Board of Directors - Part 1

Schedule Wednesday 27 May 2026, 9:30 AM — 11:45 AM BST
Venue Room 3 / Teams
Organiser Diane Waites

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AGENDA

Board of Directors (Part 1 – Public)

A meeting of the Board of Directors (Part 1 – Public) will be held at 9:30am on Wednesday 27th May 2026, in Room 3, Education Centre, Queen Elizabeth Hospital / via Microsoft Teams

AGENDA

No	Start time	Item	Purpose	Lead	Paper / Verbal
1. OPENING MATTERS					
a	09:30	Welcome and apologies for absence	Information	Chair	Verbal
b	09:32	Declarations of interest	Information	Chair	Verbal
c	09:33	Minutes of the last meeting held on 25 March 2026	Decision	Chair	Paper
d	09:34	Action log and matters arising	Assurance / decision	Chair	Paper
e	09:35	Top Organisational Risks	Information	Chair	Paper
f	09:37	Patient & Staff Story	Information	Interim Chief Nurse	Presentation
2. GOVERNANCE					
a	09:52	Chair's Report	Assurance	Chair	Paper
b	09:57	Acting Chief Executive's Report	Assurance	Acting Chief Executive	Paper
c	10:10	Assurance from Board Committees:			
		i) Finance and Performance – April and May 2026	Assurance	Chair of the Committee	Paper
		ii) Quality Governance Committee – April 2026	Assurance	Chair of the Committee	Paper
		iii) Group Remuneration Committee – March and April 2026	Assurance	Chair of the Committee	Paper
		iv) People and Organisational Development Committee – May 2026	Assurance	Chair of the Committee	Paper
		v) Digital Committee – May 2026	Assurance	Chair of the Committee	Paper
d	10.30	Annual Declarations of Interest	Decision	Company Secretary	Paper
e	10:35	Strategic Communications Report	Assurance	Acting Chief Executive / Head of Communications	Paper
3. EXCELLENT PATIENT CARE					
a	10:45	Maternity Integrated Oversight Report	Assurance	Associate Director of Midwifery/SCBU	Paper
		i) Maternity Safety Champion Report	Assurance	Maternity Safety Champion	Paper
b	11:00	Nurse Staff Exception Report	Assurance	Interim Chief Nurse	Paper
4. FIT FOR THE FUTURE					
a	11:05	Governance Reports			
		i) Organisational Risk Register	Assurance	Interim Chief Nurse	Paper

No	Start time	Item	Purpose	Lead	Paper / Verbal
		ii) Board Assurance Framework	Assurance	Company Secretary	Paper
b	11:15	Finance Report	Assurance	Group Director of Finance	Paper
c	11:20	Strategic Objectives and Constitutional Standards Report	Assurance	Group Director of Finance	Paper
5. ITEMS FOR INFORMATION / MEETING GOVERNANCE					
a	11:30	Cycle of Business 2026/27	Information	Company Secretary	Paper
b	11:32	Questions from Governors in Attendance	Discussion	Chair	Verbal
c	11:37	Any Other Business	Discussion	Chair	Verbal
d	11:40	Date and Time of Next Meeting – 9.30am on Wednesday 29th July 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. OPENING MATTERS

a - Welcome and Apologies for Absence

Presented by the Chair

b - Declarations of Interest

Presented by the Chair

c - Minutes of the Meeting Held on 25 March 2026

Presented by the Chair

Board of Directors (Part 1 – Public)

Minutes of a meeting of the Board of Directors (Part 1) held at 9.30am on Wednesday 25th March 2026 in Room 3, Education Centre, Queen Elizabeth Hospital and via MS Teams.

Name	Position
Members present	
Sir Paul Ennals	Chair
Gavin Evans	Managing Director for QE Facilities
Adam Crampsie	Non-Executive Director
Sean Fenwick	Acting Chief Executive
Joanne Halliwell	Group Chief Operating Officer
Martin Hedley	Non-Executive Director / Senior Independent Director
Carmen Howey	Group Medical Director
Robert Hughes	Non-Executive Director
Kris Mackenzie	Group Director of Finance
Gerry Morrow	Vice Chair
Beth Swanson	Interim Chief Nurse
Amanda Venner	Group Director of People & Organisational Development
Attendees present	
Jennifer Boyle	Company Secretary
Nicola Bruce	Director of Strategy and Partnerships
Karen Parker	Associate Director of Midwifery and Special Care Baby Unit (Item 26/03/3c)
Diane Waites	Corporate Services Assistant
Governors and Observers	
Steve Connolly	Lead Governor/Public Governor – Central & Eastern
Ray Dennis	Public Governor – Western Gateshead
	Four representatives from Parkinson's UK and Keep Our NHS Public North East
	Two members of the public
Apologies	
Andrew Besford	Non-Executive Director
David Elliott	Chief Digital Officer
Maggie Pavlou	Non-Executive Director

Agenda Item No		Action Owner
Opening Matters		
26/03/1a	**Welcome and apologies for absence:** The meeting being quorate, Paul Ennals declared the meeting open at 9.30am. He welcomed those present including the Trust Governors, observers and members of the public. Paul Ennals reminded the Board that as a public sector organisation, the Trust is now in the pre-election period therefore some restrictions are in place on the use of public resources and communication activities.	

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	There were no other advance items of business to be made aware of for consideration under the *Any Other Business* agenda item. Apologies were noted from Andrew Besford, David Elliott and Maggie Pavlou.	
26/03/1b	**Declarations of Interest:** There were no declarations of interest.	
26/03/1c	**Minutes of the Previous Meeting:** The minutes of the meeting of the Board of Directors held on Wednesday 28th January 2026 were approved as a correct record.	
26/03/1d	**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. A full Board development proposal is included on the agenda in Part 2 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). As above – action agreed for closure. • Action 25/12/14 relating to providing key highlights, trends, conclusions, etc within the executive summaries to support the Board in addressing key issues. Work has been undertaken to strengthen executive summaries within papers. It was agreed to close this action and assess the impact as part of the Board Effectiveness item on the 2026/27 Board Development Programme. • Action 26/01/08 relating to amending the Board Committee terms of reference. This has been completed therefore action agreed for closure. • Action 26/01/20 relating to sharing the response to Governor questions. This has been shared therefore action agreed for closure. The Board reviewed the actions closed at the last meeting which ensures actions have been closed in line with expectations and the agreements made at the previous Board meeting. There were no further comments.	

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26/03/1e	**Top Organisational Risks:** The top (composite) organisational risks were confirmed by the Executive Risk Management Committee on 2nd March 2026 as remaining the same. These are as follows: • **Financial Sustainability** – risk of inability to invest in staff and clinical services, including supporting financial collaboration with partners. • **Estates** – risk to sustainability of core infrastructure and to invest in clinical advances and the working environment for our staff. • **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. Paul Ennals reminded the Board to consider these during presentation of agenda items.	
Governance		
26/03/2a	**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 he had the pleasure of officially opening the redeveloped facilities for women and children. A recent Governor workshop took place to explore how engagement might operate in the future following the proposed legislation to formally remove Council of Governors nationally and there were some insightful suggestions as to how we might continue to work together. Meetings have also taken place with some Governors to discuss the future of Speech and Language Therapy Services, particularly with reference to patients with Parkinson's disease and a presentation will be provided by the Executive Directors at the next Council of Governors meeting in May 2026. Paul Ennals also wished to formally record the Board's sincere thanks to Dr Neil Halford, Medical Director of Strategic Relations, who retired from the Trust on 20th March 2026 following 41 years at the Trust. Gavin Evans, QE Facilities Managing Director, will also be leaving the Trust in June 2026 to take up a position within the Alliance. After consideration, it was: **RESOLVED:** to receive the report for assurance.	COG cycle of business
26/03/2b	**Chief Executive's Report:** Sean Fenwick gave an update to the Board on current issues which have been aligned to the Trust's strategic priorities.	

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	He drew attention to the key areas in relation to national policy, context and operating models and highlighted that the medium term plans have been submitted nationally with the Trust submitting a breakeven plan. The NHS Oversight Framework for Quarter 3 2025/26 ratings have been published, and the Trust has been ranked 65 which is not a statistically significant change to the last quarter position of 62. Sean Fenwick explained that the financial override is still in place due to deficit support funding however there remains a focus to continue to push improvements. The risk relating to the national disruption in the bone cement supply chain has now been resolved and is being managed. The National Cancer Plan has been published and reflects the importance of digital infrastructure to its delivery. He drew attention to the Trust's strategic priorities for Excellent Patient Care and Great Place to Work and highlighted that within the organisation, some quality assurance work has been taking place and work has commenced on the development of the Quality Account with consultation opportunities around priorities for 2026/27. Teams have been reviewing the staff survey results and further information is included in the agenda item later in the meeting. Board members have been undertaking regular visits to clinical and non-clinical areas to gain valuable feedback and understanding of staff experiences. Future reports will include an overview of the themes and trends emerging from the visits. In relation to Working Together for Healthier Communities and Fit for the Future, Sean Fenwick highlighted that a number of key workstreams have been established around transformation and service improvement to support the Trust in achieving its operational delivery goals and some key headlines have been provided in relation to the medium term plan to provide further assurance on priorities. Sean Fenwick also expressed his thanks to Neil Halford for his longstanding commitment and leadership throughout the organisation. After further discussion, it was: **RESOLVED:** to receive the report for assurance.	
26/03/2c	**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 February 2026 meeting.	

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	He reported that there were no alerts to highlight but drew attention to some advisory issues relating to breast service performance. The Committee received assurance that there were regional plans for improvement. There was a continued deterioration in cancer performance which was impacting on the service and discussions were taking place with the Integrated Care Board. Martin Hedley provided an update on the most recent meeting which took place on 24th March 2026 and advised that it was agreed to raise an alert in relation to breast services particularly around the need for a long term sustainable regional model. Jo Halliwell explained that a regional meeting is due to take place next week which is expected to receive a formal proposal for a regional model. Some internal analysis work has taken place to demonstrate short term recovery plans and this will be discussed in more detail at the Executive Committee. Adam Cramspie highlighted that this had also been raised at the Quality Governance Committee, and a report was asked to come back to the Committee to provide further assurance around mitigation plans. It was therefore noted that active engagement work is taking place regionally and assurance provided that the Executive Team continue to drive the need for improvements. Other discussions took place around the cost reduction plan for 2026/27 and the current shortfall which remains unmitigated. Kris Mackenzie explained that enhanced financial controls will be put in place from 1st April 2026 around discretionary spend and recruitment. Martin Hedley also advised the Board around contract rebasing work which is taking place prior to expected NHS England changes to tariffs and reported that this has identified some shortfalls therefore further work will need to take place to address this. Kris Mackenzie highlighted that this is a national direction of travel which may require some budget adjustments. The Committee received reports on the 2026/27 Pay Award for the Trust and QE Facilities, and Provider Selection Regime which will be presented in Part 2 of the Board and are recommended for approval. **Quality Governance Committee:** Adam Crampsie provided a brief verbal overview to accompany the narrative report following the February 2026 meeting. He reported that there are two alerts to highlight relating to cancer performance and internal audit reports in relation to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and World Health Organisation (WHO) Surgical Safety Checklist which have received limited assurance due to incomplete historic actions therefore concerns were raised by the Committee around the internal governance and escalation processes. Beth Swanson reported that significant improvements have been made to ensure that key audits and actions are	

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	reviewed and a report from the Executive Team will be presented at the next Committee meeting to highlight progress and provide assurance over controls required. The Board were assured that this is being addressed and Paul Ennals highlighted that this should also feed into the wider governance review which will also be addressed via the new Board Development Programme. Adam Crampsie also drew attention to some advisory issues relating to a recent Local Maternity and Neonatal Systems (LMNS) visit which raised some concerns linked to the Maternity Incentive Scheme (MIS) Safety Action 4. Amendments to the narrative have been completed which has been reviewed by Gerry Morrow, the Maternity Safety Champion and he confirmed that assurance can be provided that the mitigations in place are appropriate and a full report will be presented to the Committee at the next meeting. **Group Remuneration Committee:** Martin Hedley provided a brief verbal overview to accompany the narrative report following the January 2026 meeting. This meeting was a single agenda item extraordinary meeting to formally approve the extension of the secondment for the substantive Chief Executive and secondment extension of the Acting Chief Executive. **People and Organisational Development Committee:** Adam Crampsie provided a brief verbal overview to accompany the narrative report following the March 2026 meeting. He reported that there were no alerts to highlight but drew attention to some advisory issues relating to ongoing under-utilisation of the apprenticeship levy and the Committee have requested a more detailed paper to come back to the next meeting to provide a proposed approach. Another issue relates to the Trust's gender pay gap which requires sustained focus and an assurance plan will be presented to the Committee in six months' time. Discussion also took place around the staff survey results and will be discussed in more detail later in the meeting. The Committee received key assurances relating to the Trust's sickness absence rate which has continued to decrease and is now at 5.41% which is the lowest level since December 2021 and one of the lowest rates within the region. The Board congratulated Amanda Venner and the work of the People and Organisational Development Team. Another area of discussion related to the Ten Point Plan for Resident Doctors and assurance was provided that actions are in place to meet the plan which was supported by the Resident Doctor Lead and Maggie Pavlou as the Non-Executive Director representative. Adam Crampsie drew attention to an emerging risk relating to the adequacy of current controls around violence and aggression and	

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	Amanda Venner explained that this is being looked at with Beth Swanson. **Group Audit Committee:** Rob Hughes provided a brief verbal overview to accompany the narrative report following the March 2026 meeting. He reported that there were no alerts to highlight but drew attention to some advisory issues relating to the DNACPR audit mentioned earlier in the meeting and the report from the Executive Team will come to Committee in June 2026 following presentation at the Quality Governance Committee. The Committee received an updated outline report in relation to the litigation register and a further update will be provided at the next meeting. The Committee also received the failure to prevent fraud corporate offence self-assessment and an action plan will be received at a future meeting for assurance. The Committee approved the Internal Audit Plan for 2026/27 and it was noted that there has been a reduction in planned days across the Group, but Kris Mackenzie highlighted that this was due to the previous allocation benchmarking high and was agreed by the Committee. **Digital Committee:** Gerry Morrow provided a brief verbal overview to accompany the narrative report following the March 2026 meeting. He reported that that there were no alerts to highlight but drew attention to some advisory issues relating to a low compliance rate for subject access requests however the Committee was provided with assurance that mitigations are in place and a consistent approach across the Alliance is being discussed. The Committee received the Digital Strategy which is due to be presented to the Clinical Strategy Group to agree next steps around implementation. Work continues around the Digital Records Programme business case and this is expected to be presented to the Committee prior to Board. Paul Ennals thanked the Committee Chairs for their reports. After consideration, it was: **RESOLVED**: to receive the reports for assurance	
26/03/2d	**Aubrey Self-Assessment – Trust Response:** Beth Swanson presented the report which sets out the Trust's response to the areas of assurance requested by the Integrated Care Board (ICB). She reminded the Board that following the publication of the Aubrey Report in November 2025 relating to governance and clinical oversight	

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	within breast surgical services at County Durham and Darlington NHS Foundation Trust, the ICB wrote to provider organisations to request assurance regarding governance, oversight and delivery of services in line with the NHS Standard Contract. Organisations have been asked to submit a self-assessment to provide assurance regarding their arrangements by 27th March 2026 following review by Boards. Beth Swanson explained that the response has been developed through a coordinated process drawing on contributions from Executive Directors and members of their teams to ensure that the submission accurately reflects the Trust's governance arrangements, assurance mechanism and oversight processes. Paul Ennals shared some feedback received on behalf of Andrew Besford in relation to Section 4.2 integration of information services and these will be captured within the action plan. Following a query from Adam Crampsie on next steps, Beth Swanson explained that a detailed action plan has been developed which will be reviewed via the next Board Development Session and will include regional feedback. The actions have also been aligned to the Board Committees for ongoing assurance. Kris Mackenzie highlighted that the self-assessment has been reviewed by the Finance and Performance Committee and is recommended for approval. After consideration, it was: **RESOLVED**: to approve the self-assessment response for submission to the Integrated Care Board.	ES
26/03/2e	**Board Committee Terms of Reference:** Jennifer Boyle presented the terms of reference for the People and Organisation Development Committee for ratification. She explained that the Committee undertook a review of its effectiveness and terms of reference in March 2026 which has demonstrated good compliance and some minor amendments to the terms of reference were approved by the Committee. A copy of the full review is included in the Board's supplementary information paper which is accompanied by the review of effectiveness for the Digital Committee with the terms of reference being ratified by the Board in January 2026. Following consideration, it was: **RESOLVED**: to ratify the People and Organisation Development Committee Terms of Reference following recommendation from the Committee.	

<table>
<tr><th>Agenda Item No</th><th></th><th>Action Owner</th></tr>
<tr><td colspan="3"></td></tr>
<tr><td>26/03/2f</td><td>Corporate Governance Manual:

Jennier Boyle presented the Corporate Governance Manual which has been reviewed by the Group Audit Committee.

She explained that a full review of the Corporate Governance Manual took place in September 2025 therefore only minor amendments are proposed based on the transfer of decision-making authority from the former Gateshead Health Leadership Group to the Executive Committee and some minor changes relating to legacy terminology.

After consideration, it was:

RESOLVED: to approve the Corporate Governance Manual following the recommendation from the Group Audit Committee.</td><td></td></tr>
<tr><td colspan="3">Excellent Patient Care</td></tr>
<tr><td>26/03/3a</td><td>Care Quality Commission Statement of Purpose Annual Review:

Beth Swanson presented the CQC Statement of Purpose which is a CQC registration requirement document that must be regularly reviewed and updated to reflect any changes in the organisation and the description and location of services.

She drew attention to the cover sheet which highlights the key updates and explained that the statement will be submitted following the meeting. Carmen Howey highlighted that the reduction in bed base was not reflected within the report and will therefore be updated prior to submission.

Following discussion, it was:

RESOLVED: to receive the Statement of Purpose for assurance prior to CQC submission.</td><td></td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>26/03/3b</td><td>Learning from Deaths Quarterly Report:

Carmen Howey presented the report which outlines the process for review of deaths within the organisation and the way in which those review processes enable learning from good practice and learning where there is evidence that care could be improved.

She reported that considerable progress has been made to address the backlog of cases awaiting review with the number of cases reduced to 75 and reflects the hard work of the team. Following a query from Paul Ennals on next steps, Carmen Howey highlighted that support is being provided from Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust in the review of deaths for patients with serious mental</td><td></td></tr>
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	illness and is scheduled within a further Mortality Council meeting. Processes are also in place to enable learning from good practice and evidence where care could be improved across the region and has been incorporated into care plans and winter escalation plans. There is a high level of clinical engagement and commitment to improving outcomes for patient and family experience. Adam Crampsie highlighted that the report was presented to the Quality Governance Committee in February 2026 and there was some concern raised in relation to the increase to the Summary Hospital-level Mortality Indicator (SHMI). Carmen Howey explained that this was anticipated due to the removal of Same Day Emergency Care (SDEC) data activity from the nomination in response to a national requirement. Despite this some trusts have continued to include SDEC data which has therefore impacted on the calculations / comparators. It has now been clarified that all trusts are required to exclude this data, which should help in future reporting. After discussion, it was: **RESOLVED**: to receive the report for assurance noting partial assurance due to the outstanding cases awaiting review.	
26/03/3c	**Maternity Integrated Oversight Report:** Karen Parker presented a summary of the maternity indicators for the Trust for February 2026. She highlighted that there were no new alerts to report however she drew attention to some advisory issues relating to an increase in projected bookings for July to September 2026 and work is underway to ensure safe capacity with recommendations due to be presented to Operations Oversight Group. There has been one maternal death and mandatory reporting has been completed as standard. The theatre and women's health staffing business cases have been shared with the Chief Operating Officer and discussions are taking place with the Local Maternity and Neonatal System and North East and Yorkshire Perinatal Quality Surveillance Oversight Group around mitigation measures. Rob Hughes felt that further work may be required around the organisational risks relating to the maternity estate and workforce and Karen Parker explained that work continues around this and is included within the business cases however will require some level of investment. Gavin Evans highlighted that significant progress has been made around the estate and steps are in place to support risk reduction. Karen Parker highlighted that the Birmingham Symptom Specific Obstetric Triage System (BSOTS) launched this month and a review is taking place in relation to new guidance. NHS England have also launched the first iteration of the new interactive Maternity and Neonatal	

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	Equalities dashboard, and Karen Parker drew attention to the dashboard within the report. Following a query from Adam Crampsie relating to how this will be used, Karen Paker reported that this will capture service provisions and structures to provide learning, and it was felt that it would be beneficial to bring this to the Quality Governance Committee for further discussion. **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 these have been raised as part of the previous report. He explained that Martha's Rule has been expanded into maternity care and shared learning is being reviewed prior to implementation. Some queries were raised in relation to seeking second opinions and the importance of ensuring the quality of communications via clinicians and Carmen Howey explained that this was being addressed across the region to provide shared understanding across specialist areas. After consideration, it was: **RESOLVED:** to receive the reports for assurance. Karen Parker left the meeting.	QGC cycle of business
26/03/3d	**Bi-annual Inpatient Safer Nursing Care Staffing Report:** Beth Swanson presented the report which provides a triangulated review of nursing establishments to ensure staffing levels remain safe, effective and sustainable in line with national guidance and patient care needs. She reported that whilst the review demonstrates that registered nurse staffing remains broadly stable with low vacancy levels, significant pressures persist within the Health Care Assistant (HCA) workforce due to sustained vacancies, recruitment challenges and rising enhanced care demand. Beth Swanson explained that these risks will be addressed through a targeted investment of 9.23 whole time equivalent (WTE) registered nurses is proposed across medicine and surgery. This will be enabled through a revised skill mix model and improvements in rostering efficiency, which allow for the removal of 23.95 WTE long term HCA vacancies. Taken together, these changes deliver a cost neutral solution that safely rebalances workforce capacity while ensuring the right level of registered nursing expertise is available where it is most needed. Adam Crampsie highlighted that the report was discussed in detail at the Quality Governance Committee, and it was felt that the apprenticeship	

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	levy was a key area to explore but were satisfied with the mitigations that are being addressed. Following discussion, it was: **RESOLVED:** to receive the report for assurance and support the proposed establishment adjustments and workforce model changes.	
26/03/3e	**Nurse Staffing Exception Report:** Beth Swanson presented the report for January 2026 which provides assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis to provide adequate staffing levels. She highlighted that staffing challenges continue across several inpatient wards however fill rates remain stable. There continues to be high levels of sickness and a high vacancy rate for HealthCare Assistants, but Beth Swanson reported that improvements to red flag reporting and resolution are underway alongside the wider programme to review ward establishments to strengthen night staffing and ward manager supervisory time. Following a query from Adam Crampsie around whether the increase in violence and aggression incidents also relates to the higher rate of red flags, Beth Swanson explained that this could be looked at via triangulation between the Safer Nursing Care Staffing Report and Staff Survey results. Amanda Venner concurred, noting that this could be done on a thematic basis. Following discussion, it was: **RESOLVED:** to receive the report for information and assurance.	BS/AV
Great Place to Work		
26/03/4a	**Annual Staff Survey Results:** Amanda Venner provided the Board with an analysis of the staff survey results and assurance over the plans to use this data to deliver action to support the achievement of the Great Place to Work strategic ambition for the Trust. She drew attention to some of the key highlights and reported that the Group response rate was 42% compared to 53% the previous year and highlights that there are areas of both strength and concerns. The most declined scores relate to career development, organisational advocacy and feeling valued however the organisation outperformed the average in areas such as safety from harassment and discrimination, pay satisfaction and not working unpaid hours. The most improved scores	

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	include reporting less physical violence and emotional exhaustion. It was noted that the engagement score had declined for the third consecutive year. Analysis of the results by protected characteristics also indicated that the experience of those with protected characteristics varied – this had been shared with the staff networks, who recognised the findings. Key areas of focus for this year includes engagement prioritisation to ensure staff are involved, listened to and able to shape how we work. Another relates to working hard to show staff that patient care is our top priority by delivering compassionate care every day, given that the percentage of respondents who felt that patient care was the top organisational priority was one of the most declined scores. The next steps involve a cascade plan with People and Organisational Development engagement workshops to identify key areas of dissatisfaction and propose improvements. Key priorities will be approved with divisional and corporate action plans being developed and monitored via the new Performance Oversight Meetings and People and Organisational Development Committee. The Board acknowledged the deterioration in results which had been anticipated due to the significant and challenging sustainability workstreams undertaken within the last year and the focus on financial grip and control. Kris Mackenzie felt that further work could be undertaken around the communication of financial challenges across the organisation and Amanda Venner explained that it was important to ensure that line managers are provided with the skills and knowledge to share information around organisational decisions whilst considering staff experiences. Paul Ennals concluded that a lot of good work had been undertaken and the Board are assured that processes are in place to focus on improving outcomes of staff. This will be monitored by the People and Organisational Development Committee. Following discussion, it was: **RESOLVED:** to note the 2025 Staff Survey Results, the identified areas where the data shows the greatest staff dissatisfaction and support the recommended actions and deliverables to improve staff experience.	
Fit for the Future		
26/03/5a	**Governance Reports:** **Organisational Risk Register (ORR):** Beth Swanson presented the updated ORR to the Board which 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 January 2026 to 17th March 2026.	

Agenda Item No		Action Owner
	She reported that there are currently 16 risks on the ORR. Following the Executive Risk Management Group meetings in February and March 2026, there have been 3 risks added to the ORR relating to industrial action, Healthcare Assistant vacancies and organisational and cultural factors. There has been one risk reduced in relation to the revenue plan and one risk closed in relation to the Group's cash position. There has been a decline in compliance with reviews and associated actions, and these continue to be reviewed. Discussion took place around the number of risks with no movement in the past six months, and Adam Crampsie raised some concerns around the level of mitigations in place and whether these should be categorised as ALARP (as low as reasonably practicable) risks. Sean Fenwick explained that a review of all longstanding risks was being undertaken and this could be explored in more detail via the Executive Risk Management Group. After consideration, it was: **RESOLVED:** to receive the report for assurance.	
26/03/5b	**Finance Report:** Kris Mackenzie provided the Board with assurance against delivery of the approved 2025/26 revenue and capital plan as at 28th February 2026 (Month 11). She reported that the Trust has reported an actual deficit of £8.4m which is an adverse variance from plan of £0.046m. Cost reduction plan performance is on target at £29.3m and includes recurrent plans of £14.6m. The Trust has received Public Dividend Capital (PDC) funds to support recent capital schemes and cash balances are above plan which is due to improvements on working capital balances and is sufficient to meet operational expenditure without cash support. The Board acknowledged the work that has been undertaken to achieve the Trust's position and are fully assured that targets will be met this financial year. After consideration, it was: **RESOLVED:** to receive the Month 11 financial position and note partial assurance for the achievement of the 2025/26 planned financial targets.	
26/03/5c	**Strategic Objectives and Constitutional Standards Report:** Kris Mackenzie presented the report which provides the Board with oversight and assurance of the key performance metrics which underpin the delivery of the Trust strategy for Month 11 2025/26.	

Agenda Item No		Action Owner
	She drew attention to some of the main headlines which includes sustained pressures within urgent and emergency, and performance has showed marginal improvement but remains materially below trajectory. Workforce metrics indicate that turnover and vacancy rates remain high however the sickness absence rate remains the lowest ranking within the Integrated Care System. There has been a deterioration within cancer performance which represents a material and growing risk and reflects diagnostic capacity restraints and wider system dependencies. There remains ongoing risk across core patient safety domains however active mitigation plans are in place. Despite pressures, there is strong and consistent performance around Ockenden recommendations and the Maternity Incentive Scheme. Discussion took place around the plans for 2026/27 and Kris Mackenzie explained that the medium term plan has been agreed by Board and submitted whilst recognising financial and performance pressures. Jo Halliwell reminded the Board that there remain some aspects of non-compliance particularly around the 62 day cancer performance target however narrative has been provided and NHS England have been informed that a review of the position around breast services will be undertaken once discussions have taken place with regional teams. Following consideration, it was: **RESOLVED:** to receive the report for assurance and note the key areas of improvement and challenge.	
Items for Information / Meeting Governance		
26/03/6a	**Cycle of Business 2026/27:** Jennifer Boyle presented the cycle of business for 2026/27 which outlines forthcoming items for consideration by the Board. It provides advanced notice and greater visibility in relation to forward planning and Board members are asked to provide any feedback to ensure this is reflective of the required Board business. After consideration, it was: **RESOLVED:** to review the cycle of business for the new financial year 2026/27.	
26/03/6b	**Questions from Governors in Attendance:** A question was received in advance from Steve Connolly in relation to the progress of the Medical Examiner succession and Carmen Howey provided assurance that the internal succession plan is in place and the recruitment process will be undertaken following the retirement of the current Medical Examiner in Autumn 2026.	

Agenda Item No		Action Owner
	A further question was received in relation to the top organisation risks and Sean Fenwick explained that the top organisational risks are composite risks formed by analysing the key themes from the risks that have been escalated to the Trust's Organisational Risk Register. Risks are monitored by the monthly Executive Risk Management Group to seek assurance that actions are being taken to enhance controls and that steps are being taken to mitigate these risks. Ray Dennis asked a question in advance in relation to the Parkinson's specific Band 7 Speech and Language Therapist and Beth Swanson wished to provide clarity that the Board did not make the decision regarding the trial, but sought assurance that due diligence had been conducted before determining not to continue the post funded by Parkinson UK during the trial. She thanked Parkinson's UK for the submission of their petition earlier today and the opportunity to meet the representatives from the charity. She reiterated the Trust's commitment to improving speech and languages services and the access to these services. Beth Swanson confirmed that the Trust will be engaging with The Royal Berkshire NHS Trust who also trialled the role. She explained the need to use resources to the best of our ability to benefit as many patients with speech and language conditions as we can based on evidence and impact. This is core to any decision making. Beth Swanson highlighted that the Trust have, for the past decade separate to the trial, employed a specialist Parkinson's Speech and Language Therapist within our Parkinson's Services but sadly they are leaving the Trust to take up a post with the charity. She also reported that a meeting is planned to take place with representatives of the charity in April and a presentation will also be provided by the Executive Directors at the next Council of Governors meeting in May 2026.	
26/03/6c	**Any Other Business:** There was no other business raised.	
26/03/6d	**Date and Time of Next Meeting:** The next meeting of the Board of Directors will be held at 9.30am on Wednesday 27th May 2026.	
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.		

d - Action Log and Matters Arising

Presented by the Chair

PUBLIC BOARD ACTION TRACKER

(dark blue)	Not yet started
(purple)	Started and on track no risks to delivery
(amber)	Plan in place with some risks to delivery
(red)	Off track, risks to delivery and or no plan/timescales and or objective not achievable
(green)	Complete

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
26/03/2d	25/03/2026	Aubrey Self-Assessment	To reflect the continued work around digital record integration in the action plan	27/05/2026	ES	Action plan updated prior to submission of self-assessment therefore **action recommended for closure**	
26/03/3e	25/03/2026	Nurse Staffing Exception Report	To look at the increase of violence and aggression incidents against red flags and staff survey results	27/05/2026	ES/AV	Work undertaken to pull the various data streams together. Will be picked up via PODC and QGC. **Action recommended for closure**	

Closed Actions from last meeting

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. Jan 26 – plan expected at March Board **March 26 – full Board development proposal included on the agenda in Part 2. Action agreed for closure.**	
25/09/23	25/09/2025	WRES and WDES reports	To arrange a future Board development session to discuss organisational plans	05/12/2025	JB / AV	Oct 25 – added to the forward plan for Board development. To agree which date would be most appropriate for the session. The Chair, Acting CEO and Company Secretary will be working to develop a robust forward plan of Board development. Jan 26 – further discussion at POD Committee and agreement to incorporate a broader session into the Board development plan. **March 26 – full Board development proposal included on the agenda in Part 2. Action agreed for closure.**	
25/12/14 25/12/15 25/12/16	05/12/2025		To provide key highlights, trends, conclusions, etc within executive summary to support Board in addressing key issues	28/01/2026	All	**March 26 – work has been undertaken to strengthen executive summaries within papers. Agreed to close the action and assess the impact as part of**	

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
						the Board effectiveness item on the 2026/27 Board development programme.	
26/01/08	28/01/2026	Board Committee Terms of Reference	To amend terms of reference with suggested changes (clarification of the Vice Chair arrangements for Audit Committee, and the name of the new sub-group for Digital Committee)	25/03/2026	JB	**March 26 – amendments completed. Action agreed for closure.**	
26/01/20	28/01/2026	Questions from Governors in Attendance	To share the response to Steve Connolly's question on fire protection outwith the meeting.	25/03/2026	JB	**March 26 – response shared. Action agreed for closure.**	

e - Top Organisational Risks

Top Organisational Risks – May 2026

The top (composite) risks were confirmed by the ERMG on 5 May 2026 as remaining the same. These are as follows:

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

f - Patient and Staff Story

Report Cover Sheet Agenda Item: 1f

<table>
<tr><td>Report Title:</td><td colspan="4">Volunteer Story</td></tr>
<tr><td>Name of Meeting:</td><td colspan="4">Trust Board of Directors</td></tr>
<tr><td>Date of Meeting:</td><td colspan="4">May 2026</td></tr>
<tr><td>Author:</td><td colspan="4">Presentation developed by Jane Conroy, Head of Quality and Patient Experience, following Volunteer Aileen Wilson’s verbal story at the Trust’s Patient Experience Group (PEG) in January 2026</td></tr>
<tr><td>Executive Sponsor:</td><td colspan="4">Beth Swanson, Chief Nurse</td></tr>
<tr><td>Report presented by:</td><td colspan="4">Beth Swanson, Chief Nurse</td></tr>
<tr><td rowspan="2">Purpose of Report
Briefly describe why this report is being presented at this meeting</td><td>Decision:
☐</td><td>Discussion:
☐</td><td>Assurance:
☐</td><td>Information:
☒</td></tr>
<tr><td colspan="4">A volunteer story is shared with the Trust Board of Directors and this recognises and celebrates the contribution of Trust volunteers during National Volunteers’ Week and highlights the positive impact volunteering has on patients, staff, services and volunteers themselves.</td></tr>
<tr><td>Proposed level of assurance – <u>to be completed by paper sponsor</u>:</td><td>Fully assured
☐
No gaps in assurance</td><td>Partially assured
☐
Some gaps identified</td><td>Not assured
☐
Significant assurance gaps</td><td>Not applicable
☒</td></tr>
<tr><td>Paper previously considered by:
State where this paper (or a version of it) has been considered prior to this point if applicable</td><td colspan="4">The information within this presentation has been previously heard at the Trust’s Patient Experience Group (PEG) in January 2026.</td></tr>
<tr><td>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</td><td colspan="4">Volunteers make a significant contribution to patient experience, staff support and Trust culture across services.
Aileen’s story demonstrates the positive impact volunteering has on wellbeing, confidence, purpose and community connection following retirement.
Feedback highlights the importance of clear volunteer roles, local induction/support and ensuring volunteers feel included within teams.
Learning from volunteer experience will continue to inform the further development and strengthening of volunteering opportunities across the Trust.</td></tr>
</table>

	• The presentation supports recognition of volunteers during National Volunteers' Week (1-7 June 2026).
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is asked to: • Note the presentation and the contribution volunteers make across the Trust; • Recognise the positive impact of volunteering on patients, visitors, staff and volunteers themselves; • Continue to support the development of volunteering opportunities across the Trust.

Trust strategic priorities that the report relates to:	☒	Excellent patient care
	☒	Great place to work
	☒	Working together for healthier communities
	☒	Fit for the future
Trust strategic objectives that the report relates to (2025 to 2030 strategy):		

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

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):	

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

Aileen's Volunteer story

Trust Board of Directors

May 2026

Celebrating National Volunteers Week

During early June, the Trust will join organisations across the UK in celebrating National Volunteers' Week (1st-7th June), recognising the invaluable contribution volunteers make to patients, visitors, staff and the wider community.

As part of the celebration:

- A volunteer celebration event will take place in The Hub, early evening on Monday 1st June
- We will recognise the dedication and impact of our volunteers across services
- We are sharing volunteer stories to highlight the difference volunteering makes both to individuals and to the organisation

Today we are sharing the story of one of our volunteers, Aileen, whose experience demonstrates the value, energy and compassion volunteers bring to our Trust every day.

Aileen's story

"I knew when I retired I had to do something meaningful."

Aileen retired at the age of 63 after a long and varied career.

She began work at 16 as a receptionist before moving into accounts and later working for a bookmakers, a role she says she "absolutely adored".

Alongside her employment, Aileen began volunteering in a local primary school. This experience inspired her to move into education, eventually becoming a Teaching Assistant and later a Higher Level Teaching Assistant (HLTA) and Teaching Assistant Manager.

At the age of 42, Aileen returned to education herself, re-sitting Maths and English qualifications and attending university in order to progress in her role - something she described as a major personal challenge.

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Why volunteering matters?

“I didn’t want another paid job - I wanted to give something back.”

Following retirement, Aileen knew she wanted to remain active and connected to her community. After initially volunteering elsewhere, she applied to become a Trust volunteer after seeing an advert online during the Covid-19 period.

Although initially nervous about volunteering in a hospital environment, she quickly found a sense of purpose and belonging. Aileen described how volunteering has:

- Helped maintain her confidence after retirement
- Kept her mentally and physically active
- Enabled her to meet people from all walks of life
- Allowed her to build friendships and social connections
- Given her an opportunity to give back to the NHS and local community

She spoke warmly about the appreciation shown by staff, patients, and visitors, and described the role as “wonderful” and “rewarding”.

The impact of volunteers

"You feel helpful. You feel part of something."

Aileen particularly enjoys working within the Response volunteer role because of the variety it offers across departments and teams. Here volunteers wear a vocera and are available to support all Trust staff with a range of tasks.

She reflected positively on:

- The welcoming and supportive culture from staff
- The opportunity to interact with patients and visitors
- Feeling valued and appreciated
- Being able to support services during busy periods

Her story highlights the positive impact volunteering has not only on patients and services, but also on volunteers themselves through wellbeing, confidence and purpose.

Supporting volunteers to succeed

Aileen also shared important reflections about volunteering within ward environments. She explained that volunteers work best when:

- Roles are clearly defined
- Expectations are understood
- Volunteers feel included within the team
- There is structure and direction available

Her feedback reinforces the importance of:

- Clear volunteer role profiles
- Local team support and induction
- Meaningful tasks and responsibilities
- Flexible opportunities that meet differing departmental needs

This insight will help inform how we continue to develop and strengthen volunteering opportunities across the Trust.

Thank you to all of our Volunteers

Our volunteers make a significant contribution across the Trust every day through their compassion, dedication and willingness to help others.

As we celebrate Volunteers Week, we would like to thank every volunteer for the time, energy, and kindness they bring to our patients, visitors, staff and communities.

Aileen’s story is one example of the enormous value volunteers add to our organisation and the positive difference volunteering can make for everyone involved.

2. GOVERNANCE

a - Chair's Report

Presented by the Chair

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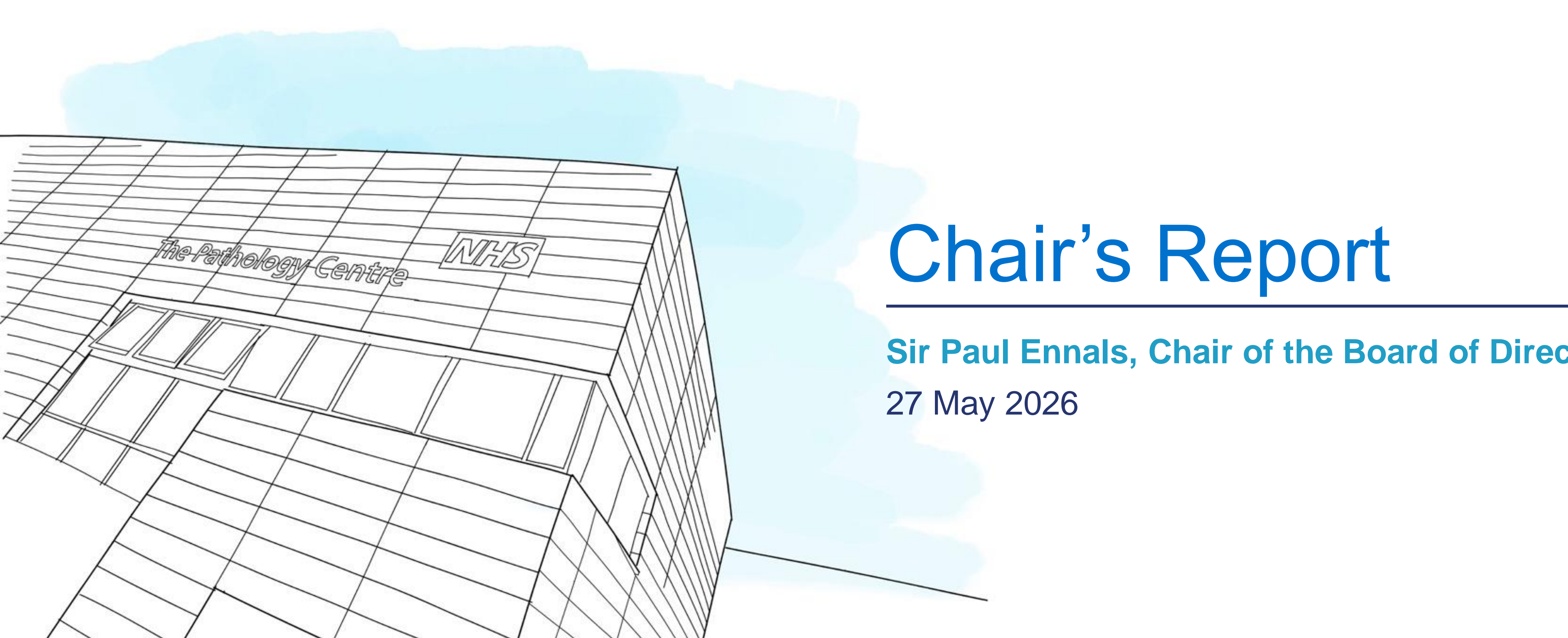

Chair’s Report

Sir Paul Ennals, Chair of the Board of Directors

27 May 2026

Key Updates

- Since the last Board meeting we have conducted interviews for our legal Non-Executive Director position. I am delighted that the Council of Governors formally approved the appointment of Gill Hunter and we look forward to welcoming Gill to the Board shortly.
- The recruitment to our substantive Chief Executive position is underway, following the announcement of Trudie Davies' appointment as the substantive Chief Executive of our Alliance partner North Cumbria Integrated Care NHS Foundation Trust (NCIC). The Board records its thanks and congratulations to Trudie on her appointment.
- I would like to formally record the Board's sincere thanks and congratulations to two colleagues who will be leaving the Trust shortly – Joanne Halliwell, Chief Operating Officer, and Gavin Evans, Managing Director of QE Facilities.
- Jo joined the Trust in 2023 and through her strategic leadership as Chief Operating Officer we have seen considerable improvement in our efficiency and operational performance, with the work around urgent and emergency care being particularly of note. Jo will be leaving us to take up an opportunity to support our Alliance partner NCIC to stabilise services and deliver improvement under the national intensive support programme. Arrangements for interim leadership / recruitment to the Chief Operating Officer position will be shared shortly.
- Gavin joined QE Facilities in 2024 and has made a significant contribution to both QE Facilities and the wider Group during this time. During Gavin's time as Managing Director QE Facilities has been integral to the delivery of significant projects such as the Community Diagnostic Centre, Northern Gynaecology and Oncology Centre and Children and Young People's Department. Gavin will take up his new role as Executive Director of Digital, Estates and Facilities at NCIC in early June.
- We look forward to welcoming Damon Kent to the QE Facilities Managing Director role on 1 June. Damon will undertake the role in addition to this current position as Managing Director of Northumbria Healthcare Facilities Management (NHFM), a wholly owned subsidiary of Northumbria Healthcare NHS Foundation Trust.
- In my role as Chair of the Great North Healthcare Alliance (GNHA) I chaired the latest Alliance Steering Group in April, the first in its new format (a single meeting with Joint Committee items clearly demarcated on the agenda). This included an initial discussion on the roadmap to support the Alliance Strategic Intent, as well as a reflection on the progress made in 2025/26.

Governor Updates

- Since the last Board meeting the Vice Chair and I have had several opportunities to engage with members of our Council of Governors, including monthly meetings with the Lead and Deputy Lead Governors.
- We worked closely with Governors on the recent legal Non-Executive Director appointment (a Governor appointment) – thank you to all Governors who dedicated their time to the interview panel or the stakeholder presentation session.
- We have been working with Governors to keep abreast of the proposed legislation to formally remove Councils of Governors nationally and reaffirm our commitment to continuing to hear the valuable voices of our communities, patients, colleagues and partners. The recent communication from NHS England provides assurance that the approach taken (continuing to work with the Council of Governors as normal, considering future engagement opportunities and pausing elections) is in line with the national direction. We look forward to continuing to work up proposals for future engagement collaboratively with the Council.
- Governors are currently providing input into the Chair and Non-Executive Director appraisal feedback process – contributions and insights are greatly valued and form an important part of the appraisals.
- The Council of Governors met on 20 May and considered a number of different topics including: a presentation on Speech and Language Therapy services (responding to Governor and wider concerns); consideration of a Council of Governor attendee role; and presentations from our Non-Executive Directors involved in the Group Audit Committee and People and Organisational Development Committees. Given the timing of this report any feedback from the meeting will be shared verbally at Board.

b - Acting Chief Executive's Report
Presented by the Acting Chief Executive

Acting Chief Executive’s Strategic Report to the Board of Directors

Dr Sean Fenwick, Acting Chief Executive

27th May 2026

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National statistics and context

National policy, context and operating models

NHS England published the Neighbourhood Health Centres Guidance in April – this outlines goals for the delivery of care at neighbourhood level. This sits alongside the recently published Neighbourhood Health Framework and the Fit for the Future: Towards Population Health Delivery Model.

Wes Streeting resigned as Secretary of State for Health and Social Care on 14 May, with James Murray appointed as his replacement.

NHS England announced a new set of clinical standards that every maternity service in England will need to meet to significantly reduce the number of women who die each year during or after pregnancy

Health Bill has been published with the second reading to take place in the House of Commons on 1 June. The Bill was referred to in the King's Speech and includes foundation trust reform measures.

NHS England announced a new Intensive Recovery Programme for those trusts at the bottom of the NOF league table. There are 5 trusts within the first wave. It is intended to bring decisive action to fix longstanding issues that cannot be resolved by organisations alone.

The Department of Health and Social Care (DHSC) published its renewed Women's Health Strategy, which sets out plans to improve women's healthcare as part of the wider 10 Year Health Plan.

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National performance headlines

National performance – March and April 2026

76.9% of patients in A&E seen within 4 hours (April) compared to 77.1% in March. There were 2.35 million A&E attendances – the busiest April on record. This remains below the 78% aim outlined in the 25/26 planning guidance.

In April for types 1 and 2 only 4 hour performance was 64.4%, which is lower than the overall 4 hour performance (note Gateshead does not have type 2).

On average in April 60.3% of patients who no longer met the criteria to reside remained in hospital compared to 57.2% in April 2025 – i.e. there is deterioration in the position.

9.3% of patients spent more than 12 hours in A&E in April, below the threshold of 10% outlined in the Urgent and Emergency Care Delivery Plan.

72.8% of referrals met the 62-day cancer standard in March, an improvement on last year (71.4%). This is below the 75% target outlined in the 25/26 planning guidance.

In March 79.4% of patients with an urgent referral were told they have cancer, or it was excluded within 28 days. This is slightly higher than the prior year (79%) and close to the target of 80% outlined in the 2025/26 planning guidance.

In March 21.2% of patients were waiting 6 weeks or more for diagnostic tests, which is a deterioration from the previous year (18.4%). In March 2026 the waiting list reached 1.92 million, the highest figure since records began in January 2006.

Waits within 18 weeks are equivalent to 65.3% of all waits (March), meeting the aim for 65% of treatments to be waiting no longer than 18 weeks by March 2026. Waits over 52 weeks accounted for 1.3% of all waits, above the threshold of 1%., but an improvement on the previous month

Excellent patient care

- Our **breast services** are facing significant pressure due to sustained demand growth, which is in part due to challenges elsewhere in the region. This is increasing the wait times for first outpatient appointment and the ability to deliver the important 28 day faster diagnosis standard for our patients. This has a detrimental impact on patient experience, increases clinical risk and impacts on our colleagues who have been working hard to see as many patients as possible. We are prioritising the development and implementation of short term recovery plans and longer term plans to be able to support our patients and colleagues.
- The **Gateshead Secondary Prevention Service** has won the Best Pharmaceutical Partnership with the NHS award at the 2026 Health Service Journal (HSJ) Partnership Awards. This celebrates the innovative collaboration between the Trust and Novartis Pharmaceuticals. The service provides holistic, evidence-based care for patients recovering from heart attacks or strokes, focus on managing cholesterol, diabetes and blood pressure.
- The **Endoscopy Unit** has been awarded annual Joint Advisory Group (JAG) accreditation again, with excellent feedback received. The accreditation is only awarded to services which have demonstrated that they meet best practice quality standards.
- On 23 April the **Nuclear Medicine** service was inspected by CQC to assess compliance against the Ionising Radiation (Medical Exposure) Regulations. We are reviewing the draft report as part of the factual accuracy checking process.
- We celebrated **International Day of the Midwife** on 5 May and **International Nurses Day** on 12 May, recognising and celebrating the hard work, dedication and expertise of our colleagues in delivering high-quality care to our patients.

Great place to work

- Resident doctors participated in **industrial action** from Tuesday 7 April to Monday 13 April. Colleagues worked hard to keep our patients, services and site safe during this period and we record our thanks to all involved.
- We recently completed our **enhanced rostering project** which is designed to make the rotas feel more secure and sustainable. Key improvements include enhanced night cover for registered nurses and healthcare assistants (HCAs), with protected supervisory time for ward managers to strengthen leadership. The divisions are actively recruiting HCAs to fill vacancies and we are progressing work on a development programme, including a Healthcare Apprenticeship pathway, to support colleagues moving from Band 2 to Band 3 roles.
- We have launched a new **Star Shoutout Board** on our intranet to help recognise colleagues who have gone above and beyond and celebrate the impact they have made. The Shoutout Board has been well utilised so far with lots of colleagues recognised in this way. The Vice Chair will select the winner of the monthly You’re a Star award from the submissions.
- Since the last Board we have continued to take up **opportunities to meet with colleagues** across the Trust and visit different areas. For example the Vice Chair and Interim Chief Nurse visited St. Bede’s and were very impressed by the commitment and enthusiasm shown by colleagues, as well as the overall welcoming feel to the department.
- In addition the Interim Chief Nurse and the Chair of the Digital Committee visited our community teams in Bensham. The pride in the service and colleagues’ ambitions for its future were clearly seen. Some helpful discussions were held where colleagues shared some concerns about unintended consequences of team reorganisations as well as some duplications between IT systems linked to the virtual ward. Opportunities for future Alliance collaboration were identified to ensure that children living in Gateshead who have been discharged from Newcastle are flagged to the Gateshead community team to ensure ongoing support is provided (where required).

Working together for healthier communities

- **Dame Lesley Regan**, the Women's Health Ambassador for England, visited Gateshead to see how local partners are working together to improve community access to women's health services. This was an excellent opportunity to showcase the joined-up care provided across the community through the Women's Health Hub. The Hub provides a one-stop approach to essential services such as cervical screening, contraception services, menstrual health support and menopause management. It allows women to manage their health needs in a single appointment and helps to address health inequalities by delivering care closer to where people live.

- The **Community Diagnostic Centre (CDC)** at the Metrocentre is expanding into Phase 2 with £10 million of additional investment secured to support this. This will create capacity for more than 38,000 additional diagnostic appointments and tests each year. Phase 2 will open in Spring 2027 and will introduce new equipment and additional clinics including
  - A new MRI scanner
  - New X-ray facilities
  - Two additional ultrasound rooms
  - A dedicated clinic space for outpatient hysteroscopy procedures

- We were one of only 3 trusts to be invited to attend the **summit on antisemitism** in London hosted by the Prime Minister. Sean Fenwick attended to represent the Trust (given the excellent work undertaken in this area) as well as the wider health sector. This was an important and powerful summit to identify actions to tackle antisemitism. We are committed to continuing to ensure that our Trust is an inclusive and compassionate place for both our colleagues and our patients.

Fit for the future

- We successfully delivered against our **financial plan** for 2025/26, reporting an actual deficit of £5.048m, a favourable variance of £0.057m against the plan (note this is the unaudited position). We successfully delivered our **capital plan** for 2025/26, investing £28.2 million in our estate to improve environments and services for patients and colleagues. Key projects delivered towards the end of the financial year included upgrades to critical equipment, essential maintenance and refurbished staff areas.
- Our **Cost Reduction Programme (CRP)** in 2025/26 delivered the highest level of recurrent savings we have ever achieved. This has been delivered through the hard work of colleagues to transform services to be more efficient, whilst ensuring that safe, high quality care for patients is prioritised.
- Our **Alliance** with neighbouring trusts in Newcastle, Northumbria and North Cumbria is an increasingly important part of the way we improve outcomes for patients, staff experience and financial sustainability. We are sharing a progress report at today's meeting to highlight the difference the Alliance is making, together with some of the challenges we are tackling. The four Trusts have agreed a strategic intent document that sets our ambition for the Alliance. We want to work together to deliver excellent tertiary and secondary hospital services, while strengthening neighbourhood care closer to patients' homes. We couldn't share this previously because of some restrictions ahead of local elections – this is now included in the supplementary paper pack to accompany today's papers.

- Three colleagues were awarded a **High Commendation in the Sustainability Project of the Year** award at the HSJ Partnership Awards with BBraun. Lucy Knightley, Senior Operating Department Practitioner, Barry Dent, Upper GI Consultant, and Iain Cameron, Obstetrics and Gynaecology Consultant, delivered a sustainability project which has swapped from using 6,000 disposable laparoscopic instruments annually to using reusable instruments. This has delivered significant financial savings and reduced 723kg of waste.
- Our **Clinical Strategy** was formally approved and launched at the Board of Directors at the end of March 2026. The document has been authored and shaped by clinical leads and colleagues throughout the Trust. The Strategy will support us to deliver our clinical priorities of: safe, high-quality services for all; excellence in women's health; and excellence in diagnostics.

c - Assurance from Board Committees

i) Finance and Performance Committee - April and May 2026 - presented by the Chair of the Committee

ii) Quality Governance Committee - April 2026 - presented by the Chair of the Committee

iii) Group Remuneration Committee - March and April 2026 - presented by the Chair of the Committee

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

v) Digital Committee - May 2026 - presented by the Chair of the Committee

3A Escalation and Assurance Report

Name of Committee / Group:	*Finance and Performance Committee*
Date of Committee / Group:	*27 April 2026*
Chair of Committee / Group:	*Martin Hedley*

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

- **Breast Services** – this remains an unmitigated issue.

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 following advisory item was identified:

- **NHSE assessment of Medium-Term Plan** – NHSE has assessed the plan as compliant with conditions for 2026-27, allowing progression into delivery but with increased regional oversight and time critical conditions. There is now a need to focus on delivery of the plan.

Assure
(key assurances received and any highlights of note)

Recommendations to Trust Board:

The Committee received the following assurances:

- **2025-26 Finances -** ended the year on target.
- **Developing our Neighbourhood** – Progress has been made on this with a framework published.
- **Committee Effectiveness Review** – positive review of effectiveness with some small amendments to the terms of reference required.
- **Underlying deficit** – Improved underlying deficit position and a good understanding of the underlying deficit.

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

- No new risks were identified.

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

- There were no cross referrals.

Committee Escalation and Assurance Report

Name of Board Committee	Quality Governance Committee
Date of Board Committee:	28 April 2026
Chair of Board Committee:	Adam Crampsie

Alert

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

Maternity - System C Badgernet national alert

- This remains an evolving situation with additional issues identified in the week prior to the Committee meeting.
- Mitigations have been introduced following identification of a System C Badgernet coding issue affecting the automatic population of high-risk Body Mass Index (BMI) data within maternity records. This created a risk that some women who should have been identified as requiring aspirin prophylaxis during pregnancy may not have been automatically flagged by the system. Manual checking processes and retrospective risk assessment reviews are now in place to identify potentially affected women and ensure appropriate treatment is provided.
- A regionally agreed approach is being taken across Trusts with each organisation reviewing its own cases.
- The Committee noted that there remain unknown elements in relation to the potential scale of harm and wider implications of the issue.
- Concerns were also raised regarding the wider governance oversight of digital systems increasingly being used as clinical decision support tools rather than solely electronic patient records.
- A cross-referral was made to the Digital Committee regarding both the Badgernet issue and wider governance oversight relating to digital clinical support functionality.

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)

Health and Safety

Risk assessment compliance

- The Committee noted concerns regarding missing, incomplete or overly generic local risk assessments and variable evidence of locally implemented controls.
- Additional training and support arrangements are being developed for ward and departmental managers.
- The Committee requested clearer trajectories and timescales for improvement and stronger divisional accountability.

Violence and aggression rates

- Violence and aggression remains the highest reported incident category across the organisation.
- The Committee acknowledged improved organisational focus and revised approaches to identifying hotspot areas and targeted interventions.
- However, the Committee noted this remains a longstanding concern and requested greater assurance regarding delivery of the Violence Reduction Strategy, impact of interventions and organisational grip.
- The Committee also highlighted the importance of understanding both incident severity and staff confidence in reporting and organisational response.

Health and safety overdue incidents and delays in investigation closure

- Persistent delays remain in the completion of health and safety investigations, including cases exceeding six months.
- Delays are most pronounced within violence and aggression investigations.
- Enhanced dashboard reporting and escalation processes are now in place and there is increased focus on divisional ownership and oversight.
- The Committee remained concerned that delayed investigations impact the organisation's ability to learn and implement timely improvements.

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and World Health Organisation (WHO) audits

- Revised actions following the internal audit reviews will be submitted through the Audit Committee for approval.
- The Committee acknowledged the significant learning identified regarding historic governance weaknesses, tracking of actions and assurance processes.
- A further update will be provided to the Committee in August 2026, at which point all actions are expected to be complete.
- The Committee noted there remains some residual risk in the interim period while revised policies, training and controls are embedded.

Caesarean section deep dive

- The Committee received assurance that Gateshead is not a regional or national outlier in relation to Caesarean section rates.
- However, the Committee noted sustained increases in complexity and operative delivery rates, with acknowledgement that the current service model and workforce arrangements require further development to reflect current demand levels.
- Workforce and theatre capacity implications are being considered through Executive Committee business cases.

Urgent and Emergency Care (UEC) performance

- Performance stabilised during March 2026 but recovery has not progressed at the same pace as regional and national comparators.
- Delays over 12 hours have reduced significantly, although mental health related delays remain a concern.

- Flow and discharge pressures continue to impact operational performance and patient experience.
- The Committee requested continued triangulation between performance metrics, patient safety and patient experience.

Breast performance

- A number of mitigating actions have now been implemented including additional clinical capacity, weekend clinics, locum support and service model review.
- The Committee acknowledged improved organisational grip and clearer recovery planning.
- However, the wider regional service position remains unclear and the Committee requested continued oversight regarding trajectory and delivery of sustained improvement.

Overdue complaints

- Overdue complaints have increased to 28 cases.
- The Committee noted ongoing delays in closure and concerns regarding organisational responsiveness and timeliness of learning.
- There is an agreed recovery trajectory with the ambition to reduce overdue complaints to 18 by the next Committee meeting in June 2026.
- The Committee requested continued oversight of complaint themes, divisional variation and links to wider patient experience concerns.

Patient Safety Investigations and Health and Safety Investigations

- The Committee noted continued pressures relating to investigation timeliness and backlog management across both patient safety and Health and Safety investigations.
- New governance arrangements are being implemented, including the Executive Learning Sign Off Panel (ELSOP), enhanced use of InPhase and strengthened divisional oversight.
- The Committee requested assurance that investigation quality, learning and organisational responsiveness improve alongside timeliness measures.

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

Positive assurances were agreed in relation to:

- Alliance shared clinical guidelines and ongoing collaborative clinical effectiveness work across partner organisations.
- Friends and Family Test performance remains strong at 92.1% overall, including positive Emergency Department patient experience feedback.
- Health inequalities work continues to progress with increasing integration into the clinical strategy, prevention agenda and organisational planning.
- Health and safety dashboard reporting has significantly improved in quality, visibility and maturity and was positively received by the Committee.
- Improved Infection Prevention and Control (IPC) rates and strengthened learning following winter pressures.

- Integrated Care Board (ICB) restructuring arrangements will continue to provide ICB representation and engagement within Quality Governance Committee structures.
- Increasing use of real-time patient feedback and revised “15 Steps” walkabouts to support assurance on patient experience.
- The Committee effectiveness review identified good compliance with Terms of Reference and only minor areas requiring strengthening.
- Referral to Treatment (RTT) performance has improved with a strong overall position and low numbers of patients waiting over 52 weeks.

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

- There were no new risks identified.

Cross-referrals (by exception only)

- A cross-referral was made to the Digital Committee in relation to the national Badgernet alert and wider governance oversight of digital clinical decision support functionality.

3A Escalation and Assurance Report

Name of Committee / Group:	Group Remuneration Committee
Date of Committee / Group:	25 March 2026 and 22 April 2026
Chair of Committee / Group:	Martin Hedley

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

- There were no matters to alert the Board to.

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)

- At its meeting in March 2026 the Committee approved the proposals for recruitment of the substantive Chief Executive (should this be required – i.e. should the Trust's substantive Chief Executive be formally appointed to North Cumbria Integrated Care NHS Foundation Trust where she is currently on secondment).
- At its meeting in April 2026 the Committee approved further extensions to the secondments of the substantive and acting Chief Executives to 30 May 2026 given the recruitment process at North Cumbria had not yet concluded. *Post-meeting note – this has now concluded and recruitment has commenced to the substantive role for Gateshead Health.*
- At its meeting in April 2026 the Committee was formally notified that the Chief Operating Officer had successfully secured an opportunity to support North Cumbria Integrated Care NHS Foundation Trust. Initial discussions commenced regarding the timing of the transition and recruitment arrangements.

Assure
(key assurances received and any highlights of note)

- The Committee approved the original plans for the recruitment to the QE Facilities (QEF) Managing Director post in March 2026. In April 2026 the Committee reconvened to approve revised plans which enabled the Group to take up an Alliance opportunity – namely for Damon Kent, current Managing Director of Northumbria Healthcare Facilities Management (NHFM), to become joint Managing Director of both NHFM and QEF. The model of shared leadership supports closer collaboration across the organisations.
- In March 2026 the Committee approved the re-designation of the QEF Director of Strategy, Planning and Performance role into the Executive Director of Corporate Services role, with an expanded remit covering People and Organisational Development, governance and Safety, Health, Environment and Quality (SHEQ). The designation of the role as an Executive Director strengthens leadership

capacity and capability. This proposal was ratified by the Board at its meeting in March 2026.
Risks (any new risks / proposed changes to risk scores)
• No new risks identified.
Cross-referrals to other Committees / Groups / Executive Director Leads
• None

3A Escalation and Assurance Report

Name of Committee / Group:	People and OD Committee
Date of Committee / Group:	Tuesday 12 May 2026
Chair of Committee / Group:	Mrs Maggie Pavlou

Alert ***(matters of significant concern requiring escalation for further action)***
HCA vacancies – Inpatient areas continue to experience sustained staffing pressures, with vacancies within the non-registered (HCA) workforce contributing to gaps in establishment, alongside increased acuity and escalation capacity. This had led to periods of staffing levels falling below planned levels requiring active mitigation (bank and agency spend) to maintain safe care delivery. Apprenticeship development programme business case in progress. However, should the business case not will become increasingly challenging to continue to mitigate the risk associated with this. Ongoing local recruitment continues with limited success. **Internal Audit Actions –** the internal audit actions for the Senior Medical Staffing Audit relating to job plans over 12PAs remain overdue and are yet to be concluded although previously indicated this would be complete in advance of May Committee. Action to be taken by CEO with support from Executive team.
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)***
Board oversight on MHPS – agreed that further Board oversight of cases would be useful and an agreement to flow this via Committee through Employee Relations activity report on a quarterly basis (and more regularly if needed). **Increasing levels of Employee Relations Activity –** We are seeing an increase in internal employee relations cases as well as an increase in Employment Tribunal applications. Currently 6 active Employment Tribunal cases in the Trust being managed appropriately. **British Medical Association (BMA) Balloting –** BMA balloting consultants and Speciality Drs (All denominations) for strike action alongside an active Resident Doctor mandate for strike action which is in place until 1st August 2026. **Board Assurance Framework (BAF) –** agreement to listen to feedback from each of the Tier 1 Committee's and for the Executive Team to review relevant BAF's as a

collectively to finesse and ensure that this is strategically positioned and useful to Board achieving the strategic objectives.

Ethnicity Pay Gap Report – highlighted the underrepresentation of BME staff compared to White colleagues, in particular at a Senior Level (Band 8b and above).

Growth & Skills (Formerly Apprenticeship) **Levy –** Without commitment to early career pipeline there is a potential that we will not be able to fully utilise the levy funds. Plans are in place around the following programmes to better utilise the levy;

- development of a business case to support Nursing and HCA apprenticeship programmes
- agreement to transfer funds into the wider NHS system
- support for local corporate / divisional commitment for apprenticeships for entry level roles.

Consideration is also being undertaken around how we take a more targeted and specific approach linked to the broader Neighbourhood Health Strategy, working with local VCSE and local authority partners.

Nursing & Midwifery Job Profiles – Working at same pace as regional group, continues to be a risk. Commitment to the regional scaling programme but acknowledgement work happening in background to line up and have JD's ready, although lack of committee oversight on progress with this. This will be provided via POD Steering Group.

WRES and WDES – Data submission for 2025/26 noted and agreed to submit for May deadline. Number of metrics have declined since last year and there are changes external to the environment which have the potential to further impact on this moving forward. Work is underway to engage with key stakeholders between now and submitting our more detailed plan in October. Agreement to review the free text comments from staff survey by way of triangulation and to support the Trust to address the issues that really matter to our staff and begin to shift the dial on each of the indicators.

Neonates and Obstetrics – Local Maternity & Neonatal System (LMNS) annual assurance report raised concerns re safe neonatal staffing. MIS Year 8 (1 April 2026 – 30 November 2026) requires a six-monthly integrated report – new report template to be devised to include maternity and neonatal staffing. Business case prepared for discussion around additional posts.

Assure
(key assurances received and any highlights of note)

Ethnicity Pay Gap (EPG) Report – Positive acknowledgement that we have started to report on the EPG. Positive assurance also received around the pay gap BME staff compared to White colleagues and agreement to re-format and publish on the Trust website ahead of the next Committee.

Guardian of Safe Working – Exception reform has been embedded. Assurance provided that effective systems and mechanisms exist to enable individuals to report appropriately.

Midwifery Staffing Report – Six-month midwifery workforce report received for Q3 and Q4 2025-26 and demonstrates compliance with the Maternity Incentive Scheme Year 8 Safety Action A – Workforce and Capacity.

Risks (any new risks / proposed changes to risk scores)
No new risks or proposed changes to risk score to note.

Cross-referrals to other Committees / Groups / Executive Director Leads
No cross-referral to note.

3A Escalation and Assurance Report

Name of Committee	Digital Committee
Date of Committee	6 May 2026
Chair of Committee	Mr Andrew Besford

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

- 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)

- **Badgernet** – Evolving issues with the Badgernet system and cross-referral from the Quality Governance Committee. Gateshead have met with the senior team at the suppliers but there is a need for an increased regional voice.
- **Systems Managed Outside of the Digital Team** – a draft list to be drawn up with recommendations on governance arrangements.
- **Non Elective Care EPR** – update provided but risks remain in relation to funding, resources, including Digital Nurse support, and the procurement processes.
- **Data Strategy** – update provided but risks around progress against strategy, capability, demand management and the Target Operating Model. The Strategy to be reported to the next meeting of the Committee.
- **Secure Data Environment (SDE)** – to be looked at on a case by case basis
- **Review of Communication Systems** – work is underway and this will highlight how clinicians are using current systems, where device consolidation may be possible and defining where we want to get to in the future.
- **Analysis of Front Door Policy** – to be provided to the next meeting.
- **Subject Access Requests** – rag rated as red with 63% completed on time and a significant backlog.
- **Information Governance/Subject Access Requests** – to be looked at from an Alliance perspective to look to standardise definitions and approach.

Assure
(key assurances received and any highlights of note)

- **Digital Strategy** – Finalising engagement and moving towards a costed plan.
- **Federated Data Platform (FDP)** – assurance provided on the approach to engaging with the FDP – this needs to be referenced within the Data Strategy.
- **Alliance KPI Pack** – framework developed for consistent approach to KPIs across the Alliance but there are some areas we don't yet have data for such as customer service.
- **Digital KPIs** – assurance provided in relation to unsupported devices.

- **Digital and Data Programme Overview –** assurance provided and overall risk improving.
- **Digital Risks** – move to thematic approach has been agreed.
- **Critical IT Incidents** – no incidents to report.
- **Organisational Risks**
- **Board Assurance Framework**
- **Audit Plan –** Audit Plan for 2026-27 has been agreed.

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.

d - Annual Declarations of Interest

Presented by the Company Secretary

Report Cover Sheet Agenda Item: 2d

Report Title:	**Annual Declarations of Interest for the Board of Directors**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 May 2026			
Author:	Diane Waites, Corporate Services Assistant			
Executive Sponsor:	Sir Paul Ennals, Chair			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To approve the latest Board of Directors' Register of Interests, ensuring it is publicly accessible through the Board papers.			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*				
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	Interests have been declared in accordance with local and national policy and in accordance with the Trust's governance documents. Unless stated on the register, declarations have been made by Board Members during May 2026 and therefore represent the latest record of interests declared.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is requested to formally approve the annual register of interests for the Board of Directors.			

<table>
<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">Declarations of interests enable the early identification of any potential conflicts which may in turn impact upon the ability to achieve the strategic objectives.</td></tr>
<tr><td>Links to CQC Key Lines of Enquiry (KLOE):</td><td colspan="2">Caring
☐</td><td>Responsive
☐</td><td>Well-led
☒</td><td>Effective
☐</td><td>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"></td></tr>
<tr><td>Has an Equality and Quality Impact Assessment (EQIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td colspan="2">Not applicable
☒</td></tr>
</table>

Forename	Surname	Position	Interest	From	To	Comments
Andrew	Besford	Non-Executive Director	Director, Shareholder and Person with Significant Control (PSC) - 55th Parallel Ltd.	27/12/2017	Ongoing	Company has not done any business with NHS organisations
			Non-Executive Dirctor role - Living Archive Limited	24/11/2021	Ongoing	The company is not carrying out any business with Alliance Trusts but has worked with a supplier to the wider NHS in the past
			Partner - employed by Percy Hedley Foundation	23/07/2024	Ongoing	
			Partner - Chair of Newcastle Carers	18/11/2019	Ongoing	
			Partner - Trustee of The Key Charity	21/11/2019	Ongoing	
Adam	Crampsie	Non-Executive Director	Chief Executive - Everyturn Mental Health	01/12/2020	present	
			Director - Mental Health Concern	01/12/2020	present	
			Non-Executive Director - County Durham and Darlington NHS Foundation Trust	01/11/2025	present	
			Board Member - Mental Health Network Advisory Board	01/07/2025	present	
Sir Paul	Ennals	Chair	Chair of Newcastle upon Tyne Hospitals NHS Foundation Trust	01/07/2024	present	Formally appointed as the substantive Chair from 01/10/2026
			Chair of Northumbria Healthcare NHS Foundation Trust	01/09/2023	present	
			Chair of the Great North Healthcare Alliance	01/10/2026	present	
			Board Member - Net Zero North East	2024	present	
			Member of North East Child Poverty Commission	2020	present	
			Spouse - volunteer at The Bay Foodbank	2014	present	
Gavin	Evans	QEF Managing Director	None			
Sean	Fenwick	Acting Chief Executive	Seconded position from South Tyneside and Sunderland NHS Foundation Trust	01/08/2025	present	
			Family member works as an underwriter for an insurance company in Manchester		present	The company has interests within North East and North Cumbria, including councils and FTs.
Joanne	Halliwell	Group Chief Operating Officer	Director and shareholder in SHC Consulting Ltd	2024	present	
Martin	Hedley	Non-Executive Director and Senior Independent Director	Chair of Board - RSCH Pharmacy Limited	01/06/2020	present	
			Governor - Gateshead College	01/06/2020	present	
			Managing Director - Vision Achievement Limited	01/02/2013	present	
Carmen	Howey	Medical Director	None	01/07/2024	present	
Robert	Hughes	Non-Executive Director	Outside employment - Fractional C-Suite Consultancy	01/01/2025	present	
			Outside employment - Tech Start up	08/12/2025	present	
			Outside employment - Community Land Company	01/02/2026	present	
Kris	Mackenzie	Group Director of Finance	None			
Gerry	Morrow	Non-Executive Director	Sunderland GP Alliance - clinical pathway rationalisation	01/05/2026	present	yearly contract
Maggie	Pavlou	Non-Executive Director	Owner / Director - People Gauge (software business)	2011	present	
			Trustee - The People's Kitchen (charitable organisation)	2020	present	
			Trustee - The Chronicle Sunshine Fund (charitable organisation)	2020	present	
			Trustee - York Theatre Royal (arts)	2022	present	
			Chair of QE Facilities Ltd (wholly owned subsidiary of GHNHSFT)	01/10/2023	present	
			Non-Executive Director - County Durham and Darlington NHS Foundation Trust	01/11/2025	present	
			Spouse - Harlow Printing (printing firm)	2022	present	
Elizabeth	Swanson	Interim Chief Nurse	Spouse - Swanson Cardiology Services Ltd (private medical practice)	01/01/2026	present	Children are beneficiaries
Amanda	Venner	Group Director of People and Organisational Development	None			

e - Strategic Communications Report Presented by the Acting Chief Executive / Head of Communications and Engagement

Report Cover Sheet Agenda Item: 2e

Report Title:	**Strategic communications report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	Wednesday 27 May 2026			
Author:	Helen Fox, Head of Communications and Engagement Clare Cruddas, Communications Manager			
Executive Sponsor:	Sean Fenwick, Acting CEO			
Report presented by:	Helen Fox, Head of Communications and Engagement			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To provide an overview of communications activity during quarter four (January to March 2026), including support for organisational priorities, leadership communication, stakeholder engagement and management of reputational risk during a period of operational pressure and national policy change.			
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*	Executive Committee on 11 May 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*	• Communications supported safe service delivery and management of reputational and stakeholder risk during quarter four, alongside delivery of organisational priorities (publication of the 2025 staff survey results, the Northern Gynaecological Oncology Centre opening and engagement for securing our sustainable future) • Delivery took place in a challenging external environment, with significant capacity absorbed by reactive media management, industrial action and rapidly changing national policy developments. • Despite this, communications delivery remained proportionate, with consistent leadership communication, sustained staff engagement and stable organisational reputation.			

	• External visibility remained strong, with 172 media articles reaching 275m potential audience and communications influencing approximately 50% of coverage.
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	To note the content of the 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):	Covers all strategic objectives	

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

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** ☒

Communications update for quarter four - January to March 2026

Helen Fox, Head of Communications and Engagement

May 2026

Supporting delivery of organisational priorities through communications

Excellent patient care

- Coordinated communication during operational pressure and industrial action to support safe service delivery
- Delivered the official opening of the Northern Gynaecological Oncology Centre, colposcopy and children and young people's services. Secured media coverage linked to women's health
- Supported winter communications and public messaging to help manage demand and liaised/worked with partners
- Led the national women's health visit (Dame Lesley Regan), linking with partners, supporting visibility of clinical priorities and service with media coverage and video development
- Secured national BBC article linked to discharges highlighting Trust's good practices
- NOF/National Cancer Plan communications support and delivery

Great place to work

- Led communication for publication of the 2025 staff survey results with the people and OD team, enabling open and transparent discussion with staff and the creation of an infographic
- Revitalised cascade model and redeveloped approach to Team Brief and leadership communications
- Developed internal communications approach to Middle East conflict
- BAU activity across internal and social channels
- Supporting the NHS Excellence Awards via awareness

Patients
People
Partners
Sustainability
Centre of Excellence Women's Health
Safe, high-quality services for all
Centre of Excellence for Diagnostic Services

Working together for healthier communities

- Coordinated communication with system partners and stakeholders
- Coordinated communications for Minister of State for Health visit to the Community Diagnostic Centre, supporting system partnership and public visibility
- Managed MP and councillor enquiries to protect the organisation's reputation
- Reset and set up quarterly MP meetings and led tour for MP to CDC
- Supported the Compassionate Gateshead launch
- Support for Gateshead Health Overview and Scrutiny

Fit for the Future

- Created programme approach for communications and engagement with CRP
- Supported leadership communication throughout the period
- Prioritised communication activity to manage demand within a reduced team structure
- Led rapid communications response to unexpected national nursing announcement, supporting leadership communication and organisational clarity
- Handling media enquiries to protect organisational reputation eg Ward 23
- Parkinson's advice and guidance on handling, media handling, protest support and advising on responses including political handling
- Horizon scanning around media, national policy and regional issues
- Began work on the CDC national funding and coordination with DHSC
- Development of the annual plan/medium-term plan communications

Quarter 4 communications activity

INTERNAL REACH

1 in 5 people

Engage weekly with organisational communication (benchmark is between 15-25%)

STAFF ENGAGEMENT

Sustained

Consistently good engagement through internal communications channels

ORGANISATION REPUTATION

Stable

Reputation remained stable during periods of operational pressure

DELIVERED THE CORE PRIORITIES

- **2025 Staff Survey:** Supported credible publication of results with integrated messaging.
- **NGOC Official Opening:** £7.4m clinical milestone investment and supporting the official opening and media management
- **Securing our Sustainable Future:** Established engagement approach.

OVERVIEW

Despite significant external pressures and capacity constraints:

- Leadership communication remained consistent and visible.
- Organisational reputation remained stable.
- Communications delivery remained proportionate

IMPACT

- **Staff engagement sustained at expected levels**
- **Media coverage: 172 articles potentially reaching 275m, with communications influencing 50% of stories (see next slide for more info)**

ENVIRONMENTAL PRESSURES

- **Reactive Media Management:** Significant capacity absorbed by sensitive local cases.
- **Industrial Action:** Extensive planning and real-time response management.
- **National Policy:** Tracking and communicating rapid policy developments.

Team impact on external communications

Potential Reach

275M

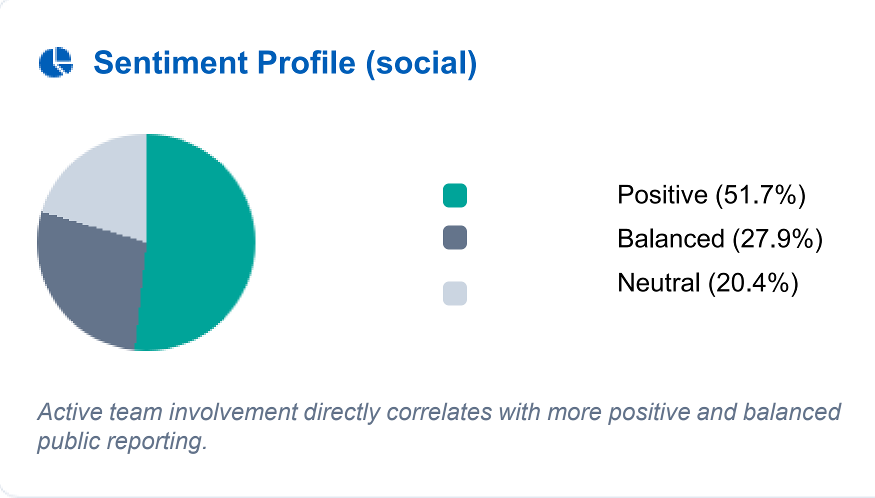
Analysis of **172 media articles** mentioning the Trust. Our communications successfully positioned Gateshead Health as a prominent leader in healthcare innovation and regional service delivery.

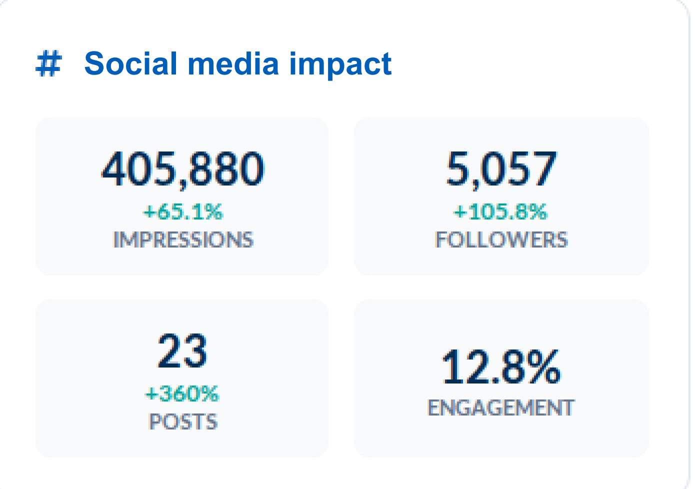
Proactive Influence (media)

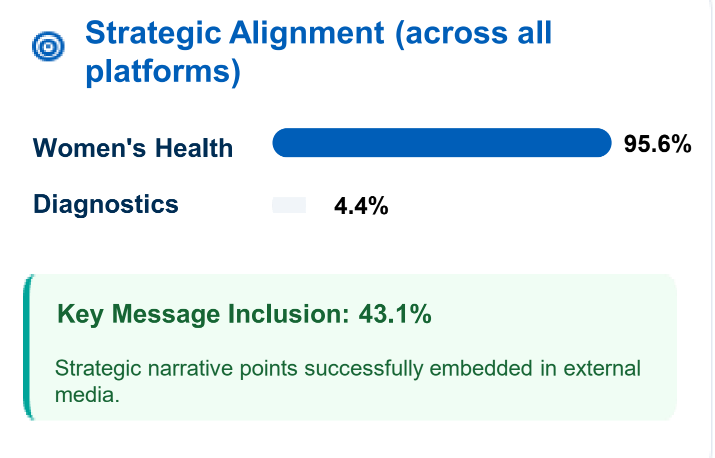
47.3%

OF ALL MEDIA STORIES DIRECTLY INFLUENCED BY TEAM

The team handled **29 specific media requests**, ensuring key strategic narratives were embedded accurately.







Looking ahead – priorities for quarter one 2026/27

01

Continuing the work following publication of the 2025 staff survey, including visible leadership communication and support for local action planning

02

Supporting communication and engagement linked to Securing our Sustainable Future and the wider financial recovery programme

03

Maintaining a regular programme of positive organisational stories, with a planned focus on one 'good news' story approximately every four weeks, aligned to communications capacity and operational service readiness

3. EXCELLENT PATIENT CARE

a - Maternity Integrated Oversight Report presented by the Associate Director of Midwifery/SCBU

Report Cover Sheet Agenda Item:

Report Title:	**Maternity Integrated Oversight Report April 2026**			
Name of Meeting:	Trust Board			
Date of Meeting:	27 May 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 April 2026			
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*	Joint Anaesthetic/Obstetrics & Gynaecology Safecare 12/5/2026 Division of Surgery, Women's Health and Children Operational Board 27/5/2026 Safecare Steering Group 19/5/26			
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** Maternal death – awaiting MNSI confirmation of investigation. Learning has been shared through joint anaesthetic/obstetric Safecare arrangements. Discussion highlighted antenatal clinic capacity as a factor requiring consideration within the wider review, particularly in relation to time available to complete comprehensive booking risk assessments and timely referral into the appropriate AIP pathway. No causative link has been established at this stage. **Advise** • MDT task & finish group to be commenced to create "bloodless surgery" pathway • NICE guidance re switch to carbotocin as 1st line for caesarean section PPH prevention – cost-risk			

<table>
<tr><td></td><td colspan="5">assessment & recommendation to be brought to divisional Safecare
Assure
• Guidelines approved – irregular fetal heart rate (LMNS), aspirin in pregnancy (updated), DVT & PE in pregnancy, Management of jaundiced babies, uterine inversion, Transitional Care, Neonatal pulse oximetry, Infant Abduction, Risk Management, Escalation
• Relocation of EPAU</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">Accept as monthly perinatal report</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">Centre of excellence for Women's Health</td></tr>
<tr><td>Links to CQC Key Lines of Enquiry (KLOE):</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):</td><td colspan="5">4852 – Maternity Theatres
2275 – SCBU workforce
4712 – Antenatal clinic capacity
4729 – Women's Health Clinic workforce</td></tr>
<tr><td>Has an Equality and Quality Impact Assessment (EQIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

Maternity
Integrated Oversight Report

Maternity data from April 2026

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

- Maternal death – awaiting MNSI confirmation of investigation. Learning has been shared through joint anaesthetic/obstetric Safecare arrangements. Discussion highlighted antenatal clinic capacity as a factor requiring consideration within the wider review, particularly in relation to time available to complete comprehensive booking risk assessments and timely referral into the appropriate AIP pathway. No direct causative link has been established at this stage.

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

- MDT task & finish group to be commenced to create "bloodless surgery" pathway
- NICE guidance re switch to carbotocin as 1st line for caesarean section PPH prevention – cost-risk assessment & recommendation to be brought to divisional Safecare

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

- Guidelines approved – irregular fetal heart rate (LMNS), aspirin in pregnancy (updated), DVT & PE in pregnancy, Management of jaundiced babies, uterine inversion, Transitional Care, Neonatal pulse oximetry, Infant Abduction, Risk Management, Escalation
- Relocation of EPAU

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	✓	✓											GAP analysis of Year 8 underway
	Maternity Outcomes Signal (MOSS)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	Regional Heatmap	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	MDT workforce	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Exception reports (as required)														
	SPC exception reports	✓	✓	0	0	0								
	PSII/MNSI/perinatal mortality – new & completed cases	0	✓	0	✓	0	✓							1 pregnancy loss in April 2026 2 completed MNSI reports
	Risk register – new emerging risks & updates	✓	✓	✓	✓	✓								SystemC update
Quarterly reports		Q2 2025/26	Q3 2025/26			Q4 2025/26			Q1 2026/27			Q2 2026/27		
	Perinatal Mortality Review Tool (PMRT)	✓				✓		✓			✓			Q3 PMRT report
	Transitional Care & ATAIN (avoiding term admissions to neonatal units)				✓		✓			✓			✓	
	SBLCB (Saving Babies Lives Care Bundle)		✓						✓			✓		Awaiting new SBLCB audit schedule/tool
	Complaints, Compliments & Incidents	✓			✓			✓			✓			
	Maternity Inequalities Dashboard			✓			✓			✓			✓	
Bi-annual reports		Q1 & Q2 2025/26	Q3 & Q4 2025/26						Q1 & Q2 2026/27					
	Legal NHSR Scorecard/DofC compliance	✓					✓					✓		
	Culture survey action plan	✓						✓					✓	
Annual reports inc staff survey, RCOG trainee survey, CQC Maternity survey			✓	✓	✓	✓								2025 NETS Trainee Survey Q4 LMNS perinatal quality & safety report –

2026/27		April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Number of perinatal losses		1											
Number of MNSI cases		1											
Number of incidents logged as moderate harm or above		0											
Minimum obstetric safe staffing on labour ward		100%											
Service user feedback	FFT “Overall how was your experience of our service” – total score for very good and good responses												
	Complaints	3											
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust		0											
Coroner Reg 28 made directly to Trust		0											
MOSS Safety Signals		0											
Regional Heatmap Score		23											

Maternity Dashboard 2026/27 – April 2026

Maternity Oversight Report SPC Tool

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Births	Apr 26	139	-			152	129	176
Spontaneous vaginal deliveries	Apr 26	62	-			65	46	84
Assited births	Apr 26	77	-			87	65	110
Induction of Labour	Apr 26	59	-			52	27	78
Maternity Readmissions	Apr 26	0	-			2	-2	6
Neonatal Readmissions	Apr 26	8	-			4	-3	11
Smoking at time of booking	Apr 26	4.92%	15.00%			5.57%	0.54%	10.59%
Smoking at time of delivery	Apr 26	3.60%	6.00%			3.85%	-0.34%	8.04%
In area CO at booking	Apr 26	96.17%	90.00%			95.04%	85.83%	104.26%
In area CO at 36 weeks	Apr 26	91.45%	80.00%			86.98%	79.28%	94.68%
Admitted directly to NNU (SCBU) (>37 weeks)	Apr 26	8	4			6	-3	16
Percentage Admitted directly to NNU (SCBU) (>37 weeks)	Apr 26	6.11%	6.00%			4.46%	-2.13%	11.06%
Preterm birth rate <=36+6 weeks at birth	Apr 26	5.07%	6.00%			5.64%	-0.19%	11.47%
Apgar < 7 (NMPA Definition)	Apr 26	3	-			4	-3	11
Apgar < 7 Percentage (NMPA Definition)	Apr 26	2.19%	-			2.77%	-2.03%	7.56%
Spontaneous Vaginal Births (%)	Apr 26	44.60%	-			42.68%	30.99%	54.38%
Induction Rate	Apr 26	42.45%	-			35.12%	19.51%	50.73%
Instrumental Delivery Rate	Apr 26	8.63%	-			11.45%	3.44%	19.46%
Elective C Section Rate	Apr 26	18.71%	-			21.06%	13.55%	28.57%
Emergency C Section Rate	Apr 26	28.06%	-			24.89%	14.76%	35.01%
C Section Rate	Apr 26	46.76%	-			45.95%	38.13%	53.77%
3rd or 4th degree tear (Total) Precentage	Apr 26	1.44%	3.00%			1.31%	-1.57%	4.19%
Massive PPH >=1.5L (All births)	Apr 26	5	2			6	0	13
Breastfeeding: Percentage of Initiated Breastfeeding	Apr 26	76.81%	66.20%			80.17%	70.40%	89.94%
Breastfeeding: Breasfeeding at Discharge (Transfer to Co	Apr 26	61.65%	56.20%			62.97%	53.49%	72.45%

There are no new SPC triggers to report in April 2026.

Gateshead MOSS
April 2026

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.

Site: Queen Elizabeth Hospital

Level 2 Threshold

Level 1 Threshold

CUSUM Statistic

Jan 25, Feb 25, Mar 25, Apr 25, May 25, Jun 25, Jul 25, Aug 25, Sept 25, Oct 25, Nov 25, Dec 25, Jan 26, Feb 26, Mar 26, Apr 26, May 26

Month of birth

Table of Events - Trust: Gateshead Health NHS Foundation Trust

Date of term birth	Events (term only)	Site name
10 Apr 26	1 Term Stillbirth(s)	Queen Elizabeth Hospital
27 Oct 25	1 Term Neonatal Death(s)	Queen Elizabeth Hospital

Summary:

- 0 safety alarms or alerts – no action required

NENC Regional heatmap April 2026

Regional Maternity Heatmap

Data refreshed: 06/05/2026 12:53:24

Scoring

Region: North East and Yorkshire

NHS England

Heatmap month: April 2026

Provider	Overall score	CQC Mat overall rating	Stake holder concerns	CQC S29a	CQC s31	Ext. ind. review	Coroner reg 28	Mat Oversight	MIS	CNST repayment	Eth. DQ	CQC Mat Survey	SBL	Midwives 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
	59.0	5.0	6	5	0	5	0	5	4	1	0	2	3	2	3		0	5	0	0	5	5	3
	44.0	5.0	3	0	0	0	0	5	3	0	0	3	5	0	5		1	5	0	0	3	3	3
	30.0	5.0	4	0	5	0	0	3	0	0	0	2	3	1	0		3	0	0	0	0	1	3
	29.0	2.0	3	0	0	0	0	3	0	0	0	0	0	2	5		1	0	0	0	5	5	3
	27.0	3.0	2	0	0	0	0	5	0	0	0	2	0	0	1		1	0	0	0	5	5	3
	27.0	3.0	2	0	0	0	0	2	0	0	0	2	3	0	4		3	0	0	1	1	3	3
	27.0	1.0	2	0	0	0	0	2	0	0	0	2	0	1	2		1	5	0	0	5	3	3
	26.3	2.3	3	0	0	0	0	0	2	0	0	3	4	0	2		1	0	0	0	3	3	3
	25.0	3.0	3	0	0	0	0	0	0	0	0	2	4	0	5		1	0	0	0	1	3	3
GATESHEAD HEALTH NHS FOUNDATION TRUST	23.0	1.0	3	0	0	0	0	0	0	0	0	0	0	1	3		1	5	0	0	3	3	3
	22.0	1.0	1	0	0	0	0	0	0	0	0	3	2	1	5		0	0	0	0	3	3	3
	22.0	1.0	1	0	0	0	0	0	0	0	0	3	0	1	2		1	5	0	1	1	3	3
	21.0	3.0	1	0	0	0	0	3	0	0	0	3	0	0	0		1	0	0	1	3	3	3
	20.0	3.0	2	0	0	0	0	0	0	0	0	2	3	0	0		1	0	0	0	3	3	3
	20.0	3.0	2	0	0	0	0	0	0	0	0	2	0	0	5		1	0	0	0	1	3	3
	20.0	1.0	0	0	0	0	0	0	0	0	0	2	2	1	3		0	0	0	0	5	3	3
	20.0	3.0	1	0	0	0	0	5	2	0	0	2	0	0	0		0	0	0	0	1	3	3
	20.0	3.0	2	0	0	0	0	0	0	0	0	1	0	0	3		0	0	0	0	5	3	3
	19.0	1.0	1	0	0	0	0	0	2	0	0	3	3	0	1		1	0	0	0	1	3	3
	16.0	1.0	1	0	0	0	0	0	0	0	0	0	0	0	2		1	0	0	0	5	3	3
	14.0	1.0	1	0	0	0	0	0	0	0	0	2	2	0	0		1	0	0	0	1	3	3

*lower score is better

NENC Regional heatmap April 2026

Regional Maternity Heatmap

Data refreshed: 06/05/2026 12:53:24

Provider Scoring Summary

Region: North East and Yorkshire

NHS England

Select a trust: GATESHEAD HEALTH NHS FOUNDATION TRUST

Overall heatmap score by month

Overall score (10–24) by Heatmap month (Sep 2025 – Apr 2026)

Heatmap month	Overall score	CQC Mat overall rating	Stake holder concerns	CQC S29a	CQC s31	Ext. ind. review	Coroner reg 28	Mat Oversight	MIS	CNST repayment	Eth. DQ	CQC Mat Survey	SBL	Midwives 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
April 2026	23.0	1.0	3	0	0	0	0	0	0	0	0	0	0	1	3		1	5	0	0	3	3	3
March 2026	24.0	1.0	4	0	0	0	0	0	0	0	0	0	0	1	3		1	5	0	0	3	3	3
February 2026	20.0	1.0	1	0	0	0	0	0	0	0	0	0	0	1	0		1	5	0	0	5	3	3
January 2026	22.0	1.0	1	0	0	0	0	0	0	0	0	0	3	0	0		1	5	0	0	5	3	3
December 2025	23.0	1.0	1	0	0	0	0	0	0	0	0	0	3	1	0		1	5	0	0	5	3	3
November 2025	23.0	1.0	0	0	0	0	0	0	0	0	0	0	3	2	0		1	5	0	0	5	3	3
October 2025	25.0	1.0	0	0	0	0	0	0	0	0	0	0	5	2	0		1	5	0	0	5	3	3
September 2025	24.0	1.0	0	0	0	0	0	0	0	0	0	0	5	1	0		1	5	0	0	5	3	3

*lower score is better

Completed PMRT Reviews Q4

Number of Completed Cases in this Quarter (see notes)	0	Number of meetings held	2 (3 cases)	% of meetings external reviewer present	100%	Number of external reviews attended	0

Any issues with MIS compliance for reporting	Year 7 full compliance confirmed

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	1

Number of C & D Graded cases where issues associated with FGR Management Identified	Q1	Q2	Q3	Q4	N/A
	0	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	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	**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	0	

Other Themes and Actions from PMRT Cases: *Please also detail any specific themes/actions relating to socioeconomic deprivation and ethnicity.*	MSU screening in antenatal period Completion of partogram

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Learning & actions

Key Themes	Key Learning and Actions
1/ •Multiple DNA's and social involvement in both cases. •Majority of DNA's followed up appropriately. On some occasions, difficult to ascertain if follow up appointments were sent or if patients DNA.	1/ •Review and update of DNA policy. •Safeguarding aspects reviewed by Safeguarding lead Midwife --> appropriately managed
2/ •Aspirin --> Late booker at 18/40. Express booking on PAU, unclear if Aspirin commenced. Aspirin given at later appointment at 20/40. •Second case --> Missed Aspirin – change of risk factors when diagnosed with Low Papp-A at 14/40. DNA ANC at 14/40 where Aspirin could have been commenced.	2/ •Learning shared with Community teams. •Ongoing work reviewing FGR/PET Risk Assessment tool following System C issue.
3/ •Smoking --> CO readings not performed at every contact.	3/ •QUIT team email reminder to community teams. •Learning shared with Community teams. •Overall compliance remains >96% at booking and >91% at 36 weeks for all patients – learning focus on those patients eligible for testing at every appointment

MDT workforce update - March 2026

Staff group	Workforce gaps			Bank usage	Minimum staffing requirements	Risks & escalations (Risk register ID where applicable)
	Vacancy rate	Sickness rate	Maternity leave rate			
	Target <2.5%	Target <4.9%				
Midwifery	-2.6%	7.53%	7.29%	1.64wte	**Q3 & Q4 Midwifery & Neonatal staffing papers presented to POD Steering Group – agreement that papers will accompany IOR quarterly to QGC & summary to be included in Chief Nurse N&M paper for POD**	Maternity theatre staffing #4859 business case to GHLF & EMT for decision
Midwife Support workers & Healthcare Assistants	-11.4%	8.0%		2.33wte		Women's Health Clinic HCA staffing #4729 business case to GHLF & EMT for decision
Obstetric Consultants **Resident doctors**					Minimum Consultant staffing on labour ward **100%**	Antenatal Clinic Capacity #4712
Neonatal Nurses	1.7%	5.72%	0%	1.04wte	BAPM compliance **Q3 2025/26 87.0%** QIS compliance **93% (1 nurse still to complete)**	SCBU/ANNP workforce #2275 business case to GHLF & EMT for decision
Paediatric Consultants **Resident doctors** **ANNP**					BAPM compliance: **Currently holding a 0.5 gap on the 1:7 Consultant rota, covered with locum – Consultant recruitment active** **Current ANNP gap of -1.54wte (but 1wte ANNP trainee in post)**	SCBU/ANNP workforce #2275 business case to GHLF & EMT for decision
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 April 2026

NHS Gateshead Health NHS Foundation Trust

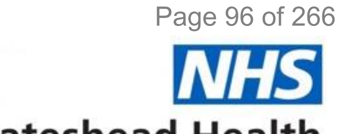
Red Flags		No	Factors		No	Actions		No
LWC supernumerary	↓	7	Unexpected midwife sickness/absence	↓	19	Delay to commence IOL/planned procedure	↓	11
1-1 care in labour	=	0	Midwife redeployed to other area	=	1	Delay in transfer to theatre	=	0
Delay in IOL	↑	7	Midwife on transfer duties	↓	1	2nd theatre in use	↓	0
Delay in meeting LSCS timing	=	0	Support staff less than rostered numbers	↓	15	Delay in ongoing IOL	↓	9
Missed or delayed care	=	0	Midwife scrubbed in theatre	↓	26	Unable to perform ward round due to acuity	↓	2
Delay in triage	=	0	2 or more Band 5 midwives on duty	↑	32	Redeploy staff internally	↑	30
			Unable to provide 2nd midwife for emergency theatre	↑	7	Staff unable to take breaks/working late	↓	2
			Unable to fill vacant shift	↓	7	Specialist midwife/manager working clinically	↓	2
						Escalate to manager on call	↓	0
Total	↓	14		↓	112		↓	56

Risk register – new emerging risks & updates

NHS
Gateshead Health

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 – estates business case underway
4852	Surg2	There is a risk of missed deterioration to mothers or babies in maternity theatre and/or on labour ward due to an outdated and inadequate workforce model that does not meet national guidance for safe obstetric theatre staffing. This could result in avoidable patient harm which could result in delay to meet emergency delivery timing standards, delays to elective caesarean section lists, avoidable admissions to SCBU, perinatal death, severe harm or never events.	20	15	5	No change – theatre business case presented to GHLF
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 – estates business case underway
4712	Surg2	Risk that we do not have sufficient antenatal clinic capacity within Consultant job pans, resulting in reduced service provision	15	12	6	No change – WHC business case presented to GHLF, does not address this risk but compliments mitigations

Risk register – new emerging risks & updates



Risk ID	Division	Description	Initial Grade	Current Grade	Target Grade	Comments
Risk review						
4882	Surg2	There is a risk of delayed or missed reviews of babies in the maternity and neonatal service. Due to the current medical workforce model that is not compliant with national safe standards for SCU Level 1 neonatal settings. This could result in delays to urgent assessment and intervention, and missed opportunities to prevent deterioration.	15	12	6	Risk added following LMNS assurance visit safety concern – final report now received & action plan underway Risk wording agreed ANNP staffing case to GHLF
4987	Obstetric	There is a risk of missed or delayed clinical risk identification, clinical decision making and care delivery in maternity and neonatal services. This is caused by recurrent BadgerNet system instability, unreliability, functional and clinical safety defects and supplier-identified safety issues (including system crashes, data loss, and delayed or ineffective resolution of known issues by the supplier.) Resulting in compromised patient safety, potential harm to mothers and babies, increased scrutiny from regulators, loss of clinical confidence in digital systems, and reputational and assurance impacts at Board, Audit Committee and regional level.	20	15	5	New risk arising from System C Advisory Notice - QMMD-447 Risk wording agreed ?for reduction in risk following completion of audit – LMNS risk review due 31/5/26 New risk to be added to reflect unknown harm due to unknown period of time risk assessments have been incorrect

2025 National Education & Training Survey (NETS)

Subject and Specialism	Indicator	2022 N	2022 Mean	2023 N	2023 Mean	2024 N	2024 Mean	2025 N	2025 Mean
Pre registration midwifery	Bullying & Undermining	3	70.33	4	50.00	4	68.75	19	85.09
	Discrimination	3	100.00	4	87.50	4	100.00	19	100.00
	Facilities	3	41.67	4	66.67	4	81.25	19	66.67
	Induction	3	70.83	4	90.63	4	71.88	19	78.95
	Overall Experience	3	65.00	4	76.25	4	73.75	19	65.00
	Quality of Care	3	71.67	4	67.50	4	71.25	19	71.58
	Raising Concerns	3	44.44	4	66.67	4	91.67	19	77.19
	Sexual Safety			4	100.00	4	100.00	19	100.00
	Supervision	3	52.08	4	57.81	4	60.94	19	60.09
	Teaching & Learning	3	45.83	4	79.69	4	75.00	19	54.06
	Teamwork	3	75.00	4	62.50	4	78.13	19	70.39
	Wellbeing	3	83.33	4	75.00	4	66.67	19	65.79
	Workload	3	50.00	4	75.00	4	50.00	19	52.63
Obstetrics And Gynaecology	Bullying & Undermining	3	77.67	7	58.33			6	88.89
	Discrimination	3	66.67	7	100.00			6	100.00
	Facilities	3	41.67	7	60.71			6	60.00
	Induction	3	54.17	7	80.36			6	93.75
	Overall Experience	3	65.42	7	75.00			6	77.78
	Quality of Care	3	60.42	7	80.00			6	69.58
	Raising Concerns	3	88.89	7	76.19			6	94.44
	Sexual Safety			7	85.71			6	100.00
	Supervision	3	61.11	7	79.46			6	73.26
	Teaching & Learning	3	54.17	7	66.96			6	66.67
	Teamwork	3	70.83	7	78.57			6	72.92
	Wellbeing	3	50.00	7	78.57			6	66.67
	Workload	3	33.33	7	78.57			6	75.00

2025 National Education & Training Survey (NETS)

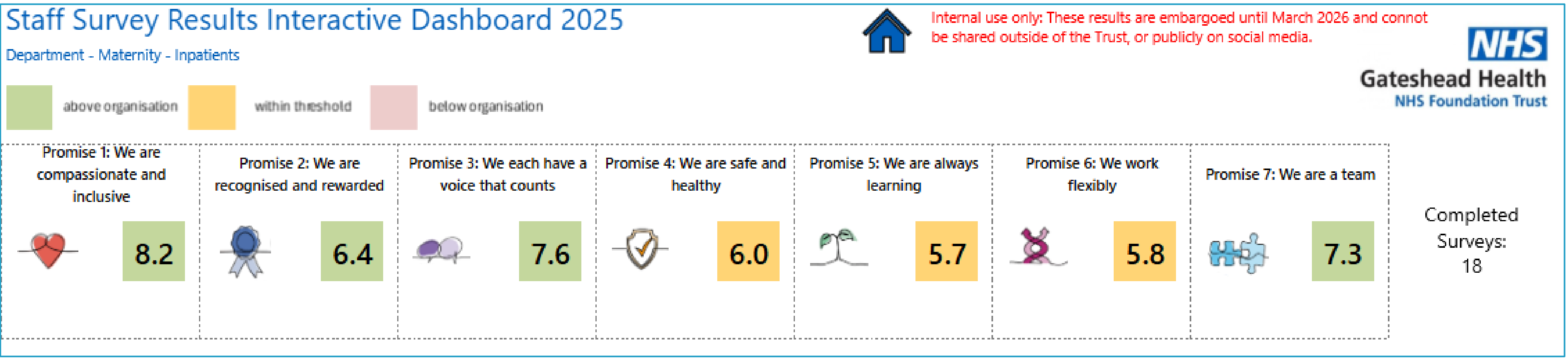
Gateshead Health
NHS Foundation Trust

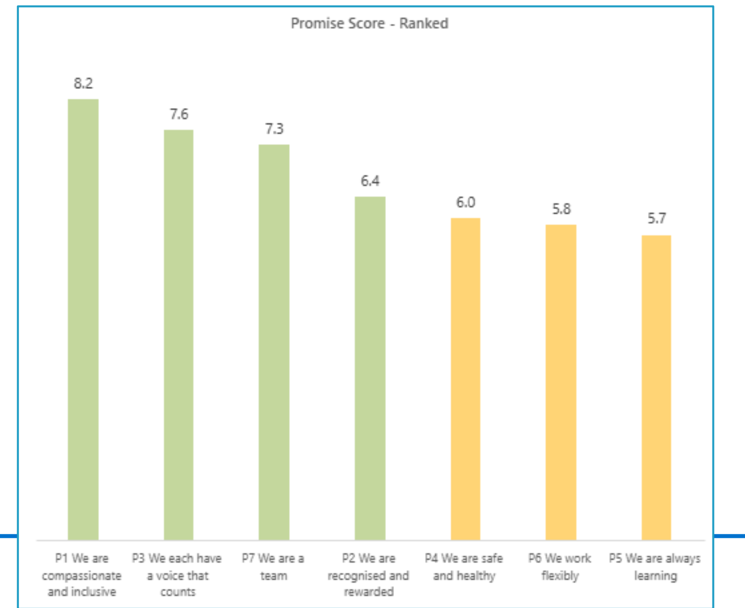
Noted in self-assessment report and discussed at Annual Dean's Quality Meeting (ADQM) on 8 May 2026

Final report awaited

Specific training concerns in Obstetrics and Gynaecology:		
• Increases in workloads and patient complexity in both areas have hugely increased with no commensurate increase in medical staffing • Geographical challenges of site coupled with increased workload complexity means trust needs separate cover for each clinical area but no increased middle tier numbers. • Training programme allocation issues resulted in only 7 people to work on middle tier. • No service line manager in Obstetrics until November 2025. No current clinical lead in Obstetrics due to service pressures and other competing demands on the senior medical team. An established College Tutor and other clinical leadership posts are filled. • Senior staff remain committed to and enthusiastic about training, but current staffing shortages are impacting educational opportunities.	Learning Environment and Culture Educational Governance and Commitment to Quality Developing and Supporting Learners Developing and Supporting Educators Delivering Programmes and Curricula	1.1, 1.5, 1.6 2.1, 2.4, 2.6 3.2, 3.5, 3.6 4.2, 4.7 5.1, 5.6

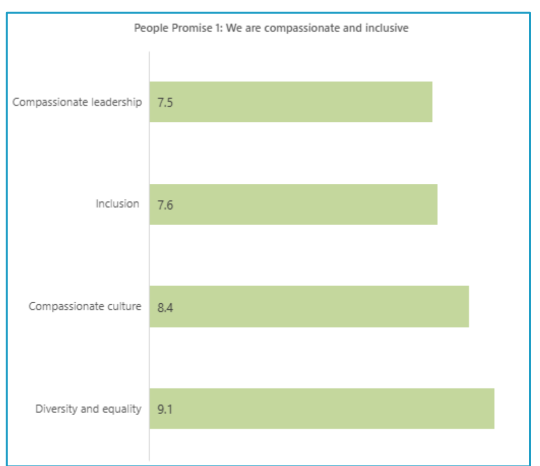
Staff Survey 2025
Maternity - Inpatients

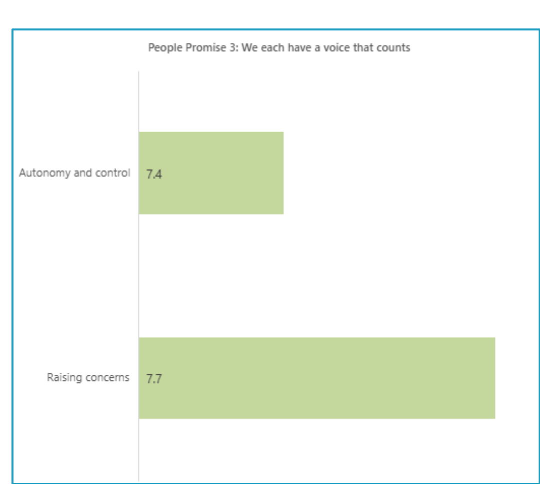


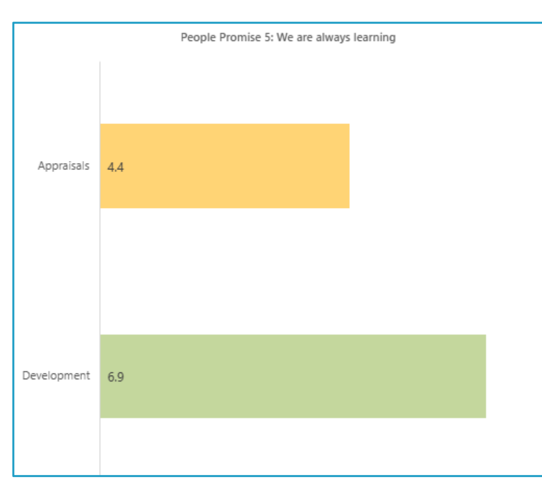


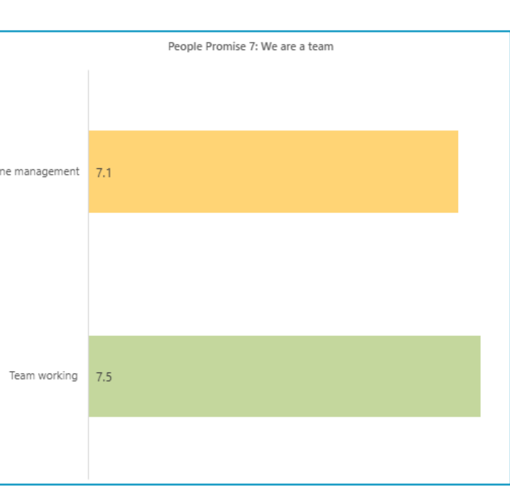
Staff Survey 2025
Maternity - Inpatients

Areas to celebrate:

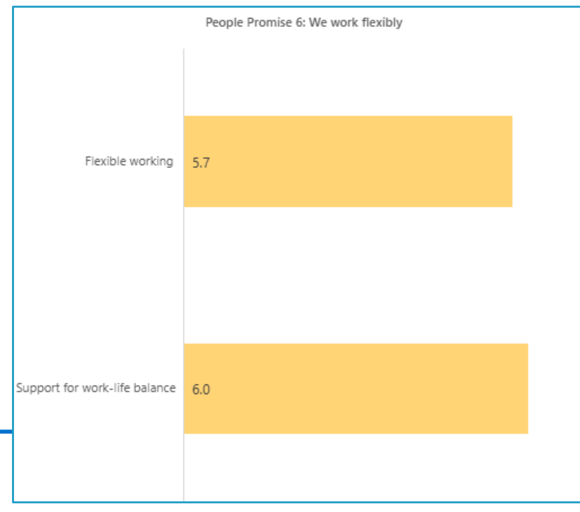


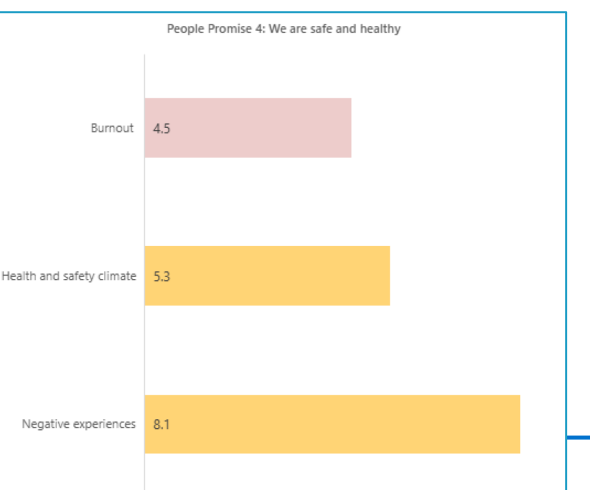






Areas for further work:





Staff Survey 2025
Maternity - Inpatients

Actions:

- Staff survey completed to assess effectiveness & preferences for monthly staff meetings
- Band 7 away day – June 2026 – review Staff Survey results & complete action plan
- Themes – burnout/health & well-being, appraisals, time/equipment pressures
- Sufficient responses only received for inpatient maternity services, no report received for SCBU, Community Midwifery or Women's Health Clinic areas

Staff Survey 2025
Maternity - Inpatients

Question breakdown	Score	What are we going to do?
Never/rarely worn out at the end of work	0%	
Never/rarely find work emotionally exhausting	0%	
Have realistic time pressures	5.60%	
Never/rarely lack energy for family & friends	16.70%	
Appraisal helped me improve how I do my job	18.80%	
Never/rarely frustrated by work	22.20%	
Never/rarely feel burnt out because of work	22.20%	
Appraisal left me feeling organisation values my work	25.00%	
Appraisal helped me agree clear objectives for my work	25.00%	
Enough staff at organisation to do my job properly	27.80%	
Organisation is committed to helping balance work & home life	33.30%	
Achieve a good balance between work & home life	33.30%	
Able to meet conflicting demands on my time at work	33.30%	
Satisfied with level of pay	38.90%	
Have a choice in deciding how to do my work	38.90%	
In last 3 months, have not come to work when not feeling well enough to perform duties	38.90%	
Never/rarely feel every working hour is tiring	38.90%	
Immediate line manager asks for my opinion before making decisions that affect my work	44.40%	
Satisfied with opportunities for flexible working patterns	44.40%	
Have adequate materials, supplies & equipment to do my job	44.40%	
In last 12 months, have not felt unwell due to workplace stress	55.60%	
Organisation offers me challenging work	61.10%	
Can approach immediate manager to talk openly about flexible working	66.70%	
Immediate manager takes a positive interest in my health and well-being	66.70%	
Opportunities to show initiative in my role	66.70%	

NENC LMNS Provider Trust Reporting (Incorporating the NE&Y Regional PQSG reporting template)

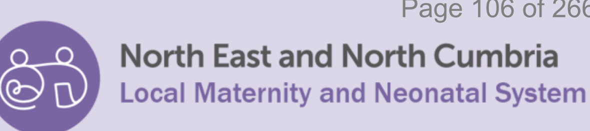
Q4 – 30 April 2026

LMNS:	North East & North Cumbria LMNS	Programme Lead:	Nicola Jackson
Trust Name:	Gateshead Health	Completed by:	Karen Parker
CQC Rating:	Good	Date:	30/4/2026

Trust Headlines relating to PQS for Q4	Comments
Achievements	BSOTS commenced 9/3/2026 Estates funding approved & work commenced for 2nd modular theatre UNICEF BFI Stage 1 Neonatal application submitted & date for assessment
Risks	Maternity Theatre staffing Antenatal Clinic Capacity Upcoming increase in bookings – July-October 2026
Escalations	LMNS assurance visit response SystemC risk assessment alert

SERVICE & ACTIVITY (INCL. STAFFING)

Overview of Activity



Percentage of Bookings completed by 9+6	72.67%	Percentage of Bookings completed by 12+0	90.5% Badger data up to 12+6	Percentage of Bookings completed greater than 12+0	9.5% Badger data from 12+6	Number of late transfers of care	8 > 32 Weeks	Total births in Quarter	536

Number of BBA's					Number of Freebirths					Any themes
Q1	Q2	Q3	Q4	Rolling Total	Q1	Q2	Q3	Q4	Rolling Total	
1	2	1	3	7	0	0	0	0	0	

Number of days at each OPEL MF Level (as per daily Sitrep) LMNS TO COMPLETE THIS TABLE

OPEL MF 1			OPEL MF 2			OPEL MF 3			OPEL MF 4		
Month 1	Month 2	Month 3	Month 1	Month 2	Month 3	Month 1	Month 2	Month 3	Month 1	Month 2	Month 3
26	25	21	3	1	1						

Completion of Sitrep – Target of 90% LMNS TO COMPLETE THIS TABLE

Q1	Q2	Q3	Q4
91%	75%	84%	

Q4 Service Overview Summary

Please complete for all birth choices provided within your current service provision (including if currently suspended)

Choice	Do you have waterbirth prevision	Number of Delayed Planned Activity (Induction / Elective Section) Greater than 6 hours	Number of External Mutual Aid Requests Made	Diverts or suspensions to services	Number of women impacted by mutual aid requests / diverts
Obstetric Unit(s)	YES	0	0	0	0
Alongside Midwifery Unit	N/A			N/A	N/A
Stand-alone Midwifery Unit	N/A			N/A	N/A
Home birth	YES			NO	N/A

Staffing - Midwifery

North East and North Cumbria
Local Maternity and Neonatal System

Midwife WTE and Midwife Vacancies				
Birthrate + recommended clinical establishment	110.61wte			
WTE budgeted clinical establishment	110.61wte			
WTE clinical midwives in post	111.30wte			
WTE clinical midwife vacancies	0			
WTE posts accepted	5.52wte (temp contracts)			
WTE vacancies still to be filled	0			
Absence rates %	Sickness	7.5%	Maternity /Parental / Adoption Leave	7.8%

Staffing – Maternity Support Worker

<table>
<tr><th colspan="5">Maternity Support Worker WTE and Vacancies</th></tr>
<tr><td>WTE budgeted establishment</td><td colspan="4">HCA 11.64wte

MSW 9.5wte</td></tr>
<tr><td>WTE MSW in post *</td><td colspan="2">Health Care Assistant

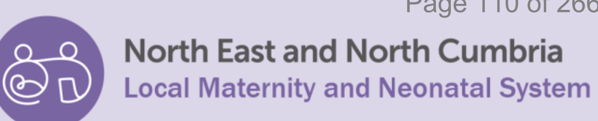
(Band 3) = 16.88wte</td><td colspan="2">Maternity Support Worker

(Band 3) = 6.58wte</td></tr>
<tr><td>WTE MSW vacancies</td><td colspan="4">Recent recruitment to 2.44wte MSW</td></tr>
<tr><td>WTE accepted</td><td colspan="4">2.44wte</td></tr>
<tr><td>WTE vacancies still to be filled</td><td colspan="4">HCA – over-establishment*

MSW – 0.48wte</td></tr>
<tr><td>Absence rates %</td><td>Sickness</td><td>3.0%</td><td>Maternity /Parental / Adoption Leave</td><td>4.9%</td></tr>
</table>

* It is acknowledged not all Trusts will utilise agreed generic job descriptions for Bands 2-4 therefore roles may vary.

Staffing – Obstetric and Anaesthetic Staffing



Obstetric WTE and Obstetric Vacancies				
Number of Vacancies	0			
Are you meeting or working towards RCOG compensatory rest guidance?	Meeting			
Absence rate%	Sickness	0%	Maternity, Paternity and Adoption Leave	7.40%
Risks and Escalations	No Obstetric Clinical lead			

Anaesthetic Staffing (MIS SA4)	
Do you have a duty Anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising Anaesthetic Consultant at all times.	Yes

Staffing - Neonatal Nursing

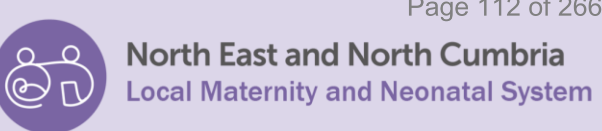
Neonatal Nursing WTE and Neonatal Vacancies

WTE budgeted clinical nursing establishment	Band 5 neonatal nurse 5.84wte Band 6 neonatal nurse 6.56wte Band 7 neonatal nurse 0.8wte
WTE clinical neonatal nursing staff in post	Band 5 neonatal nurse 7.12wte Band 6 neonatal nurse 5.24wte Band 7 neonatal nurse 0wte
Total number of WTE clinical neonatal nursing staff vacancies: I. Of which number of WTE posts accepted II. Number of WTE still to be filled	See table below
QIS Staffing Compliance	93% QIS trained

	Wte posts accepted	Wte posts to be filled
Band 5 neonatal nurse	0	0
Band 6 neonatal nurse	1.56wte	0.02wte
Band 7 neonatal nurse (ward manager)	0.8wte	0

Absence rate %	Sickness	5.72%	Maternity/Paternal/ Adoption leave	0%

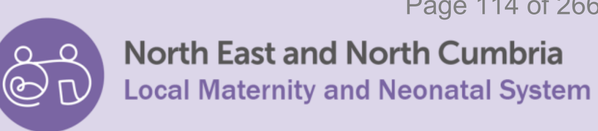
Staffing - Neonatal Medical Staff



Neonatal Medical Staff WTE and Vacancies				
Number of Vacancies	ANNP Budgeted establishment 4.14wte ANNP qualified in post 2.6wte, ANNP trainees in post 1wte ANNP vacancies 0.44wte (1wte trainee to commence Sept 2026)			
Staffed to BAPM recommended Levels	2022 BAPM – Yes, action plan in place to work towards 2025 BAPM in line with MIS Year 8 safety standards			
Absence rate %	Sickness	0.15%	Maternity, Paternity and Adoption Leave	0%
Risks and Escalations	LMNS assurance visit			

PATIENT SAFETY

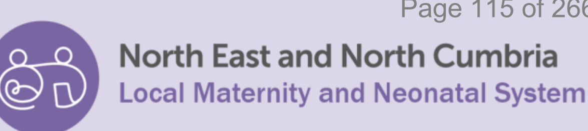
Overview of Incidents



Total number of PSII Cases registered in Quarter	0	Number of cases referred to MNSI in Quarter	1	Number of cases accepted & under investigation	1 (awaiting family consent)	Rolling number MNSI reported cases in last 12 months	3
Number of cases referred to early notification scheme		0		Number of women admitted to HDU or ICU outside of maternity		3	
Number of Moderate Harm and Above in Quarter (not meeting MNSI/PSII threshold)	0	Were these cases escalated to Trust PS panels?	Yes – MNSI case	Has duty of candour been commenced?	Yes – MNSI case		

Number of New PMRT Cases this Quarter	Late fetal loss	Antenatal stillbirth	Intrapartum stillbirth	Early Neonatal Death	Late Neonatal	Number of PMRT Cases in a rolling 12 months
	0	2	0	1	0	7

Completed PMRT Reviews Q4



<table>
<tr><td>Number of Completed Cases in this Quarter (see notes)</td><td>0</td><td>Number of meetings held</td><td>2 (3 cases)</td><td>% of meetings external reviewer present</td><td>100%</td><td>Number of external reviews attended</td><td></td></tr>
<tr><td colspan="4">Any issues with MIS compliance for reporting</td><td colspan="4">Sign off for Y7 – Compliant.</td></tr>
<tr><td colspan="4">Number of Cases Graded C or D in Quarter</td><td>1</td><td colspan="2">Number of these cases escalated to your Trust PS panel for discussion about level of investigation or previously referred / or under investigation or MNSI</td><td>1</td></tr>
<tr><td rowspan="2">Number of C & D Graded cases where issues associated with FGR Management Identified</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td><td rowspan="2" colspan="3">N/A</td></tr>
<tr><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td rowspan="2">Number of C & D Graded cases where issues associated with RFM Management Identified</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td><td rowspan="2" colspan="3">N/A</td></tr>
<tr><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td rowspan="2">Number of C&D graded intrapartum stillbirths, early neonatal deaths and severe brain injury where failures of intrapartum monitoring are identified as contributory factor.</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td><td rowspan="2" colspan="3">N/A</td></tr>
<tr><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td rowspan="2">Number of C & D Graded cases where prevention, prediction, preparation or perinatal optimisation of preterm birth was a relevant issue.</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td><td rowspan="2" colspan="3">N/A</td></tr>
<tr><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td rowspan="2">Number of C&D Graded cases where missed MSU's at booking (or missed repeats following treatment) led to poor outcomes.</td><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td><td rowspan="2" colspan="3">N/A</td></tr>
<tr><td>0</td><td>0</td><td>0</td><td>0</td></tr>
</table>

Learning from PMRT

North East and North Cumbria
Local Maternity and Neonatal System

Key Themes	Key Learning and Actions
1/ - Multiple DNA's and social involvement in both cases. - Majority of DNA's followed up appropriately. On some occasions, difficult to ascertain if follow up appointments were sent or if patients DNA.	1/ - Review and update of DNA policy. - Safeguarding aspects reviewed by Safeguarding lead Midwife --> appropriately managed
2/ - Aspirin --> Late booker at 18/40. Express booking on PAU, unclear if Aspirin commenced. Aspirin given at later appointment at 20/40. - Second case --> Missed Aspirin – change of risk factors when diagnosed with Low Papp-A at 14/40. DNA ANC at 14/40 where Aspirin could have been commenced.	2/ - Learning shared with Community teams. - Ongoing work reviewing FGR/PET Risk Assessment tool following System C issue.
3/ - Smoking --> CO readings not performed at every contact.	3/ - QUIT team email reminder to community teams. - Learning shared with Community teams.

MBRRACE Perinatal Mortality 2024 (Stillbirths)

North East and North Cumbria
Local Maternity and Neonatal System

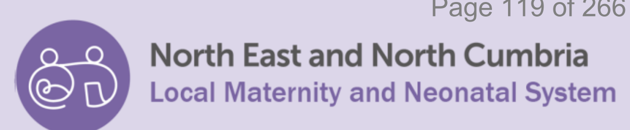
Have you reviewed your data?	Yes		
Have you identified any clinical themes?	None identified.		
Do you have any themes relating to ethnicity or deprivation?	The majority of cases within the report were babies born to those of White ethnicity. No themes identified regarding socio-economic deprivation.		
Have you undertaken any improvement work?	Not required.		
How many cases were graded C or D?	2		
How many cases were investigated by MNSI or via a trust PSII?	MNSI	0	PSII	0
Was Fetal Growth identified as a contributory factor in any of the cases?	None.		

Reducing Length of Separation (Mum and Baby) QI Project *(please copy and paste if additional slides required)*

North East and North Cumbria
Local Maternity and Neonatal System

Title of project	New project – timescales & leads tbc			
Is this a new or continuing QI Project? (if new please submit your QI full plan / driver diagram)	**New Project**		**Continuing Project**	
Progress update against QI project	Exploring new QIP in relation to time taken to stabilise/allow newborn infants to transition following birth before taking decision to move to SCBU. Plans: • Audit alongside ATAIN process time to decision to admit to SCBU, decision maker & indication • Newly recruited MSW, neonatal nurses, SCBU ward manager & trainee ANNPs – task & finish group to be agreed • Link to staffing/time 1-1 care post-delivery to support “Golden Hour”			

Neonatal Learning completed in Q4 (Please see notes on what to include here)



Neonatal - Key Themes from Incident Reviews	Neonatal - Key Safety Actions from Themes
1/ - Early decision to transfer to SCBU. Within 30 minutes → short admission with minimal care interventions. - Level of Paediatric seniority at delivery. Evidence of wider variation in who attends deliveries.	1/ - Deep dive/focus into neonatal management at delivery - Review policy/flow chart. - For wider discussion/shared learning with Paediatric Team/Region.
2/ - Increased SCBU admission of babies born by LSCS. - ANC Capacity → lack of senior oversight in ANC when counselling around MOD.	2/ - On risk register. - Current review of model/job plans to include Consultant Triage as first ANC contact. - Review MOD 'trends' into next review.
3/ - Poor compliance with early feeding & "Golden Hour", particularly with term babies (better compliance with preterm/vulnerable babies) - Theatre workforce – midwives scrubbed & therefore not present to provide 1-1 care during immediate recovery period to support early feeds	3/ - Theatre workforce on risk register & staffing business case underway - Recruitment to vacant MSW posts to support - UNICEF training recommenced for all staff

STANDARDS TO UNDERPIN CARE

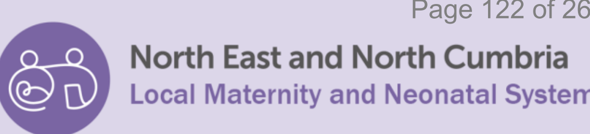
Antenatal Optimisation

North East and North Cumbria
Local Maternity and Neonatal System

ODN SBL Evidence Items	
Have your team attended the ODN Board meeting this quarter?	No
Have your team attended the ODN Governance meeting this quarter?	No

BAPM Compliance comments	
Please provide any comments relating to your BAPM Compliance for any of the Preterm birth optimisation standards e.g. rapid labour meant optimisation not completed	4 Preterm deliveries <34/40 in Q4 (1 twin pregnancy) – 3 cases. Case 1 – PPROM at 33+6/40, steroids x 1. Commenced on Erythromycin, switched to IV abx as PVB and uterine activity. Pathological CTG later the same day requiring emergency delivery. No MgSO4 (not indicated) Case 2 – 33+1/40 DCDA twins. Twin 2 - static growth, <10th centile, abnormal dopplers, known Cleft Lip and Palate. 2 doses of ANCS and Mg204 prior to delivery. MBM used for mouth care within 48hours. Case 3 – 33/40, smoker, placenta praevia. Attended with significant and ongoing APH. Emergency delivery by Category 1 EMCS. No ANCS given (no time due to clinical condition), no MgSO4 (not indicated)

Maternal Care Bundle Implementation



Element	**What have you considered?** MCB publication shared with all staff on 6/1/2026 Leads identified for each element & webinars attended Joint anaesthetic/Obstetric Safecare planned for May 2026 to discuss on agenda
Element 1 - Venous thromboembolism	Lead: Jill Sturt (Obstetric), Sarah Browbank (specialist pharmacist) Awaiting RCOG updated guidance, planning to implement VTE risk assessment & tinzaparin prescribing into EPAU pathways (consideration of utilisation of EPAU Badger module), pre-packs of Tinzaparin available & PGD to support midwifery administration during antenatal & postnatal periods. Need to establish link with responsible leads for primary care, ED etc
Element 2: Pre-hospital and acute care	Lead: Badr Elsammani (Obstetric), Sally Bell (midwifery),
Element 3: Epilepsy in pregnancy	Lead: Badr Elsammani (obstetric) Clear pathways of referral & MDT processes in place with Maternal Medicine services at NUTH
Element 4: Maternal mental health	Lead: Celia McKee, Debbie Corbett Plan on page for utilisation on MMHS funding – to include psychology support, inclusion of neonatal families, align to current service provision which include care from NTW/obstetric clinic/talking therapies weekly presence
Element 5: Obstetric Haemorrhage	Lead: Chris Izod (anaesthetist), Melis Altunel (Obstetric). Lynne Hamilton (midwifery) ROTEM machine purchased with end of year estates capital funding – working with MDT & point of care teams to identify training & implementation plan PPH monitored on SPC on maternity dashboard Carbotocin in stock – guideline update required to incorporate this – cost pressure

Bereavement Care Pathway

North East and North Cumbria
Local Maternity and Neonatal System

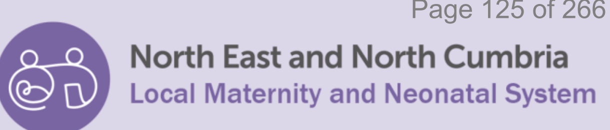
Pathway	Overall BRAG Rating	What are your Gaps / What support do you need?
Miscarriage Bereavement Care Pathway		
Termination of Pregnancy for Fetal Anomaly (TOPFA) Bereavement Care Pathway		
Stillbirth Bereavement Care Pathway		
Neonatal Death Bereavement Care Pathway		
Sudden Unexpected Death in Infancy (SUDI) Bereavement Care Pathway		

Labour Ward Coordinator framework compliance

North East and North Cumbria
Local Maternity and Neonatal System

Requirement	Progress to Date / Risk to Delivery
Trust have agreed educational requirements for all current LWC to fulfil requirements of framework and have a timescale for delivery utilising Appendix 7 or Labour Ward Coordinator Education and Development Framework Teesside Programme.	100% for labour ward coordinators
Report the percentage of LWC currently compliant with the framework.	100%
Outline the succession plan, and annual appraisal for LWC to enhance the knowledge and skills of current LWCs.	Rolling programme for core staff to attend over next 12 months

Perinatal Pelvic Health Service: Trust Implementation position



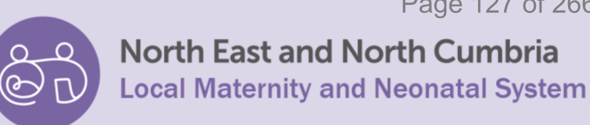
Information Required:	Evidence
Update on your PPHS recruitment and workplan	1x 0.6wte Band 7 physiotherapists in post. 1x Band 6 0.6wte physiotherapist has just left her post. Replacement of this post in recruitment process. Loss of this post is currently creating significant difficulty with implementation of the service. 1x 0.4wte band 7 midwife in post across Newcastle and Gateshead (0.2wte in each Trust)
Please list any successes or things that you are proud of	Go live of service 1st of September; 97 physio referrals & 5 midwifery referrals into the service so far. MMAT NENC mandatory training sessions delivered by PPHS midwife or specialist physio Completion of pelvic health USS course for physiotherapist lead Website content update completed with MNVP
Please list any risks, issues or challenges	Sourcing an appropriate room for the joint MW/ Physio clinic Loss of 1x 0.6 B6 to physiotherapy service, creating significant strain on the service with 1x 0.6wte B7 physiotherapist to complete service set up and clinical caseload. Communication and digital delays with creating PPHS self referral
Please describe how you are mitigating against any risks, issues or challenges	Exploring room availability options – planning in advance for appropriate clinical rooms, part of overall WHC clinic template review following new Consultant jobs plans & estates changes Data capture of readmissions for perineal wound breakdown – exploring with coding teams Liaising with digital services and comms re implementation of referrals. Replacement of B6 0.6wte; advert/recruitment and training
Is a Single Point of Access in place for all service users with perinatal pelvic health problems across all linked providers?	No

Rate of referrals to service: Clinician	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26	Rate of referrals to service: Self-referral	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26
	0	0	0	26		0	0	0	0
Number of 3rd or 4th degree tears	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26	Number of service users readmitted for emergency procedures related to perineal wound breakdown	Q4 24/25	Q1 25/26	Q2 25/26	Q3 25/26
	4	4	3	8		0	0	0	0

Perinatal Pelvic Health Service: Trust Implementation position

Information Required	Service Position / Evidence		
Please can you confirm the Trusts current recruitment position? Including Name and WTE for Physiotherapy and Midwifery Lead:	Katie Mann 0.6wte band 7 physio Emma Hindes 0.2wte band 7 midwife		
Please advise of any risk / issues and challenges faced by the service and the planned mitigation for these including: • Workforce / clinical capacity • Equipment or estate restraints • Digital infrastructure • Current pathways including ongoing support and follow up during postnatal period	• At present midwife and physio working opposite days Clinical capacity to see all PPHS referrals in one day clinic expected to be unattainable • Restraint to start joint clinic due to rota changes and day to be confirmed by service line manager • Self referral form currently with information governance (data storage issue) • 6/52 longer pelvic health questionnaire in PN period no MDT uptake . Possibility for MW FU however not enough allocation of working hours • Loss of 1x 0.6wte physiotherapist – awaiting recruitment back into post. • Inability to accept "amber cohort" patients, awaiting production of LMNS amber cohort presentation. Currently only accepting referrals of symptomatic red patients.		
Please advise of progress in respect of patient self referral, and if live number received in Q4:	Self referral form devised and complete currently with IG department		
Please advise of the number of referrals received in Q4 by patient cohort (Red / Amber / Green):	97	0	0
Please advise how many women who have utilised the service still experienced a 3rd or 4th degree tear	0		
Number of patients requiring emergency follow up care related to perineal wound breakdown within Q4.	5		
Please advise of any support required by the ICB in respect of service implementation:	Funding Completion of LMNS amber cohort patient information presentation		

Personalised Care



Please note any progress/challenges around the implementation of the NENC Personalised Care Toolkit *Please provide evidence demonstrating how the Trust is utilising the Toolkit and resources e.g. Place of Birth videos, leaflets and principles available in top 5 spoken languages*	Videos and leaflets relating to choice of place of birth available on Badgernet notes. Information given to service users at booking on where to find information. Maternity & Neonatal website refresh underway with MNVP leading Antenatal support conversations monitored and responded to 5 days per week. Service users supported in making Informed Choices in relation to Care Outside of Guidance, Service users given BRAINS leaflet to help them plan for these discussions.
Please detail the information utilised to offer woman information to make an informed decision around mode of birth	Service users offered a birth planning appointment – discussions with service users personalised to their choices at this appointment. Signposted at clinical appointments to Birth Plan section of Badger and signposed to information on Badgernet and Regional LMNS website re information.
Please record any actions/escalations from CQC Maternity Survey Personalised Care Reporting Measures including any free text comments	Repeated low scoring for Partners being able to stay overnight – improvements to this restricted due to maternity estate. Plan to improve communication for services users to highlight how requests can be made in specific circumstances and how we can individualise plans around each service user. Included on 2024 CQC Survey action plan – improvement in score seen, will be included on 2025 to ensure sustained improvements, work with ne Core postnatal ward team to ensure offer is visible & available according to clinical demand, included in information to drive estates improvement planning
Is the Trust currently carrying out an ongoing audit of 5% of records (Ockenden IEA) to ensure personalised care and support plans are offered? Yes/No	Yes
Please provide evidence of audit activity, including frequency and sample size	Annual audit planner – repeat 5% audit due for Q4 2025/26

Safe Learning Environment Charter (SLEC) compliance – Maternity and Neonatal (please copy slide if you would like to submit 2 different summaries)

<table>
<tr><th>Requirement</th><th>Progress to Date / Risk to Delivery</th></tr>
<tr><td>Progress against NHS England Safe Learning Environment Charter (SLEC) 10 priorities using the SLEC Maturity Matrix:
https://kmpctraininghub.nhs.uk/wp-content/uploads/2024/04/SLEC-Maturity-Matrix.pdf

Respect and feeling valued

Positive identity

Wellbeing

Raising concerns & speaking up

Placement induction

Communication

Flexibility

Supervision

Teaching and learning needs

Time and space for learning</td><td>
<table>
<tr><th>SLEC Priorities</th><th>Current Score on Maturity Matrix</th><th>Current views and improvements in progress</th></tr>
<tr><td>Respect and feeling valued</td><td>3</td><td>Students all continue to feel respected and valued. Newsletters sent to all students and staff around cultural awareness and a safe productive environment for all colleagues which is free from bullying, and sensitive to the needs of others.</td></tr>
<tr><td>Positive identity</td><td>3</td><td>New PA/PS update discussion around positive identity of all students and staff, ensuring all students and other colleagues called by their names, and preferred pronouns.</td></tr>
<tr><td>Wellbeing</td><td>2</td><td>Policies in place to support the wellbeing of all staff and students – new wellbeing room in progress of development to increase to matrix score of 3. Wellbeing check ins offered to all students with PPF if needed.</td></tr>
<tr><td>Raising concerns and speaking up</td><td>3</td><td>The unit maintains a zero-tolerance policy for incivility and an open-door approach for raising concerns. Rights-to-reply are completed in partnership with the University for all trigger evaluations and sharing with placement areas for up to date learning.</td></tr>
<tr><td>Placement Induct ion</td><td>3</td><td>Induction has been completed for all students, with evaluations submitted by students. Resources were emailed to all students in advance, and a unit tour is provided during induction for those who wished to attend and offered to all new students. A re-induction session is delivered at the start of each academic year to communicate any Trust updates or changes to all students.</td></tr>
<tr><td>Communication</td><td>3</td><td>Students emailed all updates in guidelines, shifts in advance and any changes to practice. Student midwife liaison meeting for any trust/ uni/student representative updates or issues. Regional PPF meetings to obtain a regional approach. Open communication for all students, regular meetings held with any student requiring support. Students invited to all risk/safecare/PMRT meetings.</td></tr>
<tr><td>Flexibility</td><td>3</td><td>Shift swaps are allowed within capacity limits, with colleague swaps encouraged when maximum capacity is reached. Flexible placement opportunities enable movement within the maternity unit to support proficiency development and essential experience.</td></tr>
<tr><td>Supervision</td><td>3</td><td>89.14% of midwives remain compliant with PA/PS updates, with 87% compliance in community and 89.47% in acute services. The ARC database is fully up to date, allocations are made in advance, and any issues are addressed promptly and professionally.</td></tr>
<tr><td>Teaching and learning needs</td><td>3</td><td>Additional study days are provided to support proficiencies, and new study days to encourage confidence and competence of 3rd years and 2nd years to demonstrate their abilities, alongside clear guidance on proficiency mapping. All staff hold the required qualifications for practice supervisors and assessors, ensuring high-quality teaching for students. Guidance and support are available to all students, Practice Assessors (PAs), and Practice Supervisors (PSs) as required.</td></tr>
<tr><td>Time and Space for Learning</td><td>2</td><td>The daily feedback sheet has been successful for all students which has increased the amount of timely feedback provided. This has also been well received by the PS as some students have attended shifts with a planned list of proficiencies to discuss with their PS, supporting the achievement of all required proficiencies within the allocated timeframe. High-quality, constructive feedback is provided on the same day. Plan for encouragement for more students to use this to increase to a 3</td></tr>
</table>
</td></tr>
<tr><td>Current Midwifery Practice Placement Facilitator (PPF) WTE available within the trust?</td><td>1wte</td></tr>
<tr><td>Any challenges or support required?</td><td></td></tr>
</table>

LISTENING TO WOMEN AND BIRTHING PEOPLE

Trust Update
Quarter: Q4 2025/26
Completed by: Karen Parker

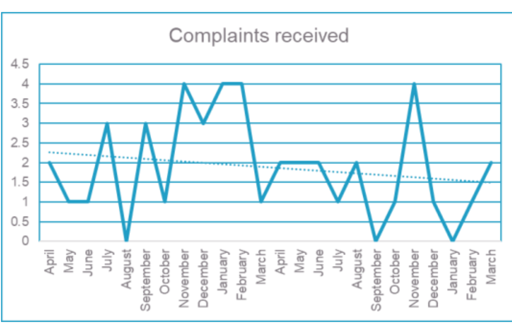
Perinatal themes from women and families

Themes from Birth Reflections / Debriefs /Family involvement in Incident reviews

Themes from Patient Experience (via your Trust complaints process) and Friends and Family Test (FFT)

6 formal complaints received in Q3
3 formal complaints received in Q4

Themes:
- Listening to patients
- Staff attitude & behaviour
- Consideration of non-obstetric causes for symptoms



2025/26		April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
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%	100%	100%	100%
	Complaints	2	2	2	1	2	0	1	4	1	0	1	2

National Maternity Survey – Key Areas of Focus (2024 results)

2024 Survey - Action plan completed:

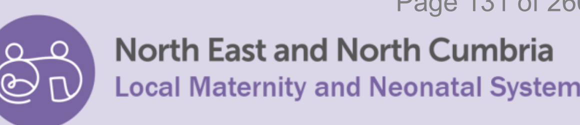
Were you given enough support for your mental health during your pregnancy?
2024 score = 8.9, 2025 score = 9
Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?
2024 score = 8.2, 2025 score = 9.2
Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?
2024 score = 4.0, 2025 score = 4.2
Were your decisions about how you wanted to feed your baby respected by midwives?
2024 score = 8.3, 2025 score = 9.2
Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?
2024 score = 8.7, 2025 score = 9.5

2025 Survey – Action plan being co-developed with MNVP for July LMNS submission

MNVP Update for MNEG

Quarter: Q4

Completed by: MNVP Co-Leads



Escalation and risks to take forward

- Unable to attend upcoming MNVP TASK AND FINISH GROUP meeting on Weds 29 April as falls on working day for all 3 of us. Between the 3 of us, we have availability on Mondays, Thursdays and Fridays.
- Unable to attend postponed MNEG 26/27 planning workshop on Weds 24 June as between the 3 of us, we have availability on Mondays, Thursdays and Fridays.

Surveys and listening events undertaken:

- F2f service user meeting on 14 Feb: 22 service users attended. Have collated feedback and generated key themes including positive and areas for improvement.
- Gayle attended LMNS visit on 10 February
- Bereaved parents session planned for June – working with Sands Volunteer and Bereavement Midwife. Have created feedback form based on template on Sands website.
- Next 15 Steps to take place on 16 May
- Gayle attended Safety Champion meeting on 10 April

Actions / Improvements undertaken / planned

- Now have access to NHS email account
- Personalised care boards for labour ward and postnatal ward – MNVP Lead feedback and SU feedback through private Facebook group
- Reviewed Perinatal Pelvic Health Service leaflet
- Reviewed Well Baby leaflet

Perinatal service user feedback themes

As above, themes from SU event have been collated – MNVP leads to review and discuss with HoM. Will also review and discuss at our next 15 Steps.

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

Report Cover Sheet Agenda Item: 3ai

Report Title:	**Maternity Safety Champion Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 May 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			

<table>
<tr><td>Outline what the meeting is expected to do with this paper</td><td colspan="5">Integrated Oversight Report, noting that updates on the key issues will be provided in the next report.</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">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</td></tr>
<tr><td>Links to CQC Key Lines of Enquiry (KLOE):</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):</td><td colspan="5">3107 - Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings (15)
2984 – Risk of delayed treatment due to maternity estate being in a separate building (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 (15)
4713 - The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis (16)</td></tr>
<tr><td>Has an Equality and Quality Impact Assessment (EQIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

Maternity Non-Executive Director Safety Champion Report May 2026

1. Executive Summary

1.1. A high quality of midwifery care provided continues to be delivered despite challenges.

1.2. Key issues to report to Board this month include:

- Women's Health Clinic;
- Maternity Incentive Scheme (MIS) Year 8 update
- Community midwives site visit
- Local Maternity and Neonatal Systems (LMNS) update

2. Introduction

2.1. This is a narrative report which complements the Maternity Integrated Oversight Report (IOR) report covering national metrics of maternal and neonatal safety.

2.2. 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.

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

3. Progress on issues

3.1. Women's Health Clinic:

Some progress achieved on identified job plans and additional capacity. Some additional telephone clinics have been undertaken to provide risk oversight assessment. Meetings are ongoing with consultant obstetricians to work on the details.

3.2. MIS Year 8 update:

National webinar April 2026. Summary outputs are as follows:

- Board accountability is unchanged
- 6 safety actions will be in place (down from 10)
- More outcome focused
- Spot checks will be conducted throughout the year (findings will be advisory not punitive)
- Perinatal Mortality Review Tool (PMRT) meetings should include the Maternity and Neonatal Voice Partnership (MNVP) lead
- Any critical safety check identified in the MOSS system should be discussed as part of the public board agenda
- Implementation March 2027

3.3. Community midwives site visit:

I attended the Tyneview Children's Centre for a day of the midwife celebration and meeting on 5th May. Issues raised included:

- Pressures on the community teams
- Communication with some GP practices on access to rooms for antenatal provision and some investigations. This has been escalated to the primary: secondary care interface meeting, via Nicola Bruce.
- Issues with limited numbers of transcutaneous bilirubin meters having an adverse impact on time and travel. We discussed the purchase of additional meters and the possibility of an application to charitable funds.

3.4. LMNS update

Advanced neonatal nurse practitioners (ANNP) recruitment and succession planning is in place and progressing to satisfy the requirements outlined by the LMNS team visit earlier this year.

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.

b - Nurse Staffing Exception Report

Presented by the Interim Chief Nurse

Report Cover Sheet Agenda Item: 3b

<table>
<tr><td>Report Title:</td><td colspan="4">Nursing Staffing Exception Report- February 2026 and March 2026</td></tr>
<tr><td>Name of Meeting:</td><td colspan="4">Board of Directors</td></tr>
<tr><td>Date of Meeting:</td><td colspan="4">27th May 2026</td></tr>
<tr><td>Author:</td><td colspan="4">Helen Larkin, Clinical Lead for E-Rostering</td></tr>
<tr><td>Executive Sponsor:</td><td colspan="4">Beth Swanson, Interim Chief Nurse</td></tr>
<tr><td>Report presented by:</td><td colspan="4">Beth Swanson, Interim Chief Nurse</td></tr>
<tr><td rowspan="2">Purpose of Report
Briefly describe why this report is being presented at this meeting</td><td>Decision:
☐</td><td>Discussion:
☐</td><td>Assurance:
☒</td><td>Information:
☒</td></tr>
<tr><td colspan="4">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.</td></tr>
<tr><td>Proposed level of assurance – to be completed by paper sponsor:</td><td>Fully assured
☐
No gaps in assurance</td><td>Partially assured
☒
Some gaps identified</td><td>Not assured
☐
Significant assurance gaps</td><td>Not applicable
☐</td></tr>
<tr><td>Paper previously considered by:
State where this paper (or a version of it) has been considered prior to this point if applicable</td><td colspan="4"></td></tr>
<tr><td>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</td><td colspan="4">This report provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls within the month of February and March 2026.

Alert
Across February and March 2026, inpatient wards continued to experience significant staffing pressures. Key challenges included sustained higher patient acuity and dependency, vacancies within the non-registered workforce, and the operation of multiple escalation areas. Ward 11 remained open as a surge area until 4 February, and Ward 23 re-opened on 31 January and continued into March. Additional escalation beds remained open on Wards 9, 10, 12, 22, 24 and 25 throughout both months, increasing demand on the available staffing resource. There were occasions in both months where staffing levels fell below 80% of the funded establishment. These</td></tr>
</table>

	areas are highlighted within the report, alongside the immediate actions taken to mitigate risk. **Advise** A Trust-wide programme reviewing nursing establishments, skill mix and rostering efficiency is underway, with implementation scheduled to begin on 5 April 2026. Targeted recruitment to the HCA workforce has been ongoing since October and continues to progress through various pipeline supplies. Dynamic risk assessment processes remain active, and the staffing escalation protocol is being consistently utilised to support daily deployment decisions. The volume and quality of staffing-related incident reporting across both months demonstrate that staff are appropriately escalating concerns in line with policy. Further work is ongoing to strengthen the assurance over escalation and intervention of red flag reporting. **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 ensure daily oversight of staffing, with redeployment, cohorting, temporary staffing solutions and professional judgement being used to maintain patient safety.
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is asked to: • receive the report for partial assurance • note the work being undertaken to address the shortfalls in staffing and support ongoing actions to mitigate risk.
Trust strategic priorities that the report relates to:	☒ Excellent patient care ☒ Great place to work ☒ Working together for healthier communities ☐ Fit for the future
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	List strategic objective here

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

Risks / implications from this report (positive or negative):	
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	There were 12 nurse-staffing incidents reported via InPhase during February and seven during March. All reported incidents related directly to ward and departmental staffing concerns. These incidents are highlighted within the report.

	Risk 4854- Risk to safe delivery of patient care due to the significant vacancy position of Healthcare Assistants (HCA) within the Trust.		
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
February 2026

1. Executive Summary

This report provides an exception overview of nursing and midwifery staffing for February 2026. While average fill rates remain broadly stable, a number of wards fell below the 80% 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. Total Trust Registered Nurse vacancy rates remain low at 2.7%, however the Healthcare Assistant vacancy rate of 18.3% continues to present a workforce challenge and is recorded on the risk register within the Medicine and Community Division and Corporate Services. Recruitment to the bank has been undertaken, with another round planned in coming months, and a Band 2 to Band 3 development pathway is being progressed. Improvements to red flag reporting and resolution are underway, alongside implementation of 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 February 2026. 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 February 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.

NHS Table 1: Whole Trust wards staffing February 2026

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 (%)
⇧ 87.2%	⇩ 73.9%	⇩ 101.5%	⇩ 108.4%

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 80%.

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 currently un in January 2026, concluding mid-February.
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 which concluded in mid-January. Revision of nursing establishments will conclude this work planned for the beginning of April 2026.

It is recognised that the current establishment rosters are not fully aligned to the acuity and dependency demands within our wards. Ward Managers and Matrons continue to work hard to staff their areas safely using the resources available. As a result, there are occasions where staff are allocated to support overall staffing levels rather than within the planned skill-mix proportions.

The exceptions to report February are as below:

February 2026	
Registered Nurse Days	**%**
Cragside Court	74.7%
Critical Care	68.5%
JASRU	79.0%
SCBU	68.6%
Ward 28 Orthopaedic Elective Ward	73.2%
Ward 22 Gen Medicine	71.6%
Registered Nurse Nights	**%**
Cragside Court	77.9%
Sunniside Unit	69.4%
Healthcare Assistant Days	**%**
Critical Care Dept	49.1%
JASRU	64.5%
SCBU	51.0%
Ward 8 Cardiology	65.7%
Ward 9 Respiratory	69.1%
Ward 10	76.5%

Ward 21 Trauma & Ortho	73.9%
Ward 28 – Orthopaedic Elective Ward	25.9%
Ward 22 Gen Medicine	74.9%
Ward 24 Jubilee Wing	56.5%
Ward 25 Jubilee Wing	67.4%
Ward 26 Gynae	68.9%
Ward 27 Treat/Centre	59.0%
Healthcare Assistant Nights	**%**
SCBU	50.8%
Ward 28 – Orthopaedic Elective Ward	36.4%

To note, the surge area (Ward 23) 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 overseen by a clinical matron and staff follow the same escalation processes.

Throughout February, 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 Registered Nurses (RN) and Health Care Assistant (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 Trust wide RN vacancy rate is 2.7%, equating to 37.2 WTE. Most vacancies are within the Band 5 and Band 6 workforce. Recruitment remains ongoing aligned with student graduation cycles.

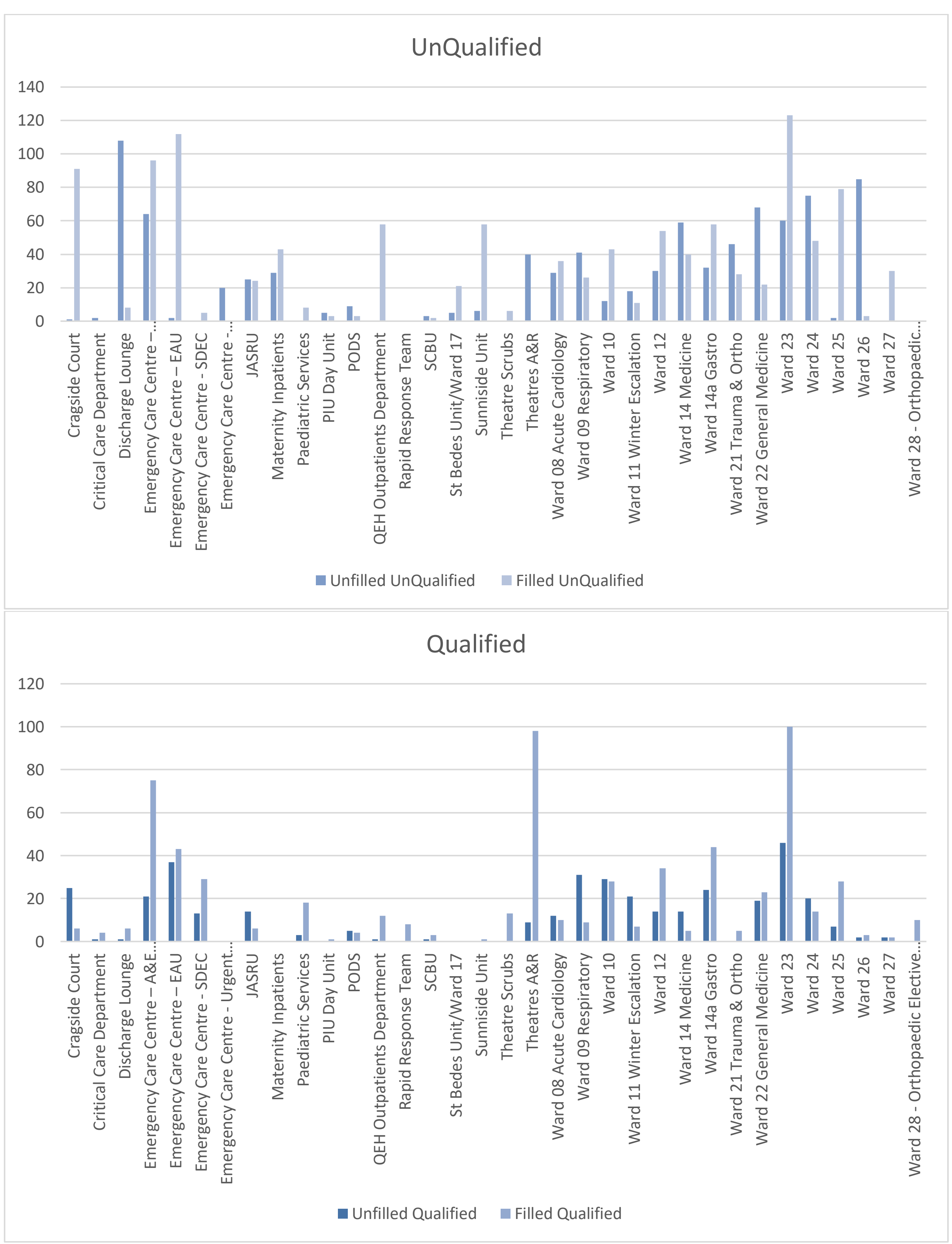
The HCA vacancy position for the Trust is 18.3% with 103.2 WTE vacant positions. Notably this position has deteriorated month on month since December 2025. The current position with HCA vacancies is on the risk register within the Medicine and Community division as well as being identified as a Corporate risk. 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. This position is also being felt regionally with challenges in recruiting staff directly into a band 3 post following the national re-banding work.

In parallel, a Band 2 to Band 3 development programme is being explored in response to the challenges experienced in recruiting candidates with the required academic level and experience for Band 3 Healthcare Assistant roles. A new job description for this post has been reviewed through Job Evaluation panel and approved. A proposal is drafted for decision. We are working closely with Derwentside College who have agreed to support the delivery of the apprenticeship pathway. The proposal will flow through POD Steering Group in March for a decision. Additional to this , a meeting with Derwentside college is in place for March to discuss potential Band 3s about to complete Health care qualifications in June for recruitment to the Trust.

5. Temporary Staffing

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



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 current home student nurses. This process is important to ensure we continue to replenish the turnover of bank only workers. This process was successful in offering 38 bank positions. A further vacancy control form has been submitted for internal candidates and students to apply for as bank 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 February, the Trust total CHPPD was 7.5. 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. Twelve staffing incidents were raised during February, including the levels of physical and psychological harm (Appendix 2). Nurse staffing was directly referenced in three InPhase in relation to harm, two low physical harm and another two with low psychological harm.

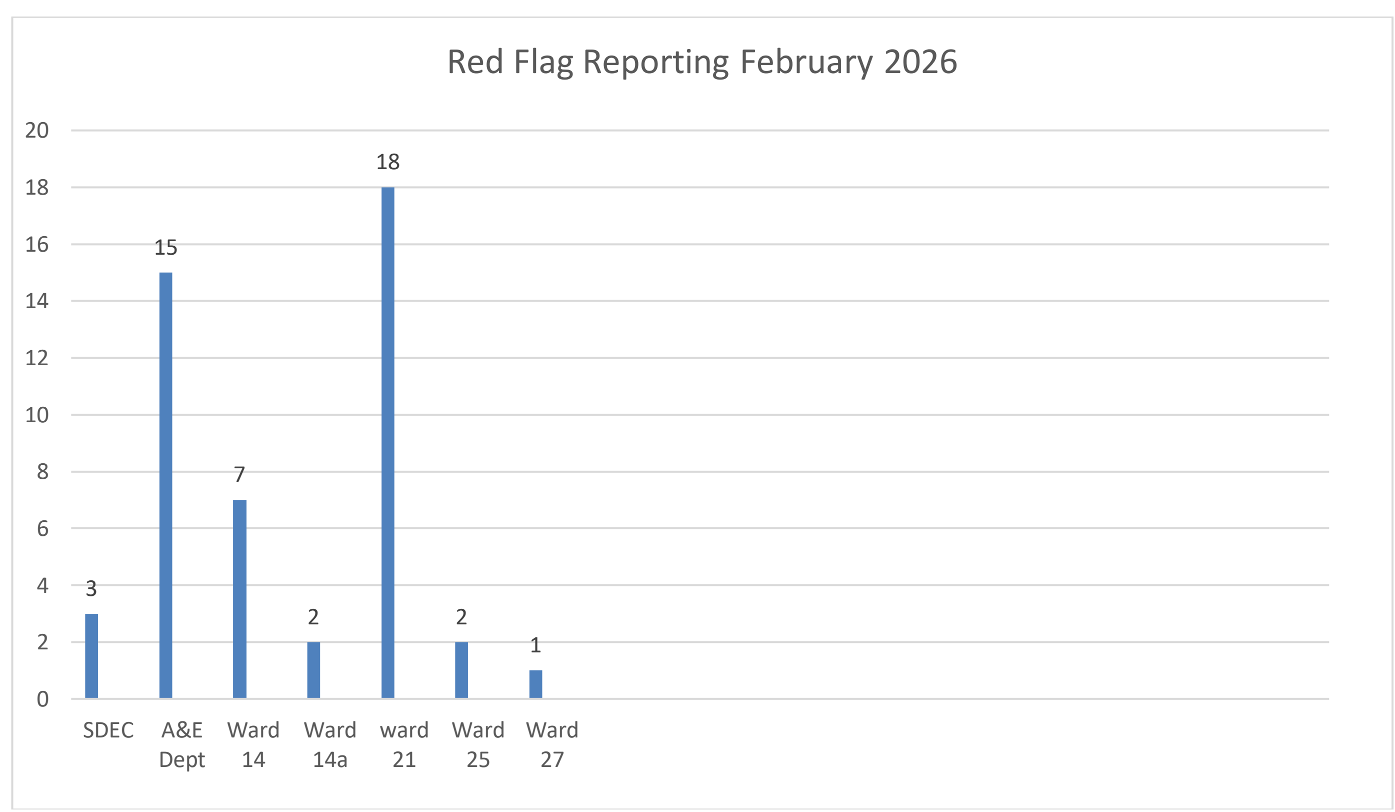
8. Nursing Red Flags

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 February 48 nursing red flags were reported, A slight reduction from the 50 raised in January. Red flags must be escalated promptly to the Matron or senior nurse for action and mitigation. However, only one the red flags raised in February was recorded as reviewed within the Safecare live system.

Mid - February saw us move to a position where we 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 was set up on the 18th of February to improve real time visibility of red flag reporting to support operational management of safe staffing and provide reporting metrics for escalation and assurance. Now in place, compliance with review, response and closure will be monitored as a key performance indicator with Divisions following the introduction of Workforce assurance meetings from May 26.

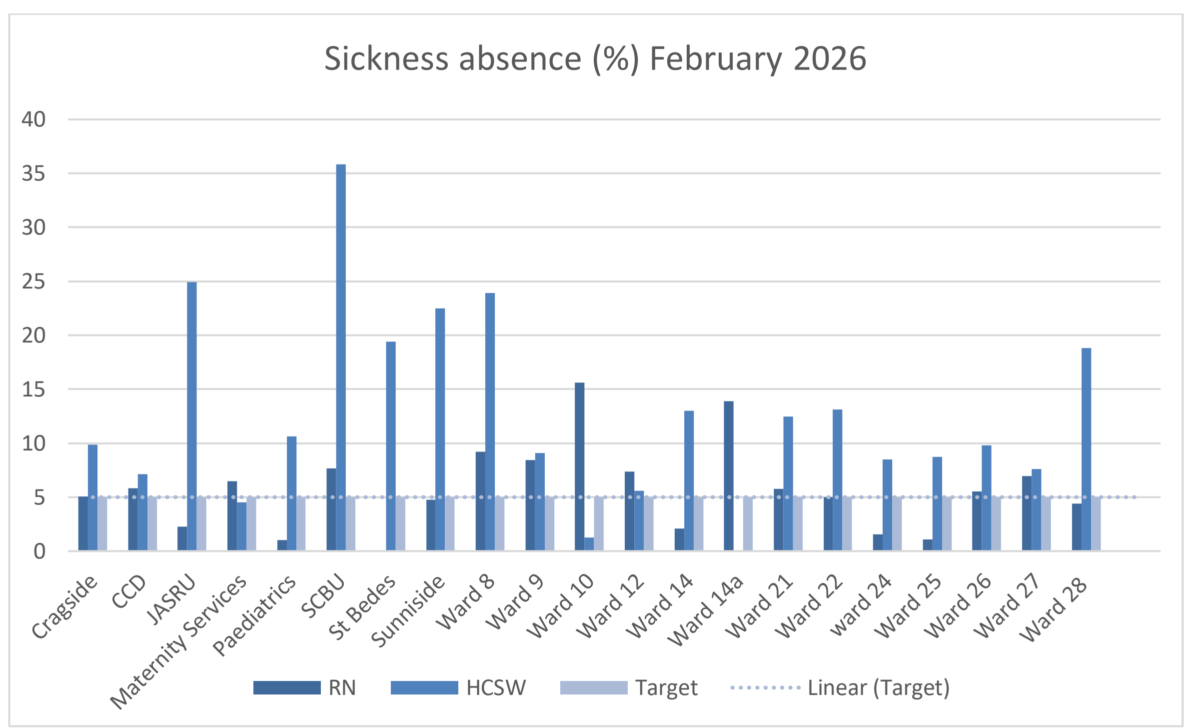
The graph below outlines the number of red flags raised per department in February. Ward 21 reported the highest number and experienced Healthcare Assistant shortfalls on both day and night shifts, demonstrating effective escalation through red flag reporting to the Matron for the area. A&E also report a significant number of Red Flags, notes indicate this is due in main to missed vital signs as a direct result of staffing gaps across the HCA and RN workforce.



9. Absence levels

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

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 80% for RN Days (68.5%) and HCA Days (49.1%). There were seven episodes of short-term sickness during the month of February within the Band 6 workforce. There are four WTE Band 5 vacancies within the team, these have been authorised on TRAC as of 5/3/26. Four staff members are absent on a long-term basis and two on maternity leave. The unit were still able to safely support non-clinical duties and supernumerary time for the newly appointed band 6s. Additional to this Critical care supported with 43 instances of redeployment of registered staff. There are 2.84 WTE vacancies across the band 3 line, 2 episodes of short-term absence and 1WTE with long term sickness. Band 3 redeployment was supported on 2 occasions.

SCBU demonstrated a daytime RN fill rate of 68.6% in February, which is, a decline from Januarys 75.4% with sickness absence levels of 7.65% also a decline from January. Two staffing incidents were raised, no harms were identified, however no red flags were raised. Demand templates are in review with Head of Midwifery and Clinical lead for e-roster.

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. There were no incidents or red flags reported.

Cragside Court report 74.7% fill rates for Registered staff days. Registrant nights are 77.9%. 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. The areas are a self-contained ward and support across both units at night to mitigate any risk of reduced RMN cover. There was one episode of Registrant sickness during January in Cragside and none on Sunniside. No red flags or InPhase incidents were raised by this area through February in either area.

A total of 15 areas demonstrate below 80% fill rates for Healthcare Assistants due to the high number of vacancies. As of February, there was 103.2 trust wide vacancies (18.3%). This is a month on month-increased number of vacancies. Active monitoring, redeployment and bank are currently being used to mitigate understaffed areas based on real time risk assessments and patient acuity and dependency. Due to increased shortages, wards and departments have to rely on agency staff also to mitigate against the risk.

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.

Appendix 1- Table 3: Ward by Ward staffing February 2026

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	74.7%	93.9%	77.9%	162.5%	330	4.0	7.0	11.0
Critical Care Dept	68.5%	49.1%	94.2%	85.2%	205	32.7	2.9	35.6
Emergency Care Centre - EAU	83.7%	84.3%	93.5%	92.9%	1230	5.6	3.9	9.5
JASRU	79.0%	64.5%	103.3%	103.1%	553	3.2	3.2	6.4
Maternity Unit	91.8%	109.0%	107.1%	119.2%	562	14.6	4.6	19.3
Special Care Baby Unit	68.6%	51.0%	114.4%	50.8%	179	9.4	1.3	10.6
St. Bedes	81.0%	85.7%	101.2%	103.0%	271	4.9	3.5	8.4
Sunniside Unit	92.5%	127.3%	69.4%	101.4%	211	6.7	5.6	12.3
Ward 08	101.4%	65.7%	96.8%	126.9%	573	4.4	2.6	7.1
Ward 09	98.1%	69.1%	110.9%	96.4%	785	2.7	1.7	4.4
Ward 10	86.2%	76.5%	102.8%	101.9%	708	2.6	2.1	4.7

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Ward 12	94.1%	81.0%	102.8%	103.9%	739	2.7	2.1	4.8
Ward 14 Medicine	83.0%	82.0%	89.5%	119.4%	707	3.3	2.3	5.6
Ward 14a Gastro	124.4%	94.3%	84.1%	137.7%	709	3.1	2.7	5.8
Ward 21 T&O	101.9%	73.9%	102.0%	96.3%	766	3.2	2.7	6.0
Ward 22	71.6%	74.9%	137.6%	142.6%	843	2.4	2.6	5.0
Ward 24	93.3%	56.5%	139.5%	128.0%	713	3.3	2.5	5.8
Ward 25	92.5%	67.4%	151.1%	140.4%	818	3.0	2.5	5.5
Ward 26	101.0%	68.9%	96.6%	93.6%	607	3.8	2.6	6.4
Ward 27	118.2%	59.0%	106.6%	102.9%	816	3.2	1.8	5.1
Ward 28	73.2%	25.9%	101.4%	36.4%	134	10.8	3.3	14.1
QUEEN ELIZABETH HOSPITAL - RR7EN	**87.2%**	**73.9%**	**101.5%**	**108.4%**	**12459**	4.7	2.8	7.5

Appendix 2 INPHASES submitted in relation to nurse staffing.

Incident Date.	Investigating Department	Category(s)	Subcategory	Level of Physical Harm	Level of Psychological Harm
2/2/26	Ward 14	Staffing/resource issue	Staffing-insufficient nurses (other reason)	Low physical harm	No psychological harm
3/2/26	Ward 24	Staffing/resource issue	Staffing – delay/difficulty in obtaining clinical assistance	No physical harm	No psychological harm
4/2/26	Ward 25	Staffing/resource issue	Staffing-insufficient (other reason)	No physical harm	No psychological harm
7/2/26	Ward 8	Staffing/resource issue	Staffing-insufficient nurses (other reason)	No physical harm	No psychological harm
9/2/26	Ward 26	Staffing/resource issue	Staffing-insufficient nurses (other reason)	No physical harm	No psychological harm
15/2/26	Peapod	Staffing/resource issue	Staffing – insufficient staff (other)	No physical harm	Low psychological harm
12/2/26	SCBU	Staffing/resource issue	Staffing/resource issue	No physical harm	No psychological harm
17/2/26	SCBU	Staffing/resource issue	Staffing – insufficient staff (other)	No physical harm	No psychological harm
23/2/26	Ward 23	Staffing/resource issue	Staffing-insufficient nurses (other reason)	No physical harm	Low psychological harm
23/2/26	SDEC	Staffing/resource issue	Staffing/resource issue	No Physical harm	Low psychological harm

26/2/26	Ward 24	Staffing/resource issue	Insufficient nurses (due to staff shortages/unfilled shifts)	Low physical harm	No psychological harm
24/2/26	Community (West Locality)	Staffing/resource issue	Staffing-insufficient nurses (other reason)	No physical harm	No psychological harm

Gateshead Health NHS Foundation trust
Nursing and Midwifery Staffing Exception Report
March 2026

13. Executive Summary

This report provides an exception overview of nursing and midwifery staffing for February 2026. While average fill rates remain broadly stable, a number of wards fell below the 80% 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. Total Trust Registered Nurse vacancy rates remain low at 2.4%, however the Healthcare Assistant vacancy rate of 18.8% continues to present a workforce challenge and is recorded on the risk register within the Medicine and community division and Corporate services. Recruitment to the bank has been undertaken, with another round planned in coming months, and a Band 2 to Band 3 development pathway is being progressed. Improvements to red flag reporting and resolution are now in place, 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.

14. Introduction

This report details the staffing exceptions for Gateshead Health NHS Foundation Trust during the month of March 2026. 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 March 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.

NHS Table 1: Whole Trust wards staffing March 2026

Day Average fill rate - registered nurses/midwives (%)	Day Average fill rate - care staff (%)	Night Average fill rate - registered nurses/midwives (%)	Night Average fill rate - care staff (%)
86.1%	74.5%	101.4%	110.6%

The Trust is required to present information on funded establishments (planned) against actual nurses on duty. The above figures are average fill rates and thus do not reflect 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 80%.

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).
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. A revision of nursing establishments and rostering efficiencies will be in place in in-patient areas from the 5th April 2026. It is anticipated this will ensure ward areas are better aligned to acuity and dependency demands within our wards.

The exceptions to report March are as below:

March 2026	
Registered Nurse Days	**%**
Cragside Court	73.0%
Critical Care	66.2%
JASRU	78.5%
SCBU	74.1%
Ward 28 Orthopaedic Elective Ward	65.9%
Ward 22 Gen Medicine	69.8%
Registered Nurse Nights	**%**
Cragside Court	77.4%
Sunniside Unit	68.8%
Healthcare Assistant Days	**%**
Critical Care Dept	55.7%
JASRU	71.1%
SCBU	35.1%
Ward 8 Cardiology	61.7%
Ward 9 Respiratory	76.8%
Ward 10	67.7%

Ward 14 Medicine	76.5%
Ward 21 Trauma & Ortho	75.8%
Ward 28 – Orthopaedic Elective Ward	28.6%
Ward 22 Gen Medicine	71.3%
Ward 24 Jubilee Wing	74.3%
Ward 25 Jubilee Wing	66.9%
Ward 26 Gynae	54.9%
Ward 27 Treat/Centre	58.0%
Healthcare Assistant Nights	**%**
Critical Care Dept	77.4%
Sunniside	68.8%

Throughout March, 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 Registered Nurses (RN) and Health Care Assistants (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.

16. Vacancies

The Trust wide RN vacancy rate is 2.4%, equating to 33.8 WTE. This is an improvement of 3.8 WTE compared to February. Most vacancies are within the Band 5 and Band 6 workforce. Recruitment remains ongoing aligned with student graduation cycles.

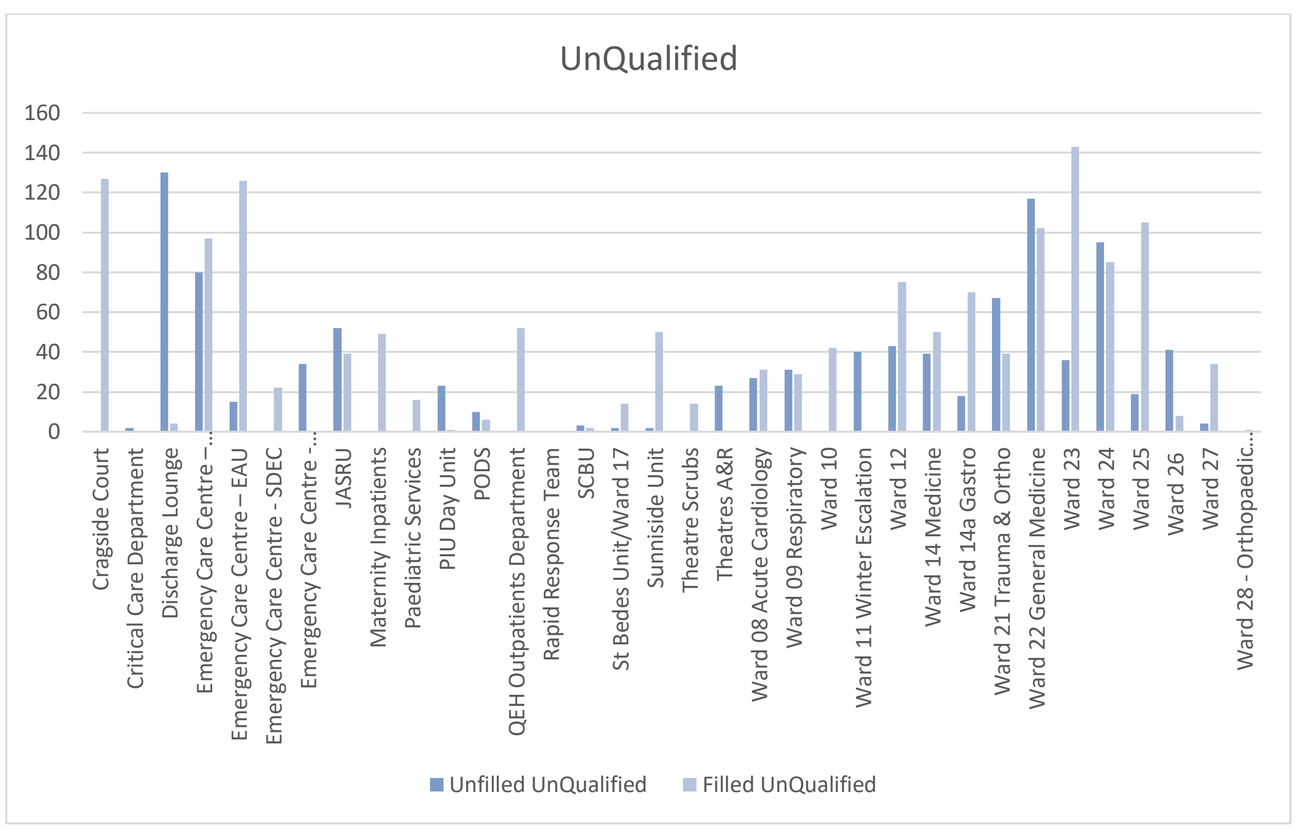
The HCA vacancy position for the Trust is 18.8% with 105.8 WTE vacant positions. This is 2 WTE in addition to February. Notably this position has deteriorated month on month since December 2025. The current position with HCA vacancies is on the risk register within the Medicine and Community division as well as being identified as a Corporate risk. This is an area of particular concern as the HCA internal bank is also depleted.

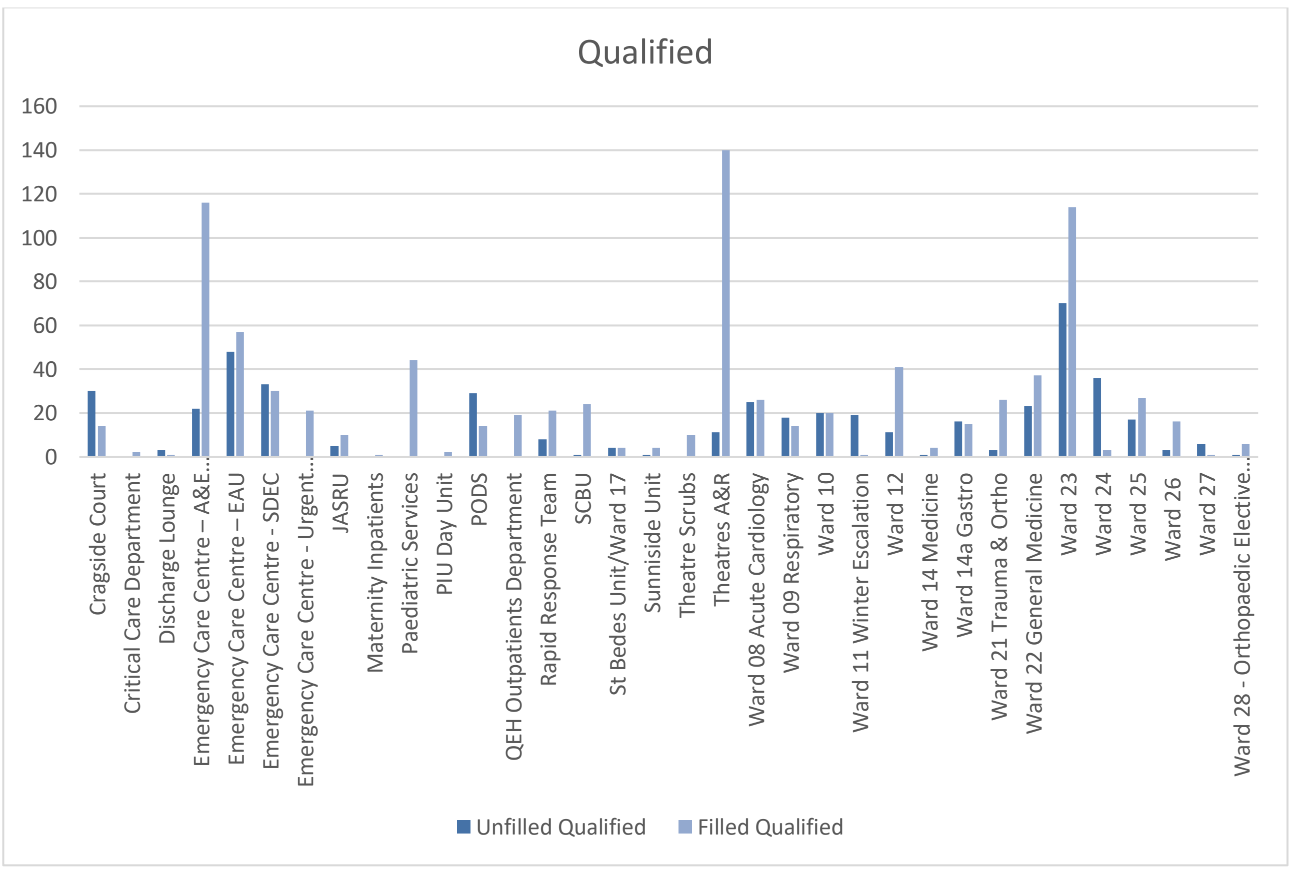
Following a Trustwide recruitment campaign, only 5.6 WTE Band 3 HCA posts were appointed from the central advertisement. As a result, recruitment will now be progressed at service line level within Divisions, as a more targeted approach is expected to be more effective. This position is also being felt regionally with challenges in recruiting staff directly into a band 3 post following the national re-banding work.

In parallel, a Band 2 to Band 3 development programme continues to be explored in response to the challenges experienced in recruiting candidates with the required academic level and experience for Band 3 Healthcare Assistant roles. A new job description for this post has been reviewed through Job Evaluation panel and approved. A proposal is drafted for decision. We are working closely with Derwentside College who have agreed to support the delivery of the apprenticeship pathway.

17. Temporary Staffing

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





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 home student nurses, with 38 successful applicants. Further bank recruitment is in process to continue replenishment of the bank pool.

18. 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 March, the Trust total CHPPD was 7.1, reduced from the February position (7.5). 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.

19. Monitoring Nurse Staffing via Incident Reporting system

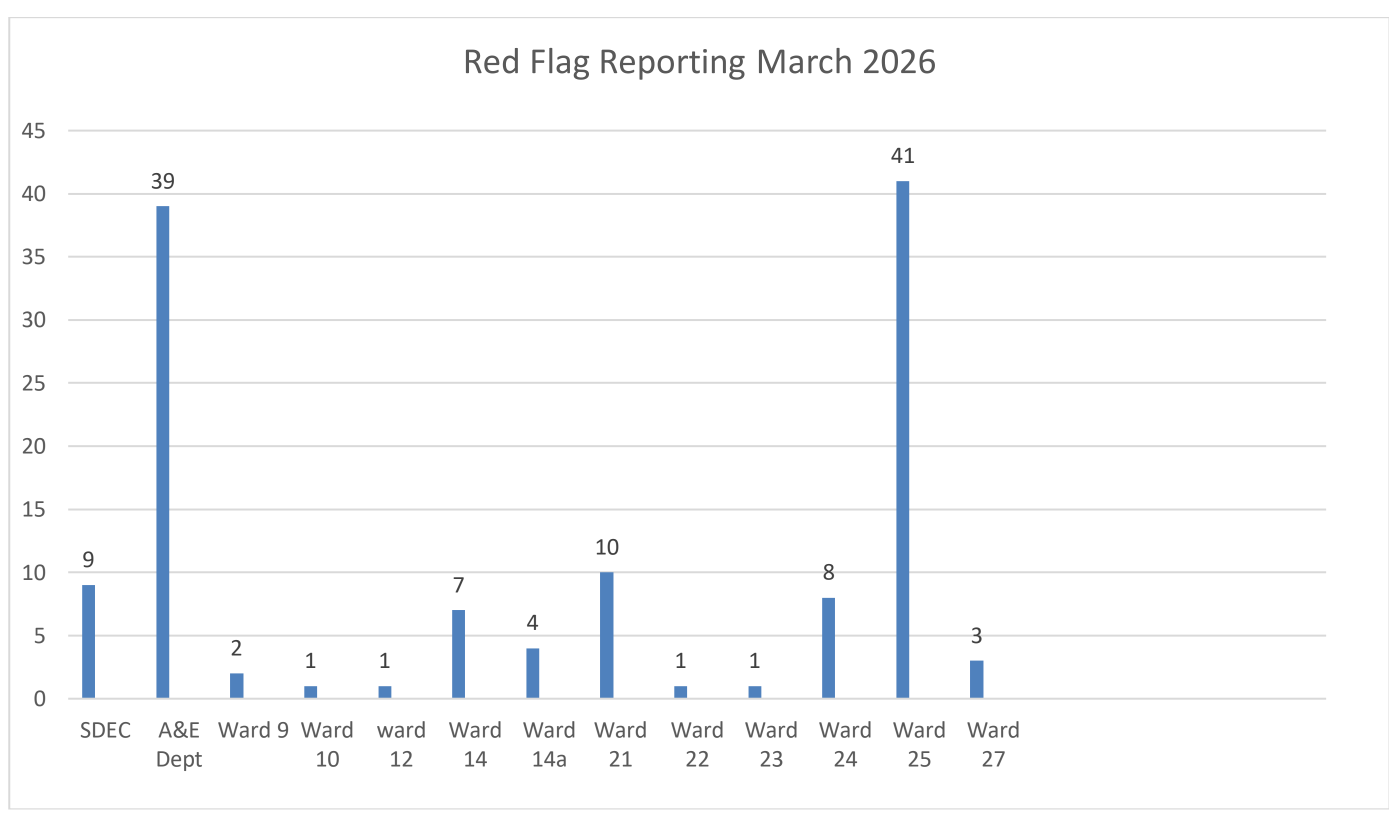
The Trust has an escalation process in place for addressing staffing shortages with identified actions to be taken. Further discussion is to take place to scope the potential for identifying thresholds that trigger when a staffing related incident should be submitted via InPhase to provide reporting 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 sub-categories 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. Seven staffing incidents were raised during March, including the levels of physical and psychological harm (Appendix 2). Nurse staffing was directly referenced in one InPhase in relation to harm, this was marked as low physical harm and low psychological harm.

20. 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 March 127 nursing red flags were reported, A significant increase from the 48 raised in February. Red flags must be escalated promptly to the Matron or senior nurse for action and mitigation. An alert process is now in place, escalating red flags to the appropriate business unit Matron for review and response where appropriate. However, none of these red flags raised in March were recorded as reviewed or mitigated within the Safecare live system. The two highest reporting areas were Ward 25 with 41 red flags and A&E with 39. Ward 25 report this was to do with the HCA vacancy challenges, A&E report

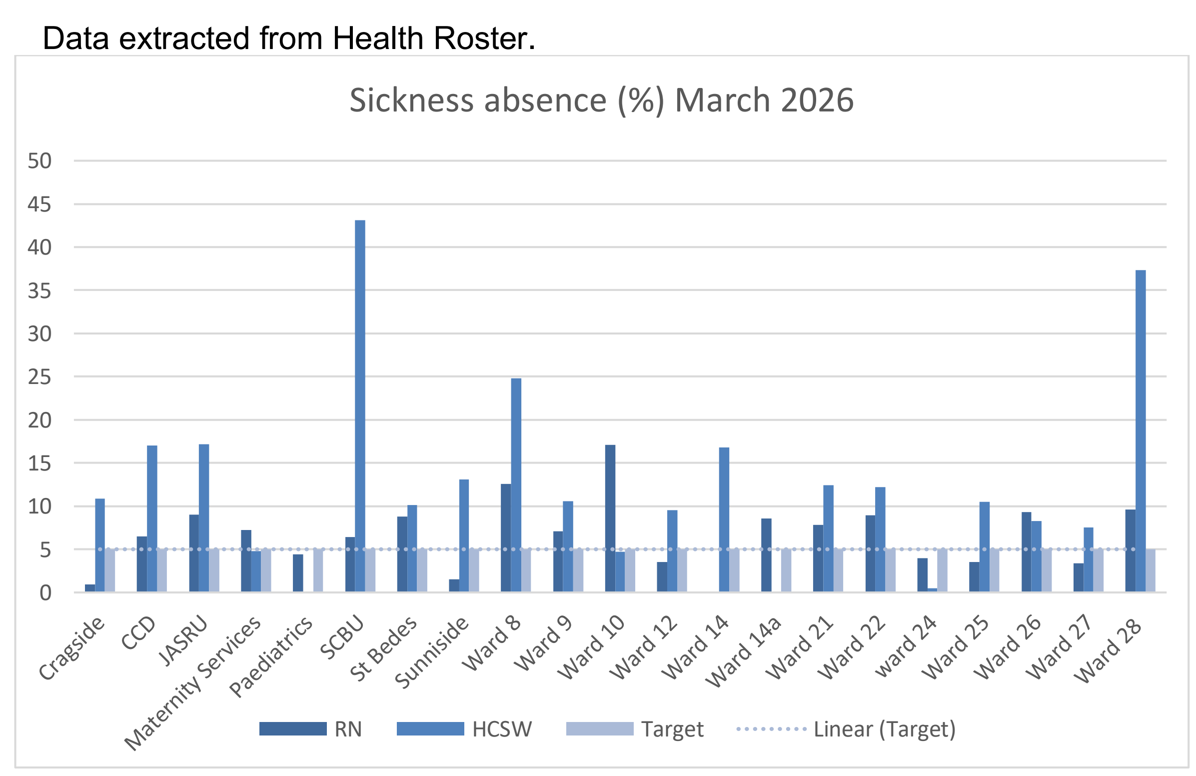
similar challenges alongside high acuity. Further work in response to this is being actioned with the operational teams.



21. Absence levels

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

Data extracted from Health Roster.



22. 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.

23. Triangulation and actions taken

Critical Care Department demonstrated fill rates below 80% for RN Days (66.2%) and HCA Days (55.7%). There were one episode of short-term sickness and one on maternity leave during the month of March within the Band 6 line. There are three episodes of long-term sickness and eight of short-term sickness as well as one on maternity leave within the Band 5 Workforce. The unit were still able to safely support non-clinical duties and supernumerary time. Additional to this Critical care supported with 25 instances of redeployment of registered staff.

SCBU demonstrated a daytime RN fill rate of 74.1% in March, which is, a slightly improved position from February. HCA fil rates were below 80% for both days and nights: 35.1% (days) and 62.2% (nights). Head of midwifery maintains the unit was safely staffed and the HCA role is not required 24/7 therefore affecting fill rates. A meeting was held between the Head of Midwifery and Health roster to review the establishments to support accurate reporting.

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. There were no incidents or red flags reported.

Cragside Court report 73% fill rates for Registered staff days. Registrant nights is 77.4%. 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. The areas are a self-contained ward and support across both units at night to mitigate any risk of reduced RMN cover. Cragside report 2 registrants on Maternity. No red flags were raised during the month of March.

Fifteen areas demonstrate below 80% fill rates for Healthcare Assistants due to the high number of vacancies. As of March, there was 105.8 trust wide vacancies (18.8%). This is a month on month-increased number of vacancies. Active monitoring, redeployment are currently being used to mitigate understaffed areas based on real time risk assessments and patient acuity and dependency. Due to increased shortages, wards and departments are utilising agency staff to mitigate against the risk.

24. 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.

Appendix 1- Table 3: Ward by Ward staffing March 2026

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	73.0%	98.1%	77.4%	189.1%	316	4.6	8.8	13.4
Critical Care Dept	66.2%	55.7%	95.2%	44.5%	219	33.4	2.7	36.0
Emergency Care Centre - EAU	83.3%	82.4%	95.9%	92.5%	1372	5.6	3.8	9.4
JASRU	78.5%	71.1%	104.9%	121.5%	609	3.2	3.7	6.9
Maternity Unit	85.4%	100.2%	108.7%	126.7%	606	14.4	4.7	19.0
Special Care Baby Unit	74.1%	35.1%	118.1%	62.2%	170	11.6	1.5	13.1
St. Bedes	86.1%	86.7%	100.7%	96.6%	300	5.1	3.5	8.6
Sunniside Unit	95.2%	143.0%	68.8%	100.8%	162	9.8	8.6	18.4
Ward 08	95.4%	61.7%	93.5%	98.1%	571	4.7	2.5	7.2
Ward 09	104.9%	76.8%	111.7%	98.3%	902	2.7	1.8	4.5
Ward 10	87.0%	67.7%	101.9%	96.8%	657	3.2	2.3	5.4

	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	101.1%	82.2%	104.7%	107.7%	832	2.8	2.1	4.9
Ward 14 Medicine	83.4%	76.5%	83.8%	104.2%	795	3.2	2.1	5.3
Ward 14a Gastro	122.0%	102.4%	86.6%	134.8%	791	3.1	2.8	5.8
Ward 21 T&O	105.2%	75.8%	98.6%	104.5%	884	3.1	2.7	5.9
Ward 22	69.8%	71.3%	136.1%	149.7%	864	2.5	2.8	5.3
Ward 24	91.4%	74.3%	137.0%	171.7%	943	2.7	2.8	5.5
Ward 25	86.3%	66.9%	144.7%	137.5%	985	2.6	2.3	4.9
Ward 26	103.9%	54.9%	95.2%	97.4%	694	3.7	2.2	6.0
Ward 27	121.3%	58.0%	102.8%	101.7%	919	3.2	1.8	5.0
Ward 28	65.9%	28.6%	101.7%	30.4%	186	8.1	2.8	10.9
QUEEN ELIZABETH HOSPITAL - RR7EN	**86.1%**	**74.5%**	**101.4%**	**110.6%**	**13777**	**4.4**	**2.7**	**7.1**

Appendix 2 INPHASES submitted in relation to nurse staffing.

Incident Date.	Investigating Department	Category(s)	Subcategory	Level of Physical Harm	Level of Psychological Harm
3/3/26	Ward 25	Staffing/resource issue	Staffing-insufficient nurses (other reason)	No physical harm	No psychological harm
7/3/26	Delivery Suite (Maternity)	Staffing/resource issue	Staffing-insufficient nurses (other reason)	No physical harm	No psychological harm
12/3/26	Surgical Services Divisional Management	Staffing/resource issue	Insufficient Nurses (due to Staff Movements)	Low physical harm	Low psychological harm
18/3/26	Ward 25	Staffing/resource issue	Insufficient Nurses (due to staff shortages/unfiled shifts)	No physical harm	No psychological harm
24/3/26	Delivery Suite (Maternity)	Staffing/resource issue	Staffing-insufficient (other)	No physical harm	No psychological harm
24/3/26	Ward 12	Staffing/resource issue	Insufficient Nurses (due to staff shortages/unfiled shifts)	No physical harm	No psychological harm
27/3/26	Ward 24	Staffing/resource issue	Insufficient Nurses (due to sickness)	No physical harm	No psychological harm

4. FIT FOR THE FUTURE

a - Governance Reports

i) Organisational Risk Register

Presented by the Interim Chief Nurse

Board of Directors Agenda Item: 4ai

Report Title:	**Organisational Risk Register (ORR)**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27th May 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 Executive Risk Management Group meeting every month, as well Risks relevant to Tier 1 and 2 Committee Business.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.*	1. Risks on the ORR were reviewed at previous ERMG meetings in April and May 2026. The following updates and movements were undertaken:			

• *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• In the period of 17th March-17th May 2026, there were 4 risks added to the ORR, 0 escalations, 0 reductions, and 3 closures. • 17 risks in total on the Organisational risk register • Summary of movements over 12-month period is shown within the attached report. • Compliance with reviews has improved in period and sits at 94% for risks and 91% for associated actions. (This is in comparison to 88% for risks and 93% for associated actions within previous 2 months data set.) 2. Formal Findings from Internal Audit report Assurance Framework and Risk Management was published and a high level of compliance with the control framework was noted, with remedial action required.
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 an improvement in risk review compliance over the 2-month period. • Be sighted on May's Top composite risks • Take assurance over the ongoing management of organisational and Strategic risk.
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

<table>
<tr><td></td><td colspan="5">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
4. We will care for our people, creating a fair, inclusive and respectful environment where everyone can thrive in their role
5. We will grow and develop our people with a focus on celebrating achievements and creating a culture of high performance and innovation
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</td></tr>
<tr><td>Links to CQC Key Lines of Enquiry (KLOE):</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks</td><td colspan="5">Included in report</td></tr>
<tr><td>Has an Equality and Quality Impact Assessment (EQIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

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), Top composite risks, as well as risks identified by the Group for inclusion as having an organisational impact and impact on delivery of strategic aims and objectives.

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

The supporting report shows the risk profile of the ORR, details of risk movements over the previous 12-month period, review compliance, and Top composite organisational risks.

This report covers the period 17th March-17th May 2026 (extraction date for this report, Via Inphase).

2. Organisational Risk Register

Movements in period

Following ERMG meetings in April and May 2026, 4 risks has been added to the ORR.
There have been 0 escalations, 0 reductions, and 3 closures.
There are currently 17 risks on the ORR, agreed by the Executive Risk Management Group as per enclosed report.

Risks added to the Organisational risk register:
4 risks have been added in period:

- **4752 (Surgery)** Risk of inability to meet cancer standards and quality of care delivery within the breast service due an evidenced capacity and demand imbalance contributed to by the service demand restrictions in place at CDDFT, and reliance upon additional sessions to provide capacity. This could result in patient harm, poor patient outcomes, a reduction in quality of care and an organisational framework assessment reduction. (16)
    - Continued performance challenges outside of 28 FDS

  - Position remains challenging to mitigate, with lack of assurance over delivery of recovery plan.

- **4885 (Finance)** There is a risk that the Trust is unable to deliver financially robust, operationally deliverable and clinically sound contracts as a result of not having a dedicated contracting function to coordinate strategy, negotiation, mobilisation and in-year contract management.
  This could lead to avoidable financial pressures, performance and quality issues, inconsistent decision-making, increased disputes with partners, reduced assurance to the Executive Committee, and compromised ability to plan and manage income and activity effectively. (16)
  - Task and finish group established to consider the purpose, scope and intended outcomes of establishing a contracting function.

- **4891 (Medical Director)** There is a risk that patients who are registered at the 9 GP Practices in Gateshead which have not agreed to the Medicines LES will have their Shared Care Agreements returned to the Trust. This is due to a lack of agreement between GP practices and the ICB leading to GP practices to revert to their standard contract regarding SCAs. Resulting in reduced concordance with medication regimes with worsening health outcomes, deterioration in our financial position, have negative impacts on our activity and ultimately lead to a deterioration in plan. (12)
  - Uncertainty around GP shared care arrangements and its potential impact on patient quality, as well as unquantified organisational impact.

- **4886 (Finance)** There is a risk that the Trust may fail to comply with the requirements of the new Failure to Prevent Fraud offence as a result of not having fully implemented the necessary organisational controls, risk assessments, staff awareness, and oversight mechanisms required to evidence reasonable prevention procedures. This could result in legal exposure, regulatory sanctions, reputational damage, financial penalties, and reduced assurance that fraud risks linked to staff, agents, subsidiaries or associated persons are being effectively mitigated. (9)
  - Self-assessment against new legislation undertaken with detailed action plan being scoped for implementation.

Risks closed:
3 Risks has been de-escalated from the ORR and closed in period:

- **4964 (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.
    - Revenue plan achieved for end of Q4 2025/26

- **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.
    - Improvement evidenced by UEC improvement programme and model of care work

- **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
    - Winter period formally concluded

3. Top Composite Organisational Risks:

The Board of Directors are asked to acknowledge that the Top composite risks remain as unchanged since the inception of the composite risk approach in January 2026.

These are:

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 our staff and ability to deliver transformation

4. Compliance with Risk reviews:

Risk review compliance in May sits at 94%. Action review compliance is 91%.

This is an improvement with compliance for Risks and a minor decline for actions since previous reporting period. (March data- 88% for risks and 93% associated actions.)

Support and training continue to be offered by Corporate and Clinical Risk Lead.

5. Audit One Audit of BAF and Risk Management

Audit one, our external audit provider, undertook their annual review of Board Assurance Framework and Risk Management in January 2026. Findings which were published in March 2026 has concluded that:

*"Governance, risk management and control arrangements provide a **good level of assurance** that the risks identified are managed effectively. A high level of compliance with the control framework was found to be taking place*."

This result is consistent with the previous 3 years.

Remedial action relating to the Board Assurance Framework is required and will be reviewed as part of Board development programme for 2026/27.

6. Recommendations

The Board of Directors are asked to:

- Review the risks and discuss and seek further information relating to risks as appropriate.
- Note the Top composite Organisational risks for May 2026, with no changes since their introduction.
- Take assurance over the development and review of the Organisational Risk Register as per risk governance framework.

Organisational Risk Report- May 2026.

Risk Sub Type	Division	Risk Id	Risk Title	Current Rating
Staff Safety	People & OD	3132	Exposure to incidents of violence and aggression	12
Wellbeing	People & OD	4797	Incivility and behaviours in the workplace	12
Resources	People & OD	4525	Risk of lack of a strategic workforce planning	9

Risk Sub Type	Division	Risk Id	Risk Title	Current 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	Digital	4704	Risk of failure to review appropriate clinical information due to multiple sources used across a variety of digital systems.	16
Safety	Medical Director's Office	4855	Resident Doctor Industrial Action (IA)	16
Safety	Nursing, Midwifery and Quality	4854	Trustwide Healthcare vacancy position	12
Experience	Surgical Services	4752	Delays to breast pathways due to reduced service capacity	16
Effectiveness	Medical Director's Office	4891	Risk that patients who are registered at the 9 GP Practices in Gateshead which have not agreed to the Medicines LES will have their Shared Care Agreements (SCA) returned to the Trust.	12

Risk Sub Type	Division	Risk Id	Risk Title	Current Rating
Business Continuity	QE Facilities	2341	There is a risk to ongoing business continuity of service provision due to ageing trust estate	16
Contracts	Finance	4885	Inability to deliver contracting services	16
Finance	Finance	4713	Risk of not delivering our sustainable future CRP on a recurring basis	16

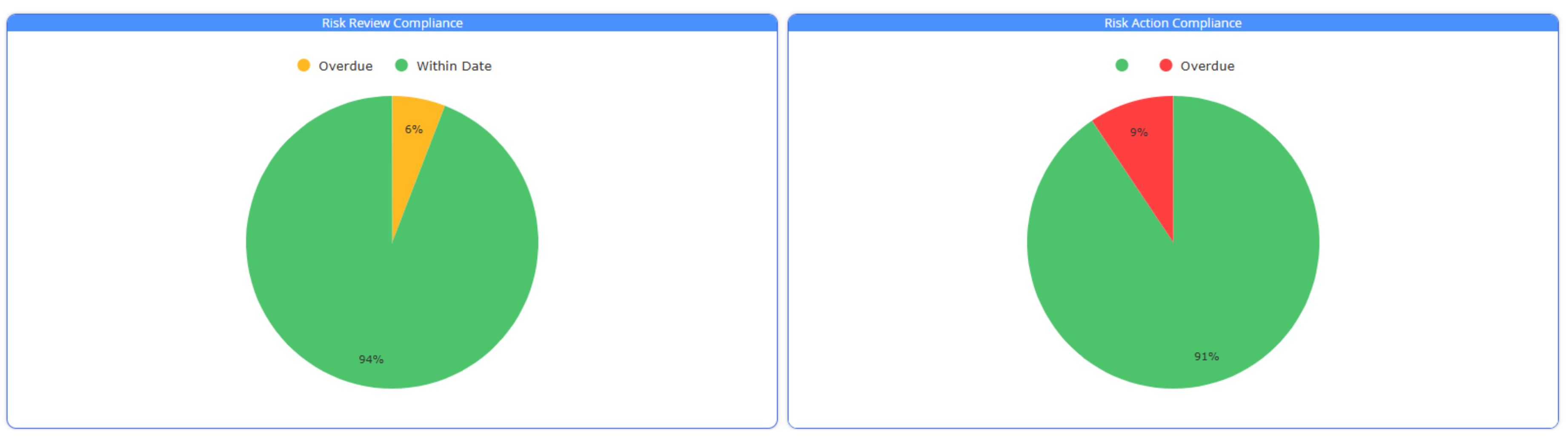
Risk Sub Type	Division	Risk Id	Risk Title	Current Rating
Compliance	QE Facilities	4839	Risk of Non-Compliance with Statutory Fire Safety Legislation	20
Compliance	Digital	4402	Inability to support legislation and best practice associated with records management	16
Compliance	Digital	4405	Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure.	8
Fraud	Finance	4886	Inability to comply with requirements of Failure to Prevent Fraud offence	9

All Organisational Risks- Movements in Scores over 12 Months. June 2025- May 2026

Changes to Current Score over 12 Months

Risk ID	Risk Stage	Risk Title	Owner	Business Unit	Service	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026
2984	Current Risk	Inability to run service from current building due to the age and condition of the maternity estate and infrastructure.	Katherine Miles	Surgical Services	Obstetrics	16	16	16	16	20	20	20	20	20	20	20	20
4839	Current Risk	Risk of Non-Compliance with Statutory Fire Safety Legislation	Genna Bulley	QE Facilities	Health & Safety							20	20	20	20	20	20
2341	Current Risk	There is a risk to ongoing business continuity of service provision due to ageing trust estate	Anthony Pratt	QE Facilities	Estates	16	16	16	16	16	16	16	16	16	16	16	16
4885	Current Risk	Inability to deliver contracting services	Kris Mackenzie	Finance	Finance											16	16
4855	Current Risk	Resident Doctor Industrial Action (IA)	Ross Peddie	Medical Director's Office	Medical Directorate									16	16	16	16
4752	Current Risk	Delays to breast pathways due to reduced service capacity	James McCourt	Surgical Services	Surgical Services - Divisional Management	16	12	12	12	12	12	16	16	16	16	16	16
4704	Current Risk	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	Current Risk	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	16
4402	Current Risk	Inability to support legislation and best practice associated with records management	Catherine Bright	Digital	Health Records	16	16	16	16	16	16	16	16	16	16	16	16
3107	Current Risk	There is a risk of delayed treatment due to maternity estate being a separate building	Katherine Miles	Surgical Services	Obstetrics	15	15	15	15	15	15	15	15	15	15	15	15
4797	Current Risk	Incivility and behaviours in the workplace	Amanda Venner	People & OD	People Services					12	9	9	9	9	12	12	12
4854	Current Risk	Trustwide Healthcare vacancy position	Laura Edgar	Nursing, Midwifery and Quality	Corporate Nursing									12	12	12	12
3132	Current Risk	Exposure to incidents of violence and aggression	Kate Clark	People & OD	People Services	16	16	16	16	16	16	16	12	12	12	12	12
4891	Current Risk	Risk that patients who are registered at the 9 GP Practices in Gateshead which have not agreed to the Medicines LES will have their Shared Care Agreements (SCA) returned to the Trust.	Carmen Howey	Medical Director's Office	Medical Directorate											12	12
4886	Current Risk	Inability to comply with requirements of Failure to Prevent Fraud offence	Kris Mackenzie	Finance	Finance											9	9
4525	Current Risk	Risk of lack of a strategic workforce planning	Claire Vesey	People & OD	Organisational Development	9	9	9	9	9	9	9	9	9	9	9	9
4405	Current Risk	Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure.	Dianne Ridsdale	Digital	Digital Transformation and Assurance	8	8	8	8	8	8	8	8	8	8	8	8

Risk review and action review compliance- May 2026



Top Composite Organisational Risks- May 2026

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 our staff and ability to deliver transformation

ii) Board Assurance Framework

Presented by the Company Secretary

Report Cover Sheet Agenda Item: 4aii

Report Title:	**Board Assurance Framework**			
Name of Meeting:	Board of Directors			
Date of Meeting:	27 May 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 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 (due to be achieved by March 2027) or reduced in score. • The People and OD Committee held a broader discussion on the BAF in May 2026 (as outlined in the narrative report). A level of concern was expressed regarding the lack of movement in summary risk scores and it was agreed that the Executive Directors would take an action to review the BAF and its strategic delivery out-with the meeting. • This view was echoed by the Quality Governance Committee. • As such the Committees have commissioned the Executive Directors and Company Secretary to undertake a full and reflective review of the BAF to			

<table>
<tr><td></td><td colspan="5">enable the Committees to exact maximum strategic benefit and assurance from this important document.
• The Board and its committees will be appraised of the discussion and any resulting changes to the way in which the BAF operates to support the control environment and reduce strategic risk.
• The BAF key is as follows:

Key | Description
[dark blue] | Not yet started
[purple] | Started and on track no risks to delivery
[amber] | Plan in place with some risks to delivery
[red] | Off track, risks to delivery and or no plan/timescales and or objective not achievable
[green] | Complete</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">To 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.</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">All – as outlined on the BAF itself.</td></tr>
<tr><td>Links to CQC Key Lines of Enquiry (KLOE):</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):</td><td colspan="5">Risks identified on the BAF</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

Board Assurance Framework – Summary from April and May 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.	1 - Clinically led 20 15 10 5 0 Nov-25 Dec-25 Feb-26 Apr-26 Jun-26 Aug-26 Oct-26 Dec-26 Feb-27 Actual Target	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. In February 2026 given the time pressures of the meeting the BAF was not reviewed in the same level of detail as usual. It was agreed it would be elevated higher on the agenda with protected time for discussion at the next meeting in April 2026. In April 2026 the Committee delegated decision-making on the BAF content to the Chair and Interim Chief Nurse and Company Secretary who met in May 2026 to review the BAF on behalf of the Committee. As a result of this discussion, it was agreed that a full reflective review of the BAF would be undertaken by the Executive Directors.

Strategic Objective	Summary risk	Risk scores	Overview
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.	2 - Patient experience	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. In February 2026 given the time pressures of the meeting the BAF was not reviewed in the same level of detail as usual. It was agreed it would be elevated higher on the agenda with protected time for discussion at the next meeting in April 2026. In April 2026 the Committee delegated decision-making on the BAF content to the Chair and Interim Chief Nurse and Company Secretary who met in May 2026 to review the BAF on behalf of the Committee. As a result of this discussion, it was agreed that a full reflective review of the BAF would be undertaken by the Executive Directors.
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	3 - Cont. Improvement (Patient Safety)	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

Strategic Objective	Summary risk	Risk scores	Overview
	credibility and reputation as an innovative and quality-driven organisation.	3 - Cont. Improvement (Research and Innovation) 18 16 14 12 10 8 6 4 2 0 Nov-25 Dec-25 Feb-26 Apr-26 Jun-26 Aug-26 Oct-26 Dec-26 Feb-27 Actual Target	safety element of the risk and 16 for the research and innovation element of the risk. In February 2026 given the time pressures of the meeting the BAF was not reviewed in the same level of detail as usual. It was agreed it would be elevated higher on the agenda with protected time for discussion at the next meeting in April 2026. In April 2026 the Committee delegated decision-making on the BAF content to the Chair and Interim Chief Nurse and Company Secretary who met in May 2026 to review the BAF on behalf of the Committee. As a result of this discussion, it was agreed that a full reflective review of the BAF would be undertaken by the Executive Directors.
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.	4 - Culture 20 15 10 5 0 Sep-25 Nov-25 Jan-26 Mar-26 May-26 Jul-26 Sep-26 Nov-26 Jan-26 Mar-26 Actual Target	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

Strategic Objective	Summary risk	Risk scores	Overview
			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. At the meeting in March 2026 the Committee reflected the gaps around the apprenticeship levy usage (noting a report would be presented at the next meeting) as well as the need to reflect the introduction of the STAR Shoutout Board. The Committee agreed to retain the current risk score of 12. At the meeting in May 2026 the Committee undertook a broader reflection on the BAF and whether this was driving improvements in controls and assurances given the lack of movement in the scores. The discussion covered the level of depth of the BAF and whether it might be pertinent to focus on fewer but more specific areas in order to drive reduction in risk scores. It also touched on the level 2 and 3 assurances and whether there were more assurances to capture on the document. It was agreed that the Executive Team would review the BAF concept outwith the meeting in order to ensure that it was being used as a tool to support the reduction in strategic risks.

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.	5 - Developing our People 14 12 10 8 6 4 2 0 Sep-25 Nov-25 Jan-26 Mar-26 May-26 Jul-26 Sep-26 Nov-26 Jan-26 Mar-26 Actual Target	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. At the meeting in March 2026 the Committee reflected the gaps around the apprenticeship levy usage (noting a report would be presented at the next meeting) as well as the need to reflect the introduction of the STAR Shoutout Board. The Committee agreed to retain the current risk score of 12. In May 2026 the Committee engaged in a broader discussion on the concept and usage of the BAF – see the overview under 4) for more detail.
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	6 - Employer of choice 14 12 10 8 6 4 2 0 Sep-25 Nov-25 Jan-26 Mar-26 May-26 Jul-26 Sep-26 Nov-26 Jan-26 Mar-26 Actual Target	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 improvements for wider cohorts of colleagues. Additional assurances were noted regarding the Guardian of

Strategic Objective	Summary risk	Risk scores	Overview
	impact on patient outcomes.		Safe Working exception report and GMC (General Medical Council) survey. It was agreed to retain the current score of 12. At the meeting in March 2026 the Committee noted the gap in control relating to HCA Band 2 to 3 progression. It was also noted that whilst the reporting of payroll errors for resident doctors had been noted as a gap in assurance this was based on national reports rather than local circumstances. The Committee reflected that it was therefore not an issue at Gateshead and not a gap that needed to be address on the BAF. The important role of the Trust as an anchor institute for local employment was noted as a control. It was agreed to retain the current score of 12. In May 2026 the Committee engaged in a broader discussion on the concept and usage of the BAF – see the overview under 4) for more detail.
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	7 - Health Inequalities 14 12 10 8 6 4 2 0 Nov-25 Dec-25 Feb-26 Apr-26 Jun-26 Aug-26 Oct-26 Dec-26 Feb-27 Actual Target	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. In February 2026 given the time pressures of the meeting the BAF was not reviewed in the same level of detail as usual. It was agreed it would be elevated higher on the agenda with protected time for discussion at the next meeting in April 2026. In April 2026 the Committee delegated decision-making on the BAF content to the Chair and Interim Chief Nurse and Company

Strategic Objective	Summary risk	Risk scores	Overview
	poor patient outcomes and an inability to deliver against the NHS 10 Year Plan sickness to prevention shifts		Secretary who met in May 2026 to review the BAF on behalf of the Committee. As a result of this discussion, it was agreed that a full reflective review of the BAF would be undertaken by the Executive Directors.
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	8 - Neighbourhoods 18 16 14 12 10 8 6 4 2 0 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26 Apr-26 Actual Target	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. At the January 2026 meeting the Committee discussed the Community Diagnostic Centre business case and noted that in time this would further support the provision of neighbourhood health. The Committee concluded that whilst this should be

Strategic Objective	Summary risk	Risk scores	Overview
			reflected on the BAF it was too early to reduce the score, and therefore the current score of 16 was retained. In February 2026 the Committee held a shortened meeting and therefore the BAF was not discussed in detail, but the Committee assured that a detailed review would take place in March 2026. At the March 2026 meeting the Committee approved the proposed changes and the actions recommended for closure (relating to the governance of neighbourhood at place). It was agreed to retain the current score of 16. At the April 2026 meeting the Committee noted that discussions were underway on the possible configuration of neighbourhoods with some potential streamlining of service models. As this is in the early stages it was agreed to retain the current score of 16.
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	9 - Collaboration - Place risk 18 16 14 12 10 8 6 4 2 0 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26 Apr-26 Actual Target	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.

Strategic Objective	Summary risk	Risk scores	Overview
	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	9 - Collaboration - Place risk 18 16 14 12 10 8 6 4 2 0 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26 Apr-26 Actual Target	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. At the December 2025 meeting the BAF was reviewed and no changes proposed to the score. At the January 2026 meeting it was noted that the CEO, Medical Director of Strategic Relations and Director of Strategy and Partnerships are meeting with the CEO of Gateshead Council to discuss place-based leadership arrangements. In time this could support a reduction in the score, but at present the Committee felt the current scores of 16 for the risks should be retained. In February 2026 the Committee held a shortened meeting and therefore the BAF was not discussed in detail, but the Committee assured that a detailed review would take place in March 2026. At the March 2026 meeting the Committee approved the proposed changes and the actions recommended for closure (relating to the Alliance Strategic Intent and place-based governance structures). It was agreed to retain the current score of 16. At the April 2026 meeting the Committee was assured that agreements had been made in respect of firming up the model

Strategic Objective	Summary risk	Risk scores	Overview
			for place-based governance. A discussion was held as to whether this was sufficient to enable the Committee to consider a reduction to the current risk score. On balance it was felt that further clarity was required in relation to strategic commissioning at place and neighbourhood level and the risk score of 16 was therefore retained.
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.	10 - Finance 25 20 15 10 5 0 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26 Apr-26 Actual Target	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. At the time of the January 2026 meeting work was still being progressed to develop the next iteration of the medium term plan. At this point it was not clear whether the Board-approved plan would be compliant with the requirements set and therefore there were no proposed changes to the current risk score of 20. Members also reflected that whilst the in-year position was delivering against plan there remained a challenging underlying position. In February 2026 the Committee held a shortened meeting and therefore the BAF was not discussed in detail, but the Committee assured that a detailed review would take place in March 2026. At the March 2026 meeting the Committee approved the proposed changes and the actions recommended for closure (recruitment to the finance team and the development of divisional CRP plans). It was agreed to retain the current score of 20 to reflect the continued challenges in respect of the underlying deficit. In April 26 the Committee acknowledged the progress made and the improvement in the underlying position. Given however that the underlying deficit remained significant the Committee agreed to retain the score of 20.

Strategic Objective	Summary risk	Risk scores	Overview
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.	11 - Digital 25 20 15 10 5 0 Sep-25 Nov-25 Jan-26 Mar-26 May-26 Jul-26 Sep-26 Nov-26 Jan-27 Mar-27 Actual Target	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. In March 2026 the Committee recognised the progress made in a number of areas which supported the closure of gaps in controls and assurance relating to the Committee structure, the Digital Delivery Plan and the agreement of the future direction of travel for digital records. Progress was also noted in respect of the plans in place to train 20 CSOs and introduce new KPI reporting into the Committee (which should assist in closing remaining gaps in assurance relating to SIRO and Information Governance KPIs). It was agreed that a further review of the

Strategic Objective	Summary risk	Risk scores	Overview
			BAF content ahead of the next meeting would be helpful. The Committee agreed to retain the current score of 20. In May 2026 the Committee acknowledged the addition of controls and assurances on the BAF, providing a good evolving picture. It was felt that the key issue in delivering the objective (which would benefit from being disaggregated into smaller component objectives to support overall delivery) is the ability to develop an achievable and costed plan. This would be critical for the delivery of each step towards overall objective achievement. The Committee identified the lack of costed plans to be an issue in respect of the Digital Records Programme and the data plan, alongside resourcing pressures. On this basis it was agreed to retain the current score of 20.
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		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.

Strategic Objective	Summary risk	Risk scores	Overview
	sustainability commitments.		At the January 2026 meeting members noted that the BAF should be updated to reflect the fire safety risk identified and the work undertaken in relation to the capital programme. No changes were proposed to the current score. In February 2026 the Committee held a shortened meeting and therefore the BAF was not discussed in detail, but the Committee assured that a detailed review would take place in March 2026. At the March 2026 meeting there were no specific updates to note, but the Committee agreed to retain the current score of 20. At the April 2026 meeting the Committee agreed to retain the score of 20. It was noted that improvements to the estate would have a longer term impact of driving up efficiencies and therefore interlinks with the finance risk on the BAF.

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:	Apr-26
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.	1 - Clinically led

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 - Risk of not delivering our sustainable 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.~~ Risk now closed as plan delivered and target risk achieved ~~4768 - Risk of demand overwhelming capacity over the 25-26 Winter period (16).~~ Risk closed - winter plan formally concluded. 4525 - Risk of Lack of a strategic workforce planning (9) 2341 - There is a risk to ongoing business continuity of service provision due to ageing trust estate (16)
	Composite risk - Financial Sustainability - Risk of inability to invest in staff and clinical services, including supporting financial collaboration with partners. 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 Composite risk - Estates - Risk to sustainability of core infrastructure and to invest in clinical advances and the working environment for our staff 4752 - Delays to breast pathways due to reduced service capacity (16) 4891 - Risk that patients who are registered at the 9 GP Practices in Gateshead which have not agreed to the Medicines LES will have their Shared Care Agreements (SCA) returned to the Trust (12)

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	April 26 - revisions have been made to the governance structure with new ToR in place for Executive Committee, Clinical Strategy Group, Operational Oversight Group and the new divisional performance meeting. This provides greater clarity on clinical leadership and decision-making in the Trust. **Action agreed as closed.**	

Assurance (Level 1: Operational Oversight)		Gaps in assurance and corrective action (all levels)	Owner	Timescale	Update	Action status
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	~~01/03/2026~~ May 2026	April 26 - in the process of creating a register of clinical leaders / influencers to be drawn from to inform clinical decision-making / clinical strategy work. **Proposal to extend timescale for completion to May 2026.**	
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	~~01/03/2026~~ September 2026	April 26 - governance refresh underway. Tier 2 ToR have been refreshed but further work to be undertaken to operationalise the clinical input and attendance and ensure that this is working effectively. **Revised timescale proposed as September 2026**	
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	~~01/03/2026~~ December 2026	April 26 - new performance meetings being launched. Once embedded this will support a review of divisional leadership. It also links to the appointment of a substantive CEO to support identification of next steps from a strategic leadership perspective. **Revised timescale proposed as December 2026**	
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	~~01/03/2026~~ June 2026	April 26 - EQIA process has been reviewed. A new screening tool has been developed and a dedicated weekly meeting will occur to review EQIAs associated with clinical change (CN and MD are core members). Policy to flow through formal review and approval process. **Proposed revised date June 2026**	
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	~~01/03/2026~~ June 2026	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. April 26 - Nursing Midwifery and AHP Professional Forum developed and launching in May. Included in revised meeting structure. **Proposed revised date of June 2026**	
Leading Forward Programme in place		No bespoke leadership programme in place for senior nursing staff. Action - delivery of Dare to Lead Programme planned for senior nursing, midwifery and AHP staff. This will complement Leading Forward	CN	Jun-26		
Revised terms of reference in place for Executive Committee, Clinical Strategy Group and Operational Oversight Group						

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	~~01/02/2026~~ August 2026	April 26 - EQIA statistics and overview to be included in Chief Nurse report to QGC from Quarter 1 onwards. This will include an overview of the EQIAs reviewed and the conclusion reached. **Proposed revised date of August 2026**	
Evidence of triumvirate decision-making within divisional governance reporting		Incorporate attendance matrix to all Tier 2 meetings. This can then be monitored and audited. Plan to review Tier 2 effectiveness and include a review of attendance and quoracy (as per the Tier 1 reviews)	COO/ MD/ CN	~~01/03/2026~~ March 2027	**Proposal to realign the reviews of effectiveness to the year end - March 2027**	
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	~~01/03/2026~~ June 2026	April 26 - Nursing Midwifery and AHP Professional Forum developed and launching in May. Included in revised meeting structure. This will link to Clinical Strategy Group with a dotted line to Executive Committee. Clinical Strategy Group has also been reviewed and new structure about to launch with reporting line to Executive Committee. **Proposed revised date of June 2026**	
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	~~01/03/2026~~ June 2026	April 26 - Board development session planned to be delivered by CQC - this will inform the next steps and determine the scale and timeframes for the review. **Proposed update to be provided in June 2026**	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)		Identified areas for strengthening from the Aubrey self-assessment. Action - develop a plan to address identified areas	CN	Apr-26	April 26 - action plan developed and shared with Board for assurance in March. Actions will flow through Board committees. **Action agreed as closed.**	
OOG & CSG 3A reporting to Executive Committee						
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						
POD Committee oversight of leadership development, workforce sustainability and succession planning						
Self-assessment undertaken against Aubrey report and submitted to the ICB						
Aubrey action plan developed and reviewed at Board						
Assurance (Level 3 – external)						

JAG reaccreditation confirmed						
CQC Nuclear Medicine inspection report						

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:	Apr-26
Summary risk	
There is a risk that patients do not have the best possible experience due to a number of potential contributory factors. This would lead to patient dissatisfaction, poor reputation and poor staff morale.	2 - Patient experience (chart: y-axis 0–14; x-axis Nov-25, Dec-25, Feb-26, Apr-26, Jun-26, Aug-26, Oct-26, Dec-26, Feb-27; legend: Actual, Target)

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

Links to risks on 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)

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

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

~~4734 - Risk of patient harm due to variability in meeting 4 hour ED Emergency Care standard (12).~~ Risk closed -improvement evidenced by UEC improvement programme and model of care work

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).~~ Risk closed - winter plan formally concluded.

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

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

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

4854 - Trustwide healthcare assistant vacancy position (12)

4752 - Delays to breast pathways due to reduced service capacity (16)

Controls		Gap in controls and corrective action	Owner	Timescale	Update	Action status

PSIRF policy and plan in place (note it is out of date - see associated action)		EQIA clinical oversight inconsistent and not evidenced. Action -Review EQIA process; implement divisional clinical sign-off; establish EQIA assurance reporting to QGC.	MD/CN	~~01/03/2026~~ August 2026	April 26 - EQIA statistics and overview to be included in Chief Nurse report to QGC from Quarter 1 onwards. This will include an overview of the EQIAs reviewed and the conclusion reached. **Proposed revised date of August 2026**	
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	~~01/03/2026~~ June 2026	April 26 - to commence from May 2026. The group will agree and deliver a mental health, autism and LD strategy. MH reporting into Safecare has already been strengthened. **Proposed new date of June 2026**	
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	April 26 - CN has reviewed current approach and recommends moving to quality priorities, PSIRF workstream and clinical assurance processes rather than a separate Quality Improvement Plan. **Action therefore recommended to close given change in approach.**	
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	~~01/03/2026~~ June 2026	April 26 - ILOM introduced and Executive Oversight Meeting about to launch. Reviewing potential opportunities for investment in Inphase audit module to support triangulation. **Proposed date change to June 2026**	
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	~~01/03/2026~~ June 2026	April 26 - terms of reference reviewed. Further work underway to ensure appropriate flow of patient stories through the governance structure to inform Board patient story agenda item. **Proposed date change to June 2026**	
Cancer Lead Nurse in post		PSIRF plan out of date Action 1 - update the plan and developed workstreams Action 2 - closer alignment quality priorities for 2027/28 onwards against the PSIRF plan	CN	Action 1 - 01/09/2026 Action 2 - June 2027	April 26 - group being convened to review and agree new PSIRF plan and associated workstreams for 2026 - 2028.	
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	Dec 25 - Committee closed the related action on the action log and concluded that report has been updated and shared. Ongoing monitoring of actions and movement to business as usual with monitoring via division Safecare with escalation to Safecare and QGC. **Action agreed for closure**	
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 (note this will now report to Safecare)	Chief Nurse	01/06/2026	April 26 - to commence from May 2026. The group will agree and deliver a mental health, autism and LD strategy. MH reporting into Safecare has already been strengthened. Proposed new date of June 2026 - agreed.	
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	01/03/2026 June 2026	April 26 - terms of reference reviewed. Further work underway to ensure appropriate flow of patient stories through the governance structure to inform Board patient story agenda item. **Proposed date change to June 2026**	
Mental health report to Safecare		Feedback from Board walkabouts no longer being formally documented and therefore no reported to Board. Action - review process and reporting	Chief Nurse	01/03/2026 July 2026	April 2026 - Revised Board walkabout process in place with the aim for the Board to engage with both staff and patients. New reporting form under development to capture feedback in real time. This will then link to the CEO report at Board. **Proposed new date July 2026**	
New Safety Huddle meeting every two months to share learning across the organisation						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Patient experience metrics reported to Quality Governance Committee						
Mental health report to Quality Governance Committee						
Patient experience metrics reported to the Board as part of the performance report						
Safecare Steering Group reports to Executive Committee 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 Executive Committee						
Walkabout Wednesdays in place provide protected time for the Board to visit services and speak with patients and colleagues						
SSI action plan reviewed by Quality Governance Committee						
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:	Apr-26
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.	3 - Cont. Improvement (Patient Safety) 3 - Cont. Improvement (Research and Innovation)

	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 - Risk of not delivering our sustainable 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.~~ Risk now closed as plan delivered and target risk achieved

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

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

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

4752 - Delays to breast pathways due to reduced service capacity (16)

Controls		Gap in controls and corrective action	Owner	Timescale	Update	Action status
EQIA process in place for all policies and major service changes		EQIA clinical oversight inconsistent and not evidenced. Action -Review EQIA process; implement divisional clinical sign-off; establish EQIA assurance reporting to QGC.	MD/CN	~~01/03/2026~~ August 2026	April 26 - EQIA statistics and overview to be included in Chief Nurse report to QGC from Quarter 1 onwards. This will include an overview of the EQIAs reviewed and the conclusion reached. **Proposed revised date of August 2026**	
Innovation Manager is a dedicated post in the Trust						
New learning forum in place						
Research and innovation 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	ToR of Research and Innovation Group to be reviewed and to report to Strategy and Partnerships Group in governance refresh. To be supported through Internal Audit of Research and Innovation governance.	MD	01/09/2026	ToR of R&I Group drafted and shared with MD April 2026.	
Research and Development tier 3 meeting reporting to CSG					
ILOM meeting in place to identify and share learning					
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 Quality Governance Committee 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					
RRDN visit 01/04/2026					

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:	May-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 (12)

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

4797 - Incivility and behaviours in the workplace (12)

Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Health and wellbeing offer in place	FTSU Guardian temporarily absent - recruitment of an interim Guardian underway	Executive Director of POD	Sep-25	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	March 26 - identified by the Committee as an emerging concern given sustained level of incidents. Work ongoing to enhance support and visibility of actions and controls. Future update to come to PODC. Propose to close	

New prevention of violence at work policy developed		To develop an action plan to address the emerging findings of the staff survey, including a specific focus on supporting colleagues with protected characteristics	Executive Director of POD	Mar-26	March 26 - update report provided to the Committee outlining an analysis of the free text comments and the next steps in relation to key areas of focus. Committee agreed that a further assurance report be presented in six months time. **April 26 - based on above action recommended for closure (with the six month report noted below as an action for assurance)**	
Staff networks in place						
EQIA process in place for all policies and major service changes						
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		Multi-year plan needed to support addressing the gender pay gap report findings. Plan to be developed and presented to the Committee in 6 months time.	Executive Director of POD	Sep-26		
Staff survey action plans in place		Committee requires strategic overview of employee relations activity. Agreed that a report will be considered and an update provided at a future Committee meeting	Executive Director of POD	Sep-26		
Positive reduction noted in long term sickness absence data.		Ongoing assurance required over implementation of staff survey action plan. Committee agreed to receive a further update in six months time	Executive Director of POD	Sep-26		

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						
Trust and QEF gender pay gap reports received						
GMC Survey Action Plan reported to the POD Committee - full assurance provided						
EDI reporting to POD Committee including progress against the EDI strategy						
Trust and QEF gender pay gap reports published						
Group Ethnicity Pay gap report received						
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:	May-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 - Risk of not delivering our sustainable 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~~. Risk now closed as plan delivered and target risk achieved

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

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

4797 - Incivility and behaviours in the workplace (12)

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 with a more proactive and strategic and proactive approach needed.	Head of Staff Experience	Jan-26	March 26 - more detailed paper to be presented to the May 2026 Committee on the actions taken re: apprenticeships. Action complete	
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	Driven by national publication	April 2026 - NHS 10 Year Workforce Plan publication still awaited	
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					
STAR Shoutout Board launched on the intranet					
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 March 26 - more detailed paper to be presented to the May 2026 Committee on the actions taken re: the Apprenticeship Levy. The paper to include a focus on HCA recruitment / development	
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:	May-26
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.	6 - Employer of choice (chart: Actual, Target; Sep-25 to Mar-26)

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 - Risk of not delivering our sustainable 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.~~ Risk now closed as plan delivered and target risk achieved

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

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	May 26 - session developed for induction and shared with Medical Education, awaiting confirmation from Medical Education as to if this has been incorporated into the resident doctor induction.	
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~~ Associate Director of Medical Staffing?	Mar-26	May 26 - discussions ongoing within the medical directorate regarding blood transfusion for resident doctors. This is not logged within ESR and not a core competency	
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.		Continued challenges in HCA vacancy rate. An apprenticeship development programme is being scoped to provide opportunities to fill the vacancies and support career development. Update report due at May Committee	Executive Director of People and OD	May-26		
Appointment of the Senior Lead for Resident Doctor Experience and appointment of the Resident Doctor Peer Lead for resident doctor experience.						
Trust takes a leading role as an Anchor Institution with regards to employment in the local area and apprenticeships						
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						
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						
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 survey results reviewed by POD Committee for assurance						

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
Board Committee Oversight:	Quality Governance Committee
Date of Last Review:	Apr-26
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

7 - Health Inequalities

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 - Risk of not delivering our sustainable 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.~~ Risk now closed as plan delivered and target risk achieved

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

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

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

4891 - Risk that patients who are registered at the 9 GP Practices in Gateshead which have not agreed to the Medicines LES will have their Shared Care Agreements (SCA) returned to the Trust (12)

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	March 26 - SLM and Information Team working with Public Health trainee from local authority work plan being developed with aim to reduce HI to reduce DNAs in T&O service. **Action recommended for closure**	
Public Health engagement and involvement in health inequalities within the Trust	Health Inequalities Ambassadors not yet in place	MD	~~01/03/2026~~ June 2026	Work been undertaken to develop intranet page - to be launched in April and this will be key to engagement and the recruitment of the Ambassadors. **Proposed new date June 26**	

Health inequalities workplan in place		Lack of visibility of health inequalities through Trust comms channels	MD	~~01/03/2026~~ May 2026	Work been undertaken to develop intranet page - to be launched in April and this will be key to engagement and the recruitment of the Ambassadors. **Proposed new date May 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 HI	MD & CN	~~01/03/2026~~ May 2026	HI now considered as part of EQIA - policy to be updated in April 26. **Recommend update to date of May 26**	
Key priorities identified following a review by the Specialty Registrar in Public Health Medicine		Health inequalities group reporting line to be adjusted to new Strategy and Partnerships Group	MD	~~01/04/2026~~ June 2026	**April 26 - propose to update date June 26 to allow time for the Strategy and Partnerships Group to be launched**	
Significant engagement at Place including the CEO chairing the Gateshead Place Committee		Work plans to support the Health and Wellbeing Strategy not yet developed	MD	May-26		
Engagement in the Community Promise at Alliance level		Place committee governance structure currently under review. Proposal to H&WB Board in March with immediate implementation to follow	MD	Apr-26	Agreed that CEO will be co-chair of Gateshead H&WB sub-group	
Practitioners recruited into the HIVE programme to address health inequalities in the lung cancer pathway		Head of Programme Lead for Health Inequalities at ICB post has been disestablished. New relationship to be established with ICB Director of Population Health	MD	Jun-26		
HI now considered as part of EQIA considerations						
Health and Wellbeing Manager engaged in HI Group re impact of HI on staff						
New Health and Wellbeing Strategy in place						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
Health Inequalities reporting to Strategy and Partnerships group		Lack of dedicated reporting on Place and collaboration at Board committee level - to include health inequalities	MD	Jun-26		
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Strategy and Partnerships Group to report to QGC						

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
Board Committee Oversight:	Finance and Performance Committee
Date of Last Review:	Apr-26
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	8 - Neighbourhoods (chart: Actual, Target; Sep-25 to Apr-26)

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.~~ Risk now closed as plan delivered and target risk achieved

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

4891 - Risk that patients who are registered at the 9 GP Practices in Gateshead which have not agreed to the Medicines LES will have their Shared Care Agreements (SCA) returned to the Trust (12)

Controls		Gap in controls and corrective action	Owner	Timescale	Update	Action status
Medical Director 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	NHSE publication date	National guidance documents awaited. In the meantime contributing to the development of the Gateshead neighbourhood plan for the deadline of April 2026. Note date adjusted to *NHSE publication date*, as the timescale is not within our control April 26 - Neighbourhood health document now published and under review by the Director of Strategy and Partnerships	
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 / MD / Director Strategy and Partnerships	Mar-26	There is now clarity around future structures - transition plan to be determined. Action recommended for closure March - action agreed as closed	

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 / MD / Director Strategy and Partnerships	~~01/03/2026~~ June 26	Note this is intrinsically linked to the H&WB Board structures and workplans which are in development. Recommend to adjust timescale to enable assessment to be made as the new structures are launched and embedded March - Committee approved revised timescale of June	
Community Diagnostic Centre expansion provides greater scope for neighbourhood health provision	New place-based structures not yet implemented. Action - transition to the new structures in collaboration with place partners.	CEO / MD / Director Strategy and Partnerships	Jun-26	April 26 - discussions taking place regarding possible configuration of neighbourhoods at place level.	
Neighbourhood Health Framework published by NHSE					
CEO and local authority CEO to co-chair the Health and Wellbeing Board Integrated Neighbourhood Sub-Group					
Governance structure now established at place-level					

Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
Neighbourhood work to flow through new Strategy and Partnerships Group	Workplans in their infancy against draft health and wellbeing strategy for Gateshead.	Medical Director / Director of Strategy	Apr-26	Prioritisation work has taken place - frailty and respiratory. Women's health and child and adolescent work to also remain priorities. Note that these are shared priorities for Gateshead	
	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 / Director Strategy and Partnerships	Mar-26	Agreement that this will flow through the Strategy and Partnerships Group. Action recommended for closure March 26 - Committee approved closure of action.	

Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Board approval of Community Diagnostic Centre business case					
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
Board Committee Oversight:	Finance and Performance Committee
Date of Last Review:	Apr-26
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

9 - Collaboration - Place risk

Sep-25, Oct-25, Nov-25, Dec-25, Jan-26, Feb-26, Mar-26, Apr-26 — Actual, Target

9 - Collaboration - Wider System risk

Sep-25, Oct-25, Nov-25, Dec-25, Jan-26, Feb-26, Mar-26, Apr-26 — Actual, Target

	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.~~ Risk now closed as plan delivered and target risk achieved

~~4734 - Risk of patient harm due to variability in meeting 4 hour ED Emergency Care standard (12).~~ Risk deescalated from the ORR

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

4891 - Risk that patients who are registered at the 9 GP Practices in Gateshead which have not agreed to the Medicines LES will have their Shared Care Agreements (SCA) returned to the Trust (12)

Controls		**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Appropriate director level attendance at Gateshead Overview and Scrutiny and Health and Wellbeing Boards		Work is underway to align constitutions around Chair provisions	Company Secretary	Jan-26	Sept 25 - collaborative working with NUTH and NHCT supported with legal advice. Feb 26 - GHFT element of the review complete but awaiting completion by all Alliance partners before taking through Trust governance.	

Collaborative approach to capital in place with Alliance and Provider Collaborative partners		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. Feb 26 - this was approved at the Alliance meetings in Feb 26 and will flow through to the next Board as part of the Alliance Strategic Intent document. Action recommended for closure as work completed. March 26 - action agreed as closed	
CEO, Medical Director of Strategic Relations and Director of Strategy and Partnerships meeting with the CEO of Gateshead Council to discuss place-based leadership arrangements		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 Medical Director	Mar-26	There is now clarity around future structures - transition plan to be determined. Action recommended for closure March - action agreed as closed	
Direct engagement with GPs and PCNs through PCN Lead meetings		Place committee governance structure currently under review. Proposal to H&WB Board in March with immediate implementation to follow	MD	Apr-26	April 26 - place-based governance structures now in place via the Health and Wellbeing Board. Action agreed as closed	
Systems approach taken to winter planning						
Strong representation at the Alliance for GHFT - Committee in Common, Joint Committee, Alliance Formation Team						
Weekly meetings of Alliance CEOs						
Shared Chair in place from 1/10/25						
Governor events held across the Alliance						
Alliance risk management framework in place						
Governor engagement across the Alliance through Lead Governors						
Jointly funded Quality Assurance Manager role in place with NUTH to support larger scale collaborative research and commercial opportunities						
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						
Chief Digital Officer in place across the Alliance						
Engagement in the Alliance Construction Programme with market engagement undertaken						
Second Alliance Governor event held 24 October						
East Coast MD events taken place to consider medical clinical priorities across the Alliance						
Alliance Clinical Framework Reference Group in development						
Collaborative working re: the medium term financial plan across the Alliance						
Governance structure now established at place-level						
CEO and local authority CEO to co-chair the Health and Wellbeing Board Integrated Neighbourhood Sub-Group						
Alliance Strategic Intent developed to set future direction - approved at Board						
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 Forum & Executive Committee		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 / Co Sec	Mar-26	Agreement that this will flow through the Strategy and Partnerships Group. Action recommended for closure March 26 - Committee approved closure of action.	
Neighbourhood work to flow through new Strategy and Partnerships Group		Alliance Strategic Intent document not yet formally reviewed by the Board - to be presented at the March Board meeting	CEO / MD / Co Sec	Mar-26	On agenda for the Board in March - action recommended for closure March 26 - Committee approved closure of action.	
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						
Board approval of Community Diagnostic Centre business case						
MMC reporting to Board - decision-making, risk sharing, finance						
Alliance Strategic Intent document developed and reviewed by the Alliance Steering Group - approved at March Board						
Assurance (Level 3 – external)						

FIT FOR THE FUTURE

Strategic objective:	10) We will ensure effective and efficient use of our resources identifying opportunities to improve productivity and ensure best use of public money
Executive Owner:	Group Director of Finance / Chief Operating Officer
Board Committee Oversight:	Finance and Performance Committee
Date of Last Review:	Apr-26
Summary risk	

Summary risk	10 - Finance	CURRENT RISK SCORE			TARGET RISK SCORE		
		Likelihood	Impact	Score	Likelihood	Impact	Score
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.		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.~~ Risk now closed as plan delivered and target risk achieved
4704 - Risk of failure to review appropriate clinical information due to multiple sources of data stored across a variety of digital systems (16)
COMPOSITE RISK - Financial Sustainability - Risk of inability to invest in staff and clinical services, including supporting financial collaboration with partners.
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)

4891 - Risk that patients who are registered at the 9 GP Practices in Gateshead which have not agreed to the Medicines LES will have their Shared Care Agreements (SCA) returned to the Trust (12)
4854 - Trustwide Healthcare vacancy position (12)

4752 - Delays to breast pathways due to reduced service capacity (16)

4855 - Resident Doctor Industrial Action (IA) (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 Feb 26 - plan submitted - action recommended for closure March 26 - Committee approved closure	
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. March 26 - Committee approved closure of the action following successful recruitment to the team	

Corporate Governance Manual updated and ratified at the March 2026 Board		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 March 26 - Committee approved 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 26-27						
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						
Additional capital secured to be spent by 31 March 2026 - governance process in place to oversee delivery						
Governance for 26-27 CRP agreed at Executive Committee - enhanced controls in place						
Divisional CRP plans in development						
Key vacancies filled within finance team						
Medium term financial plan in place						
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**
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		Detail of higher risk CRP schemes to be presented to F&P / Board	DoF	~~01/03/2026~~ June 2026	Note also included within draft Board development plan with an indicative date of June 2026 for presentation **April 26 - proposal to update the timescale to June to align with Board development**	
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 workshops during the year						
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						
Board approved additional capital funding 25/26 and spending schemes - with delegated authority agreed to support delivery in timescales						
Board approved final submission of a compliant medium term financial plan - Feb 26						
Achievement of financial plan for 25/26 reported to F&P Committee (subject to audit)						
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 and Group Director of Finance
Board Committee Oversight:	Digital Committee
Date of Last Review:	May-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.

11 - Digital

25 20 15 10 5 0

Sep-25 Nov-25 Jan-26 Mar-26 May-26 Jul-26 Sep-26 Nov-26 Jan-27 Mar-27

Actual Target

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 (16)

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

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

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

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 March 26 - terms of referenced reviewed and approved at the Jan meeting. Action recommended for closure. March 26 - action agreed as closed.	
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 March 26 - confirmed SIRO training has been delivered and action agreed as closed	

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 March 26 - Committee agreed to leave this action open and revisit at the next meeting May 26 - continues to be no costed plan for the Digital Records Programme. Funding is the key issue - a need to identify the collective actions needed to build an achievable and costed plan for the digital plan delivery	
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 March 26 - update included on March Committee agenda. March 26 - Committee agreed to close this action as a direction of travel has been agreed. Progress to be tracked as a delivery project	
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	March 26 - Committee confirmed progress has been made with plans in place to train 20 CSOs, which is in line with the aspiration of having in place 20 CSOs. Agreed to keep the action open until the capacity is realised (i.e. the training is complete).	
Digital strategic plan in place						
Digital Committee terms of reference reviewed and revised to ensure appropriate governance in place						
SIRO training delivered						
Direction of travel for digital records programme agreed and approved						
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 March 26 - Committee agreed to close this action as a direction of travel has been agreed. Progress to be tracked as a delivery project	
		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~~ May 2026	March 26 - The Committee agreed that an update on enhanced assurance reporting to be provided at the next meeting.	
		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 March 26 - Committee agreed that there would be a cross-check between the new KPI report and key metrics for SIRO and IG to check for completeness and identify any omissions	
		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)		Gap in assurance in relation to the existence of an achievable and costed plan to support delivery of the overall digital objective	Chief Digital Officer	Jul-26		
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						
Regular assurance updates to Committee on the digital records programme delivery now that direction of travel is agreed						
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, Badgernet - Reasonable Assurance						

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:	Apr-26
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.

12 - Estates

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.~~ Risk now closed as plan delivered and target risk achieved

4839 - Risk of non-compliance with statutory fire safety legislation (20)

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

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 ratified at the March 2026 Board	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 Feb 26 - elements of the survey commissioned for completion before 31 March 2026 with the additional funding secured	
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					
Capital plan in place					
Additional capital secured to be spent by 31 March 2026 - governance process in place to oversee delivery					
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					
Board approved additional capital funding 25/26 and spending schemes - with delegated authority agreed to support delivery in timescales					

Assurance (Level 3 – external)						

b - Finance Report

Presented by the Group Director of Finance

Report Cover Sheet   Agenda Item: 4b

<table>
<tr><td>Report Title:</td><td colspan="4">Consolidated Finance Report</td></tr>
<tr><td>Name of Meeting:</td><td colspan="4">Board of Directors</td></tr>
<tr><td>Date of Meeting:</td><td colspan="4">27th May 2026</td></tr>
<tr><td>Author:</td><td colspan="4">Ms Jane Fay, Deputy Director of Finance</td></tr>
<tr><td>Executive Sponsor:</td><td colspan="4">Ms Kris Mackenzie, Group Director of Finance</td></tr>
<tr><td>Report presented by:</td><td colspan="4">Ms Kris Mackenzie, Group Director of Finance</td></tr>
<tr><td rowspan="2">Purpose of Report
Briefly describe why this report is being presented at this meeting</td><td>Decision:
☐</td><td>Discussion:
☐</td><td>Assurance:
☒</td><td>Information:
☐</td></tr>
<tr><td colspan="4">The purpose of this paper is to provide assurance against financial corporate objectives and address financial risks</td></tr>
<tr><td>Proposed level of assurance
– to be completed by paper sponsor:</td><td>Fully assured
☐
No gaps in assurance</td><td>Partially assured
☒
Some gaps identified</td><td>Not assured
☐
Significant assurance gaps</td><td>Not applicable
☐</td></tr>
<tr><td>Paper previously considered by:
State where this paper (or a version of it) has been considered prior to this point if applicable</td><td colspan="4">N/A</td></tr>
<tr><td>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</td><td colspan="4">The Trust has an approved 2026-27 planned deficit of £0.384m before adjustments for donated asset depreciation, and a breakeven plan after.

As of April 2026, the Trust has reported an actual deficit of £0.570m after adjustments for donated asset depreciation. This is an adverse variance of £0.570m from the planned deficit for reasons detailed in the body of this report.

The Trust's 2026-27 capital plan totals £31.486m including £20.074m PDC funded schemes and £11.412m internally funded schemes. Spend up to the end of April 2026 is £0.356m, and an under-spend of £2.354m for the year-to-date.

Cash balances are £30.110m at 30th April 2026 which is £26.600m above planned levels for the reasons detailed in the body of this report.</td></tr>
</table>

<table>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The recommendation to the Trust Board is to receive the report, and record partial assurance for the achievement of 2026-27 planned financial targets.</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">We will ensure efficient and effective use of our resources, identifying opportunities to improve productivity and ensure best use of public money.</td></tr>
<tr><td>Links to CQC Key Lines of Enquiry (KLOE):</td><td>Caring
☐</td><td>Responsive
☐</td><td>Well-led
☒</td><td>Effective
☐</td><td>Safe
☐</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):</td><td colspan="5"></td></tr>
<tr><td>Has an Equality and Quality Impact Assessment (EQIA) been completed?</td><td>Yes
☐</td><td colspan="2">No
☐</td><td colspan="2">Not applicable
☒</td></tr>
</table>

1.0 Introduction

1.1 This report intends to provide assurance against delivery of the approved 2026-27 revenue and capital plan.

1.2 Reporting for 2026-27 is against the Trusts approved financial plan.

2.0 Key Financial Performance Indicators

2.1 Performance against key performance indicators for April 2026 is detailed in Table 1.

Finance KPIs	Month 01 - Apr-26 Budget £ '000	Actual £ '000	Variance £ '000	RAG	YTD Budget £ '000	Actual £ '000	Variance £ '000	RAG
I&E (Surplus) / Deficit (adjusted perf.)	(1)	570	571		(1)	570	571	
Operating Income	-36,967	-36,863	104		-36,967	-36,863	104	
Pay Expenditure	24,637	24,818	181		24,637	24,818	181	
Non Pay Expenditure	11,740	12,059	319		11,740	12,059	319	
Non Operating Income	-8	-109	(101)		-8	-109	(101)	
Non Operating Expenditure	629	698	69		629	698	69	
Remove capital donations / grant I&E Impact	-32	-33	(1)		-32	-33	(1)	
Balancing adj to NHSE Plan	0	0	0		0	0	0	
Agency Expenditure	64	196	132		64	196	132	
CRP Delivery	2,136	578	(1,558)		2,136	578	(1,558)	
Capital Expenditure	2,710	356	(2,354)		2,710	356	(2,354)	
Cash position	3,510	30,110	26,600		3,510	30,110	26,600	
Liquidity (days)	21	11	(9.9)		21	11	(9.9)	
Better Payment Practice Code (BPPC)								
NHS	95.0%	52.5%	-42.5%		95.0%	52.5%	-42.5%	
Non NHS	95.0%	99.0%	4.0%		95.0%	99.0%	4.0%	
Aged Debt								
Receivables over 90 days NHS	10.0%	42.9%	32.9%		10.0%	22.3%	12.3%	
Receivables over 90 days non NHS	10.0%	33.8%	23.8%		10.0%	30.2%	20.2%	

Table 1: Finance KPIs

2.2 The Trust has reported a deficit for the month of April of **0.570m**, which is an adverse variance of **£0.571m** against plan. This is mainly due to under achievement against the Cost Reduction Programme.

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

3.0 Cost Reduction Programme

3.1 Performance against the year to date target is £0.579m against a target of £2.137m resulting in a year to date under achievement of £1.558m. This variance comprises of £0.807m relating to unidentified schemes known at February plan submission stage,

which have not yet been identified and £0.751m slippage against identified schemes, as detailed in Table 2.

Business Unit	Target as at Apr 26 £000	Achieved as at Apr 26 £000	(Under)/ Over as at Apr 26 £000	26-27 Annual Target £000	26-27 Forecast £000	26-27 (Under)/ Over Forecast £000
Chief Executive	13	0	(13)	166	27	(139)
Chief Operating Officer	20	6	(14)	265	196	(69)
Clinical Support & Screening Services	674	86	(588)	8,729	5,819	(2,910)
Community Diagnostic Centre	22	0	(22)	290	0	(290)
Digital	89	25	(64)	1,152	745	(407)
Estates & Facilities	21	0	(21)	274	0	(274)
Finance	9	15	6	116	181	65
Information & Performance	15	2	(13)	189	190	1
Medical Director	9	20	11	121	237	116
Medicine & Community	590	144	(446)	7,641	2,134	(5,507)
Nursing & Midwifery	18	6	(12)	233	70	(163)
POD	19	11	(8)	244	218	(26)
Surgery	554	101	(453)	7,178	1,966	(5,212)
Central Unallocated Target	84	163	79	1,075	2,609	1,534
Total	**2,137**	**579**	**(1,558)**	**27,673**	**14,392**	**(13,281)**

Table 2 Cost Reduction Performance

3.2 The annual achievement is forecast at an under-achievement of £13.281m and whilst at a very early stage in the financial year this risk has been escalated to the Executive Management Group to inform possible mitigations.

3.3 Forecast performance is reported and monitored via the Cost Reduction Steering Group in accordance with the CRP Governance Framework.

4.0 Underlying Trust Financial Position

4.1 The Trust medium term financial plan set a target underlying exit deficit of £34.9m at the end of March 27, due to the early stage of the financial year the Trust is forecasting achievement of this target.

5.0 Capital

5.1 The 2026-27 capital plan was approved as part of the overall Trust plan at £31.486m.

5.2 As at April 2026 the Trust has reported capital expenditure totalling £0.356m against a year-to-date plan of £2.710m. Expenditure is mainly against the Theatre Ventilation totalling £0.285m as well as £0.065m relating to prior-year schemes. There has also been a small amount of expenditure on the CDC phase 2 programme.

Capital Scheme	2026/2027 Annual Plan £000's	2026/2027 In-Year Approvals £000's	2026/2027 Updated Annual Plan £000's	2026/2027 YTD Plan £000's	2026/2027 YTD Actual £000's	2026/2027 YTD Variance £000's	2026/2027 Forecast £000's
Gamma Camera	2,358		2,358	295	0	(295)	2,358
Theatre Ventilation	529		529	88	285	197	529
Agile Lift	24		24	24	0	(24)	24
IPS/UPS SCBU	257		257	43	0	(43)	257
Estates - Fire Safety	1,000		1,000	83	0	(83)	1,000
Estates - Primary Electrical Infrastructure	2,500		2,500	208	0	(208)	2,500
Estates - General M&E	1,300		1,300	108	0	(108)	1,300
Estates - General	250		250	20	0	(20)	185
Medical Equipment Replacement	520		520	0	0	0	520
Business Critical Equipment Replacement	60		60	60	0	(60)	60
Digital	100		100	0	0	0	100
IFRS16 Lease Renewal	1,311		1,311	109	0	(109)	1,311
Clinical EPR	1,203		1,203	0	0	0	1,203
25-26 Carry Forward Scheme	0		0	0	65	65	65
Sub-total Internally Funded	**11,412**	**0**	**11,412**	**1,038**	**351**	**(687)**	**11,412**
2026-27 Maternity	12,000		12,000	1,000	0	(1,000)	12,000
2026-27 Estates Safety Fund	1,074		1,074	89	0	(89)	1,074
2026-26 Community Diagnostic Centre Phase 2	2,500		2,500	208		(208)	
							2,500
2026-26 Community Diagnostic Centre Phase 2	4,500		4,500	375	5	(370)	
							4,500
Sub-total PDC Funded	**20,074**	**0**	**20,074**	**1,672**	**5**	**(1,667)**	**20,074**
Total Capital 2026-27	**31,486**	**0**	**31,486**	**2,710**	**356**	**(2,354)**	**31,486**
Funded By:							
CDEL Depreciation	11,412	0	11,412	1,038	351	(687)	11,412
Public Dividend Capital	20,074	0	20,074	1,672	5	(1,667)	20,074
Charitable Funds	0	0	0	0	0	0	0
Total Funding	**31,486**	**0**	**31,486**	**2,710**	**356**	**(2,354)**	**31,486**

Table 4: Capital Programme Spend

5.3 Capital expenditure is forecast to catch up to plan in the remaining months.

6.0 Cash Balances

6.1 Group cash at 30 April 2026 totalled £30.110m, £26.600m more than planned, and is mainly driven by trade and other payables being £13.629m higher than plan.

6.2 The cash balance is the equivalent to an estimated 25.41 days operating costs (March 19.14 days).

6.3 Performance against the Better Payment Practice Code increased in month in terms of value, with 97.8% of invoices paid within 30 days against the target 95% (March: 73.8%); alongside an increase in total numbers of invoices paid at 93.1% (March 88.5%); (target 95%).

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

7.0 Conclusion

7.1 The Trust has reported a deficit of **£0.570m** against a plan of £0.001m resulting in an adverse variance of **£0.571m** for month 1.

7.3 The Trust has reported year-to-date capital spend totalling £0.356m against a plan of £2.710m resulting in an under-spend of £2.354m. Expenditure to date has been incurred against the Theatre Ventilation Scheme and CDC Phase 2 as well as £0.065m relating to prior year schemes, with expenditure forecast to catch up in future months.

7.4 The Trust has reported achievement of £0.579m against the 2026-27 cost reduction plan, with £14.392m forecast against annual target of £27.667m; of which £12.041m is anticipated on a recurring basis, resulting in an early indicative shortfall of £13.281m that will need to be bridged to achieve the breakeven financial performance plan.

7.5 Group cash at 30 April 2026 totalled £30.110m, £26.600m more than planned, and is mainly driven by trade and other payables being £13.629m higher than planned.

Kris Mackenzie
Group Director of Finance
May 2026

Appendix A – Statement of Comprehensive Income (SOCI)

Statement of Comprehensive Income	Month 01 - Apr-26 Budget £ '000	Actual £ '000	Variance £ '000
Operating Income from Patient Care activities			
Income From NHS Care Contracts	-33,319	-34,084	(765)
Income From Local Authority Care Contracts	-46	-30	16
Private Patient Revenue	-65	-58	7
Injury Cost Recovery	-42	-63	(21)
Other non-NHS clinical revenue	-13	-15	(2)
Total Operating Income From Patient Care activities	**-33,485**	**-34,250**	**(765)**
Other Operating Income			
Education and Training Income	-1,090	-1,105	(15)
R&D Income	-75	-97	(22)
Funding outside of System Envelope	0	0	0
Other Income	-2,317	-1,412	905
Donations & Grants Received	0	0	0
Cost Improvement Programme - Income	0	0	0
Total Other Operating Income	**-3,482**	**-2,613**	**869**
Total Operating Income	**-36,967**	**-36,863**	**104**
Operating Expenses			
Employee Expenses - Substantive	23,850	23,659	(191)
Employee Expenses - Bank	627	856	229
Employee Expenses - Agency	64	196	132
Employee Expenses - Other	96	107	11
Cost Improvement Programme - Pay	0	0	0
Total Employee Expenses	**24,637**	**24,818**	**181**
Purchase of Healthcare - NHS bodies	780	917	137
Purchase of Healthcare - Non NHS bodies	160	172	12
Purchase of Social Care	0	0	0
NED's	15	13	(2)
Supplies & Services - Clinical	3,345	3,800	455
Supplies & Services - General	247	238	(9)
Drugs	2,084	2,022	(62)
Research & Development expenses	1	-1	(2)
Education & Training expenses	158	111	(47)
Consultancy costs	22	22	0
Establishment expenses	310	436	126
Premises	1,692	1,523	(169)
Transport	172	145	(27)
Clinical Negligence	670	690	20
Operating Leases	221	124	(97)
Other Operating expenses	576	532	(44)
Movement in credit loss allowance	-50	-13	37
Cost Improvement Programme - Non Pay	0	0	0
Reserves	0	0	0
Operating Expenses included in EBITDA	**10,403**	**10,731**	**328**
Depreciation & Amortisation - Purchased / Constructed	1,032	1,039	7
Depreciation & Amortisation - Donated / Granted	32	33	1
Depreciation & Amortisation - Finance Leases	273	256	(17)
Impairment & Revaluation	0	0	0
Operating Expenses excluded from EBITDA	**1,337**	**1,328**	**(9)**
Total Operating Expenses	**36,377**	**36,877**	**500**
(Profit)/Loss from Operations	**(590)**	**14**	**604**
Non-Operating Income			
Finance Income	-8	-109	(101)
Gains on Disposal of Assets	0	0	0
Total Non-Operating Income	-8	-109	-101
Non-Operating Expenses			
Finance Expense	58	107	49
Gains / (Losses) on Disposal of Assets	0	0	0
PDC dividend expense	467	467	(0)
Total Finance Costs (for non-financial activities)	**525**	**573**	**48**
Other Non-Operating Expenses			
Misc. Other Non-Operating expenses	0	0	0
Total Non-Operating Expenses	**525**	**573**	**48**
(Surplus) / Deficit Before Tax	**(73)**	**478**	**551**
Corporation Tax	104	125	21
(Surplus) / Deficit After Tax	**31**	**603**	**572**
Balancing Adjustment to NHSE Plan			0
(Surplus) / Deficit After Tax from Continuing Operations	**31**	**603**	**572**
Remove impact of impairments	0	0	0
Remove capital donations / grants I&E impact	-32	-33	(1)
Adjusted Financial Performance (Surplus) / Deficit	**(1)**	**570**	**571**

Appendix B Statement of Financial Position

	2026/27 April 2026 Group Plan £000	2026/27 April 2026 Group Actual £000	Movement from plan £000
Assets			
Non-Current Assets			
Investment Property	80	80	-
Property, Plant and Equipment, Net	186,183	174,059	(12,124)
Right of Use Assets	13,533	12,569	(964)
Trade and Other Receivables, Net	1,567	933	(634)
Finance Lease - Intragroup	-	-	-
Trade and Other Receivables - Intragroup Loan	-	-	-
Total Non Current Assets	**201,363**	**187,641**	**(13,722)**
Current Assets			
Inventories	4,403	4,507	104
Trade and Other Receivables - NHS	4,785	7,205	2,420
Trade and Other Receivables - Non NHS	16,890	14,013	(2,877)
Trade and Other Receivables - Intragroup	-	-	-
Trade and Other Receivables - Other	-	-	-
Cash and Cash Equivalents	3,510	30,110	26,600
Total Current Assets	**29,588**	**55,836**	**26,248**
Liabilities			
Current Liabilities			
Deferred Income	3,376	3,458	82
Provisions	930	2,104	1,174
Trade and Other Payables	43,276	56,886	13,610
Lease Liabilities	2,613	3,272	659
Trade and Other Payables - Capital	913	911	(2)
Other Financial Liabilities - Borrowings FTFF	999	999	(0)
Other Financial Liabilities - Borrowings Other (Non-DHSC)	12	12	-
Total Current Liabilities	**52,119**	**67,642**	**15,523**
NET CURRENT ASSETS (LIABILITIES)	**(22,531)**	**(11,807)**	**10,724**
Non-Current Liabilities			
Deferred Income	1,647	1,646	(1)
Provisions	1,878	1,778	(100)
Trade and Other Payables - Other	-	-	-
Lease Liabilities	10,914	10,019	(895)
Other Financial Liabilities - Accruals	-	-	-
Other Financial Liabilities - Intragroup Borrowings	-	-	-
Other Financial Liabilities - Borrowings FTFF	9,014	9,016	2
Other Financial Liabilities - Borrowings Other (Non-DHSC)	84	84	-
Finance Lease - Intragroup	-	-	-
Total Non-Current Liabilities	**23,537**	**22,543**	**(994)**
TOTAL ASSETS EMPLOYED	**155,295**	**153,292**	**(2,003)**
Tax Payers' and Others' Equity			
PDC	179,828	183,838	4,010
Taxpayers Equity			
Share Capital	-	-	-
Retained Earnings (Accumulated Losses)	(37,303)	(42,191)	(4,888)
Other Reserves			
Revaluation Reserve	12,671	11,547	(1,124)
Misc Reserve	99	98	(1)
TOTAL TAXPAYERS EQUITY	**155,295**	**153,292**	**(2,003)**
TOTAL ASSETS EMPLOYED	**155,295**	**153,292**	**(2,003)**

c - Strategic Objectives and Constitutional Standards Report

Presented by the Group Director of Finance

Report Cover Sheet Agenda Item: 4c

Report Title:	Strategic Objectives & Constitutional Standards			
Name of Meeting:	Tier 1 and Tier 2 Committees			
Date of Meeting:	Wednesday 27th May 2026			
Author:	Deborah Renwick: Associate Director of Planning & Performance			
Executive Sponsor:	Kris Mackenzie: Group Director of Finance			
Report presented by:	Kris Mackenzie: Group Director of Finance Joanne Halliwell: Chief Operating Officer			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☐	**Information:** ☐
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*	**Overall position** The April 2026 position marks the **start of the 2026/27 reporting cycle** and presents a **high-risk and deteriorating assurance picture**, despite sustained strength in core safety standards. While maternity compliance, VTE performance and elements of training continue to demonstrate strong and consistent delivery, this is outweighed by **worsening patient flow, continued workforce fragility, deterioration in cancer performance and early financial under-delivery** in the new financial year. Urgent and emergency care performance remains below the revised standard, with sustained system pressure linked to length of stay and discharge challenges. Cancer standards show **further deterioration following the partial recovery seen in March**, and financial performance in Month 1 is **off plan**, with a significant gap in CRP delivery.			

Overall, the Trust enters 2026/27 with a **materially elevated and interdependent risk profile**, with limited headroom across operational, workforce and financial domains.

Key risks and areas requiring Board attention

1. Urgent & Emergency Care – sustained under-delivery against revised standard
Urgent and emergency care performance remains **below the revised 2026/27 trajectory (>82%)**, with only modest improvement and continued volatility.

- **A&E 4-hour performance improved to 77.0%**, but remains below the new >82% standard.
- **ED attendances >12 hours remain high at 4.83%**, significantly above the <0.4% ambition.
- **12-hour waits reduced compared to March**, but performance remains above target.
- **Ambulance handover delays remain elevated**, with ongoing system pressure.

The narrative confirms this is driven by **sustained high attendances (~10,000 per month), high bed occupancy and flow constraints**, with escalation capacity still required.

Board implication: UEC performance remains a **persistent safety and reputational risk**, with limited resilience to further pressure.

2. Patient flow and discharge – worsening position
Patient flow continues to deteriorate and remains the **primary system constraint** affecting emergency, elective and cancer pathways.

- **Average non-elective length of stay increased further to 8.45 days**, worsening from March (8.25 days).
- **Patients with no Criteria to Reside remain high at 51**, marginally improved but significantly above the <10 target.
- **RTA to bed within 1 hour remains critically low at 9.4%**, against a 60% trajectory.

Narrative highlights **ongoing discharge constraints, limited availability of community placements and package of care capacity**.

Board implication: Flow remains the **most significant enabler risk**, directly impacting UEC, cancer delivery and workforce pressure.

3. Workforce – continued fragility with limited improvement

	Workforce indicators continue to reflect **structural fragility**, with limited sustained improvement.
	• **Vacancy rate remains high at 7.2%**, significantly above the ≤2.5% target.
	• **Turnover remains elevated at 12.1%**, above the ≤12% target (10.5% excluding QEF impact).
	• **Sickness absence increased to 5.48%**, with:
	  ○ Mental health accounting for **36.6% of absence**
	  ○ Estimated **£3.8m cost**
	• **Staff engagement remains at 6.5**, below the 7.3 ambition.
	
	While agency spend remains controlled, it has **increased to 0.8%**, with reliance on temporary staffing across multiple services.
	
	Board implication: Workforce pressures continue to **undermine operational performance and recovery capacity**, particularly in UEC and cancer pathways.
	
	4. Cancer performance – renewed deterioration and constitutional risk
	Cancer standards demonstrate **clear deterioration in April**, reversing the modest recovery seen in March.
	• **28-day Faster Diagnosis Standard fell sharply to 40.3%**, significantly below the >80% standard and deteriorating month-on-month.
	• **62-day cancer standard remains below target at 65.7%**, against an increased >80% standard.
	• **31-day standard remains compliant at 97.4%**, providing some stability.
	• **6-week diagnostic standard deteriorated to 89.8%**, below the 95% standard.
	•
	This reflects **ongoing diagnostic capacity constraints, workforce pressures and flow impacts**, with limited resilience across cancer pathways.
	
	Board implication: Cancer performance now represents a **priority constitutional, quality and reputational risk**, requiring sustained oversight and system escalation.
	
	5. Quality & Safety – mixed picture with ongoing infection and estates risk
	There is a **mixed position across safety domains**, with some improvement offset by ongoing risk.
	• **C. difficile rate increased to 50.4**, remaining significantly above the ≤3.2 target despite earlier improvement.
	• **Harm falls improved to 3.31 per 1,000 bed days**, approaching the 3.2 target but still above threshold.
	• **48 harm falls reported** including 1 severe harm.

Estates risk shows slight deterioration:

- **Risk score increased to 206** (from 205 in March) with a new risk identified.
- **6 patient safety incidents linked to estates**, above the ≤4 target.

Environmental inspections highlight **infrastructure, storage and cleanliness issues**, indicating ongoing estate pressures.

Board implication: Estates, IPC and flow continue to represent **interdependent safety risks**.

Areas of sustained strength and assurance

Despite the above risks, there remain **areas of strong and consistent delivery**:

- **Ockenden recommendations:** sustained at 100% compliance.
- **Maternity Incentive Scheme:** sustained at 100%.
- **VTE risk assessment:** 99.1%, consistently above standard.
- **Mental Health Act training:** improved to 94.4%, above target.

These provide **strong assurance in core safety and governance processes**.

Finance and productivity
The April position highlights **early deterioration in financial performance** and emerging risk for 2026/27.

- **Planned position:** breakeven
- **Actual position:** £0.570m deficit (adverse variance)
- **CRP delivery:** £0.579m delivered against £2.135m plan (significant shortfall)
- **Cash position:** £30.1m, above minimum threshold but with limited future headroom

The narrative highlights **unidentified savings gaps and reliance on recurrent CRP delivery**, alongside pressures on delegated budgets.

Board implication: Financial position is now **fragile at the start of the year**, with clear risk to plan delivery.

Executive conclusion

April 2026 confirms a **deteriorating and highly interdependent risk profile at the start of 2026/27**, with **urgent and emergency care pressures, worsening patient flow, workforce fragility, declining cancer performance and early financial under-delivery** collectively driving risk across constitutional standards and patient outcomes.

<table>
<tr><td></td><td colspan="5">While strong assurance remains in maternity safety, clinical governance and elements of workforce training, these are increasingly offset by persistent delivery challenges across access standards, infection control, estates and financial recovery. The deterioration in cancer performance, alongside sustained UEC pressures and flow constraints, represents a material quality, constitutional and reputational risk.

Overall, the Trust enters the new financial year with limited resilience and increasing sensitivity to system pressures.

Sustained Board focus is required on flow recovery, UEC improvement, cancer pathway stabilisation, workforce retention, infection prevention and recovery of the CRP programme, alongside continued system-level escalation and oversight of financial sustainability.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">The recommendations to the Board are to receive this report, discuss the potential implications and note the improvement or challenge in key areas</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">All strategic objectives</td></tr>
<tr><td>Links to CQC Key Lines of Enquiry (KLOE):</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):</td><td colspan="5">Areas requiring attention:

Excellent patient care:
• Quality Improvement Plans
• Learning Disability & Autism Training
• Mental Health Act training
• Estates risks and incidents
• Harm falls rates
• C-difficile rates

Great place to work:</td></tr>
</table>

<table>
<tr><td></td><td colspan="3">

- Staff engagement
- turnover rates
- vacancy rates
- sickness absence rates.

Fit for the future:

- All cancer standards now at risk
- RTT WL size, performance, and long waiters
- UEC, 4 hour and long waits performance
- Criteria to reside and non-elective LOS
- Maintaining financial sustainability, reducing expenditure, and achieving CRP.

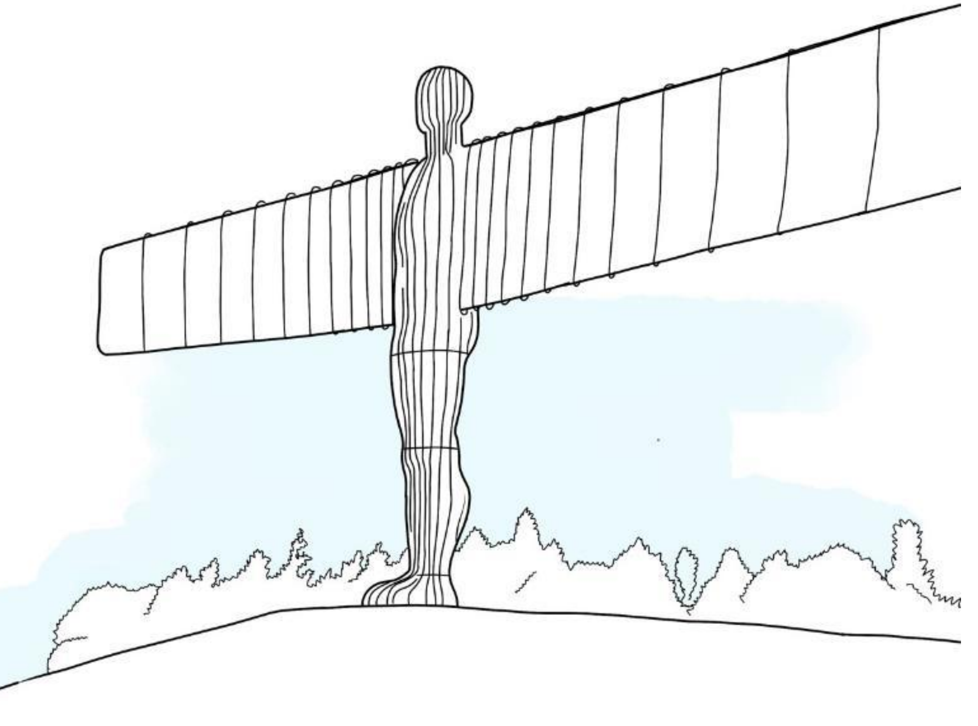
Working together for healthier communities:

- Waiting times for Gynaecology and Paediatric Autism patients
- Smoking status recording

</td></tr>
<tr><td>Has an Equality and Quality Impact Assessment (EQIA) been completed?</td><td>Yes
☐</td><td>No
☐</td><td>Not applicable
☒</td></tr>
</table>

Strategic Objectives 2026/27

Leading Indicators and Breakthrough Objectives



Including Constitutional standards monitoring metrics

Reporting Period: April 2026

Strategic Objectives 2026/27 | What are we aiming for

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 2026/27

Executive Summary

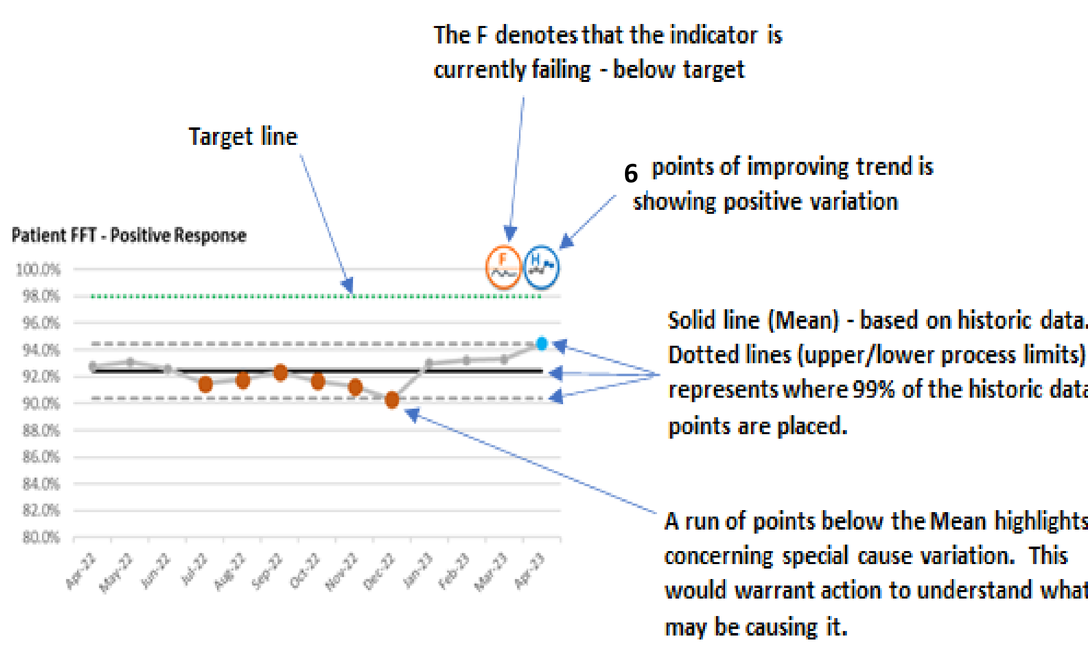
Improved	No Change	Needs further attention
We will continuously improve the quality and safety of our services for our patients		
	Scoring in domains in areas of PLACE inspection not available	Quality Improvement Plans
	Ockenden recommendations	C.Difficile rate
	Maternity Incentive Schemes	Reduction in patient safety incidents linked to estate issues
	Strategic approach to development of EPR	Harm rate from falls
	Venous thromboembolism (VTE) risk assessment	Mental Health Act Training for all registered staff
		Compliance with Level 1 training plans for learning Disability & Autism
		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 2026/27 | **How to interpret the SPC icons and charts**

The Trust has adopted the NHSEI 'Making Data Count' methodology and standard templates which demonstrates where historic performance/activity is subject to natural variation or where action may need to be taken where there may be cause for 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.		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.		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 2026/27 | **Leading Indicator and Breakthrough Objectives Assurance Heatmap**

	P	?	F
Improving		85% compliance learning disability and autism training	Achievement of the internal sickness absence standard of 4.9% Compliance with the quality improvement plan indicated by the % of actions on track Reduction in the wait for gynaecology outpatients to no more than 26 weeks
Neither improving or deteriorating	Venous thromboembolism (VTE) risk assessment Reduction in temporary staffing spend of pay bill evidenced month on month	Ockenden Recommendations % compliance with Total Recommendations Maternity Incentive schemes % compliance with Total Recommendations Harm falls rate per 1000 bed days Achievement of the trajectory to reduce >12 hour total time in Emergency Department Achievement of the 4 hours trajectory C.Diff Healthcare associated rate per 100,000 occupied bed days Achievement of the 52 week RTT standard Reduce % of FU Outpatient without procedures Achievement of the % to reduce >12 hour total time in Emergency Department 90% of staff to complete Mental Health Act training Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 by March 2025 Reduction in patient safety incidents related to estates issues	Increase in the number of digital devices repurposed to the local community Reduce the number of patients with no Criteria to Reside Achievement of the trajectory to achieve RTA to Bed within 1 hour Average Length of Stay Non-Elective <4 days
Deteriorating		Reduction in severity of risk score linked to estates	Achievement of the internal turnover standard Maintain the vacancy rate at <=2.5% Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients by March 2025
	Consistency in PASSING the target	**Inconsistency in HITTING, PASSING and FALLING SHORT of the target**	**Consistency in FAILING the target**

Strategic Objectives 2026/27 — 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

Metric	Target	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	Ass/Var	Trend
LEADING INDICATORS																	
Ockenden Recommendations % compliance with Total Recommendations	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Maternity Incentive Schemes % compliance with Total Recommendations	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Reduction in patient safety incidents linked to estate issues	<=4	2	9	5	6	2	2	6	8	6	5	7	5	4	6		
Compliance with the quality improvement plan indicated by the % of actions on track	100%	68%	76%	80%	80%	76%	84%	84%	84%	84%	84%	84%	84%	84%	84%		
BREAKTHROUGH OBJECTIVES																	
Reduction in severity of risk score linked to estates	TBA	256	244	260	276	266	234	246	240	256	244	263	267	205	206		
Harm falls rate per 1000 bed days (5% reduction)	3.2	4.27	3.49	4.27	3.93	4.61	4.78	4.12	3.75	4.38	5.45	3.69	5.24	4.57	3.31		
C.Diff Healthcare associated rate per 100,000 occupied bed days	<=3.20	70.1	28.7	7.1	28.3	28.9	0.0	46.1	42.8	22.2	14.0	20.4	70.4	34.9	50.4		
90% of staff to complete Mental Health Act training.	90%	85.0%	86.0%	88.0%	86.0%	88.0%	86.0%	91.0%	89.0%	87.0%	82.0%	86.0%	87.0%	91.0%	94.4%		
Venous thromboembolism (VTE) risk assessment	95%	99.0%	99.0%	99.5%	98.9%	99.1%	99.0%	99.3%	98.9%	99.0%	99.2%	99.3%	99.0%	99.2%	99.1%		
85% of staff to complete Learning disability and autism training	85%	68.31%	68.31%	75.74%	76.83%	79.39%	80.86%	81.76%	83.00%	83.72%	84.48%	86.17%	86.95%	87.24%	82.46%		

Strategic Objectives 2026/27

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

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

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.
2	Compliance with the quality improvement plan indicated by the % of actions on track.	Latest reported data relates to April 2026 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. 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 has dropped to 2.54% 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.	The number of mental health staff trained is currently 94.4% which is an increase from 91% in March. Compliance for qualified staff has improved and is currently is 96%. Compliance for HCAs & support workers has improved to 90%. Cragside are 97% compliant with training, this is an improvement from 86% in March 2026. Sunniside remians at 75% compliant. The CPN team, Younger Persons Memory Service, Mental Health Liaison Team and Memory Hub team all remain at 100% compliance with training. The OT team remians at 92% compliance. 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 2025. This training is available to any other staff on request. MHA awareness training has been provided for 50 acute staff, training was cancelled in April due to no attendees booking on the course. 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. Additional training sessions for the MH wards have been delivered to support with increasing compliance levels.
	Improve our IPC C.Difficile infection rates per 100 000 occupied bed days.	Rates per 100 000 bed days have reduced to 34.9, seven cases were reported in April 2026. 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.
	Venous thromboembolism (VTE) risk assessment	Healthcare associated venous thromboembolism (VTE), commonly known as blood clots, is a significant international patient safety issue. The first step in preventing death and disability from VTE is to identify those at risk so that preventative treatments (prophylaxis) can be given. This data collection quantifies the numbers of hospital admissions (aged 16 and over at the time of admission) who are being risk assessed for VTE to identify those who should be given appropriate prophylaxis based on guidance from the National Institute for Health and Care Excellence (NICE). The Trust continuously performs well against the standard of 95% with April performance reported at 99.1%.
	Harm related falls will reduce by 5%.	48 harm falls were reported in April 2026, one of these was 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	Reduction in risks and severity of scores linked to estate issues	April position, 18 Risks with combined critical infrastructure risk score of 206 (increased from 205 in March). One new risk identified [ref, 4416, Da Vinci steriliser], 0 risks decreased, one risk removed [ref, 4503, Kiestra MLS system]
	Reduction in patient safety incidents linked to estate issues	6 patient safety incidents related to estates issues in April 2026. 2 incidents were related to falls and 2 were related to temperature control. 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 April visits took place in wards 9 and 14a, Critical care and Cragside. Ward 9 has a lack of storage, please note only one shower room for 30 patients. The bathroom is used as storage due to nowhere else being available for the equipment. Critical care toilet signs are not dementia friendly, estates are aware. Cragside external locks require replacement due to them been thumb locks at present, estates are aware. ward 14a patients raised that the cleanliness in between patient toilet use was not to standards and the staff were vaping in the staff room this was addressed at the time
	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. The capital programme has been confirmed and an update will be available when capital projects are completed.

Strategic Objectives 2026/27

We will be a great organisation with a highly engaged workforce

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

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

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

Metric	Target	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	Ass/Var	Trend
LEADING INDICATORS																	
Maintain the vacancy rate at <=2.5%	<=2.5%	5.0%	3.2%	5.8%	5.9%	6.6%	6.3%	5.6%	6.7%	7.2%	7.3%	7.5%	7.5%	7.2%			
Improve the staff engagement score to 7.3	>=7.3		6.17			5.63						5.88			5.97		
BREAKTHROUGH OBJECTIVES																	
Achievement of the internal turnover standard of 12%	<=12%	11.5%	11.8%	11.9%	11.9%	12.0%	11.7%	12.1%	12.6%	12.4%	12.1%	12.0%	12.0%	12.2%	12.1%		
Achievement of the internal sickness absence standard of 4.9%	4.90%	5.70%	5.71%	5.64%	5.61%	5.58%	5.58%	5.57%	5.52%	5.50%	5.45%	5.41%	5.43%	5.46%	5.48%		
Reduction in temporary staffing spend of pay bill evidenced month on month	<=2.3%	0.5%	0.4%	0.2%	0.5%	0.5%	0.5%	0.3%	0.5%	0.4%	0.4%	0.7%	0.5%	0.6%	0.8%		

Measures requiring focus this month

Measure	Summary
Maintain the vacancy rate at <=2.5%	Awaiting finance data for Month one 26/27.
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 have been cascaded throughout in January/February, and the Board and senior leaders have agreed two key areas of focus; working harder to show that patient care is our top priority and prioritising engagement. Divisions are reporting on local progress via People and OD Steering Group in June 2026.
Achievement of the internal turnover standard of 9.7%	Turnover decreased slightly in April to 12.1% from 12.2% in March 2026. This trend is likely to persist in the coming months as the QEF TUPE-related outlier continues to feed through the 12-month rolling turnover calculation. Excluding QEF reduces group turnover from 12.1% to 10.5%.
Achievement of the internal sickness absence standard of 4.9%	Sickness absence increased by 0.02% for a rolling 12 months in April 2026. In-month sickness absence was 5.1% in April 2026, matching April in the previous year. Anxiety, stress & depression continues to be the most prevalent reason for absence accounting for 36.6% of all sickness absence in the past 12 months with an estimated cost of £3.8M. Long-term mental health related illness has caused the recent plateau in sickness absence rolling rates. GHFT ranks second lowest for rolling sickness absence behind Northumbria in the ICS and below median average in NE&Y and amongst peer organisations.
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 0.8% and has been consistently under target in the past 12 months. Agency spend continues in hard to fill roles in Elderly Care, Surgery, Cardiac Diagnostics and QEF Pathology Transport. Agency is also being used for gaps in Healthcare Support Worker staffing due to high vacancy rates.

Strategic Objectives 2026/27 — 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

Evidence of reduction in cost base and an increase in patient care related income

Metric	Target	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	Ass/Var	Trend
LEADING INDICATORS																	
Average Length of Stay Non-Elective ** *Reset April 2025 to align with operational guidance definitions*	<=4	7.18	8.70	8.38	8.65	7.66	7.66	7.75	8.13	7.51	7.59	8.14	7.92	8.25	8.45		
Achievement of the 4 hours trajectory ** *Standard reset April 2026 to align with 2026/27 plan*	>82%	74.5%	72.5%	79.0%	76.7%	82.2%	82.3%	77.4%	73.7%	77.6%	73.0%	69.1%	75.1%	75.1%	77.0%		
Achievement of the 52 week RTT standard **	0	0	16	1	18	35	55	52	41	33	25	20	26	17	9		
Achievement of financial Plan - Variance (£k)	Figure in brackets favourable	(0.046)	0.272	0.224	0.261	0.337	-0.027	-0.174	-0.185	-0.032	-0.007	-0.207	-0.041	-0.057	0.570		
Finance - Forecast Out-turn Deficit (Plan)	tbc	2,146	8,381	8,381	8,381	8,381	8,381	8,381	8,381	8,381	8,381	8,381	8,381	5,048	0		
BREAKTHROUGH OBJECTIVES																	
Achievement of the trajectory to reduce >12 hour total time+B1 in Emergency Department (Type 1) ** *Standard reset April 2026 to align with 2026/27 plan*	0	71	52	31	47	16	13	67	337	98	240	567	182	308	262		
	0.4%	0.7%	0.9%	0.5%	0.8%	0.3%	0.23%	1.19%	5.68%	1.61%	3.85%	9.59%	3.43%	5.13%	4.83%		
Reduce the number of patients with no Criteria to Reside **	<10	47	43	46	54	49	45	43	45	42	48	48	54	54	51		
Achievement of the trajectory to achieve RTA to Bed within 1 hour **	60.0%	6.3%	6.4%	16.1%	10.8%	19.1%	16.9%	10.3%	8.3%	13.5%	9.4%	5.9%	10.3%	8.7%	9.4%		
Reduce % of Follow up Outpatient without procedures *Reset April 2025 to align with 2025/26 operational guidance definitions*	<=67%	67.6%	67.5%	66.2%	64.6%	66.4%	66.7%	65.0%	65.1%	65.2%	65.7%	64.4%	63.8%	64.0%	67.9%		
CRP Delivery Variance	Figure in brackets favourable	0	517	523	19	0	0	0	0	0	0	0	0	0	1556		
No less than £5m cash as per forecast at year end	>=£5m	£5m	£32m	£28m	£16m	£24m	£31m	£22m	£24m	£18m	£19.3m	£19.9m	£31m	£30m	£30m		

Validated data unavailable at time of report

** improvement workstream in place

Strategic Objectives 2026/27 — 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

Evidence of reduction in cost base and an increase in patient care related income

Measures requiring focus this month

Measure		Summary
1	**Average Length of Stay Non-Elective <4 days**	Length of stay has continued to increase, with ongoing pressures for placements and provision of packages of care. The discharge sprint activity work is now been embedded on a second ward, and the 21 day review MDT is increasing to twice weekly
	Achievement of the 4 hours trajectory	ED 4-hour performance improved in April compared with March, although it remains below the >82% target, with attendances remaining similarly high at around 10000 for each month, and reflecting the challenges with patient flow
	Achievement of the trajectory to reduce >12 hour total time in Emergency Department	There has been a reduction in 12-hour waits compared with March, indicating improvement from the previously reported deterioration, though performance remains above target, reflecting the high bed occupancy, with the escalation ward still required to be in use during April
	Achievement of the trajectory to achieve 60% RTA to Bed within 1 hour	Performance improved slightly but remains substantially below the 60% target, reflecting continued bed capacity pressures
	Reduce the number of patients with no Criteria to Reside	The number of patients without criteria to reside has reduced marginally, although levels remain well above the target of <10, indicating continuing discharge flow challenges including procurement of beds and package of cares for P2/3 patients
	Achievement of the 52 week RTT standard and delivery of the waiting list trajectory	We are reporting a decrease in the number of patients waiting over 52 weeks for treatment with almost all patients awaiting Urology care. We utilised sprint monies in Q4 25/26 to improve the position, but this arrangement ceased at the end of March. This is forecast to increase next month. The Urology position remains challenging and we continue to work through a series of actions to mitigate the current position, including consideration of the continuation of insourcing, additionality from current workforce and wider work within the alliance.
	Increase in New Outpatient activity	We continue to scope alternative ways of working to ensure we achieve the standard through the elective care transformation group with the aim to achieve the required standard consistently.
2	**Evidence achievement of the financial plan**	The Trust planned deficit for 2026-27 financial year is breakeven, and breakeven at month 1. Actual performance was £0.570m deficit which is an adverse variance of £0.570m. This is largely driven by unmet CRP plans and unidentified gap. Risks remain around overspending against delegated budgets and identification and delivery of CRP on both a recurrent and non-recurrent basis. The Trust planned CRP target for April was £2.135m and actual performance of £0.579m. Focus remains on identifying recurrent savings schemes to support future financial sustainability. Cash was £30.110m at 30.04.26 which is above the £5m target set within the trust plan However, the headroom between current cash balance and future run rate commitments ,particularly capital expenditure, should CRP plans not be cash releasing in 2026-27 is challenging.
3	**Review & revise the green plan & align with the group structure**	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 2026/27

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

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

Metric	Target	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	Ass/Var	Trend
BREAKTHROUGH OBJECTIVES																	
Increase in the number of digital devices repurposed to the local community	>300	0	0	30	64	0	0	66	0	164	0	0	0	0	0		
Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients *Reset September 2025 to align with National definitions*	>=98%	92.8%	90.6%	88.8%	94.1%	95.5%	93.7%	91.0%	90.9%	89.2%	89.8%	90.5%	90.3%	89.9%	88.0%		
Reduction in the wait for gynaecology outpatients to no more than 26 weeks	<=26	28.9	28.9	31.1	31.7	33.0	32.0	32.0	32.0	29.9	29.0	29.0	28.9	27.0	27.0		
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30	<=30	74	61	52	65	42	69	38	27	62	58	32	61	40	89		

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 2026/27.
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 in 2025/26.
Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients	April compliance 88%, 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 was due to be implemented from late Feb 2026 which will ensure smoking status collection on weekends, however due to a staff member leaving this has been delayed.
Reduction in the wait for gynaecology outpatients to no more than 26 weeks	The median wait for 1st OP appointment in Gynaecology maintained at 27 weeks in April. We 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 is planned to go live imminently following a successful pilot to focus on demand and ensuring patients are seen at the right place by the right team.
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 weeks	Current median wait has increased to 89 weeks due to the number of patients being seen in the revised pathway for ASD. Overall waiting list size has increased slightly due to a reduction in capacity- sickness/ leavers within the service and a workshop is planned in June to review the operational delivery model. Continues to be monitored weekly through Access & Performance meetings.

Strategic Objectives 2026/27 — We will develop and expand our services within and beyond Gateshead

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

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

Metric	Target	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	Ass/Var	Trend
LEADING INDICATORS																	
0.5% increase in QEF externally generated turnover from previous financial year	>=0.5%	0.0%	0.0%	7.5%	19.3%	24.0%	28.6%	22.9%	20.0%	19.0%	11.1%	11.0%	9.2%	13.3%	18.8%		

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. Pharmacy is up compared to prior year with high revenue in April in External Homecare due to a number of new contracts with Northumbria and North Cumbria.

Constitutional Standards 2026/27

Reporting Period: April 2026

Constitutional standards 2026/27 | **Constitutional Standards metrics Assurance Heatmap**

NHS Gateshead Health NHS Foundation Trust

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

Constitutional Standards 2026/27

Metrics

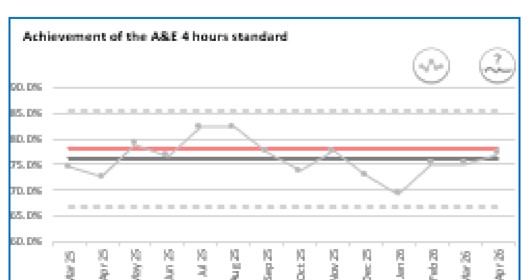
Gateshead Health NHS Foundation Trust

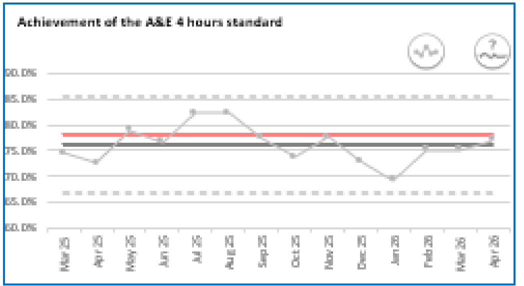
Metric	Target	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	Ass/Var
Achievement of the A&E 4 hour standard **	>82%	73.6%	74.5%	72.5%	79.0%	76.7%	82.2%	82.3%	77.4%	73.7%	77.6%	73.0%	69.1%	75.1%	75.1%	77.0%	
12 hour trolley waits (DTA to left department)	0	0	2	0	1	2	1	0	2	21	6	2	12	1	1	0	
% of ED attendances > 12 hours in department (Type 1) ** *Reset April 2025 to align with 2025/26 operational guidance definitions* *Standard reset April 2026 to align with 2026/27 plan*	<0.4%	2.5%	0.7%	0.88%	0.52%	0.77%	0.25%	0.23%	1.19%	5.68%	1.61%	3.85%	9.59%	3.43%	5.13%	4.83%	
Ambulance handover delays 30-60 minutes	0	4	6	11	4	16	5	1	8	21	7	23	72	15	27	21	
Ambulance handover delays over 45 minutes **	0			3	1	5	0	0	0	8	1	15	37	6	15	16	
Ambulance handover delays 60 minutes +	0	0	7	1	0	0	0	0	0	3	0	9	19	1	9	5	
Achievement of the RTT 18 week standard **	>92%	71.3%	71.0%	69.4%	68.5%	68.3%	68.6%	67.4%	68.3%	67.9%	69.5%	70.1%	71.4%	71.6%	77.5%	76.0%	H F
Achievement of the 52 week RTT standard **	0	66	0	16	1	18	35	55	52	41	33	25	20	26	17	9	
Achievement of the 6 week diagnostic standard (DM01) **	>95%	86.4%	82.6%	77.4%	74.2%	77.3%	74.8%	71.1%	81.6%	86.3%	96.6%	95.8%	94.6%	96.2%	95.2%	89.8%	H
Achievement of the Cancer 28 day standard ** *Reset April 2025 to align with operational guidance standard*	>80%	80.7%	80.5%	70.1%	69.9%	77.2%	76.0%	75.6%	64.9%	74.7%	80.3%	72.2%	39.4%	55.2%	60.8%	40.3%	L
Achievement of the Cancer 31 day standard **	>96%	100.0%	100.0%	99.5%	99.5%	97.9%	100.0%	97.9%	96.7%	100.0%	97.2%	92.2%	91.5%	99.0%	97.4%		
Achievement of the Cancer 62 day standard ** *Reset April 2026 to align with 2026/27 operational guidance standard*	>80%	81.0%	82.1%	73.7%	67.7%	72.7%	75.3%	70.8%	71.1%	72.7%	69.3%	60.1%	52.0%	63.0%	65.7%		

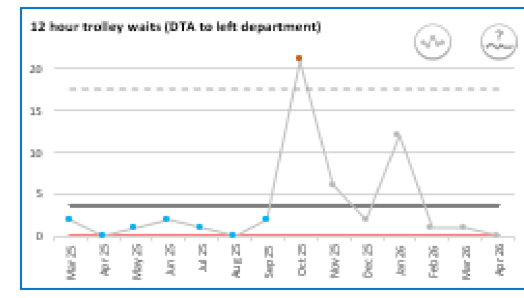
Validated data unavailable at time of report

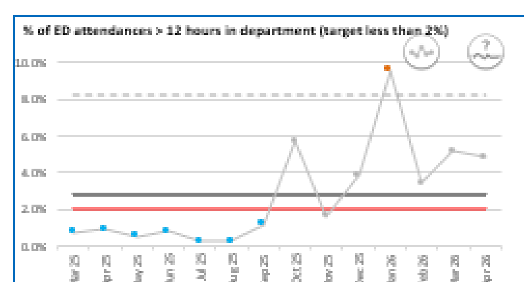
Metrics (SPC)

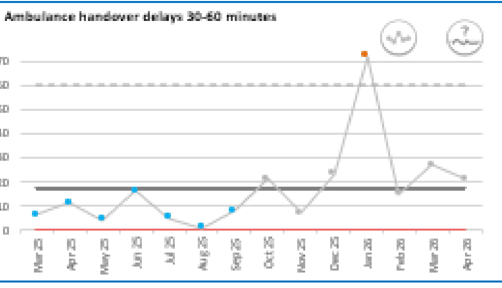
NHS
Gateshead Health
NHS Foundation Trust

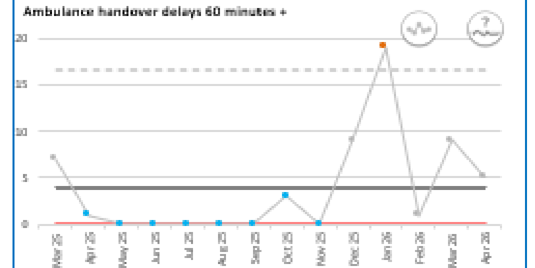


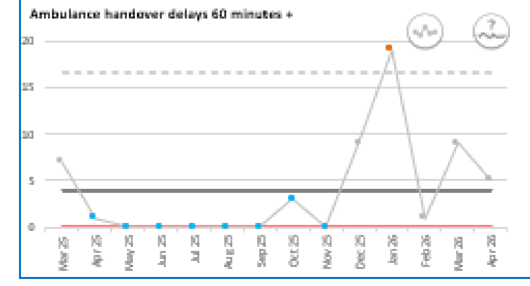


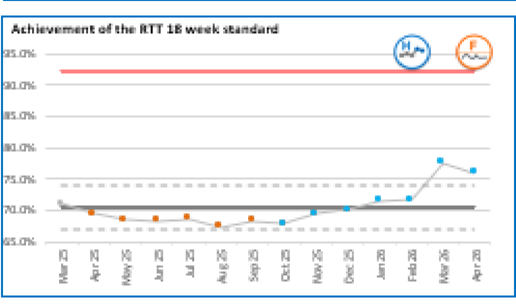




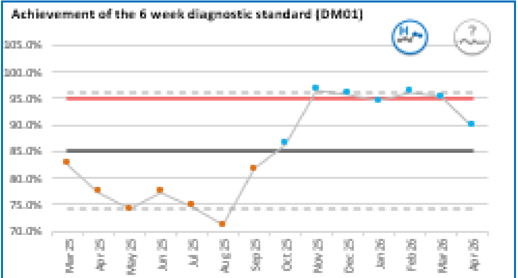


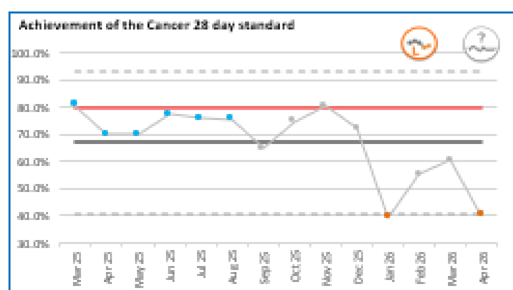


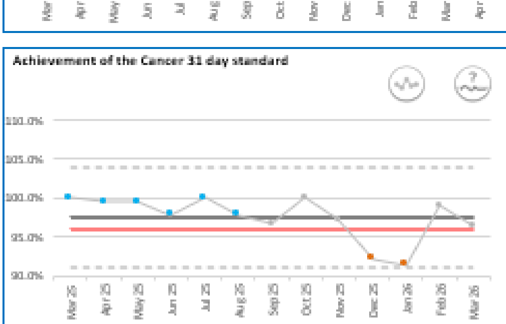


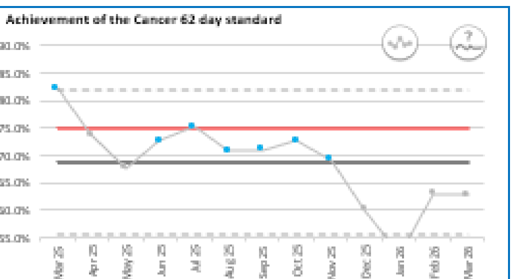


Achievement of the 52 week RTT standard









5. ITEMS FOR INFORMATION / MEETING GOVERNANCE

a - Cycle of Business 2026/27

Presented by the Company Secretary

Meeting:	Trust Board
Chair:	Sir Paul Ennals
Financial year:	2026/27

	Lead	Type of item	Public/Private	May-26	June 26 (year end only)	Jul-26	Sep-26	Nov-26	Jan-27	Mar-27
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	√						√
Standing Financial Instructions, Delegation of Powers, Constitution and Standing Orders - annual review	Company Secretary / Group Director of Finance	Item for Decision	Part 1							√
Calendar of Board Meetings	Company Secretary	Item for Decision	Part 1				√			
Winter Plan	Chief Operating Officer	Item for Decision	Part 1			√	√			
Responsible Officer Report	Medical Director	Item for Decision	Part 1				√			
Board Committee Annual Reviews of Effectiveness and Terms of Reference Update	Company Secretary	Item for Decision	Part 1							√
Green Plan	QEF Managing Director	Item for Decision	Part 1				√			
Premises Assurance Model	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	√		√	√	√	√	√
Strategic Communications Report	Chief Executive / Head of Comms	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				√			√
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				√			
Great North Healthcare Alliance Progress Report and notes	Director of Strategy and Partnerships	Item for Assurance	Part 1 & Part 2	√		√	√	√	√	√
Items for Information			Part 1 & Part 2							
Register of Official Seal	Company Secretary	Item for Information	Part 1				√			
Ad Hoc Items (i.e. items emerging during the year)			Part 1 & Part 2							
Charitable Funds Audited Financial Performance	Group Director of Finance	Item for Board of Trustees	Part 1						√	

b - Questions from Governors in Attendance

c - Any Other Business

d - Date and Time of Next Meeting -
09:30am on Wednesday 29 July 2026

Meeting Closure and Exclusion of the Press and Public