turnover decreased to 12.1% in December 2025. Promotion as a voluntary leaving reason has shown an increasing trend since March 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 5.45% for a rolling 12 months in December 2025. In-month sickness absence was 6.1% in December 2025, 0.6% lower than the December 2024 rate. Anxiety, stress & depression continues to be the most prevalent reason for absence accounting for 34.7% of all sickness absence in the past 12 months with an estimated cost of £3.4M.
Reduction in temporary staffing spend evidenced month on month reduction and no higher than 2.3 % of pay bill.	Agency spend remains under target at 0.4% and has been consistently under target in the past 12 months. Both bank and agency spend increased in December. Agency spend continues in hard to fill specialist roles, Theatres (Nursing), Elderly Care (Consultant), Cardiac Diagnostics (HCS) and QEF (Coventry).

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	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 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	8.26	7.24	7.88	7.31	7.18	8.70	8.38	8.65	7.66	7.66	7.75	8.13	7.51	7.59		
Achievement of the 4 hours trajectory	>78%	73.0%	65.6%	71.2%	73.6%	74.5%	72.5%	79.0%	76.7%	82.2%	82.3%	77.4%	73.7%	77.6%	73.0%		
Achievement of the 52 week RTT standard	0	111	102	83	66	0	16	1	18	35	55	52	41	33	25		
Achievement of 2025/26 financial Plan - Variance (£k)	Figure in brackets favourable	(0.143)	(0.1)	(0.1)	(0.167)	(0.046)	0.272	0.224	0.261	0.337	-0.027	-0.174	-0.185	-0.032	-0.007		
Finance - Forecast Out-turn Deficit (Plan)	tbc	7,088	7,088	2,192	2,192	2,146	8,381	8,381	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	495	1036	466	208	71	52	31	47	16	13	67	337	98	240		
Reset April 2025 to align with 2025/26 operational guidance definitions	0.2%	5.1%	10.5%	5.2%	2.5%	0.7%	0.9%	0.5%	0.8%	0.3%	0.23%	1.19%	5.68%	1.61%	3.85%		
Reduce the number of patients with no Criteria to Reside	<10	41	40	44	46	47	43	46	54	49	45	43	45	42	48		
Achievement of the trajectory to achieve RTA to Bed within 1 hour	60.0%	4.7%	4.2%	4.3%	5.7%	6.3%	6.4%	16.1%	10.8%	19.1%	16.9%	10.3%	8.3%	13.5%	9.4%		
Reduce % of Follow up Outpatient without procedures *Reset April 2025 to align with 2025/26 operational guidance definitions*	<=67%	67.2%	66.3%	66.9%	67.3%	67.6%	67.5%	66.2%	64.6%	66.4%	66.7%	65.0%	65.2%	65.4%	67.2%		
2024-25 CRP Delivery Variance	Figure in brackets favourable	2,539	2,994	2,082	73	0	517	523	19	0	0	0	0	0	0		
No less than £5m cash as per forecast at March 2026	>=£5m	£5m	£5m	£5m	£5m	£5m	£32m	£28m	£16m	£24m	£31m	£22m	£24m	£18m	£19.m		

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**	Average Length of Stay increased slightly during December. This reflects ongoing challenges with patients for whom a suitable out of hospital placement has been difficult to source. Close monitoring of all discharges continues with focus on further reducing delays for pathway 0 patients as part of a NHSE sprint which the Medical Division is participating in.
	Achievement of the 4 hours trajectory	ED performance decreased to 73%. There was a clear focus on this throughout the month and this was supported through additional senior decision making capacity during the Industrial Action and actions implemented as part of the GIRFT "Further Faster" program for UEC. December attendances peaked at 10,468. This is the highest number since the pandemic occurred with a number of days seeing over 400 attendances which has not occurred during the last five years.
	Achievement of the trajectory to reduce >12 hour total time in Emergency Department	The number of 12 hour waits decreased in December, there were a number of challenging days (referenced above) when patients did not move from the ED in a timely manner. Planning discharge resource will support this.
	Achievement of the trajectory to achieve 60% RTA to Bed within 1 hour	This remains below target reflecting pressure on beds during December. Further work is being undertaken
	Reduce the number of patients with no Criteria to Reside	The December average patients was 48 reflecting further work around 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, all over 52 week waiters are in Trauma & Orthopaedics (lower limb) and 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. T&O waiters continue to reduce month on month.
	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 ensure we achieve the standard through the elective care transformation group.
2	**Evidence achievement of the 24-25 financial plan**	The Trust has a planned deficit at M9 of £8.182 and actual performance of £8.175m deficit which is a favourable variance of £0.0.07m. 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 M9 is £22.582m and actual performance of £22.582m; of which £14.744m 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 3 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	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Ass/Var	Trend
BREAKTHROUGH OBJECTIVES																	
Increase in the number of digital devices repurposed to the local community	>300	0	0	0	0	0	0	30	64	0	0	66	0	164	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%	90.0%	86.5%	88.4%	91.7%	92.8%	90.6%	88.8%	94.1%	95.5%	93.7%	91.0%	90.9%	89.1%	89.8%		
Reduction in the wait for gynaecology outpatients to no more than 26 weeks	<=26	40.3	38.3	37.0	32.6	28.9	28.9	31.1	31.7	33.0	32.0	32.0	32.0	29.9	29.0		
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30	<=30	61	61	65	70	74	61	52	65	42	69	38	27	62	58		

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 324 devices being recycled to date in 2025/26.
Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients	December compliance 89.8%, 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. Weekend working for the QUIT team is being implemented from late Jan 2026 which will ensure smoking status collection on weekends.
Reduction in the wait for gynaecology outpatients to no more than 26 weeks	The median wait has remained at 29 weeks in December. 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 commenced in November to focus on demand and ensuring patients are seen at the right place by the right team. Work continues to progress to mature this new way of working.
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 weeks	Current median wait has decreased to 58 weeks. Overall waiting list size continues to decrease each month but there continues to be a range of waits reported due to eligibility for the revised pathway, impacting the reported median wait. 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	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Ass/Var	Trend
LEADING INDICATORS																	
0.5% increase in QEF externally generated turnover from previous financial year	>=0.5%	4.0%	5.0%	6.0%	0.0%	0.0%	0.0%	7.5%	19.3%	24.0%	28.6%	22.9%	20.0%	19.0%	11.1%		

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

NHS
Gateshead Health
NHS Foundation Trust

Constitutional Standards 2025/26

Reporting Period: December 2025

Constitutional standards 2025/26	Constitutional Standards metrics Assurance Heatmap

NHS Gateshead Health NHS Foundation Trust

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

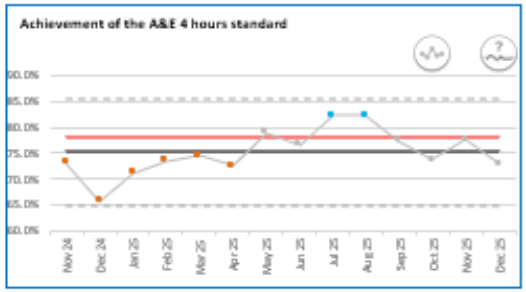
Metric	Target	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Ass/Var
Achievement of the A&E 4 hour standard	>78%	73.0%	65.6%	71.2%	73.6%	74.5%	72.5%	79.0%	76.7%	82.2%	82.3%	77.4%	73.7%	77.6%	73.0%	
12 hour trolley waits (DTA to left department)	0	1	30	0	0	2	0	1	2	1	0	2	21	6	2	
% of ED attendances > 12 hours in department (Type 1) *Reset April 2025 to align with 2025/26 operational guidance definitions*	0.2%	5.1%	10.5%	5.2%	2.5%	0.7%	0.88%	0.52%	0.77%	0.25%	0.23%	1.19%	5.68%	1.61%	3.85%	
Ambulance handover delays 30-60 minutes	0	10	43	21	4	6	11	4	16	5	1	8	21	7	23	
Ambulance handover delays over 45 minutes	0						3	1	5	0	0	0	8	1	15	
Ambulance handover delays 60 minutes +	0	1	51	14	0	7	1	0	0	0	0	0	3	0	9	
Achievement of the RTT 18 week standard	>92%	69.2%	69.8%	70.6%	71.3%	71.0%	69.4%	68.5%	68.3%	68.6%	67.4%	68.3%	67.9%	69.5%	70.1%	
Achievement of the 52 week RTT standard	0	111	102	83	66	0	16	1	18	35	55	52	41	33	25	
Achievement of the 6 week diagnostic standard	>95%	86.8%	83.3%	81.4%	86.4%	82.6%	77.4%	74.2%	77.3%	74.8%	71.1%	81.6%	86.3%	96.6%	95.9%	
Achievement of the Cancer 28 day standard *Reset April 2025 to align with 2025/26 operational guidance standard*	>80%	83.2%	84.1%	77.0%	80.7%	80.5%	70.1%	69.9%	77.2%	76.0%	75.6%	64.9%	74.7%	80.3%	73.3%	
Achievement of the Cancer 31 day standard	>96%	98.5%	98.9%	99.4%	100.0%	100.0%	99.5%	99.5%	97.9%	100.0%	97.9%	96.7%	100.0%	97.2%		
Achievement of the Cancer 62 day standard *Reset April 2025 to align with 2025/26 operational guidance standard*	>75%	74.8%	75.6%	80.2%	81.0%	82.1%	73.7%	67.7%	72.7%	75.3%	70.8%	71.1%	72.7%	69.3%		

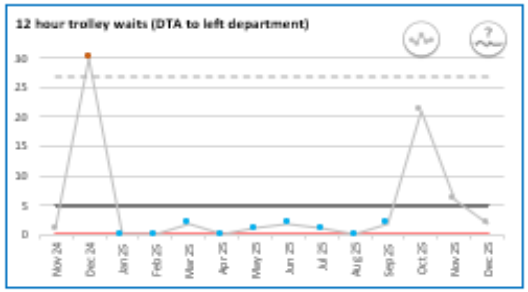
Validated data

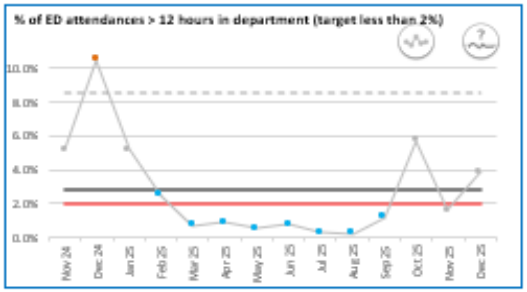
Constitutional Standards

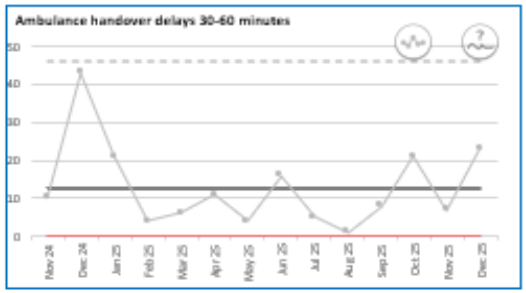
Metrics (SPC)

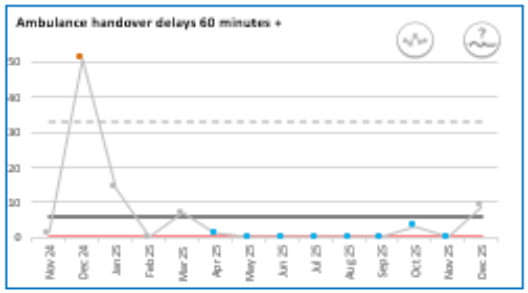
NHS Gateshead Health NHS Foundation Trust

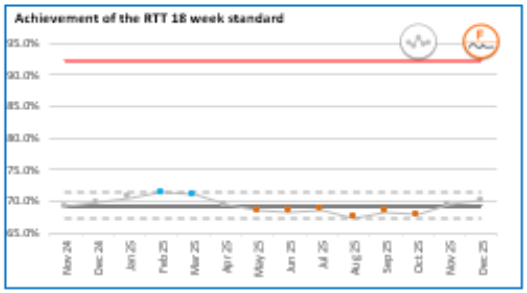


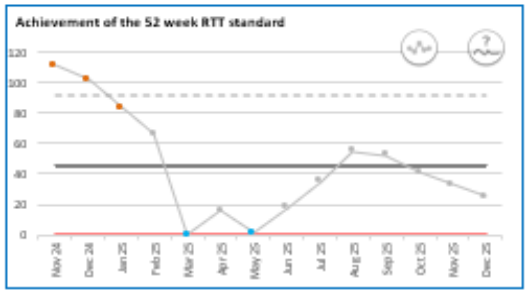


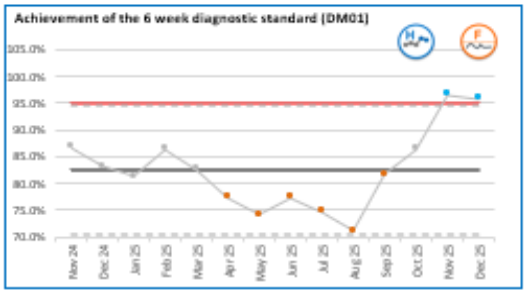


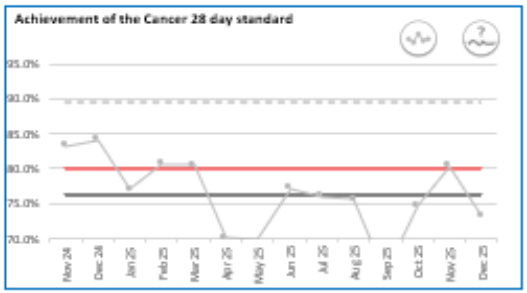


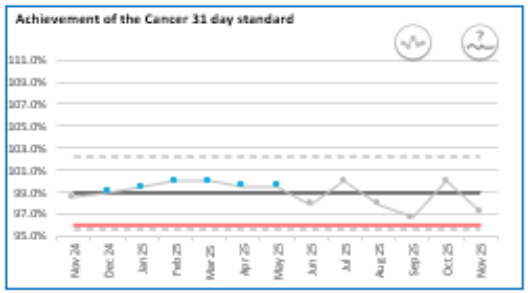


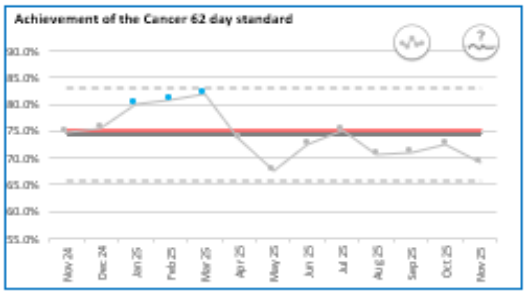












15. EPRR Core Standards Self-Assessment Report

Presented by the Group Chief Operating Officer

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 15

Report Title:	**EPRR annual assurance report 2025**			
Name of Meeting:	Trust Board			
Date of Meeting:	28 January 2026			
Author:	Patrick Cunningham – Business Continuity Coordinator			
Executive Sponsor:	Jo Halliwell - Group Chief Operating Officer and Accountable Emergency Officer (AEO)			
Report presented by:	Jo Halliwell - Group Chief Operating Officer and Accountable Emergency Officer (AEO)			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	The purpose of this report is to present the EPRR annual assurance report 2025 including the NHSE Core Standards self-assessment final submission.			
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:	Business Resilience Group 18 December 2025 Accountable Emergency Officer (January 2026) North East North Cumbria (NENC) ICB EPRR team (January 2026) Operational Oversight Group 6 January 2026			
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*	• It is a requirement that NHS Providers submit an annual self-assessment statement of assurance against the EPRR core standards to the Trust Board. • There were no significant changes to the core standards nor to the national assurance process in 2025. • The North East North Cumbria (NENC) Integrated Care Board (ICB) implemented a revised local check and challenge timeline and submission governance process for the 2025 submission that included: ○ A requirement for all organisations to submit their core standards self-assessments to the NENC ICB for 2025. ○ A revised focus on the core standards where an organisation had assessed that their compliance had			

<table>
<tr><td></td><td colspan="5">increased from red (non-compliant) or amber (partially compliant) to green (compliant)

• A robust internal check and challenge process with executive oversight from the Accountable Emergency Officer was undertaken prior to the submission.
• Following this process, the self-assessment of the EPRR core standards resulted in a self-assessed compliance rating of substantial compliance.
• The Trusts self-assessment was ratified and agreed by the ICB and partners through the check and challenge process confirming a rating of substantial compliance overall for 2025.
• It should be acknowledged that the Head of EPRR was unexpectedly absent from work from September 2025 and left the trust at the end of November 2025. The new Head of EPRR commences in post on 5 January 2026</td></tr>
<tr><td>Recommended actions for this meeting:</td><td colspan="5">The Trust Board are asked to:

a) Acknowledge the way in which the self-assessment process has been conducted resulting in a sustained Trust compliance rating of substantial compliance for 2025.
b) Acknowledge and reference the work of the EPRR and wider operational management team in the unexpected absence of the Head of EPRR to successfully conclude this process
c) Be assured that the self-assessment will be used to develop and prioritise the trust EPRR work-programme for 2026
d) Endorse the assurance provided within the 2025 Annual Assurance Report
e) Support the inclusion of the compliance rating in the Trust’s annual report for 2025.</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"></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>
</table>

Links to risks:	Risk 4571 - Failure to comply with EPRR NHS Core Standards Resulting in breach in compliance with associated increase in clinical and reputational risk.		
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

Gateshead Health
NHS Foundation Trust

Emergency Preparedness, Resilience and Response (EPRR)

Annual Assurance Report 2025

[EPRR Team]
Published: January 2026
Review date: July 2026

Gateshead Health NHS Foundation Trust

Contents

Gateshead Health NHS Foundation Trust

1. Introduction

The Civil Contingencies Act 2004 (CCA) (UK Government 2004) imposes a statutory duty on Gateshead Health NHS Foundation Trust (known as the Trust) to have in place arrangements to respond to incidents and emergencies. Under the terms of the CCA the Trust is a Category 1 Responder. This places a statutory duty upon the Trust to be able to respond to internal or external disruptive events that might impact on the Trust's ability to deliver its services.

The CCA also places other duties on Category 1 responders including the requirement to:

- Assess the risk of emergencies
    - Identify potential emergencies or incidents and their effects, then put plans into place to mitigate the effects or avoid it all together.
- Undertake Business Continuity Management
    - Create methods to ensure a swift return to business as usual.
- Plan for emergencies
    - Develop planned strategies that will mitigate the effects of an incident.
- Warn, inform and advise the public
    - Share information relevant to the public to raise awareness of actions before, during and after an incident.
- Co-operate
    - Through the Local Resilience Forum (LRF), category 1 and 2 responders establish best practice and common principles of action (JESIP)
- Share information
    - All relevant information that can support all responders must be shared to ensure a coherent and coordinated response.

The NHS Emergency Preparedness, Resilience and Response (EPRR) Guidance (NHS England 2015) requires the Trust to:

- Have suitable and up-to-date incident response plans which set out how the Trust would respond to and recover from a major incident/emergency which is affecting the wider community or the delivery of services
- Have business continuity plans that enable the Trust to maintain or recover the delivery of critical services in the event of a disruption.

The minimum requirements which the Trust must meet regarding EPRR are set out in the NHS England Core Standards for EPRR (Core Standards). These standards are in accordance with the CCA 2004 and the NHS Act 2006 (as amended). The standards are published annually. The Trust undertakes a self-assessment against these standards as part of the annual national assurance process and submits results to the Board for approval along with a summary of EPRR activities from the previous 12 months.

This report covers the period from January 2025 to December 2025.

Gateshead Health NHS Foundation Trust

2. Purpose of this report

This annual assurance report is intended to update on progress with the Trust's compliance level with the NHS England's Emergency Preparedness, Resilience and Response (EPRR) Core Standards and other statutory requirements placed upon the Trust by the Civil Contingencies Act (CCA) (2004) and the NHS England EPRR Framework.

It will summarise the NHS Core Standards annual self-assessment for the 2025 submission and will demonstrate the Trust's assurance position using information from multiple sources, independent reviews and organisational learning.

3. What are the NHS EPRR Core Standards?

It is a requirement that NHS providers submit an annual self-assessment statement of assurance against the Emergency Preparedness, Resilience and Response (EPRR) core standards to their board.

The purpose of the NHS core standards for emergency preparedness, resilience and response (EPRR) is to:

- enable health agencies across the country to share a common approach to EPRR
- allow co-ordination of EPRR activities according to the organisation's size and scope
- provide a consistent and cohesive framework for EPRR activities
- inform the organisation's annual EPRR work programme.

The EPRR assurance process is based on the NHS England (NHSE) Core Standards for EPRR that cover ten core domains:

1. Governance
2. Duty to risk assess
3. Duty to maintain plan.
4. Command and control
5. Training and exercising
6. Response
7. Warning and informing
8. Co-operation
9. Business continuity
10. Chemical biological radiological nuclear (CBRN) and hazardous material (HAZMAT).

In previous years there has been a request to undertake a thematic deep dive review. This was not required for the 2025 submission.

4. How are we assessed?

The overall EPRR assurance rating is based on the percentage of core standards that trusts self-assess against and their compliance with these. NHS provider organisations are required

to provide a RAG-rating for each applicable standard and provide evidence to support this assessment.

This is explained in further detail in figure 1:

Organisational rating	Criteria
Fully compliant	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non- compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

Figure 1 – NHS EPRR Core Standard ratings (November 2024)

The Trust's previous self-assessment position from 2024 was Substantial compliance (94%).

5. What is the process for NHS Core Standards Assurance Process 2025?

The national letter and excel template from NHS England setting out the process for the 2025 core standards assurance was received on 18 July 2025.

There were no significant changes to the core standards nor the assurance process nationally in 2025 however, there were changes to the local submission and check and challenge process.

Integrated Care Boards (ICBs) are responsible for determining and documenting their local assurance approach. This process must be clearly defined, formally agreed and signed off at the Local Health Resilience Partnership (LHRP).

As part of the 2025/26 assurance process, the following expectations apply:

- Evidence reviews must take place, with a specific focus on standards that have moved to "green" (fully compliant) since the 2024 submission
- The format of evidence reviews may vary to suit local system needs. This could include the use of evidence portals, face-to-face "show and tell" sessions or dip sampling. However, the method chosen must be clearly documented and aligned with the agreed local process
- Peer review should be included where providers have found it to be a valuable tool for

reflection and improvement

- ICBs should facilitate supportive assurance meetings to guide providers through the process, ensuring clarity, consistency, and a shared understanding of expectations.

NHS England will seek assurance that these local processes are robust, transparent, and enable meaningful evaluation of progress—particularly for standards previously assessed as non-compliant or partially compliant that are now reported as fully compliant.

6. What is the Trust position and how has governance been managed?

As a trust we continue to recognise the principles of this core standards process and acknowledge that this is important in light of the recent recommendations from the public enquiries into Covid-19, Manchester Arena and the Grenfell Tower fire.

The Trust has continued to work with the NENC ICB to review the self-assessment position to provide context, support and leadership.

A robust internal governance process was implemented to ensure there was appropriate risk assessment of the Trust self-assessment. This included

- a collation and review of all the evidence available and which would be presented in support of the assessment rating by the EPRR team
- an internal review process through the Trusts multidisciplinary Business Resilience Group
- review and compliance with the self-assessment process and associated self-assessment rating through the Operational Oversight Group
- a formal process of review and oversight from the Trust's Accountable Emergency Officer on the evidence and self-assessment compliance rating prior to final submission.

The NENC ICB undertook a review of the initial self-assessment and met with the Accountable Emergency Officer and Business Continuity Coordinator on 6 November 2025 to understand the self-assessment position. The purpose of this discussion was to support more objective local assurance and highlight areas for further work to strengthen arrangements with the changes in compliance rating of standards.

7. What is the Trust's final compliance assurance position?

The Trust accepted a number of recommendations from the check and challenge process from 2024 that were included as part of the EPRR work programme for 2025.

In 2024 the Trust achieved full compliance in 58 out of 62 standards with 4 standards being partially compliant resulting in a 94% overall rating and an organizational assessment of substantial compliance

The four partially compliant standards from 2024 were:

- Standard (14) - Countermeasures within the Duty to maintain plans
- Standard (29) - Decision-logging within the Response
- Standard (53) - Assurance of commissioned providers / suppliers BCPs within the Business Continuity
- Standard (49) - Data Protection & Security Toolkit compliance

The evidence submitted for 2025 included the following developments and improvements

- Standard (29) - Decision-logging within the response moved to fully compliant
- Standard (49) - Data Protection & Security Toolkit moved to fully compliant

- Standards (14) - Countermeasures and (53) - Assurance of commissioned providers / suppliers BCPs remain as partially compliant with further work to undertake in relation to assurance of supplier's business continuity plans. This has been raised as a challenge through the regional team to the national procurement team

- All the other standards remain compliant (60 out of 62 standards at 97%)

The Trust's final reported self-assessment for 2025 was:

Overall assessment:	Substantially compliant

Although the rating remains the same as 2024 there is evidenced improvement in standard compliance.

A summary of the standards submission assessment scores for 2025

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non-Compliant
1 **Governance**	6	6	0	0
2 **Duty to Risk Assess**	2	2	0	0
3 **Duty to Maintain Plans**	11	11	0	0
4 **Command and Control**	2	2	0	0
5 **Training and Exercising**	4	4	0	0
6 **Response**	7	6	1	0
7 **Warning and informing**	4	4	0	0
8 **Cooperation**	4	4	0	0
9 **Business Continuity**	10	9	1	0
10 **Hazmat/CBRN**	12	12	0	0
Total	**62**	**60**	**2**	**0**

The check and challenge session held between the Trust and representatives from the ICB on the 6 November 2025 reviewed the body of evidence and confirmed the movement in key standards from previous submissions. The internal self-assessment was validated in this meeting with no feedback received which would amend the self-assessment undertaken.

A final check and challenge session with the Local Health Resilience Partnership (LHRP) took place on 20 November 2025. The final Gateshead Health self-assessment and compliance rating was verified by the partnership.

8. What does this mean and how do we compare regionally?

As a trust there continues to be a clear ambition and intent to continue to develop and enhance our capabilities and capacity in line with the NHSE EPRR Framework.

The Trust continues to meet the requirements of the Civil Contingencies Act 2004, the NHS Act 2006, the Health and Care Act 2022, the NHS standard contract and NHS England business continuity management framework.

A regional comparison of the final self-assessment ratings highlighted below demonstrates that the Trust is amongst the highest achieving final provider self-assessment ratings

Organisation	Assurance rating 2025
Northumbria Healthcare	Substantial
Northeast Ambulance Services (NEAS)	Substantial
Gateshead Health NHS Foundation Trust	Substantial
South Tyneside and Sunderland NHS Foundation Trust	Substantial
County Durham and Darlington NHS Foundation Trust	Substantial
North Cumbria Integrated Care Foundation Trust (CIC)	Substantial
North Tees NHS Foundation Trust	Partial
Cumbria, Northumberland, Tyne and Wear Mental Health Trust (CNTW)	Substantial
South Tees NHS Foundation Trust	Partial
Newcastle upon Tyne Hospitals NHS Foundation Trust (NuTH)	Partial
Tees, Esk and Valley Mental Health Foundation Trust (TEWV)	Partial
North East North Cumbria Integrated Care Board (NENC ICB)	Substantial

9. How can we demonstrate assurance?

Our journey has continued on a pathway to develop and improve our EPRR capacities, capability and compliance rating. The Trust can demonstrate a number of specific examples from various internal and external sources highlighting our EPRR approach during 2025 this includes:

- an embedding of our strengthened governance and oversight arrangements
- an annual review of plans, arrangements, frameworks and protocols with newly developed plans for new and emerging pandemics, evacuation, lockdown and protected individuals
- a review of our Business Continuity Policy and continued progress with the business continuity review
- a focus on exercising to ensure our staff are competent and confident including a live CBRN exercise
- a constant evolving pathway of organisational learning and opportunities for improvement
- a critical incident declaration (PACS outage in April 2025) having a significant impact involving SCC support with substantial identified organisational learning

A robust internal trust governance process for 2025 was implemented with:

- development of this year's submission through our corporate governance structure (with support from the Deputy Accountable Emergency Officer) within a multi-disciplinary team approach
- an external peer review with North Tees Foundation Trust on 11 September 2025
- an internal check and challenge with oversight and agreement from the Accountable Emergency Officer on 30 October 2025

The following section provides a summary of progress within the core standard domain areas:

Domain 1 – Governance

- The Trust has identified a formal deputy at an Executive level to provide resilience to the Accountable Emergency Officer.
- The Trust has an up-to-date EPRR Policy aligned to requirements of the core standards with supporting work programme and resource; an embedded process for continuous improvement; an annual report presented to Trust Board; with oversight from the Accountable Emergency Officer that demonstrates a strong approach to governance.
- The Business Resilience Group provides assurance that the Trust is delivering on its statutory responsibilities' duties under Civil Contingencies Act 2004 and is compliant with the responsibilities as a Category One responder as part of the corporate governance structure.
- The EPRR Team have coordinated 16 debriefing programmes during 2025 on a range of issues from training and exercising feedback and from response to issues, identifying organisational learning which has resulted in changes to policy, training opportunities and improvements in clinical risk management for example through the Surgical Site Infection response.

Domain 2 – Duty to risk assess

- A robust risk assessment and management process can be illustrated that regularly assesses threat and risk from a national, community and Trust perspective; monitored within EPRR with appropriate escalation as an organisation when required

- The EPRR/Business Resilience Group Risk Register takes account of the Northumbria Local Resilience Forum community risk register (re-published in April 2025) and includes reasonable worst-case scenarios specific to the Trust.
- Actions to mitigate the assessed risks where required are agreed and form part of the EPRR Work Programme.

Domain 3 – Duty to maintain plans

- There is a continuous annual programme of review to ensure that the duty to maintain plans remains current.
- Plans are reflective of national guidance and risk assessments as well as national planning assumptions and are developed in collaboration with other partners.
- Strong engagement and collaboration arrangements can be emphasised internally and externally to develop and review plans in a balanced and proportionate approach dependent upon the level of threat and risk.

Domain 4 – Command and control

- A resilient and dedicated 24:7 on-call mechanism can be highlighted to appropriately respond and escalate issues with ongoing professional development of on-call staff.
- The trust has developed a formal training and exercising plan for on-call teams to ensure annual training to support the delivery of the NHS England Principles of Health Command and a dynamic training needs analysis underpins this.
- The Strategic and Tactical health commander portfolios were launched to on-call teams during 2024, and opportunities for training are accessible to team members to ensure compliance.

Domain 5 – Training and exercising

- A robust training and exercising programme was implemented with a number of exercises held during 2025.
- Exercise Antidote was a no notice clinically led, management supported live major trauma simulation exercise that was held on 10 July 2025.
- There was participation in Exercise Pegasus – national tier 1 exercise on pandemic preparedness and with Exercise Cerberus – regional exercise on response following the recommendation of the Manchester arena enquiry
- Exercise Paddington has been undertaken within Maternity Services which identified additional safety mechanism to be put into place by the team
- Local exercising to test local risks and business continuity planning has continued to take place with teams and services throughout this year.

Domain 6 – Response

- On 7 April 2025, the Trust declared a critical incident following a total loss of the PACS (Picture, Archive and Communication System) IT system. This response involved external health system organisations supporting with mutual aid to assist the robust

internal response that was stood down on 17 April 2025. The full Incident Response followed the principles and processes embedded with our EPRR response with internal and external organisational debrief programmes taking place to capture identified learning. This has been factored into a number of Business Continuity plan changes

- The Trust can demonstrate a number of robust arrangements in place to support the response element – this has been evidenced in our response to a number of internal and external issues including:

    - Internal organisational response to severe site pressures (December 2024 to January 2025)
    - External closure of the Gateshead Flyover (December 2024 onwards)
    - Planning and response to Storm Eowyn (January 2025)
    - Internal PACS (Picture, Archive and Communication System) system issues (February to March 2025)
    - Internal PACS system outage with a critical incident declaration (April 2025)
    - External NEAS IT outage issue with critical incident declaration (May 2025)
    - Industrial action - Resident Doctors (3 periods) (July 2025, November 2025 and December 2025)
    - Planning for protest activity (September 2025)
    - Internal loss of emergency bleep system (September 2025)
    - GP collective action (Throughout the year)
    - Various blood shortage alerts (Throughout the year)
    - Paediatric audiology issue (Throughout the year)

- Various requests for mutual aid supported by our health provider organisations.

Domain 7 – Warning and informing.

- There are effective arrangements in place to warn and inform; communicate with partners and stakeholders and liaise with the media when required.
- A formal and informal information cascade process is in place and has been demonstrated as effective throughout the year
- The arrangements have been reviewed, extensively tested and demonstrated in the Trust response to the critical incident declaration during April 2025.

Domain 8 – Co-operation

- The Trust continues to co-operate with partner organisations within the Northumbria Local Resilience Forum (NLRF) and Local Health Resilience Partnership (LHRP) and as part of recognised arrangements regional and locally with NHS England (NHSE) and the North East North Cumbria Integrated Care Board (ICB)

Domain 9 – Business Continuity

- A review programme of business continuity continues and has progressed throughout the year

- The Trust has transitioned from a paper-based Business Continuity system to a digital platform to strengthen monitoring of plans and arrangements, regularly review, test and exercise with a clear direction of travel for 2026

Domain 10 – CBRN/HazMat

- Exercise Antidote was a no notice clinically led, management supported live major trauma simulation exercise that was held on 10 July 2025 that focussed on a CBRN scenario. This was delivered in partnership with NEAS and QEF colleagues.
- Identified learning has been captured and will be reviewed and embedded in preparation for an external audit that will take place in July 2026 on our response arrangements.

10. What are the priority areas for development?

Providing the self-assessment process remains consistent, the Trust has a clear picture of the expectations and development required for 2026 submission. In the event that the standards are amended we will review our workplan accordingly.

Our priority areas and direction of travel for 2026 include:

- Continued testing and amending of our plans to ensure that teams are familiar with their content and that they actively reduce clinical and organisational risk
- A focus on sustaining a substantial compliance rating
- A clear trust ambition to continue to develop and enhance our EPRR capabilities and capacity, strengthening our quality of evidence
- A continued focus on training and exercising across all domains
- Implementation of the business continuity software solution to allow us to provide consistency to alleviate and assist with the day-to-day management of issues
- A continued review of plans, frameworks and protocols to strengthen our arrangements
- An embedding of identified organisational learning
- Use of the self-assessment as a benchmark for prioritisation of the trust EPRR development work-plan for 2026
- A trajectory to continue to work collaboratively with the NENC ICB and other health providers to identify best practice and enhance threshold of evidence

11. Conclusion and next steps

The evidence provided within this report provides assurance that the Trust continues to anticipate; assess; prevent; prepare; respond and recover from any disruptive events or incidents as part of the Integrated Emergency Management cycle.

There is a recognition that this self-assessment process is a constantly evolving journey and pathway of organisational learning. The EPRR Team have continued to use the core standards as a benchmark for directing the priorities of the Trust EPRR workplan; indicate a measure of

progress, and to identify and embed internal organisational learning and opportunities for improvement.

12. Further information

For further information, please contact:

Emergency Preparedness, Resilience and Response (EPRR) Team,
Gateshead Health NHS Foundation Trust

16. Freedom to Speak Up Guardian Report

Presented by the Freedom To Speak Up Guardian

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 16

Report Title:	**Freedom to Speak Up Report - Update**			
Name of Meeting:	Board of Directors			
Date of Meeting:	Wednesday 28th January 2026			
Author:	Andrew Lamb, Interim Freedom to Speak Up Guardian			
Executive Sponsor:	Beth Swanson, Interim Chief Nurse and Professional Lead for Midwifery and AHP Amanda Venner, Group Director of People and OD			
Report presented by:	Andrew Lamb, Interim Freedom to Speak Up Guardian			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To provide an update of the FTSU activity for the period of January – December 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*	QGC meeting 19th December 2025 POD Steering Group 6th January 2026 POD Committee 13th January 2026			
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*	During the period of July – October 2025 there was no FTSUG cover in the Trust due to the substantive post holder requiring to take a period of leave of absence. Interim cover arrangements we put in place from 13th October 2025, initially for a period of 6 months. Interim FTSUG has completed the National Guardians Office training and is now registered as the Trusts FTSUG with the NGO. Inappropriate behaviour remains a recurrent theme highlighted by teams across the organisation The introduction of the Staff Experience and Inclusion Oversight Group and POD Culture Insight and Triangulation meetings support sharing of data for triangulation and will also support future improvement programmes.			

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Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	• Note this report as evidence of the ongoing work of the Freedom to Speak Up Guardian in supporting our staff in making speaking up business as usual. • Recognise the work to date that commits our organisation to embed the 'Speak Up, Listen Up and Follow Up' principles and practices • Continue the Trusts commitment to ensuring every voice is heard.	
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):	1.1 We will be a clinically-led organisation focused on delivering safe, high quality care and improving health outcomes for our patients. 1.2 We will ensure our patients experience the best possible compassionate care and make every contact count. 2.1 We will care for our people, creating a fair, inclusive and respectful environment where everyone can thrive in their role.	

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):	4797 - There is a risk that colleagues have negative experiences at work and do not feel valued or respected in the workplace as highlighted by the staff survey. This is a result of poor behaviours displayed by other colleagues that are not acceptable and not line with Trust values or behavioural framework. This results in ongoing low engagement, increased turnover, burnout, and higher levels of sickness absence which may result in compromised quality of care for patients.

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

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Freedom to Speak Up Guardian Report

1. Executive Summary

This report summarises Freedom to Speak Up (FTSU) activity between January and December 2025. While the absence of the substantive Guardian led to a temporary dip in reported cases during Q2, interim cover has now been established with full training and NGO registration. The data continues to highlight concerns about behaviours, culture and civility, with particular hotspot areas in Theatres, Recovery, Domestic Services and EAU. Protected characteristic groups remain less likely to raise concerns, which reinforces the need for targeted support and visible leadership action. Work is underway to strengthen triangulation, improve transparency and embed learning through listening sessions, refreshed policy and SOPs, publication of the route map, and monthly engagement with senior managers. National data submissions remain on schedule and links across the regional Guardian network have been established. The Board is asked to note the progress to date, recognise the strengthened infrastructure around FTSU, and support the Trust's ongoing commitment to "Speak Up, Listen Up and Follow Up" so that every voice is heard and acted upon.

2. Introduction

Freedom to Speak Up is about encouraging a positive culture where people feel they can speak up and their voices will be heard, and their suggestions acted upon. Freedom to Speak Up Guardians (FTSUG) ensure that people who speak up are thanked, their issues are responded to and the person speaking up receives feedback on the actions taken.

The Board has a key role in shaping the culture of the Trust. Freedom to Speak Up is an important component in respect of developing an open, transparent and learning culture.

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

The FTSUG reports to the Board twice per annum and presents a paper to People and OD Committee. Papers are also submitted to the Quality Governance Committee (QGC) and Audit Committee.

During the period of July – October 2025 there was no FTSUG cover in the Trust due to the substantive post holder requiring to take a period of leave of absence. Interim cover arrangements we put in place from 13th October 2025, initially for a period of 6 months.

Interim FTSUG has completed the National Guardians Office training and is now registered as the Trusts FTSUG with the NGO.

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This report provides the Board with a summary of FTSU activity from 1st January 2025 – 31st December 2025

3. Key issues / findings

- Appendix 1 below provides an oversight of the FTSU cases from Q4 2024-25 to the end of Q3 2025-26.

    - It should be noted that there is a decrease in FTSU activity during this period compared to the previous year due to no FTSU cases being reported in Q2 as substantive FTSU Guardian was on a leave of absence and interim cover arrangements were being organised,

    - The current data demonstrates the following
        - 64% of cases reported relate to concerns raised about staff – culture, bullying and harassment, inappropriate behaviours and attitudes etc.
        - 18% of cases reported related to worker safety
        - 11% of cases reported related to patient safety or quality of patient care
        - The remaining 7% related to various miscellaneous issues including detriment, fraud or non-classified cases,
        - As per page 11 this data suggests that we are broadly in line with the national reporting for categories of concern.

    - To support Business Unit awareness and learning, monthly meetings are now in place with senior management.

3.2 What currently is this telling us?

- Staff with protected characteristics are the group of staff who are less likely to raise concerns. Currently 44 cases out of a possible 83 (53%) were linked to protected characteristics.
- During this period the data informs us that there have been some key hotspot areas including Theatres, Anaesthetics and Recovery, Domestic Services and EAU.
- Further interventional work has been undertaken in these areas of the Trust following both number and nature of concerns raised and incidents which have occurred within this reporting period. This includes listening sessions in EAU for historic cases, and theatres to support staff following recent incidents which have occurred and current broader data analysis for theatres to look at incivility, behaviours and leadership.
- The data also allows us to see where our key areas of improvement are still required. Incivility, managers not displaying ICORE Values, communication and lack of care/compassion being the highest priority areas. The continued collection of the data also highlighted the

requirement of other categories to be included in the key word findings to support learning which will be incorporated and collected in future reports.

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

- The introduction of the Staff Experience and Inclusion Oversight Group and POD Culture Insight and Triangulation meetings support sharing of data for triangulation and will also support future improvement programmes.
- All cases have been discussed with the appropriate Senior Manager and Executive Lead for FTSU, as well as being escalated to line managers / business unit leads to be investigated and resolved.
- Route map for raising concerns has been developed and published
- Development of FTSU policy SOP
- FTSU policy updated with contact information for key contacts and reference to the FTSU route map.
- Quarterly data submitted to NGO as per schedule
- Quarterly network meetings established with other FTSU Guardians within the Great North Healthcare Alliance in addition to meetings organised by NGO.

3.4 National Update:

- Following the government's acceptance of the Dash review recommendation, it has been confirmed that the National Guardian's Office (NGO) is planned to close on 30th June 2026.
- This timeline allows for an engagement process with NGO staff, guardians, NHS leaders and broader stakeholders about the future of the Freedom to Speak Up programme and its functions and will ensure continued support for guardians during the transition.
- In January 2026, NHS England, on behalf of the closure board, will be seeking views on what should stop, start or continue, and what functions might become the responsibility of employers. The feedback gathered will inform proposals for the future of Freedom to Speak Up.

4. Solutions / recommendations

The Trust Board is asked to:

Note this report as evidence of the ongoing work of the Freedom to Speak Up Guardian in supporting our staff in making speaking up business as usual.

Recognise the work to date that commits our organisation to embed the 'Speak Up, Listen Up and Follow Up' principles and practices.

Continue the Trusts commitment to ensuring every voice is heard.

5. Next Steps:

The committee will be kept informed of any developments or recommendations arising from the National Guardian Office.

The Freedom to Speak Up Guardian will provide further updates and assurance to the Board, People and OD Steering Group, Audit Committee and Gateshead Quality Governance Committee as per the cycle of business.

Following feedback for the POD Committee held on 13th January 2026, the Freedom to Speak Up Guardian will work with the Freedom to Speak Up NED Lead to strengthen how future data is presented to ensure it is more transparent and supports discussion, scrutiny and assurance.

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Appendix 1

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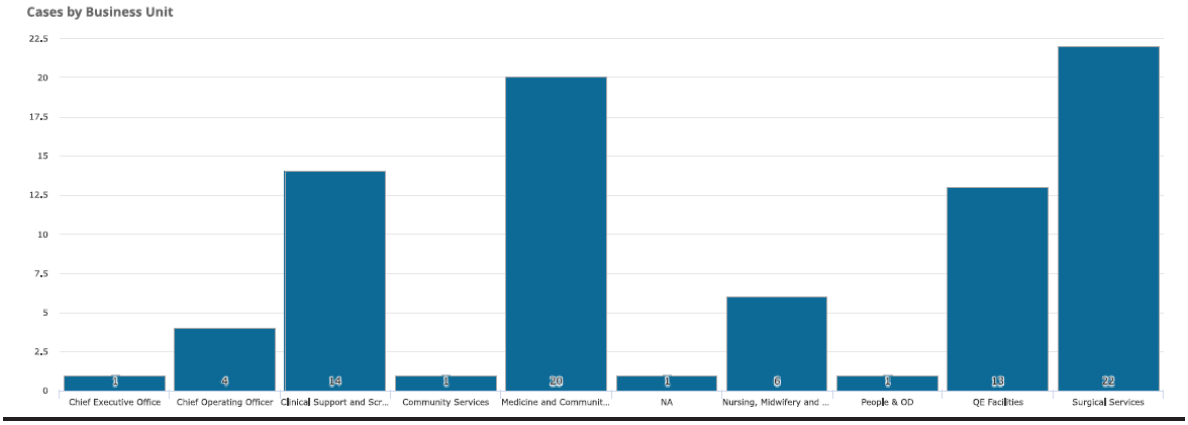
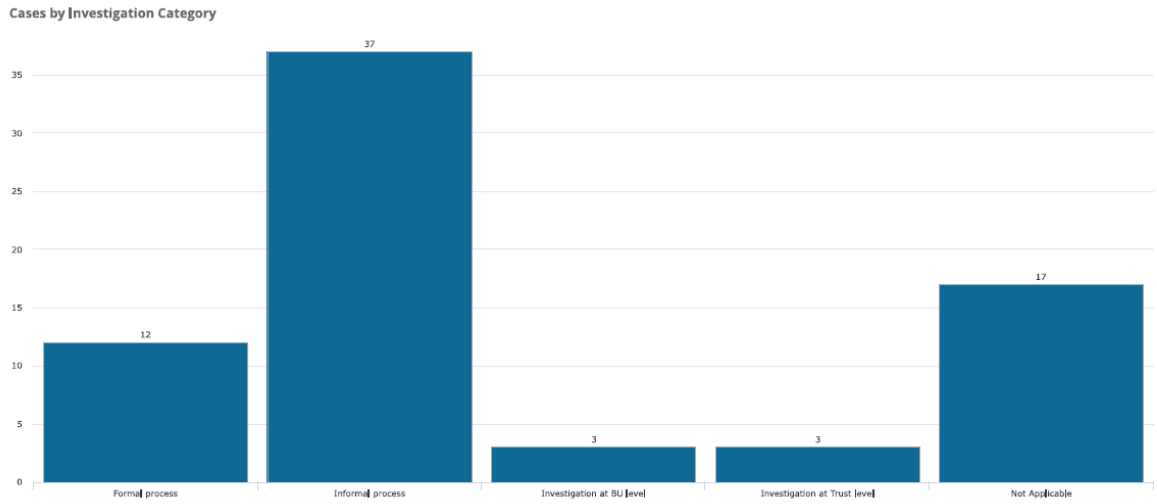
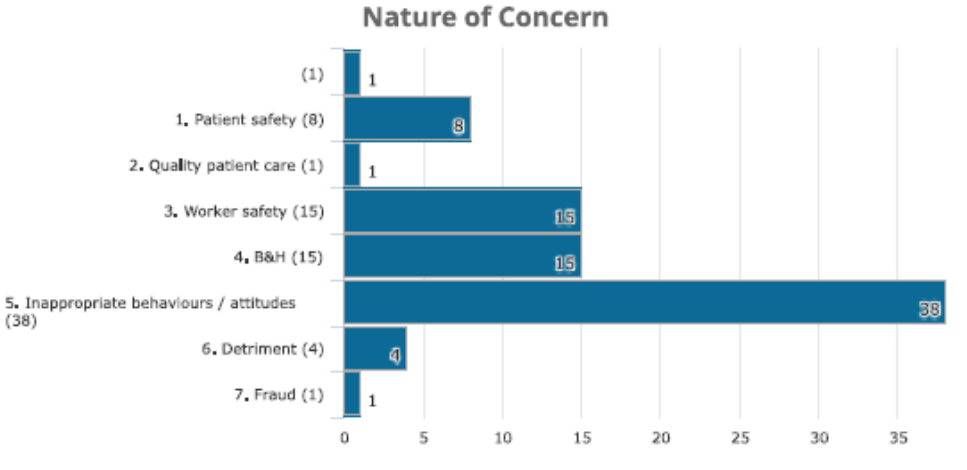
FTSU Report – Areas, Concern & Learning







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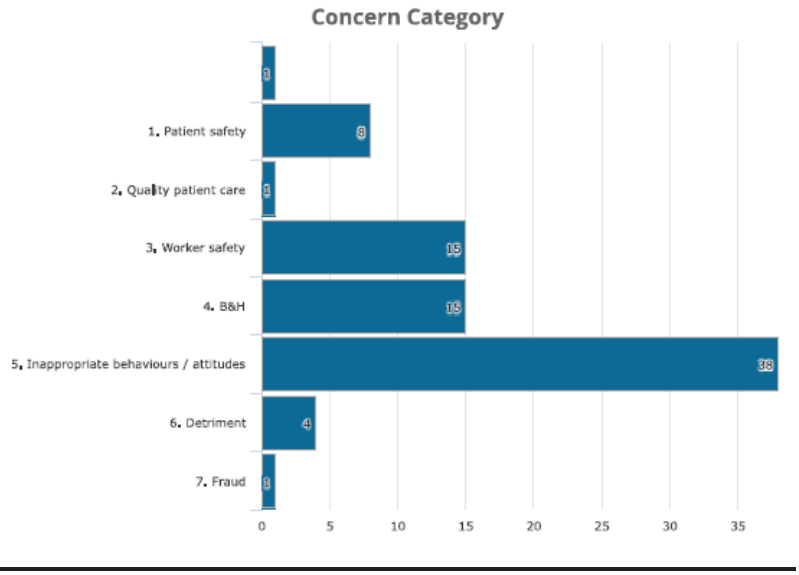

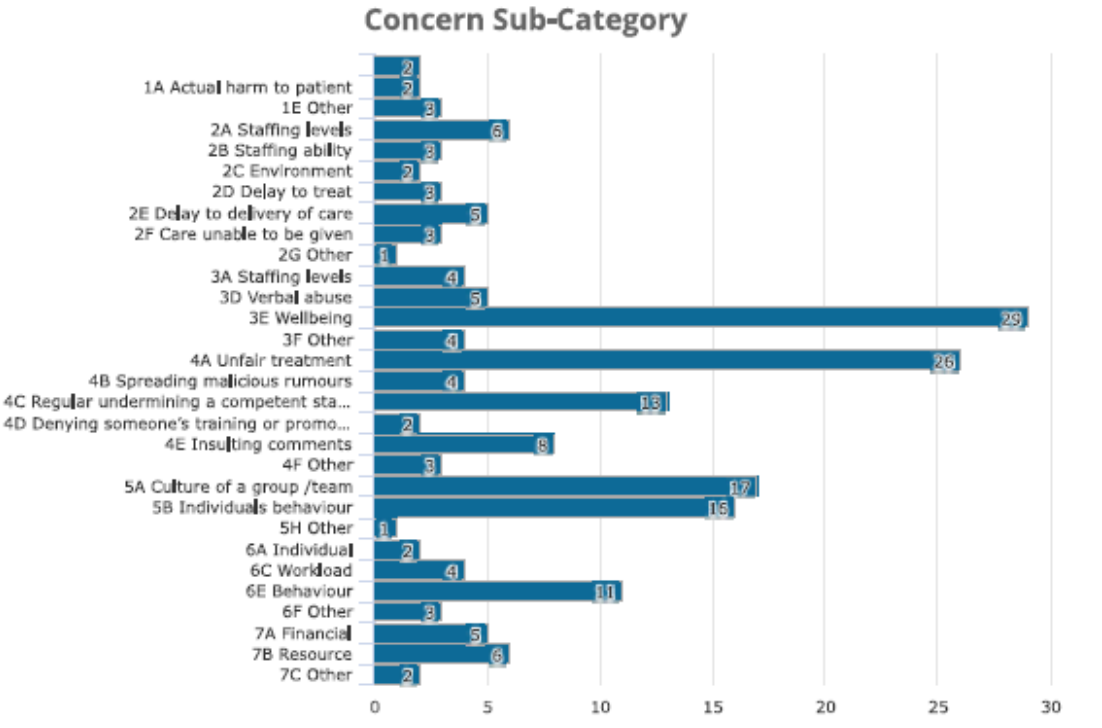

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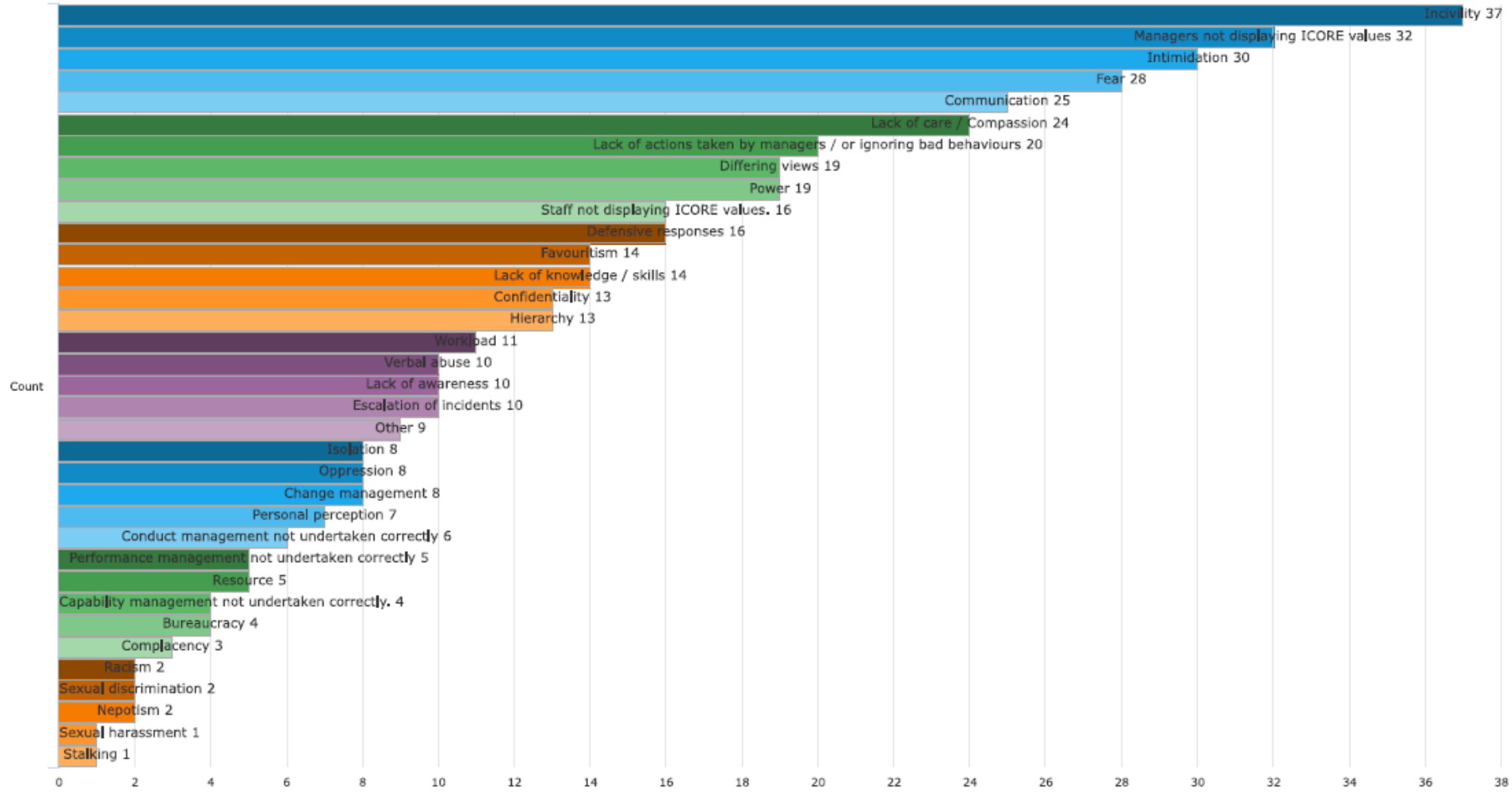
The graph below shows key phrases & number of occurrences allocated to freedom to speak up cases.



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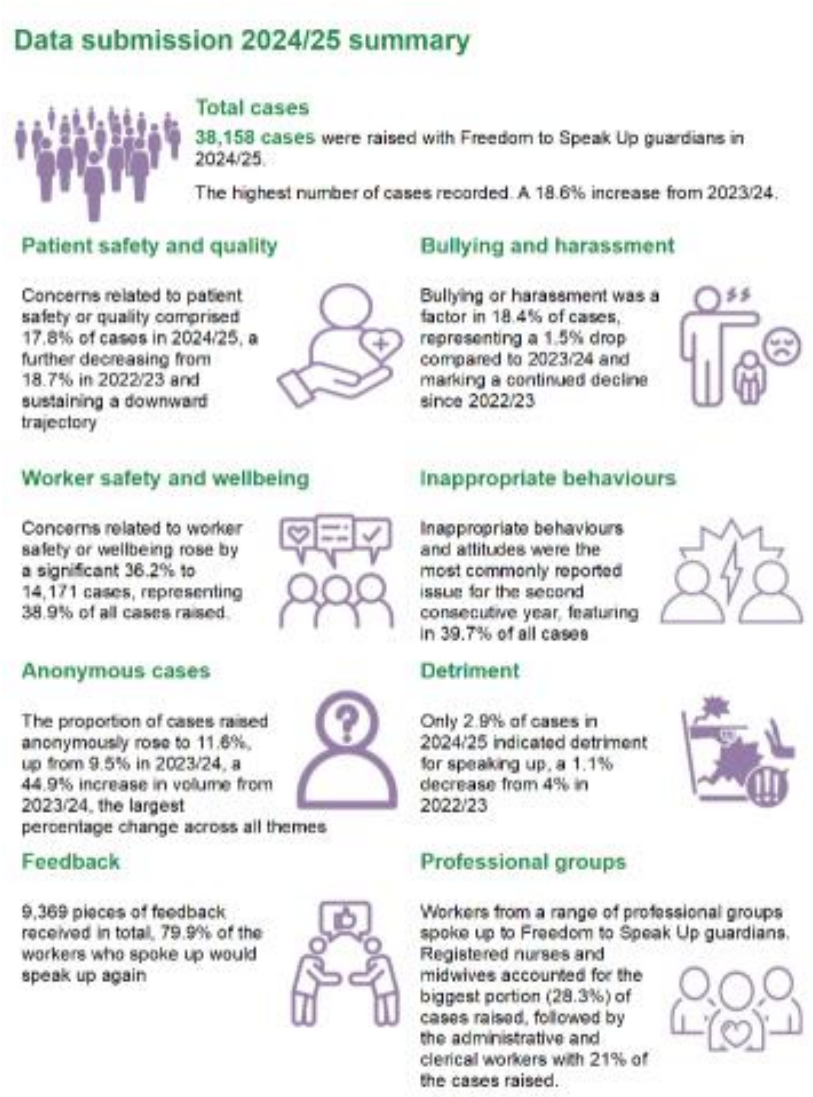
Appendix 2 – NGO Data Submission 2024/25 Summary



Full Annual Report available on the NGO website for 2024/25
[20250702-Annual-data-report-2425-Publishable.docx]

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

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 17

Report Title:	**Maternity Integrated Oversight Report December 2025**			
Name of Meeting:	Trust Board			
Date of Meeting:	28th January 2026			
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 and neonatal metrics for December 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 13/01/2026 Division of Surgery, Women's Health and Children Operational Board 28/01/2026			
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** • Increase in caesarean section rate now flagging on SPC • Risk register – emerging/increasing risks – Maternity Theatre staffing (#4852, grade = 15) & Antenatal Clinic Capacity (#4712, grade = 12) • 5 red flag events in December 2025 – main cause is midwife scrubbed in theatre, escalation used to maintain safety (delays to elective care, redeployment of staff) **Advise** • Maternity Incentive Scheme Year 7 – final compliance/sign-off – SA 2, 3, 5, 7 & 8 evidence reviewed & signed off by safety champions, remaining evidence awaiting confirmation at Q3 LMNS meeting of compliance then for final sign-off by QGC in February			

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	• Workforce – red flags, theatre & ANC as per risk register, review of ANNP/paediatric rota gaps • New format IOR – based on national templates, approved by safety champions – for feedback please **Assure** • Regional (NEY) maternity heatmap – currently awaiting procurement of software to enable access, Gateshead ranked 6/21 • Complaints – no clear themes, listening to patients/attitudes & behaviours feature, delay for non-obstetric input • Duty of Candour Q1-Q3 compliance, 100%, 2 cases till under review • Perinatal culture action plan review – not underone formal review but actions have been ongoing, feeding into 2026/26 service line priority planning
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	Accept this paper as minimum data reporting to Trust Board/QGC and assurance/escalation of the service Approve final sign-off arrangements for MIS Year 7
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):	2369 – Maternity Theatres – risk closed & replaced by emerging risk 4852 4712 – Antenatal clinic capacity

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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 December 2025

New format IOR – for feedback please

Executive Summary

Alert: Alert to the matters that require the Board's attention or action, eg. non-compliance, safety or a threat to the Trust's strategy

- Increase in caesarean section rate now flagging on SPC
- Risk register – emerging/increasing risks – Maternity Theatre staffing (#4852, grade = 15) & Antenatal Clinic Capacity (#4712, grade = 12)
- 5 red flag events in December 2025 – main cause is midwife scrubbed in theatre, escalation used to maintain safety (delays to elective care, redeployment of staff)

Advise: Advise of areas of ongoing monitoring or development or where there is negative assurance. Discussion of ongoing risks or identification of new risks

- Maternity Incentive Scheme Year 7 – final compliance/sign-off – SA 2, 3, 5, 7 & 8 evidence reviewed & signed of by safety champions, remaining evidence awaiting confirmation at Q3 LMNS meeting of compliance then for final sign-off by QGC in February
- Workforce – red flags, theatre & ANC as per risk register, review of ANNP/paediatric rota gaps
- New format IOR – based on national templates, approved by safety champions – for feedback please

Assure: Assure and inform the Board where positive assurance has been achieved, share any practice, innovation or actions that have been identified

- Regional (NEY) maternity heatmap – currently awaiting procurement of software to enable access, Gateshead ranked 6/21
- Complaints – no clear themes, listening to patients/attitudes & behaviours feature, delay for non-obstetric input
- Duty of Candour Q1-Q3 compliance, 100%, 2 cases till under review
- Perinatal culture action plan review – not underone formal review but actions have been ongoing, feeding into 2026/26 service line priority planning

Slide No.	Metric *data reporting is for preceding month - January 2026 report is December 2025 data	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Notes
Monthly reports														
	Minimum board measures data set	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	Monthly Maternity dashboard activity data	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	Maternity Incentive Scheme compliance	✓	✓	✓										Year 7 final submission March, await Year 8
	Maternity Outcomes Signal (MOSS)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	Regional Heatmap	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	No access yet to Heatmap
	MDT workforce	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Exception reports (as required)														
	SPC exception reports	✓												LSCS rate ↑
	PSII/MNSI/perinatal mortality – new & completed cases	0												
	Risk register – new emerging risks & updates	✓												
Quarterly reports		Q3 2025/26			Q4 2025/26			Q1 2026/27			Q2 2026/27			
	Perinatal Mortality Review Tool (PMRT)	✓			✓			✓			✓			
	Transitional Care & ATAIN (avoiding term admissions to neonatal units)			✓			✓			✓			✓	
	SBLCB (Saving Babies Lives Care Bundle)		✓			✓			✓			✓		Q4 SBLCB dates/monitoring tbc
	Complaints, Compliments & Incidents	✓												
	Maternity & Neonatal Workforce		✓			✓			✓			✓		
Bi-annual reports		Q3 & Q4 2025/26						Q1 & Q2 2026/27						
	Legal NHSR Scorecard/DofC compliance	✓				✓						✓		Scorecard reported in Dec 25, DofC compliance in Jan IOR
	Culture survey action plan	✓						✓						
Annual reports inc staff survey, RCOG trainee survey, CQC Maternity survey														Variable dates

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	0	0			
Number of MNSI cases		0	0	0	0	0	0	1	1	0			
Number of incidents logged as moderate harm or above		0	0	1	0	0	0	1	1	0			
Minimum obstetric safe staffing on labour ward		100%	100%	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%	94.3%	88.2%			
	Night shift	97.8%	99.1%	99.3%	99.5%	98.8%	99.0%	99.1%	100.1%	100.8%			
	Midwife:Birth ratio									TBC			
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				93.3%			
	Complaints	2	2	2	1	2	0	1	4	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	0	0			
Coroner Reg 28 made directly to Trust		0	0	0	0	0	0	0	0	0			

Maternity Dashboard 2025/2026

Maternity

Gateshead Health NHS Foundation Trust

Safe

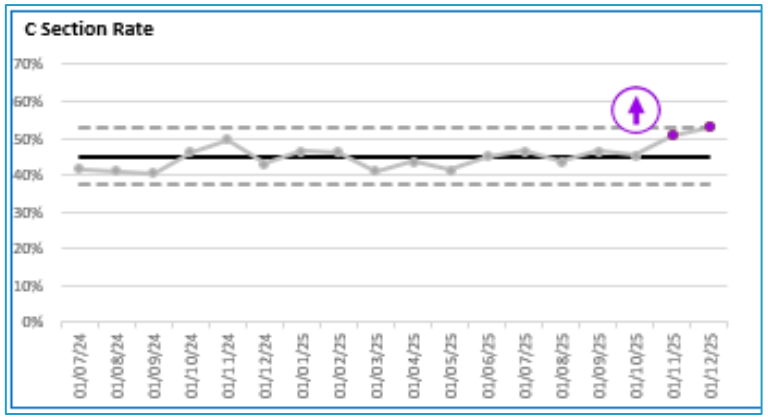
Responsive

Effective

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Births	Dec 25	140	-			160	125	194
Spontaneous vaginal deliveries	Dec 25	49	-			70	47	92
Assited births	Dec 25	91	-			90	66	114
Induction of Labour	Dec 25	39	-			52	21	84
Maternity Readmissions	Dec 25	1	-			2	-2	7
Neonatal Readmissions	Dec 25	10	-			4	-2	10
Smoking at time of booking	Dec 25	7.98%	15.00%		P	6.65%	0.85%	12.46%
Smoking at time of delivery	Dec 25	4.38%	6.00%		?	4.35%	-0.70%	9.41%
In area CO at booking	Dec 25	95.71%	90.00%	H	?	94.18%	83.03%	105.33%
In area CO at 36 weeks	Dec 25	90.35%	80.00%		?	84.96%	75.67%	94.25%
Admitted directly to NNU (SCBU) (>37 weeks)	Dec 25	4	4		?	7	-4	17
Percentage Admitted directly to NNU (SCBU) (>37 weeks)	Dec 25	3.08%	6.00%		?	4.35%	-2.54%	11.24%
Preterm birth rate <=36+6 weeks at birth	Dec 25	7.14%	6.00%		?	5.44%	-0.79%	11.67%
Apgar < 7 (NMPA Definition)	Dec 25	4	-			4	-3	12
Apgar < 7 Percentage (NMPA Definition)	Dec 25	2.99%	-			2.76%	-1.94%	7.45%
Spontaneous Vaginal Births (%)	Dec 25	35.00%	-			43.67%	34.15%	53.20%
Induction Rate	Dec 25	28.47%	-			33.32%	17.05%	49.59%
Instrumental Delivery Rate	Dec 25	12.41%	-			11.30%	4.60%	18.00%
Elective C Section Rate	Dec 25	21.43%	-			21.02%	13.58%	28.46%
Emergency C Section Rate	Dec 25	31.43%	-			24.04%	16.24%	31.84%
C Section Rate	Dec 25	52.86%	-	↑		45.06%	37.19%	52.93%
3rd or 4th degree tear (Total) Precentage	Dec 25	2.19%	3.00%		?	1.34%	-2.24%	4.93%
Massive PPH >=1.5L (All births)	Dec 25	5	2		?	6	-1	13
Breastfeeding: Percentage of Initiated Breasfeeding	Dec 25	85.40%	66.20%		P	80.71%	70.32%	91.10%
Breastfeeding: Breasfeeding at Discharge (Transfer to Co	Dec 25	63.91%	56.20%		?	63.87%	52.06%	75.68%

Maternity Dashboard 2025/26

Gateshead Health NHS Foundation Trust



Safe

Responsive

Background

- NHSE national maternity statistics for 2023/24 published in December 2025 showed national LSCS rates of 42%, this is an increase of 16% over the previous ten years & requires a review of current workforce models to ensure safe provision of care

Assessment

- Gateshead metrics follow this same increase, accompanied by increasing acuity in the overall patient population
- This is now flagging as a sustained increase on SPC but this increase in theatre activity been noted & flagged as a concern by the service for over 18 months
- Planned visit by COO to Maternity theatre in September unavoidably cancelled – data pack prepared in advance

Actions

- Gateshead theatre workforce has been on the risk register since July 2021 (#2599 risk has recently been closed in favour of a new risk which reflects current guidance, workforce, activity & patient safety concerns #4859)

Recommendations

- Risk rating & wording to be agreed with divisional leadership team/COO
- Need to reconsider activity cap safe number in light of increased demand & acuity
- Theatre paper in final stages of development – this paper has stalled at many stages & now requires urgent consideration & action
- Rearrange cancelled visit to maternity theatres by COO & update data pack

6. Progress in MIS 10 safety actions – Year 7

Gateshead Health NHS Foundation Trust

	Current Position
SA1 – Perinatal mortality reporting (PMRT)	Q3 PMRT report to M&M steering group 3/2/26
SA2: Digital / data (MSDS)	Evidence signed off by safety champions
SA3: Transitional care/ATAIN	Evidence signed off by safety champions
SA4: Medical staffing	Neonatal staffing submitted to ODN – awaiting sign-off
SA5: Midwifery staffing	Evidence signed off by safety champions
SA6: Saving Babies' Lives care bundle	Awaiting Q3 evidence sign-off from LMNS (100% confirmed 16/1/26)
SA7: Maternal and neonatal voices (MNVP)	Evidence signed off by safety champions
SA8: Training	Evidence signed off by safety champions
SA9: Safety Champions	Update on culture action plan in Jan IOR
SA10: MNSI/EN reporting	DofC compliance in Jan IOR

6. Progress in MIS 10 safety actions – Year 7

Gateshead Health NHS Foundation Trust

Summary:

- Evidence review completed with perinatal leadership team & safety champions – 9/1/2026
- Reporting schedule approved for Trust board & CEO sign-off
- Awaiting Q3 LMNS review (10/2/2026)
- Expect to report full compliance with 10 safety actions for Year 7 scheme

Overview of progress on MIS year 7 safety action requirements

*Mandated Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	0	7	0	7
2	0	0	0	2	2
3	0	0	0	6	6
4	0	0	4	15	19
5	0	0	0	12	12
6	0	3	6	0	9
7	0	0	0	4	4
8	0	0	0	21	21
9	0	2	0	7	9
10	0	1	0	8	9
Total	0	6	17	75	98

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

*Non-mandated sctions will not be included in this table.

Gateshead MOSS December 2025

Gateshead Health NHS Foundation Trust

Maternity Outcomes Signal - Cumulative sum (CUSUM) - Gateshead Health NHS Foundation Trust

This chart produces 'signals' of potential safety issues in maternity care arising during labour and birth using term stillbirths and term neonatal deaths up to 28 days.

The maternity unit's perinatal leadership team should carry out a critical safety check when any signal arises to make sure care on the labour ward is safe. Further guidance on this is available in the MOSS Standard Operating Procedures.

Chart guidance can be found using the "I" icon.

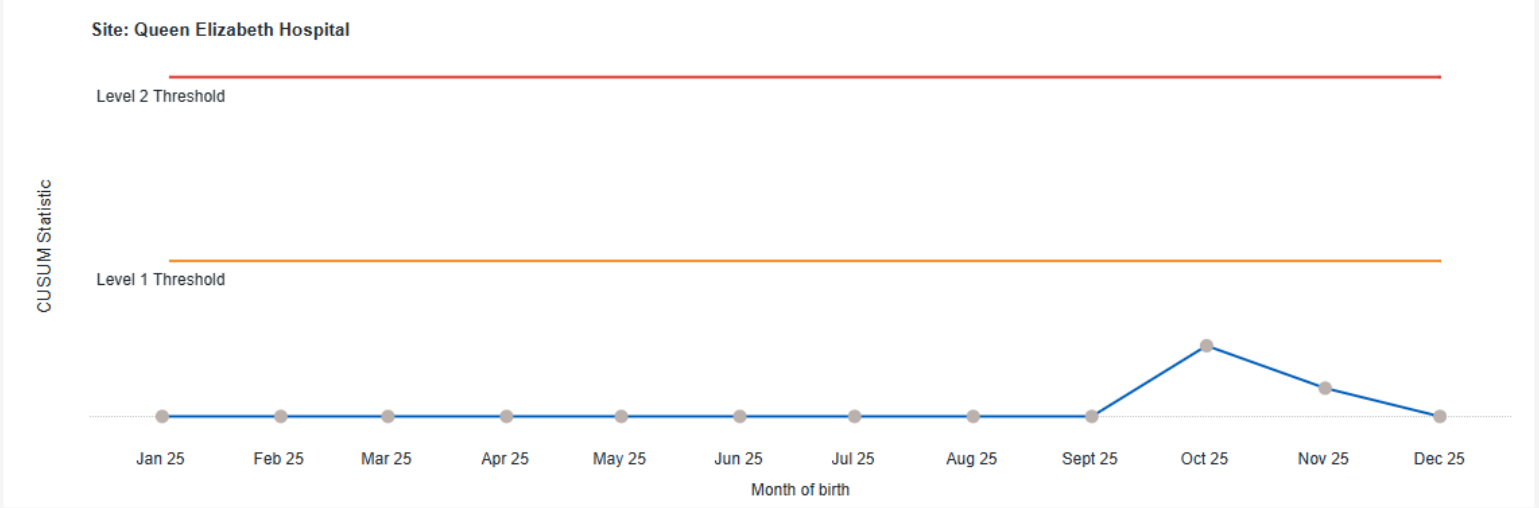


Table of Events - Trust: Gateshead Health NHS Foundation Trust

Date of term birth	Events (term only)	Site name
27 Oct 25	1 Term Neonatal Death(s)	Queen Elizabeth Hospital

Summary:

- 0 safety alarms or alerts – no action required
- Awaiting access for all members of perinatal leadership & safety champion team

NENC Regional heatmap December 2025

Gateshead Health NHS Foundation Trust

Regional Maternity Heatmap

Data refreshed: 30/12/2025 13:57:25

Scoring

Region: North East and Yorkshire

NHS England

Heatmap month: December 2025

Provider	Overall score	CQC Mat overall rating	Stake holder concerns	CQC S29a	CQC s31	Ext. ind. review	Coroner reg 28	Mat Oversight	MIS	CNST repay ment	Eth. DQ	CQC Mat Surve y	SBL	Midw ives vac.	MSW vac.	Obs vac.	Unfilled roles	Snr L'ship not in post	Safety champs	Birthrate + (last 3 yrs)	Neonatal death rate	Perinatal death rate	Stillbirth rate
[redacted]	58.0	5.0	6	5	0	5	0	5	0	1	0	3	3	3	3		1	5	0	0	5	5	3
	42.0	5.0	2	0	0	0	0	5	4	0	0	3	4	0	4		3	5	0	0	1	3	3
	34.0	5.0	2	0	5	0	0	5	0	0	0	4	3	1	2		3	0	0	0	0	1	3
	31.0	2.0	3	0	0	0	0	5	0	0	0	2	0	2	5		1	0	0	0	5	3	3
	30.0	3.0	1	0	0	0	0	0	2	0	0	2	5	0	4		0	0	0	0	5	5	3
	27.0	1.0	1	0	0	0	0	0	0	0	0	3	4	1	0		1	0	3	0	5	5	3
	27.0	3.0	4	0	0	0	0	2	0	0	0	3	2	1	4		3	0	0	1	0	1	3
	27.0	3.0	3	0	0	0	0	0	0	0	3	3	0	0	5		0	0	0	1	3	3	3
	26.0	1.0	3	0	0	5	0	0	0	0	0	3	2	0	0		1	0	0	0	5	3	3
	26.0	3.0	0	0	0	0	0	5	0	0	0	2	3	0	0		1	0	0	1	5	3	3
	25.0	3.0	2	0	0	0	0	5	0	0	0	3	0	0	0		3	0	0	0	3	3	3
	25.0	3.0	2	0	0	0	0	0	0	0	0	3	3	0	0		1	0	0	0	5	5	3
	25.0	1.0	1	0	0	0	0	2	0	0	0	2	2	1	1		1	5	0	0	3	3	3
	24.3	2.3	2	0	0	0	0	0	0	0	0	3	4	1	0		3	0	0	0	3	3	3
GATESHEAD HEALTH NHS FOUNDATION TRUST	24.0	1.0	0	0	0	0	0	0	0	0	0	3	4	1	1		1	5	0	1	1	3	3
	23.0	1.0	1	0	0	0	0	0	0	0	0	0	3	1	0		1	5	0	0	5	3	3
	22.0	3.0	1	0	0	0	0	0	0	0	0	3	4	1	0		1	0	0	0	3	3	3
	22.0	1.0	1	0	0	0	0	0	0	0	0	4	2	1	4		0	0	0	0	3	3	3
	18.0	3.0	0	0	0	0	0	0	0	0	0	3	2	1	0		0	0	0	0	3	3	3
	16.0	3.0	1	0	0	0	0	5	0	0	0	2	0	0	0		0	0	0	1	0	1	3
	13.0	1.0	1	0	0	0	0	0	0	0	0	1	0	0	1		0	0	0	0	3	3	3

Summary:

- 1 stakeholder concern – **SQAS (Section 7a national team)**: *Existing concern not yet closed* – Antenatal and Newborn screening governance review January 2026
- Senior leadership – no Obstetric CL – maximum score – 5
- Perinatal mortality rate – based on 2023 MBRRACE data

MDT workforce update December 2025

Gateshead Health NHS Foundation Trust

Staff group	Workforce gaps			Minimum staffing requirements	Risks & escalations Risk register ID where applicable)
	Vacancy rate	Sickness rate	Maternity leave rate		
Midwifery				Fill rates: **Day 88.2% Night 100.8%** Midwife:birth ratio TBC Bank usage: **1.67wte**	Maternity theatre staffing #4859
Midwife Support workers **Health Care Assistants**				Fill rates: TBC Bank usage: **1.58wte**	MSW vacancies – awaiting Trac approval to recruit to 2.92wte Women's Health Clinic HCA staffing #4729
Obstetric Consultants **Resident doctors**				Minimum Consultant staffing on labour ward **100%**	Antenatal Clinic Capacity #4712
Neonatal Nurses				BAPM compliance **Q2 2025/26 94.6%** QIS compliance **93% (1 nurse still to complete)**	SCBU/ANNP workforce #2275
Paediatric Consultants **Resident doctors/ANNP**				BAPM compliance: **Current ANNP gap of -1.54wte (but 1wte ANNP trainee in post)** **Currently holding a 0.5 gap on the 1:7 Consultant rota, covered with locum**	SCBU/ANNP workforce #2275
Obstetric Anaesthetists				Obstetric anaesthetist immediately available for the obstetric unit 24 hours a day with clear lines of communication to anaesthetic Consultant **100%**	

MDT workforce update December 2025

Gateshead Health NHS Foundation Trust

Red Flags	No	Factors	No	Actions	No
LWC supernumary	2	Unexpected midwife sickness/absence	11	Delay to commence IOL	8
1-1 care in labour		Midwife redeployed to other area	6	Delay in transfer to theatre	1
Delay in IOL	2	Midwife on transfer duties	4	2nd theatre in use	2
Delay in meeting LSCS timing		Support staff less than rostered numbers	14	Delay in ongoing IOL	9
Missed or delayed care	1	Midwife scrubbed in theatre	34	Unable to perform ward round due to acuity	1
Delay in triage		2 or more Band 5 midwives on duty	23	Redeploy staff internally	43
	5	Unable to provide 2nd midwife for emergency theatre	1	Staff unable to take breaks	2
				Specialist midwife working clinically	4
				Escalate to manager on call	4
Total	5		93		74

Risk register – new emerging risks & updates

Gateshead Health NHS Foundation Trust

Risk ID	Division	Description	Initial Grade	Current Grade	Target Grade	Comments
Top Service Risks						
2984	Surg2	There is a risk to our ability to continue to run maternity services from the designated building due to a catastrophic failure of the steam supply, resulting in enactment of a business continuity plan	20	20	8	No change
4852	Surg2	Current maternity theatre staffing model does not meet national safe staffing standards due to an outdated model that does not match current demand acuity, This could result in patient harm.	20	15	5	Emerging risk – replaces previous risk – risk wording/grade to be agreed at divisional risk management meeting 21/1/26
3107	Surg2	There is a risk of delayed treatment due to maternity estate being in a separate building resulting in the potential for severe harm to mothers & babies	20	15	5	No change
4712	Surg2	Risk that we do not have sufficient antenatal clinic capacity within Consultant job pans, resulting in reduced service provision	15	12	6	Increase in risk grading advised by the service due to demand outstripping clinic capacity significantly resulting in multiple patient safety concerns & delay to provide minimum antenatal care To be discussed at divisional risk management meeting 21/1/26

6. Completed PMRT Reviews Q3

Responsive

Safe

Gateshead Health NHS Foundation Trust

Number of Completed Cases in this Quarter (see notes)	**2**	**Number of meetings held**	**1**	**% of meetings external reviewer present**	100%	**Number of external reviews attended**	**2**
Any issues with MIS compliance for reporting			N/A				
Number of Cases Graded C or D in Quarter			1	**Number of these cases escalated to your Trust PS panel for discussion about level of investigation or previously referred / or under investigation or MNSI**		N/A	

Number of C & D Graded cases where issues associated with FGR Management Identified	**Q1**	**Q2**	**Q3**	**Q4**	N/A
	0	0	0		
Number of C & D Graded cases where issues associated with RFM Management Identified	**Q1**	**Q2**	**Q3**	**Q4**	N/A
	0	0	0		
Number of C&D graded intrapartum stillbirths, early neonatal deaths and severe brain injury where failures of intrapartum monitoring are identified as contributory factor.	**Q1**	**Q2**	**Q3**	**Q4**	N/A
	0	0	0		
Number of C & D Graded cases where prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.	**Q1**	**Q2**	**Q3**	**Q4**	N/A
	0	0	0		

Other Themes and Actions from PMRT Cases: ***Please also detail any specific themes/actions relating to socioeconomic deprivation and ethnicity.***	Review of all PMRT cases 2023 onwards to identify any concerns relating to IG21 patient safety alert – details of review on following slides "C" grade due to potential missed opportunity to refer/investigate for polyhydramnios

Gateshead Health NHS Foundation Trust

Learning & actions

Review of PMRT cases pre/during/post-IG21 implementation completed

- 19 cases (3 pre-IG21, 8 during cross-over, 8 post-IG21)
- 4 cases reviewed identified changed birth weight centile when compared against WHO/Hadlock

Learning

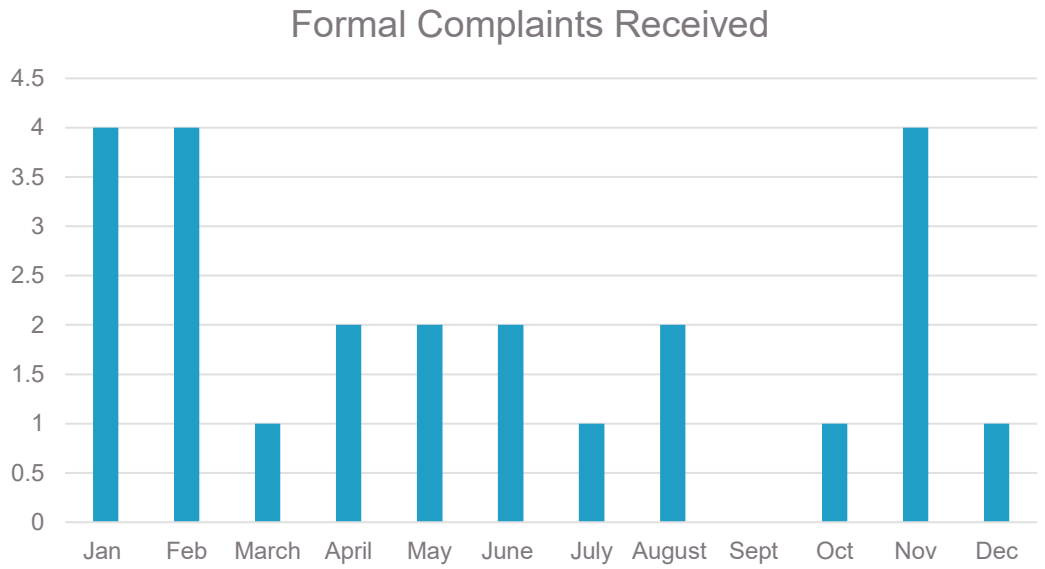
- In all 4 cases above, use of different charts would not have changed pathway/care plans or outcomes
- New awareness of FGR/SGA definition in these cases

Actions

- Share with LMNS IG21 meeting to identify other Trust actions
- Shared with NENC fetal medicine group to agree any regional actions
- Consider need to share audit findings with families to inform future pregnancy care plans – NENC agreement for clear communications to staff & service users re change in charts
- Await MNSI report/learning for 1 case

Complaints Q3

Gateshead Health NHS Foundation Trust



The service received 6 formal complaints in Q3 2025/26 – this is a reduction on the Q4 but an increase from Q2.

There were no clear themes

- 5 written responses
- 4 face to face meetings

All complaints responses are signed off by the Chief Nurse

Learning:

- Delay in recognition of non-obstetric medical complications
- Patients not feeling listened too.
- Staff behaviours and attitudes.

Actions:

- Staff booked to attend cultural competency training and customer care training, funded by 2025/26 CPD allocation.
- Updates to postnatal guideline in relation to escalation to non-obstetric medical staff when patients have multiple attendances with same concern/no diagnosis.
- Communication/escalation relating to patient nutrition and dietary requirements.

Duty of Candour compliance Q1-Q3 2025/26

Gateshead Health NHS Foundation Trust

Duty of Candour Verbal Compliance

Business Unit Combined: 2 selected | Status of Completing verbal Duty of Candour.: 4 selected | Verbal Duty of Candour Compliance: All 4 selected

Incident ID.	Business Unit Combined	Stage	Service Combined	Investigating Department	Level of Physical Harm	Level of Psychological Harm	Category.	Incident Date.	Reported Date Combined	Date to STG.	Date level of harm agreed	Date Verbal Duty of Candour is Due	When was the patient/appropriate person informed (dd/mm/yyyy)	Status of Completing verbal Duty of Candour.	Verbal Duty of Candour Compliance	Open Form in Tab
15716	Surgical Services	Approved	Obstetrics	Delivery Suite (Maternity)	Moderate physical harm	No psychological harm	Maternity/foet	24/03/25	24/03/25		28/03/25	11/04/25	28/03/25	Carried Out	Compliant - Complete	
17049	Surgical Services	Approved	Obstetrics	Delivery Suite (Maternity)	Moderate physical harm	Low psychological harm	Maternity/foet	07/05/25	12/05/25		01/07/25	15/07/25	26/06/25	Carried Out	Compliant - Complete	
21594	Surgical Services	Awaiting Investigation	Obstetrics	Delivery Suite (Maternity)	Moderate physical harm	Low psychological harm	Infection prevention & control	19/10/25	19/10/25						Still Time	
21858	Surgical Services	Being Investigated	Obstetrics	Delivery Suite (Maternity)	Moderate physical harm	Moderate psychological harm	Maternity/foet	27/10/25	28/10/25		04/11/25	18/11/25	30/10/25	Carried Out	Compliant - Complete	
22278	Surgical Services	Being Investigated	Obstetrics	Delivery Suite (Maternity)	No physical harm	Moderate psychological harm	Maternity/foet	11/11/25	11/11/25		10/12/25	24/12/25	11/11/25	Carried Out	Compliant - Complete	
23093	Surgical Services	Being Investigated	Obstetrics	Delivery Suite (Maternity)	Moderate physical harm	Low psychological harm	Delay/failure to treat/monitor	08/12/25	11/12/25						Still Time	
23152	Surgical Services	Being Investigated	Obstetrics	Delivery Suite (Maternity)	Moderate physical harm	No psychological harm	Maternity/foet	13/12/25	13/12/25						Still Time	

Duty of Candour Notification Letter Compliance

Business Unit Combined: 2 selected

Incident ID.	Business Unit Combined	Stage	Service Combined	Investigating Department	Level of Physical Harm	Level of Psychological Harm	Category.	Incident Date.	Reported Date Combined	Date to STG.	Date level of harm agreed	When was the patient/appropriate person informed (dd/mm/yyyy)	Date Notification letter is due	Date Notification Letter Sent	Duty of Candour Notification Letter Compliance	Open Form in Tab
17049	Surgical Services	Approved	Obstetrics	Delivery Suite (Maternity)	Moderate physical harm	Low psychological harm	Maternity/foet	07/05/25	12/05/25		01/07/25	26/06/25	10/07/25	09/07/25	Compliant - Complete	
22278	Surgical Services	Being Investigated	Obstetrics	Delivery Suite (Maternity)	No physical harm	Moderate psychological harm	Maternity/foet	11/11/25	11/11/25		10/12/25	11/11/25	25/11/25	20/11/25	Compliant - Complete	

Outstanding verbal DofC:
21594 – under review via ATAIN process
23093 – downgraded following review – DofC not indicated
23152 – under review via risk process

Culture survey action plan review

Maternity

NHS Gateshead Health NHS Foundation Trust

Culture survey repeated as part of NHSE perinatal leadership & culture work – reported with action plan in November 2025

Due to lack of robust perinatal Quad – whilst culture work has been ongoing within the department, no formal review of the actions completed, impact or new actions has taken place

Action plan reviewed as part of MIS evidence review & Safety Champions meeting 9/1/2026

Theme	Actions to support	Values	Outcome	Update	Ongoing
Communication	Team meetings, newsletters, display posters, 1-1s	Openness, engagement, informative	Develop communication strategy	Monthly team meetings, ward/core team meetings, ward manager drop-in, quarterly newsletters	Development of comms strategy
Leadership	Leadership development, perinatal quad	Leaders will enact ICORE values, role modelling, lead by example	Zero tolerance	December 25 – SLM commenced, safety champions in post, no Obs CL	Establish perinatal Q&S/divisional meetings
Team working	Project Promise	Team working, positive relationships	Project Promise events, core teams, staff rotation	Funding utilised, end survey/LMNS feedback completed Postnatal culture work completed with POD Core teams in place	Establish social events group
Support offer	TRiM, PMA/PNA	Compassionate support, psychological safety	TRiM, PMA/PNA strategy	Working with Trust PNA lead to offer joint engagement, training, policy	Finalise joint PMA/PNA strategy
Work-life balance	Roster clinics, flexible working, TOIL, recruitment	Retention & recruitment	BR+, recruitment to vacancies, policies	BR+ agreed, recruitment ongoing Rotation/preceptorship review	Workforce concerns – theatre, WHC, ANNP, Band 3 Enhanced rostering work in maternity/SCBU

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

NHS Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 17i

Report Title:	**Maternity Safety Champion Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	28 January 2026			
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			

Gateshead Health NHS Foundation Trust

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** ☒			

Gateshead Health NHS Foundation Trust

Maternity Non-Executive Director Safety Champion Report January 2026

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.

2.2. Antenatal clinic booking and capacity.

2.3. Midwives as scrub nurses.

2.4. Maternity Incentive Scheme progress

3. Progress on issues

3.1. Ongoing concern regarding absence of obstetric clinical lead. Service Line Manager appointed - Katherine (Kat) Miles priority setting exercise now being undertaken as part of her work plan.

3.2. Safety lead in place - Jill Sturt. Note that this is not the obstetric safety champion position

3.3. Challenges continue in the Antenatal Clinic with insufficient capacity for appointment demand. Booking appointments now regularly exceeding 25 weeks gestation (target and guidance is 12-weeks' gestation). Issues here are:

- Several near misses of harm, including missed aspirin, scanning, tinzaparin, and uterine artery dopplers for high-risk pregnancies

- Missed opportunities for positive intervention – such as Vaginal Birth After Caesarean (VBAC) discussions
- Increased complexity of the obstetric caseload requiring more time for consultations

Recent discussions with Beth Swanson to raise this issue once more at the maternity champions meeting, particularly around the scope to create a business case to support expansion of the team to provide greater capacity. Interestingly of the 160 women booked for maternity in care in one month, 64 were defined as 'out of area', that is they were non-Gateshead residents. This provoked a discussion about a potential cap on out of area bookings as a short-term solution to the overcapacity issue.

3.4. Midwives scrubbing in theatres for caesarian sections. I am aware that there is a larger piece of work ongoing around theatres and service provision, this issue is part of that project. Fiona Gow and David Tate have written a paper to provide information to the surgical division regarding obstetric service provision needs. It was noted that the current training for scrub nurses is unique to Gateshead and as such may be identified as a risk to us. Again, recent discussions with Beth Swanson to raise this issue once more at the maternity champions meeting.

3.5. The Maternity Incentive Scheme (MIS). At our most recent maternity safety champion's meeting we discussed all 10 safety actions which underpin this scheme in detail. We were provided with detailed information by Karen Parker and her colleagues regarding compliance with the scheme. Most criteria have already been met but there will be additional information which will be provided by the LMNS prior to submission. This will be presented at the January 2026 Board.

3.6. Finally, the NEWTT2 updates (newborn early warning and trigger), go live later this month.

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.

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

Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 18

Report Title:	**Nursing Staffing Exception Report- November 2025**			
Name of Meeting:	Board of Directors			
Date of Meeting:	28 January 2026			
Author:	Helen Larkin, Clinical Lead for E-Rostering			
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: *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 provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls within the month of November 2025. **Alert** November 2025 continued to present staffing challenges across a number of inpatient wards. Key pressures related to the escalation area on Ward 11, vacancies within the non-registered workforce, and ongoing higher patient acuity and dependency across the Trust. Additional escalation beds remain open on Wards 9, 10, 12, 22, 24 and 25, which has increased demand on the available staffing resource. There were instances where staffing levels fell below 75% of the funded establishment, and these have been highlighted within the body of the report together with the actions taken in response.			

<table>
<tr><td></td><td colspan="6">Advise
A programme of work to review nursing establishments, skill mix and rostering efficiency is currently in progress, with outcomes expected by mid-January 2026. Targeted recruitment to the non-registered workforce has been ongoing since October and continues.
Dynamic risk assessment remains in place and the staffing escalation protocol is being actively utilised to manage daily staffing deployment. This is evidenced by the number of staffing-related incident reports submitted, which demonstrates staff are appropriately escalating concerns.
In line with RCN Workforce Standard 9, it is proposed that future staffing exception reporting will highlight any areas where staffing falls below 80% of the planned level, strengthening transparency and Board oversight.

Assure
Despite the ongoing pressures, there is evidence that safe systems of monitoring, escalation and mitigation are in place and operating as intended. Senior nursing leadership maintain daily oversight of staffing, with redeployment, cohorting, temporary staffing solutions and professional judgement being used to maintain patient safety.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">The Board is asked to:
• receive the report for partial assurance
• note the work being undertaken to address the shortfalls in staffing and support ongoing actions to mitigate risk.</td></tr>
<tr><td rowspan="4">Trust strategic priorities that the report relates to:</td><td>☒</td><td colspan="5">Excellent patient care</td></tr>
<tr><td>☒</td><td colspan="5">Great place to work</td></tr>
<tr><td>☐</td><td colspan="5">Working together for healthier communities</td></tr>
<tr><td>☒</td><td colspan="5">Fit for the future</td></tr>
<tr><td>Trust strategic objectives that the report relates to (2025 to 2030 strategy):</td><td colspan="6">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 colspan="2">Safe
☒</td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):</td><td colspan="6">There were 14 nurse-staffing incidents raised via InPhase during the month of November. The incidents relative to the wards/departments are highlighted within this report</td></tr>
</table>

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
November 2025

1. Executive Summary

This report provides an exception overview of nursing and midwifery staffing for November 2025. While average fill rates remain broadly stable, a number of wards fell below the 75% staffing threshold and are reported by exception, largely due to Healthcare Assistant vacancies, sickness absence and maternity leave. The Trust continues to mitigate daily operational pressures through Matron-led professional judgement, redeployment based on patient acuity and demand, and targeted recruitment activity. The Registered Nurse vacancy rate remains low at 1.6%, however the Healthcare Assistant vacancy rate of 17.3% continues to present a workforce challenge and is recorded on the risk register within the Medicine and community division. Recruitment to the bank has been undertaken, and a Band 2 to Band 3 development pathway is being progressed. Improvements to red flag reporting and resolution are underway, alongside a wider programme to review ward establishments and strengthen night staffing and Ward Manager supervisory time. The Board is asked to note the current position and support the actions being taken to strengthen workforce resilience and staffing governance.

2. Introduction

This report details the staffing exceptions for Gateshead Health NHS Foundation Trust during the month of November 2025. The staffing establishments are set utilising the Safer Nursing Care staffing tool (SNCT) within a triangulated approach of professional judgement and clinical outcomes. SNCT is a recognised, nationally used evidence-based tool that matches the acuity of patients with the staffing requirements for acute medical and surgical wards. Varying tools for the Emergency Department and Paediatrics are utilised. Mental health Services use the Mental Health Optimal Staffing Tool (MHOST), and Maternity use the Birth Rate Plus tool. Bi-annual reviews are reported to Quality Governance Committee and the Trust Board.

2. Staffing

The actual ward staffing against the planned, budgeted establishments from November are presented in Table 1. Trust in-patient ward staffing levels are presented within this report in appendix 1, broken down into each ward areas staffing. In addition, the Trust submit monthly care hours per patient day (CHPPD) as a national requirement to NHS Digital and are available via The Model Health System.

Table 1: Whole Trust wards staffing November 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 (%)**
85.4%	**76.7%**	**102.7%**	**106.1%**

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 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.
There is a programme of work ongoing within the organisation to review Ward establishments in response to rostering practice efficiencies. This is in response to a recognised need to strengthen nurse staffing levels at night, and support designated supervisory time for Ward Managers to drive safety and quality patient care. This work has included a 30-day staff consultation period with conclusion expected for mid-January. Revision of nursing establishments will conclude this work planned for the beginning of April 2026.

The exceptions to report November are as below:

November 2025	
Registered Nurse Days	**%**
Cragside	65.3%
Critical Care	71.5%
SCBU	66.7%
Ward 14 Medicine	73.2%
Ward 28	64.3%
Ward 22	73.3%
Registered Nurse Nights	**%**
Cragside Court	68.3%
Sunniside	70.0%
Healthcare Assistant Days	**%**
Critical Care	55.4%
JASRU	63.1%
Ward 08	67.1%
Ward 09	69.6%
Ward 10	70.5%
Ward 21	61.2%
Ward 28	33.2%
Ward 24	65.7%
Ward 25	64.6%
Ward 26	61.3%

Healthcare Assistant Nights	%
Critical Care	66.2%
SCBU	61.5%
Ward 28	33.3%

To note, Ward 11 (winter escalation ward) is not included in the above exception report as they do not have a funded establishment. However, they are included in the daily staffing reviews, are over seen by a clinical matron and staff follow the same escalation processes.

Throughout November, areas of staffing deficit were escalated in line with the Trust staffing policy, and mitigations were implemented by Matron teams using professional judgement in response to the acuity and demand in each area. This 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.

4. Vacancies

The Trustwide Registered Nursing vacancy rate is 1.6%, equating to 22 WTE. Most vacancies are within the Band 5 and Band 6 workforce. Recruitment remains ongoing aligned with student graduation cycles.

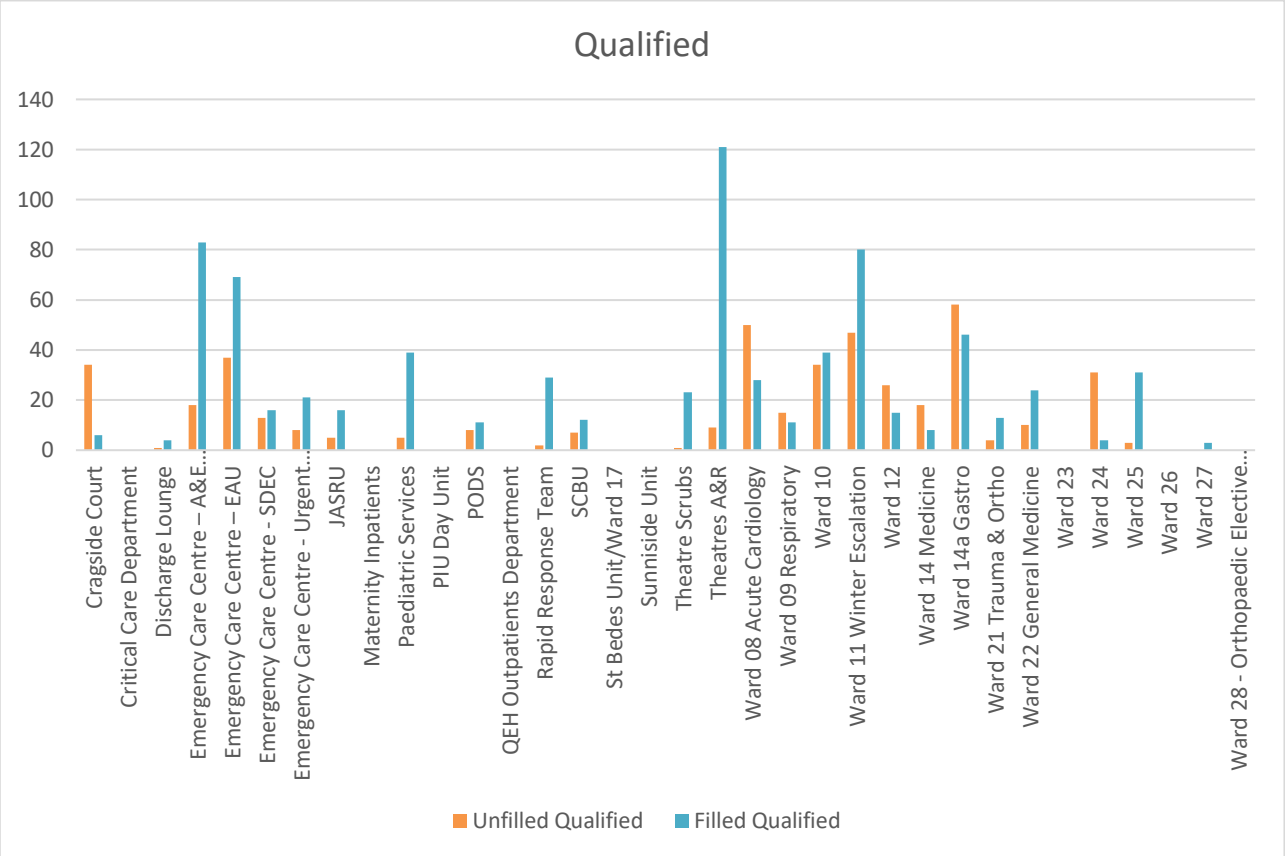
The Healthcare Assistant (HCA) vacancy position for the Trust is 17.3% with 97.6 WTE vacant positions. The current position with HCA vacancies is on the risk register within the Medicine and Community Business unit (Risk 4770 and 4686). This is an area of particular concern as the HCA internal bank is also depleted.

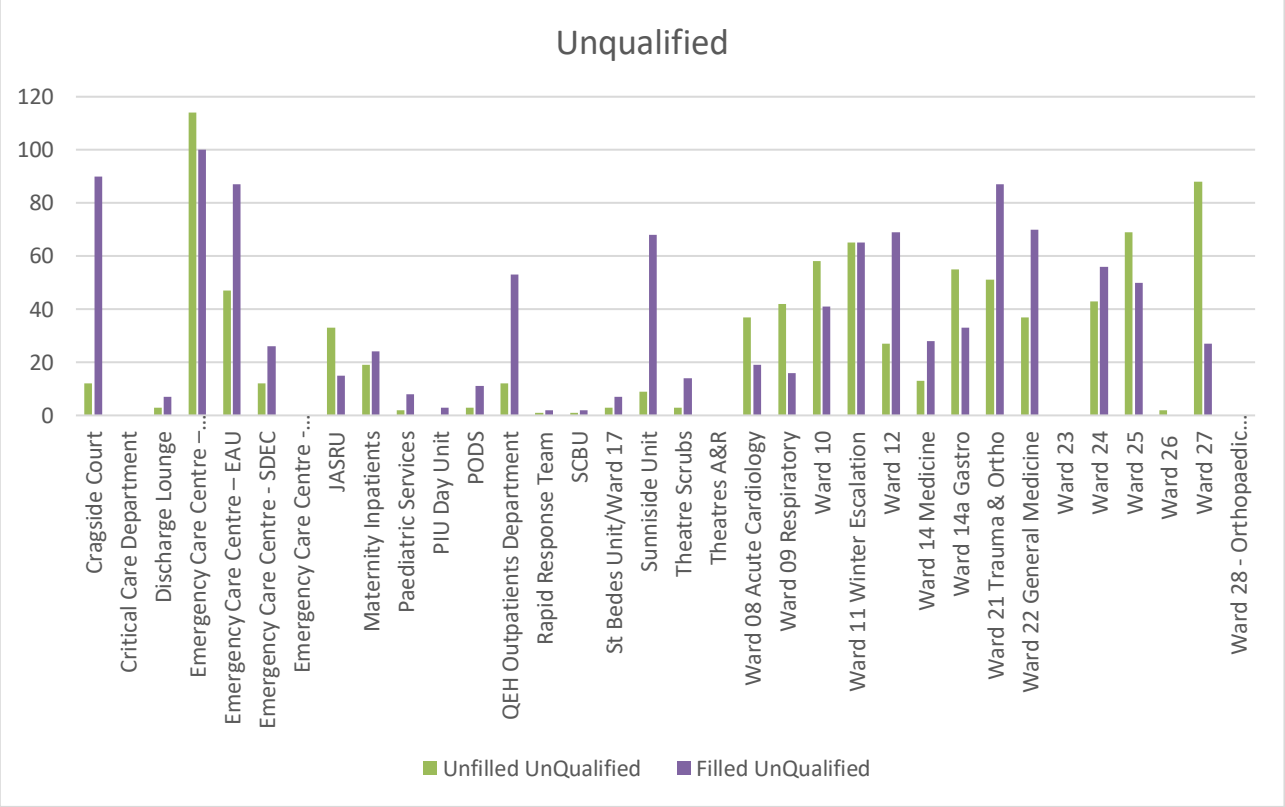
Following a Trustwide recruitment campaign, only 5.6 WTE Band 3 HCA posts were appointed from the central advertisement. As a result, recruitment will now be progressed at service line level within Divisions, as a more targeted approach is expected to be more effective.

In parallel, a Band 2 to Band 3 development programme is being progressed in response to the challenges experienced in recruiting candidates with the required academic level and experience for Band 3 Healthcare Assistant roles.

5. Temporary Staffing

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





Some HCA bank shifts have been challenging to fill, specifically due to the volume of shifts available. Recent recruitment activity for bank only HCA positions has taken place, specifically to offer positions to our student nurses. This process is important to ensure we continue to replenish the turnover of bank only workers. This process was successful in offering 39 bank positions. It is proposed a further vacancy is advertised externally for bank only workers to ensure we have sufficient staff to meet demand.

6. 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 November, the Trust total CHPPD was 7.2. This compares lower when benchmarked with other peer-reviewed hospitals (7.9 peer average) and is likely impacted by our HCA vacancy position and patient dependency levels.

7. 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 via inphase 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 redeployment or inability to fill the rota. 14 staffing incidents were raised during November, including the levels of physical and psychological harm (Appendix 2). Nurse staffing was not directly referenced in any inphases in relation to patient harm or PSIRF reports.

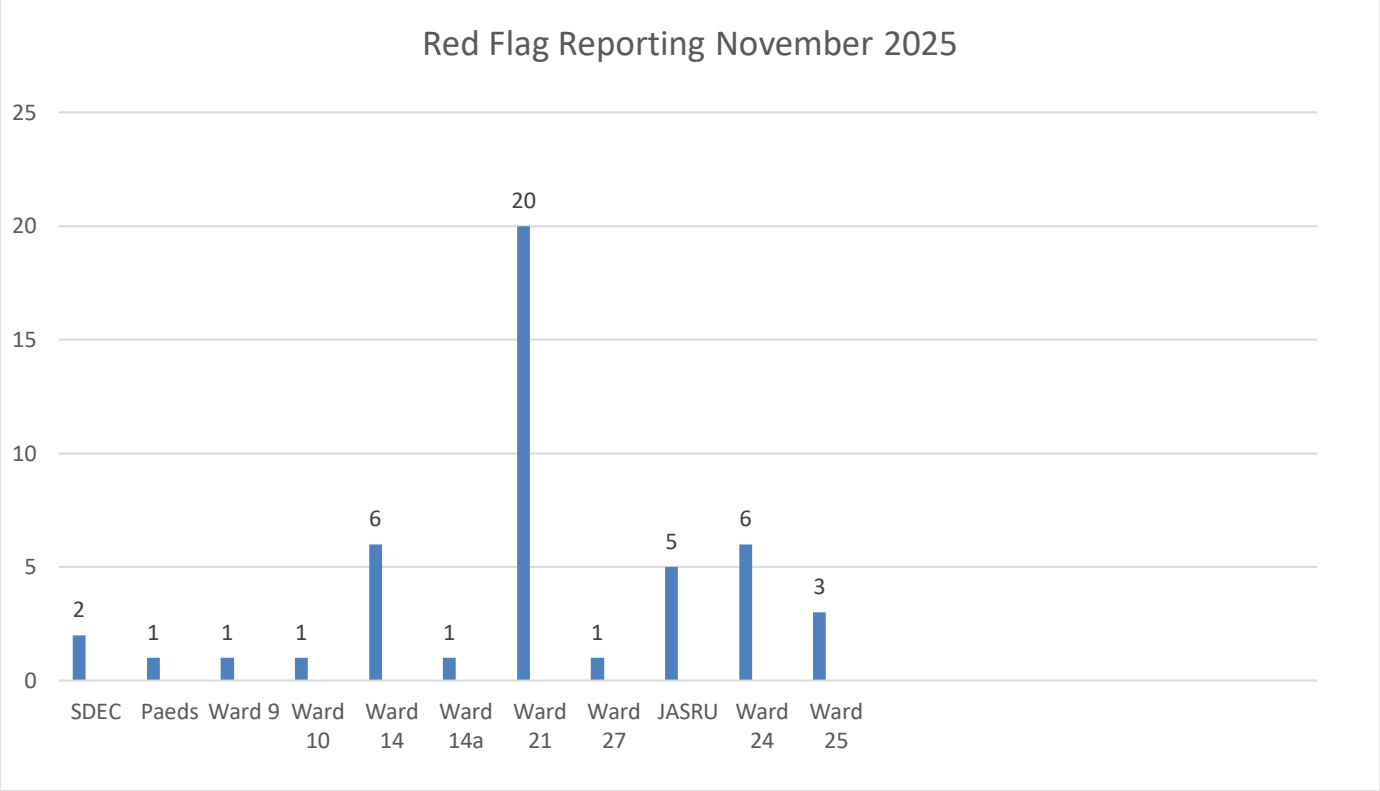
8. Nursing Red Flags

The National Institute for Health and Care Excellence (NICE) guideline for Safe Staffing for nursing in adult inpatient wards in acute hospitals (2014) recommends the use of nursing Red Flag reporting. A nursing red flag may be raised due to rostering practice or staffing shortfalls, or by the nurse in charge where staffing levels fall below required standards.

During November, 47 nursing red flags were reported, a reduction from 98 in October. Red flags must be escalated promptly to the Matron or senior nurse for action and mitigation. However, only one of the 47 red flags raised in November was recorded as resolved within the Safecare live system.

The Trust will move to a position where it can provide clear assurance that red flags are being raised appropriately, acted on in a timely way, and closed with clear evidence. Work with Optima Allocate is underway to improve real time visibility of red flag reporting to support operational management of safe staffing and provide reporting metrics for escalation and assurance. Once in place, compliance with review, response and closure will be monitored as a key performance indicator with Divisions.

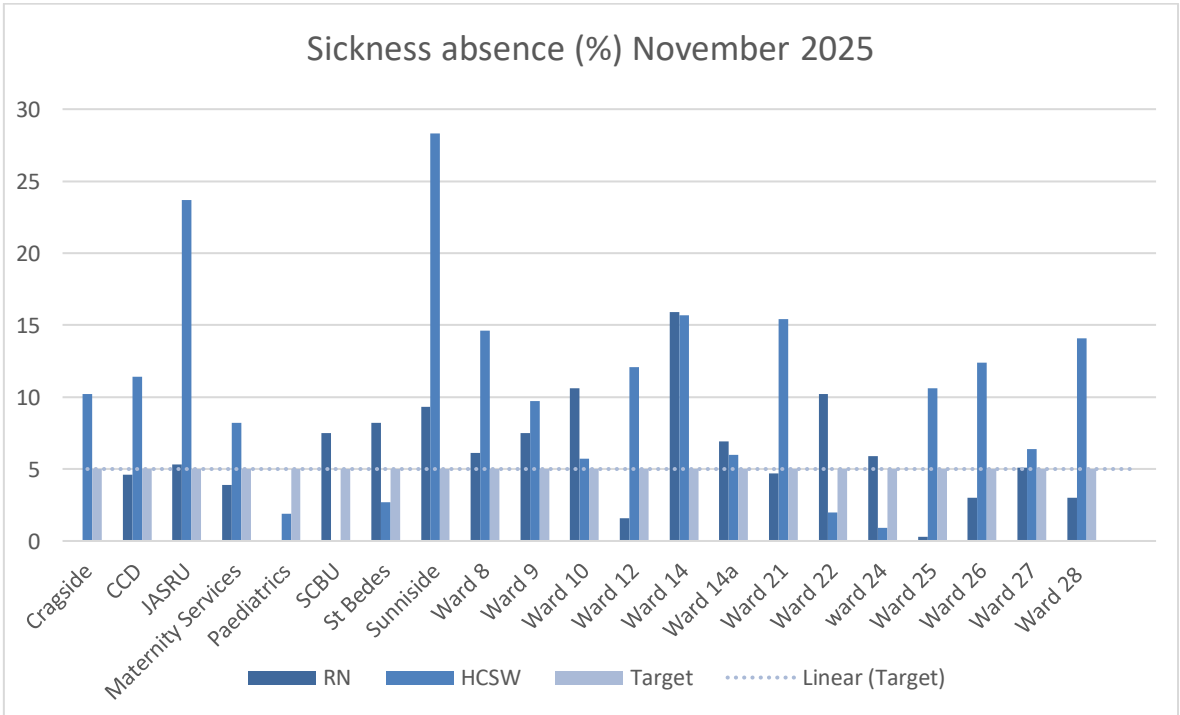
The graph below outlines the number of red flags raised per department in November. Ward 21 reported the highest number and experienced Healthcare Assistant shortfalls on both day and night shifts, demonstrating effective escalation through red flag reporting to the Matron for the area



9. Absence levels

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

Data extracted from Health Roster.



10. 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. The system is utilised during site management meetings to identify areas most at risk and requiring intervention/support.

11. Triangulation and actions taken

Critical Care Department demonstrated fill rates below 75% for Registered Nurse (RN) Days (71.5%) and Healthcare Assistant (HCA) days due to lower occupancy rates, therefore able to support non-clinical time. There were also 55 redeployment episodes made to support other areas. In addition, the supernumerary pathway was supported on both days and nights for new RN's. Whilst there were multiple short term sickness episodes across registered bands and two registrants on Maternity leave, the senior Nursing team ensured the unit was safely staffed.

SCBU demonstrated a daytime RN fill rate of 66.7% with sickness absence levels of 7.5% down from 12.8% in October. No staffing incidents or red flags were raised. Demand templates are in review with Head of Midwifery and Clinical lead for e-roster.

Ward 14 reported RN Day fill rates of 73.2%. The roster highlights multiple episodes of both long-term and short-term sickness as well as one RN on Maternity leave. Shifts were sent to bank to mitigate against risk however many remained unfilled. Six red flags were reported however no inphase were made.

Ward 22 report RN day fill rate as 73.3%. The ward report Maternity leave and sickness absence, two long-term and two short-term. No InPhase incidents or red flags were raised.

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 bed occupancy and acuity/dependency of the ward. Average bed occupancy during November reported at 39% filled. There were no incidents or red flags reported.

Cragside Court report 65.3% fill rates for Registered staff days and 68.3% 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 to both areas. Cragside reported a reduced bed occupancy of 36% for November. The areas are a self-contained ward and support across both units at night to mitigate any risk of reduced RMN cover. There was no Registrant sickness during November. No red flags or InPhase incidents were raised by this area through November. Cragside report two registrants on Maternity leave and two vacancies, with appointed candidates in the recruitment process.

Twelve areas demonstrate below 75% fill rates for Healthcare Assistants due to the high number of vacancies. As of November, there was 97.6 trust wide vacancies (17.3%). Active monitoring, redeployment and bank are currently being used to mitigate understaffed areas based on real time risk assessments and patient acuity and dependency.

At present, any hours provided by additional clinical support staff (such as Housekeeper roles and ward clerks) are not included in fill rates. This is being reviewed locally to understand their contribution to patient care, aligned to the National guidance from NHS England. Should any change be made to include these staff groups, it will be clearly identified in future reports.

In line with RCN Workforce Standard 9, future reports will highlight by exception any areas where staffing falls below 80% of the planned fill rate level, strengthening transparency and Board oversight.

12. Recommendations

The Board is asked to receive this report for partial assurance. It is asked to support with the identified actions highlighted within the report.

Gateshead Health NHS Foundation Trust

Appendix 1- Table 3: Ward by Ward staffing November 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	65.3%	97.9%	68.3%	170.5%	154	8.1	16.7	24.8
Critical Care Dept	71.5%	55.4%	102.3%	66.2%	211	36.1	3.0	39.1
Emergency Care Centre - EAU	77.7%	81.4%	96.4%	88.8%	1284	5.6	3.8	9.4
JASRU	83.1%	63.1%	101.2%	105.0%	564	3.5	3.4	6.8
Maternity Unit	94.3%	125.2%	100.1%	122.2%	667	13.2	4.6	17.8
Special Care Baby Unit	66.7%	142.8%	114.1%	61.5%	113	15.6	3.7	19.3
St. Bedes	80.4%	98.5%	101.5%	107.9%	284	5.0	4.0	9.0
Sunniside Unit	94.1%	131.5%	70.0%	125.5%	269	5.7	5.4	11.1
Ward 08	96.2%	67.1%	96.1%	118.5%	610	4.3	2.6	6.9
Ward 09	93.7%	69.6%	93.9%	97.2%	840	2.5	1.7	4.2
Ward 10	80.1%	70.5%	105.2%	98.4%	746	2.6	2.0	4.6

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Ward 12	87.8%	85.8%	105.6%	104.7%	789	2.6	2.2	4.8
Ward 14 Medicine	73.2%	91.5%	88.5%	99.3%	753	3.0	2.3	5.4
Ward 14a Gastro	106.7%	99.5%	93.9%	133.4%	766	2.9	2.7	5.6
Ward 21 T&O	102.0%	61.2%	101.7%	96.7%	811	3.3	2.5	5.8
Ward 22	73.3%	75.3%	138.8%	127.0%	920	2.4	2.5	4.8
Ward 24	90.6%	65.7%	150.5%	132.0%	910	2.8	2.3	5.1
Ward 25	95.5%	64.6%	155.6%	126.6%	970	2.8	2.1	4.9
Ward 26	108.6%	61.3%	101.0%	95.2%	685	3.8	2.3	6.2
Ward 27	115.4%	75.4%	112.5%	89.7%	840	3.4	2.1	5.5
Ward 28	64.3%	33.2%	93.6%	33.3%	171	8.1	3.3	11.5
QUEEN ELIZABETH HOSPITAL - RR7EN	**85.4%**	**76.7%**	**102.7%**	**106.1%**	**13863**	4.4	2.8	7.2

Appendix 2 INPHASES submitted in relation to nurse staffing.

Incident Date.	Investigating Department	Category(s)	Subcategory	Level of Physical Harm	Level of Psychological Harm
02/11/25	Ward 22 (Care of the Elderly)	Staffing/resource issue	Insufficient nurses (due to staff movements)	No physical harm	No psychological harm
05/11/25	Ward 11 (Gastroenterology)	Staffing/resource issue	Insufficient nurses (due to staff shortages/unfilled shifts)	Low physical harm	Low psychological harm
07/11/25	Ward 12	Staffing/resource issue	Staffing - insufficient nurses (other reason)	No physical harm	No psychological harm
10/11/25	Ward 24 (Care of the Elderly)	Staffing/resource issue	Staffing - insufficient nurses (other reason)	No physical harm	Low psychological harm
09/11/25	Ward 14A (Gastro)	Staffing/resource issue	Insufficient nurses (due to staff movements)	No physical harm	No psychological harm
10/11/25	Cragside (Older Persons Mental Health)	Staffing/resource issue	Staffing - delay / difficulty in obtaining clinical assistance	Low physical harm	No psychological harm
13/11/25	Ward 25 (Care of the Elderly)	Staffing/resource issue	Insufficient nurses (due to staff movements)	Low physical harm	Low psychological harm
13/11/25	Ward 25 (Care of the Elderly)	Staffing/resource issue	Insufficient nurses (due to staff movements)	Low physical harm	No psychological harm
07/11/25	Surgical Services - Divisional Management	Staffing/resource issue	Insufficient nurses (due to staff shortages/unfilled shifts)	Low physical harm	No psychological harm
19/11/25	Emergency Surgical Assessment Unit (ESAU)	Staffing/resource issue	Insufficient nurses (due to sickness)	No physical harm	No psychological harm

01/11/25	Theatres	Staffing/resource issue	Insufficient nurses (due to sickness)	No physical harm	No psychological harm
21/11/25	Special Care Baby Unit	Staffing/resource issue	Insufficient nurses (due to staff shortages/unfilled shifts)	No physical harm	No psychological harm
25/11/25	T27 (General Surgery)	Staffing/resource issue	Insufficient nurses (due to sickness)	No physical harm	No psychological harm
28/11/25	General Medicine- Ward 11	Staffing/resource issue	Staffing - insufficient nurses (other reason)	Low physical harm	No psychological harm

ITEMS FOR INFORMATION / MEETING GOVERNANCE

19. 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	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		
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 Safety Champion Report	Maternity Safety Champion	Item for Assurance	Part 1	√	√
Maternity Staffing Report	Chief Nurse	Item for Assurance	Part 1		
Nurse Staffing Exception Report	Chief Nurse	Item for Assurance	Part 1	√	√
Bi-annual Inpatient Safer Nursing Care Staffing Report	Chief Nurse	Item for Assurance	Part 1	deferred	√
Learning from Deaths (quarterly report)	Group Medical Director	Item for Assurance	Part 1		√
EPRR Core Standards Self-Assessment Report	Chief Operating Officer	Item for Assurance	Part 1	√	
CNST Maternity Compliance Report	Chief Nurse	Item for Assurance	Part 1	√	
Freedom to Speak Up Guardian Report	Group Director of People & OD	Item for Assurance	Part 1	√	
WRES and WDES Report	Group Director of People & OD	Item for Assurance	Part 1		
Board Walkabout Feedback	Chief Nurse	Item for Assurance	Part 1	none	√
Great North Healthcare Alliance Progress Report	Director of Strategy and Partnerships	Item for Assurance	Part 1 & Part 2	not required	√
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	√	

20. Questions from Governors in Attendance

21. Any Other Business

22. Date and Time of Next Meeting - 09:30am Wednesday 25 March 2026

Meeting Closure and Exclusion of the Press and Public