Council of Governors - Part 1

Schedule	Wednesday 20 May 2026, 10:00 AM — 12:30 PM BST
Venue	Rooms 9 and 10, Trust HQ / Microsoft Teams
Organiser	Diane Waites

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AGENDA

Council of Governors (Part 1 – Public)

A meeting of the Council of Governors (Part 1 – Public) will be held at 10:00am on Wednesday 20 May 2026, in Rooms 9&10, Education Centre, Queen Elizabeth Hospital / via Microsoft Teams

AGENDA

No	Start time	Item	Purpose	Lead	Paper / Verbal
1.	10:00	Welcome and Apologies for Absence	Information	Chair	Verbal
2.	10:02	Declarations of interest	Information	Chair	Verbal
3.	10:03	Minutes of the last meeting held on 18 February 2026	Decision	Chair	Paper
4.	10:04	Action log and matters arising	Assurance / decision	Chair	Paper
TRUST UPDATES INCLUDING STRATEGY					
5.	10:05	Introduction to Non-Executive Directors	Discussion	Non-Executive Directors	Verbal
6.	10:15	Showcase presentations / patient / staff story			
		i) Speech and Language Therapy Services	Assurance	Executive Directors	Presentation
7.	10:40	Great North Healthcare Alliance update	Assurance	Director of Strategy and Partnerships	Paper
8.	10:50	NHS Staff Survey Results	Assurance	Group Director of People and Organisational Development	Presentation
9.	11:00	Governor response to the Quality Accounts	Decision	Interim Chief Nurse	Paper
BOARD AND COMMITTEE UPDATES					
10.	11:10	Acting Chief Executive's update			
		i) Strategic Report	Assurance	Acting Chief Executive	Paper
		ii) Finance Report	Assurance	Acting Chief Executive	Paper
		iii) Governor Dashboard	Assurance	Acting Chief Executive	Paper
		iv) Questions from Governors	Assurance	Chair	Verbal
11.	11:30	Board Committee Assurance update:			
		i) People and Organisational Development Committee	Assurance	Chair of the Committee	Presentation
		ii) Group Audit Committee	Assurance	Chair of the Committee	Presentation
GOVERNANCE					
12.	11:50	Council of Governors Attendee Role	Decision	Company Secretary	Paper

No	Start time	Item	Purpose	Lead	Paper / Verbal
UPDATES FROM GOVERNOR COMMITTEES AND GROUPS					
13.	12:00	Membership, Governance and Development Committee Assurance Report	Assurance	Chair of the Committee	Paper
14.	12:05	Governor Remuneration Committee Assurance Report	Assurance	Chair of the Committee	Paper
ITEMS FOR INFORMATION / MEETING GOVERNANCE					
15.	12:10	Cycle of Business 2026/27	Information	Company Secretary	Paper
16.	12:12	Top 3 Messages	Discussion	Chair	Verbal
17.	12:15	Any Other Business	Discussion	Chair	Verbal
18.	12:20	Review of Meeting	Discussion	Chair	Verbal
19.	12:25	Date and Time of Next Meeting – 10:00am on Wednesday 30 September 2026	Information	Chair	Verbal

1. Welcome and Apologies for Absence

2. Declarations of interest

3. Minutes of the previous meeting held on 18 February 2026

Council of Governors Part 1

Minutes of a meeting of the Council of Governors held at 10.00am on Wednesday 18th February 2026 in Rooms 9&10, Education Centre and MS Teams.

Name	Position
Members present	
Sir Paul Ennals	Chair
Helen Adams	Staff Governor
Cllr Dorothy Burnett	Appointed Governor
Steve Connolly	Public Governor – Central & Eastern
Lynsey Curry	Staff Governor
Ray Dennis	Public Governor – Western
Barry Hill	Appointed Governor
Carol Hindhaugh	Public Governor – Central & Eastern
Paul Johnson	Public Governor – Central & Eastern
Moira Ledger	Public Governor - Western
Michael Loome	Public Governor – Central & Eastern
Susan McKenna	Public Governor – Central & Eastern
Adaeze Obiayo	Staff Governor
Aron Sandler	Appointed Governor
Gemma Frances Spiers	Appointed Governor
Sheena Sykes	Public Governor – Central & Eastern
Karen Tanriverdi	Public Governor – Central & Eastern
Chris Toon	Appointed Governor
Jon Twelves	Public Governor – Western
In Attendance	
Jennifer Boyle	Company Secretary
Adam Crampsie	Non-Executive Director
Sean Fenwick	Acting Chief Executive
Neil Halford	Medical Director of Strategic Relations
Joanne Halliwell	Group Chief Operating Officer
Carmen Howey	Group Medical Director
Kathryn Jobes	Charity Manager, Women's Cancer Detection Society (26/02/06)
Rachel Lockerbie	Specialist Breast Care Nurse (26/02/06)
Gerry Morrow	Vice Chair
Beth Swanson	Interim Chief Nurse
Emily Turnbull	Specialist Breast Care Nurse (26/02/06)
Diane Waites	Corporate Services Assistant
Apologies	
John Bedlington	Public Governor – Central & Eastern
Andrew Besford	Non-Executive Director
Michael Brown	Appointed Governor
Sarah Craig	Public Governor – Western
Gavin Evans	QE Facilities Managing Director
Martin Hedley	Non-Executive Director
Rob Hughes	Non-Executive Director
Andrew Lowes	Staff Governor

Kris Mackenzie	Group Director of Finance
Lakkur Murthy	Public Governor – Western
Maggie Pavlou	Non-Executive Director
Julia Perry	Appointed Governor
Amanda Venner	Group Director of People & Organisational Development
Brenda Webb	Public Governor – Central & Eastern

Agenda Item No		Action Owner
26/02/01	**Welcome and Chair's Business** Paul Ennals opened the meeting and welcomed the Governors and Board Members. He drew attention to the government proposals around the removal of Council of Governors from April 2027 and highlighted that there is a commitment to work with the Council to develop a future engagement model. A workshop has therefore been set up on Wednesday 4th March 2026 to discuss further and consider future opportunities. There were no other items of business to be made aware of.	
26/02/02	**Declarations of interest** There were no declarations of interest.	
26/02/03	**Apologies for absence:** Apologies were received as per the attendance register.	
26/02/04	**Minutes of the previous meeting:** The minutes of the previous meeting held on 19 November 2025 were approved as a correct record.	
26/02/05	**Action log and matters arising:** The Council of Governors' action log was updated accordingly to reflect matters arising from the minutes and discussions took place below: • Action 25/09/06 relating to sharing further information for staff retention once focus work has been completed. This is ongoing therefore action to remain open until completed. • Action 25/11/06 relating to assurances of mechanisms to support colleagues raising and resolving concerns. A full list of spaces that colleagues can use for confidential discussions have been distributed across the Trust as a direct result of the query raised by Governors. Action agreed for closure.	

Agenda Item No		Action Owner
	• Action 25/11/06 relating to the possibility of sharing staff or patient stories around themes of improvement from Alliance workstreams. It was reported that this is being looked at by the Alliance Formation Team and Governors will be briefed when these are available and shared. Action agreed for closure on this basis. • Action 25/11/25 relating to providing a response around difficulties experienced submitting a compliment online. It was reported that changes have been proposed to the website therefore action agreed for closure. • Action 25/11/06 relating to distributing a full list of questions and responses to the Council. This was circulated following the previous meeting therefore action agreed for closure. The Council 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 Council meeting. No further requirements were highlighted.	
26/02/06	**Showcase Presentations:** **Breast Services Governor Visit:** Steve Connolly, Michael Loome and Sheena Sykes provided feedback on a recent visit undertaken in breast services. They reported that this was an informative visit which demonstrated the exceptional service provided by the staff and they also received positive feedback in relation to the patient experience. Sean Fenwick shared a slide outlining the service's performance challenges and improvement actions which highlights the increase in referrals and subsequent cancer performance pressures. Regional discussions are taking place to develop a breast reconfiguration strategy which will include psychology support, and the Trust is also reviewing future workforce modelling to expand clinical capacity. **Children's Books:** Rachel Lockerbie and Emily Turnbull, Specialist Breast Care Nurses, attended the meeting with Kathryn Jobes from the Women's Cancer Detection Society to highlight the development of three children's books which help explain cancer to families who have been impacted by this. The three books (Mammy has Chemotherapy, Mammy has Breast Surgery and Mammy has Radiotherapy) are provided free of charge to patients at the hospital and have received excellent feedback from patients, their families and healthcare professionals. The books have attracted national interest and are also available within local libraries and schools. Rachel and Emily explained that the team are also looking at developing additional books covering male breast pathways and grandparents.	

Agenda Item No		Action Owner
	Following a query from Adam Crampsie in relation to health inequalities and whether consideration was being given to develop the books in different languages, Rachel Lockerie explained that discussions have been taking place with one of the Macmillan translators therefore it is hoped that these will be available in the future. Paul Ennals thanked the team for highlighting their excellent work with Governors and Board Members also expressing their gratitude and support. Rachel Lockerbie, Kathryn Jobes and Emily Turnbull left the meeting.	
26/02/07	**Acting Chief Executive's Update:** Sean Fenwick provided an update on current issues relating to the Trust within the organisational strategic priorities. He began by drawing attention to some key points in relation to national policy, statistics and context and highlighted that the medium term planning submission had been made with check and challenge meetings taking place with NHS England and the Integrated Care Board and feedback expected this week. The NHS Oversight Framework Quarter 2 ratings have been published with the Trust seeing an improvement on the previous quarter. NHS Providers and NHS Confederation have recently merged to form a new membership organisation and Sean Fenwick explained that this will provide a single, stronger national voice which will improve collaboration and reduce duplication. It was noted that resident doctors have voted in favour of further industrial action and Sean Fenwick explained that this will continue to be reviewed and plans put in place to manage this. Engagement work is currently being undertaken by NHS Providers to gather views on the potential future changes in Foundation Trust governance particularly around the proposal to remove the requirement to have Councils of Governors and this will be discussed in more detail at the planned Governor workshop. Sean Fenwick drew attention to some of the national performance headlines and the detailed slide around the Trust's key operational performance headlines which demonstrates the Trust's position against national and peer benchmarking. He highlighted that pressures have continued through the winter period with significant challenges during December however it is recognised that the Trust remains a top performer in ambulance handovers. Following a query from Sheena Sykes in relation to the increase in A&E attendances and whether this related to patients being directed to A&E instead of other pathways, Carmen Howey explained that this mainly related to the number of independent patient attendances rather than referrals. Paul Johnson queried whether there were any plans in place to consider first level volunteer triage to support ambulance handovers and	

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	Sean Fenwick explained that this is being considered as part of the national plans to improve services within the community and highlighted the current model already in place within the Jewish community. Michael Loome requested further information around the impact of the resident doctors strike and Carmen Howey explained that this had been managed effectively with minimal impact on outpatient appointments. Following a query from Jon Twelves in relation to the level of ambition of the medium term plan, Sean Fenwick explained that this is a clear, deliverable, credible baseline position and the Trust will strive to exceed this position wherever possible. **Finance Report:** Sean Fenwick reported that the Trust is currently on plan to achieve its cost reduction target which is a great achievement for the organisation however plans for next year will be challenging to ensure the Trust achieves its breakeven position. Paul Ennals reminded the Council that they will continue to receive updates via the Governor workshops. **Governor Dashboard:** Sean Fenwick drew attention to the top organisational risks which have been reviewed to provide summative risks aligned to the Trust's strategic priorities. He drew attention to some of the people metrics and following a query raised by Susan McKenna, in relation to whether work has been undertaken to review teams with low sickness rates to provide learning and best practice. Adam Crampsie highlighted that this is a key area reviewed by the People and Organisational Development Committee to ensure a consistent approach is managed. Sean Fenwick highlighted some of the recent Patient-Led Assessments of the Care Environment (PLACE) visits which Governors are welcome to join on a weekly basis. These have been largely positive and enable teams to receive feedback around possible improvements. **Planning Update:** Paul Ennals highlighted that discussions have already taken place around the medium-term planning submission and explained that cost reduction plans will require some transformational decisions, but plans are in place to achieve the breakeven position and eradicate a deficit position within the next 3 years. Following a query from Jon Twelves around what plans were in place for 2026/27, Sean Fenwick explained that £18m definitive plans have already been identified and the Executive team will continue to review schemes however some will require support from stakeholder partners. **Questions from Governors:** The Chair informed the Council that some questions had been received in advance of the meeting but have been addressed within discussions.	

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	Those Governors who had pre-submitted questions confirmed that they were satisfied that the discussion had appropriately covered the responses. After discussion, it was: **RESOLVED:** to receive the updates for assurance and information.	
26/02/08	**Board Committee Assurance update:** **Quality Governance Committee:** Adam Crampsie provided an update on key issues and assurances, key risks and priorities from the Committee. He drew attention to some of the main areas of discussion which included: • Examples of issues considered include additional assurances provided to the Committee around serious incidents and Freedom to Speak Up (FTSU) updates relating to clinical concerns. Adam Crampsie explained that FTSU updates are also provided to the People and Organisation Development Committee in relation to case metrics. • The Committee is currently monitoring key risks linked to the Board Assurance Framework (BAF) on the Organisational Risk Register and work continues around achieving target scores. • Adam Crampsie drew attention to the case study report relating to increased surgical site infections and explained that the Committee had received findings from the review which was undertaken which identified that this had been multi-factorial. There have been no further infections reported as a result of the ongoing work and normal assurance reporting is now in place. • Key priorities for assurance over the next 6 months includes health inequalities, complaints, and the quality impact and mitigations of cost improvement programmes. Following a query from Sheena Sykes in relation to the small number of complaints recorded and whether this was realistic, Beth Swanson explained that these relate to formal complaints however most complaints are dealt with at local levels to enable early resolution. Detailed metrics are shared via the Patient Experience Group which is reported into the Quality Governance Committee. **Finance and Performance Committee:** Gerry Morrow provided an update on key issues and assurances, key risks and priorities from the Committee. He drew attention to some of the main areas of discussion which have included: • Key issues considered and assurances received by the Committee include financial risks, performance improvement and major business cases.	

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	• The Committee is currently monitoring 8 key risks linked to the Board Assurance Framework (BAF) on the Organisational Risk Register and Gerry Morrow provided assurance that these are being reviewed at every meeting to ensure work continues to achieve target scores. • Key priorities for assurance over the next 6 months include ensuring all Divisions deliver against plan and generate recovery activities where necessary and challenge cost reduction efforts to ensure the Trust becomes a financially sustainable entity that plays a full part in the Alliance. After further discussion, it was: **RESOLVED:** to receive the reports for assurance.	
26/02/09	**Council of Governors' Register of Interests:** Jennifer Boyle presented the Council of Governor' register of interests for 2026. Jennifer Boyle thanked Governors for submitting their declarations and highlighted that there have been some minor revisions since the report was published. She reported that the Trust's constitution requires all Governors to declare interests which are material and relevant. It is therefore good practice to review the interests annually and be made available on request to any member who wishes to view the register. After consideration, it was: **RESOLVED:** to note and record in the minutes, the declared interests of new and current Governors.	
26/02/10	**Governor Committee Terms of Reference:** Jennifer Boyle presented the terms of reference for the Membership, Governance and Development Committee and Governor Remuneration Committee. She reported that the terms of reference have been presented to the relevant Committees, and no changes have been proposed therefore are recommended for ratification by the Council of Governors. It is noted that there is one vacancy for a public Governor on the Governor Remuneration Committee and interested Governors are invited to express an interest. Following consideration, it was:	All

Agenda Item No		Action Owner
	RESOLVED: to ratify the terms of reference for the Membership, Governance and Development Committee and Governor Remuneration Committee.	
26/02/11	**Lead Governor and Deputy Lead Governor Appointment Process:** Steve Connolly and Michael Loome left the meeting for this section. Jennifer Boyle presented the report which outlines options for the process of appointing the Lead and Deputy Lead Governors, considering the upcoming legislative changes that may abolish Councils of Governors by April 2027. Jennifer Boyle explained that this has led to the development of an alternative option to the usual appointment process which is to extend current appointments of Steve Connolly and Michael Loome to provide stability and continuity until the Council ceases to exist, until 18th May 2027 or until their Governor terms of office expire. It was noted that Michael Loome's term is due to end in January 2027. The Council considered the options and confirmed that the preferred option would be to extend the appointments of the current postholders. It was agreed that this would provide stability and preserve established relationships particularly the strong links with counterparts across the Alliance. After discussion, it was: **RESOLVED:** to approve the preferred option to extend the appointments of the current postholders and retain Steve Connolly as Lead Governor and Michael Loome as Deputy Lead Governor until the end of the Council of Governors, 18th May 2027, or the end of their terms of office, whichever comes soonest. Steven Connolly and Michael Loome returned to the meeting.	
26/02/12	**Council of Governors' Annual Effectiveness Survey Results:** Jennifer Boyle shared the results of the effectiveness survey and highlighted some of the themes, trends and actions. She reported that overall, the survey results have been positive and indicates good alignment between the views of the Council and the views of the Board which provides assurance over the direction of travel and the relationship between the Board and the Council. The results have been compared to the previous year and there is no significant difference between 2024/25 and 2025/26. Holding Non-Executive Directors (NEDs)	

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	to account was an area of focus following last year's survey and the results demonstrate that developments around this area have been made and interaction between the Board and Governors has improved. There is a general view that feedback from Board Committee observations requires attention, and further discussion will take place at the next Membership, Governance and Development Committee to determine whether any additional actions are needed to support Governors. Jennifer Boyle highlighted that the results also show that the area with the greatest range of Governor responses is in relation to membership engagement and representation which is similar to last year's results. It is felt improvements around public engagement is required and this will be an area for discussion at the Membership, Governance and Development Committee. Paul Ennals felt that the process provided good assurance that relationships were working well and further discussion around key areas will take place at the Membership, Governance and Development Committee. Following discussion, it was: **RESOLVED:** to receive the results for assurance and note that the Membership, Governance and Development Committee will consider the results in more detail and agree any next steps for development.	
26/02/13	**Membership, Governance and Development Committee update:** Steve Connolly provided the Council with an update on the key messages from the recent Membership, Governance and Development Committee held on 7 January 2026 He reported that there were no issues identified as requiring escalation to the Council for further action however drew attention to some of the areas subject to ongoing monitoring which included: • The Committee participated in the consultation for the Gateshead Council Joint Health and Wellbeing Strategy and shared views and feedback to assist in providing an organisational response. During these discussions, it was felt that it would be beneficial to learn more about some community services and Helen Adams agreed to provide further information around the health inequalities work at the next Governor workshop. • Other subjects included the role of Governors holding Non-Executive Directors to account and the Board Committee observer role which have also been highlighted within the effectiveness survey results shared earlier in the meeting.	

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	Observer feedback was shared at the Governor pre-meeting before this Council meeting. • The Committee discussed the future role of the Governors in light of the proposals within the NHS 10 year plan and as highlighted previously in the meeting, Governors will have the opportunity to discuss this in more detail at the planned future workshop. • The Committee agreed to rename the Medicine for Members events to Spotlight on Services to make it more open. After discussion, it was: **RESOLVED:** to note the update from the Membership, Governance and Development Committee	
26/02/14	**Governor Remuneration Committee Assurance Report:** Chris Toon provided the Council with an update on the key messages from the recent Governor Remuneration Committee meeting held on 22nd January 2026. He reported that there were no issues identified as requiring escalation to the Council for further action however drew attention to some of the areas subject to ongoing monitoring which included: • Discussion took place around the current legal Non-Executive Director recruitment process. Chris Toon explained that following the meeting a late application was received and shortlisted but unfortunately later withdrew therefore an updated process will need to be undertaken and will be discussed in Part 2 of the meeting. • The reappointment of two of the Non-Executive Directors is recommended for approval by the Council and will be discussed in more detail in Part 2 of the meeting. • The Committee received the annual review of remuneration for the Chair and Non-Executive Directors and will be discussed in more detail in Part 2 of the meeting. Following discussion, it was: **RESOLVED:** to note the update from the Governor Remuneration Committee.	
26/02/15	**Cycle of Business 2026/27** Jennifer Boyle presented the cycle of business for the Council of Governors for 2026/27. This provides the Council with a forward view of future meetings for the next financial year.	

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	Following consideration, it was: **RESOLVED:** to receive the cycle of business for information.	
26/02/16	**Top 3 Messages:** This agenda item enables the Council to agree on the top three messages from the meeting which Governors can use to inform their discussions with staff, members, and the public. The Council agreed that this included: • Highlighting the excellent work of our colleagues Rachel Lockerbie, Emily Turnbull and Kathryn Jobes in the development of three children's books to help explain cancer to families who have been impacted by this. The books have been made possible with the support of the Women's Cancer Detection Society Gateshead. The books have attracted interest nationally and we are incredibly proud of our team. • The NHS 10 Year Plan has outlined the removal of Council of Governors models which is likely to happen in April 2027, should the legislation be passed. Governors are well valued and the Trust is working collaboratively with Governors to identify mechanisms through which we can continue to seek their valuable engagement and contributions in the future under a revised engagement model. • The Trust is on track to achieve its financial deficit plan for 2025/26. A significant amount of work has been undertaken in relation to financial sustainability during the year whilst making sure that clear safeguards are in place to prevent negative impacts on patient care. It is also noted that the Trust has submitted its medium term plan for the next three years, with the Trust anticipating being able to return to a break-even position in 2026/27. The activity and performance aspects of the plan include a clear focus on elective recovery, urgent and emergency care patient flow, diagnostic testing, community activity and outpatient transformation. In line with normal practice Jennifer Boyle will share these in more detail within the Governor update email along with the details of the event being run by the Resuscitation Team to teach the public a number of skills including CPR, choking recovering and child resuscitation as highlighted by Michael Loome.	
26/02/17	**Any Other Business:** There was no other business to discuss.	

Agenda Item No		Action Owner
26/02/18	**Review of Meeting:** The Council were invited to share any areas of improvement or learning which can also be sent directly to Jennifer Boyle and Steve Connolly. Paul Johnson felt that there has been a lot of good news shared about services within the Trust and the Council wished to thank the Communications team for their efforts around this.	
26/02/19	**Date and Time of Next Meeting:** The next meeting of the Council of Governors will be held on Wednesday 20th May 2026.	

4. Action log and matters arising

Council of Governors’ Action Log

Colour	Status
(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	Status
25/09/06	24/09/25	Acting Chief Executive’s update – questions from Governors	To share further information in relation to staff retention once focus work has been completed	19/11/25	SF/AV	November 25 – ongoing. Update to be provided once work completed.	(purple)
26/02/10	18/02/26	Governor Committee Terms of Reference	Interested Governors are invited to express an interest for the vacancy for a public Governor on the Governor Remuneration Committee	20/05/26	JB	May 2026 – vacancy remains.	(purple)

Actions closed from last meeting

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
25/11/06	19/11/25	Freedom to Speak Up (FTSU)	People and Organisational Development Committee (PODC) to: 1. Seek assurance regarding the provision of confidential spaces for colleagues to use following the removal of the staff listening space 2. Seek assurance over the effectiveness of the mechanisms in place to support colleagues raising and resolving concerns prior to the FTSU stage.	18/02/25	MP / AV (via PODC)	With regards to action 1 a full list of the spaces that colleagues can use for confidential discussions was collated and communicated to all colleagues in the Trust. This was a valuable exercise and came as a direct result of the query raised by Governors. **Action agreed for closure on this basis.**	
25/11/06	19/11/25	Great North Healthcare Alliance Update	To explore the possibility of sharing staff or patient stories around themes of improvement from Alliance workstreams – to discuss with the Alliance Formation Team	18/02/25	NB	It was reported that this is being looked at by the Alliance Formation Team and Governors will be briefed when these are available and shared. **Action agreed for closure on this basis.**	
25/11/08	19/11/25	Governor Dashboard	To provide a response in relation to difficulties experienced submitting a compliment online	30/11/25	JB	Changes have been proposed to the website to clarify that the relevant webpages can be used for both the submission of compliments as well as complaints (Share your experience - Gateshead Health page, the Send us your feedback - Gateshead Health and Patient Advice and Liaison Service (PALS) - Gateshead Health pages). **Action agreed for closure.**	
		Questions from Governors	To distribute full list of questions and responses to rest of Council	30/11/25	JB / DW	Circulated following the previous meeting. **Action agreed for closure.**	

TRUST UPDATES INCLUDING STRATEGY

5. Introduction to Non-Executive Directors (verbal)

6. Showcase presentations / patient / staff story

i) Speech and Language Therapy Services

Adult Speech and Language Therapy Services.

Lorna Dace AD AHPS & Alex Cox / Sarah Illingworth ASLT Leads

20.05.26

Adult Speech and Language Services.

Who we see

Inpatient Services

- Any patient requiring specialist dysphagia assessment admitted to hospital and onward therapy / review
- Any patient with specialist communication needs

Community Services

- Any patient referred to the service for specialist dysphagia assessment
- Any patients with ongoing or newly developed speech, language, voice and communication needs.

What we do

- Carry out specialist assessment and management for patients with dysphagia and / or communication needs.
- Instrumental assessment as indicated: Fibreoptic Endoscopic Examination of Swallow (FEES) and Videofloroscopy examination.
- Training for swallow screening for appropriate healthcare professionals
  - In hospital
  - In care settings
- Collaborative working with dietetics and nutrition services for patients who are NBM / intravenously fed and / or have dietary modifications in place.
- Collaborative working with tertiary service specialists eg ENT
- Provide opportunities for voice banking and comms aids
- Provide specialist equipment.

Which patients need our help?

Patients with **progressive neurological diseases** such as
Multiple Sclerosis
Motor Neurons Disease
Parkinsons Disease
Huntington's disease
Muscular dystrophy

Patients with complications following surgery / radiation therapy that can impact swallowing or communication

Patients with **structural difficulties**
Inflammation/ reflux
Oesophageal strictures/ obstruction
Cleft palate
Vocal cord paralysis
Head and neck cancer surgery

Patients with **brain injury or insult** such as
Traumatic brain injury
Non traumatic head injury such as stroke, haemorrhage, aneurysm
Tumours
Poisoning / toxin
Drug induced injury

Patients who have
Age related changes
Chronic respiratory disease
Dementia
Some medications
Cerebral palsy

What is dysphagia?

Dysphagia is the medical term for swallowing difficulties. It is a complex medical condition that affects eating, drinking and swallowing.

Without proper management, dysphagia can lead to choking, aspiration pneumonia, malnutrition and dehydration and social isolation.

Speech and Language Therapists manage dysphagia through assessment, diet and fluid modification, rehabilitation and education.

Where are we within Gateshead Health?

- We have worked hard to meet the national recommendation on ensuring that patients who have an urgent need for a dysphagia assessment are seen within 48hrs of referral
  - As an inpatient we achieve this 85% of the time (currently no weekend provision)
  - **Within the community we do not achieve this. Measures are unvalidated but currently our waiting times for patients with the most urgent need can be waiting between 6-8 weeks.**
- We meet evidenced based practice guidance from RCSLT by carrying out instrumental assessment for patients within the hospital and the community
  - Videofloroscopy
  - Fibreoptic Endoscopic Examination of Swallow (FEES)
- All of our staff work within national guidance for Speech and Language Therapists eg EDS (Eating, drinking and swallowing) competency frameworks, AHP Competency framework for PND

Where are our gaps?

- Our service needs to be modernised to meet the demand now placed on the service
- We need to ensure that ALL staff are trained to carry out instrumental assessment where clinically appropriate
- Targeted work to ensure that we meet national guidance that patients with most urgent need are seen within 48 hrs irrespective of setting.
- Improving the inpatient response time to > 90% of patients are assessed within 48hrs of referral
  - Provision of funded weekend cover for all inpatient areas
- **Focus on improving response times for patients within the community**
  - **Apply standardised triage system to ensure that patients who have the most urgent need are categorised appropriately**
  - **Creation of rapid response system where all community SLTs have opportunities to see those patients who have the most urgent need as quickly as possible.**
- Continue to develop professional relationships with ENT colleagues enabling us to respond to needs such as ILO/PTS
- Gaps in funded access to SLT front of house and within critical care

Gateshead Health
NHS Foundation Trust

What other work do we need to do to ensure we succeed?

1. Focus on training appropriate staff to screen patients who may have a swallow difficulty.
    - staff at QEH
    - staff within residential care
    - carers within the community
2. Improve our information for patients, relatives and carers to ensure they are aware of support needs & options and how to access the service.
3. Ensure consistency across all areas of the services (acute and community) in patient management and documentation
4. Work with our other AHP, nursing and medical colleagues to ensure that SLT is considered as part of any investment programme and development of services from the outset.
5. Make use of guidance on progressive neurological conditions to ensure a level of specialism is present across all therapists appropriate to grade

Changes to the service

- ASLT now forms part of the new therapies service line within CSS alongside all other allied health professionals. (OT, PT, Dietetics, CSLT, Podiatry) allowing for stronger professional leadership and support, clear lines of governance including supervision and professional development and collaboration across disciplines
- Change to professional leadership within ASLT following retirement
- Review of performance / outcomes within the department in line with national guidance and local service provision in other areas of the region.
- Review and modernisation of the service structure including roles and responsibilities to enable improved responsiveness
- Review of current triage standards in line with national and local comparators and guidance

staffing structure Aug 25

- 8a Professional Lead
  - B7 idiopathic PD fixed term
  - B7 PD 0.8
  - B7 Inpatient 0.8
    - 1.0 B6
    - 0.8 B6
  - B7 Community 0.8
    - 0.6 B6
    - 1.0 B6
  - B7 Voice and Fluency 0.8
    - 0.6 B6
  - B7 stroke 0.6 community
    - 0.9 B6
    - 1.0 B6
    - 1.0 B6
    - 1.0 B6 Community

Purple box indicates vacancy
Red box indicates unfunded post

New Staffing Structure May 26

- 8a Professional Leads
  - B7 0.8 Inpatient
    - 0.8 B6
    - 1.0 B6
  - B7 0.8 Community now filled
    - 1.0 B6 now filled
    - 1.0 B6
    - 0.6 B6
    - 0.6 Voice / Fluency
  - B7 Stroke 0.6 community
    - 1.0 B6 community
    - 0.9 B6 acute
    - 1.0 B6 acute now funded
    - 1.0 B6 acute now funded.
  - B7 0.8 Inpatient and Instrumental lead Now filled
  - B3 Assistants
    - B3 0.6
    - B3 0.6
  - B3 Admin
    - B3 Admin 0.6
    - B3 Admin 0.6

Decisions that have been made

- **Did not recurrently fund the pilot Parkinsons Disease post**
  - Did not meet objectives as had been planned
  - Did highlight a greater need that could be met in a different way

- **Realigned B7 roles to create additional capacity within the community**
  - Enables rapid response dysphagia service within community
  - Enables improved access to instrumental assessment
  - Creates capacity for training all SLT staff in instrumental assessment as a core skill
  - Enables capacity for care staff training within the community
  - Unfunded posts within stroke service have now been funded again
  - Enables a return to 7-day service within stroke
  - Enables ability to meet national Stroke standards
  - Enables integration of acute and community stroke teams

Parkinsons UK Pilot study

- 2yr funding for 1.0 WTE B7 post
  - Included only patients with idiopathic Parkinsons Disease
  - Saw 3-4 patients per week as inpatient (inclusion criteria admitted with idiopathic PD irrespective of need)
  - Saw 1 patient per fortnight as urgent community dysphagia assessment (inclusion criteria P1 Category only)
  - Followed up 1 patient per week in community (inclusion criteria reviewed x1 post discharge then transferred back to community team)
  - On busiest week maximum patient caseload was 6 patients per week

Limitations of pilot

- Singlehanded therefore only covered Mon-Fri 9-5 hours and created inability to ensure that standards and targets set could be achieved as large proportions of time remained uncovered
- Limited inclusion for patients with Parkinson's disease in community meant that capacity across the wider clinical team was not lessened.
- Did not improve access to specialist instrumental assessment
- Created inadvertent inequality to access for patients with PD and did not enable any improvement to services for other patients in urgent priority
- Limited ongoing development of general staff to gain / maintain skills and expertise in the condition.
- Didn’t incorporate communication assessments / management for these patients.

What we have ensured following the pilot

- We continue to have skilled and experienced therapists who have expertise in Parkinsons disease and the management of the condition
- We ensure that all our staff use the AHP competency framework for progressive neurological conditions as part of CPD
- We will continue to work with experts in the field for all progressive illnesses to ensure that our practice remains up to date and evidenced based
- We have a plan to increase our capacity to carry out instrumental assessment for all patients including those with PD
- We will ensure that staff have the skills to work across a range of settings and with a range of conditions to improve resilience within the team
- We continue to strengthen supervision frameworks for staff, including group supervision for dysphagia and communication.
- We have an opportunity to develop training programmes for carers, care facilities and families within the community to support those patients who have difficulties with swallow.
- We can provide a rapid response service for patients who have an urgent need for specialist dysphagia assessment, irrespective of location or condition.
  - Aiming to work within the expected timescales of
    - 48 hrs for patients admitted to hospital
    - 48 hrs for the most urgent need
    - 10 days for a rapid response.
    - Within the national 18 week criteria for routine response.

Next Steps

- Continued recruitment into roles that are currently vacant
- Develop improved systems for speedy triage
- Ensure that the rapid response service for urgent community assessment is resilient
- Look at clinical gaps in service as explained above and work with wider clinical teams to develop robust input into those services.
- Ensure that we are able to provide support and training for the wider staff groups where appropriate so that patients with swallowing difficulties can be screened and referred on quickly and appropriately no matter where they are or what condition they have

Thank you!

7. Great North Healthcare Alliance update
To be presented by Nicola Bruce, Director of Strategy and Partnerships

Report Cover Sheet Agenda Item: 7

<table>
<tr><td>Report Title:</td><td colspan="4">Great North Healthcare Alliance update</td></tr>
<tr><td>Name of Meeting:</td><td colspan="4">Council of Governors (Part 1 – Public)</td></tr>
<tr><td>Date of Meeting:</td><td colspan="4">20th May 2026</td></tr>
<tr><td>Author:</td><td colspan="4">Martin Wilson, Director - Great North Healthcare Alliance</td></tr>
<tr><td>Executive Sponsor:</td><td colspan="4">Dr Sean Fenwick, Acting Chief Executive</td></tr>
<tr><td>Report presented by:</td><td colspan="4">Nicola Bruce, Director of Strategy and Partnerships</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">To provide an update to Governors on the work of the Great North Healthcare Alliance including a 2025/26 progress report and information on a refreshed strategic intent that was considered by Trust Board in March 2026</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">Strategic intent considered by Trust Board in March 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">This paper is intended to provide Governors with an update of the work of the Great North Healthcare Alliance that includes a refreshed strategic intent that has been agreed by Trust Boards. The intent clarifies that the Alliance will focus on:

• Delivering excellent tertiary and secondary hospital services
• Strengthening neighbourhood care closer to patients
• Supporting patient choice and reducing inequalities
• Improving sustainability and financial resilience through collective action</td></tr>
</table>

<table>
<tr><td rowspan="1">Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="5">Council of Governors are asked to note the update and refreshed strategic intent for the Great North Healthcare Alliance as detailed within the paper.</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 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"></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>

2025/26 Progress report

April 2026

This report sets out delivery against 25/26 objectives

This report sets out:

- Overall context of progress made
- Delivery against each of the 5 strategic priorities for 25/26
- Progress against the wider set of 25/26 milestones
- Progress updates from each of the 3 bilateral relationships – including lessons learned
- Examples of progress made during 25/26, written in a way that may be helpful with patient, staff, governor and board facing communications about the impact of the Alliance
- Next steps including refreshed strategic intent

In 2025/26 we have made good progress in some areas, with further work to do in others

The Alliance Steering Group and Trust Boards have all agreed that the Alliance is making fair, but not great, progress. This is not a criticism of anyone involved and is likely driven by factors such as:

- What “we” are trying to achieve through “our Alliance” is not easy. It requires trust between partners at many levels of the organisations, and this takes time to develop. The Alliance is learning about how best to make cross organisational changes happen.
- NHS accountability mechanisms reinforce the primacy of individual organisational delivery, such as through NHS Oversight Framework (NOF) ratings. It is noted that as management and leadership capacity is tight, the focus is drawn to the urgent in-organisation activities rather than the equally important inter-Alliance activities which are key to longer term sustainability and delivery.
- There has been change in leadership within the Trusts in the Alliance, including 4 chief executives who have all been in post for 3.5 years or less, and of these 3 are in acting roles. Similarly two of the three chairs who were involved in establishing the Alliance are no longer in post.
- The Bilateral model continues to support progress in many areas. That said, some discussions and networks across the Alliance are not as robust as may be required to deliver high impact. The light touch / informality of some of these arrangements was deliberately designed to avoid placing a burden on busy colleagues, but a consequence may be that people have not prioritised sufficient time to engage with partners in the other Alliance trusts that is required to develop the trusting relationships which are required (see first bullet above).
- Alongside this, our discussions around the strategic intent of the Alliance considered how to improve the interface between the Alliance Steering Group, wider Board members, and executives and senior leaders, in particular clinical leaders.
- When it comes to corporate service efficiency opportunities there are the complications of 1) understandable desire to keep services locally run and 2) potential duplication with ICS / regional discussions particularly in HR.

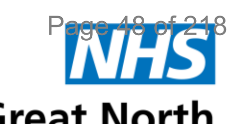
The Alliance Steering Group agreed 5 strategic priorities for 2025/26, with progress shown below (p 1 of 2)

25/26 Priorities	Progress by year end March 2026 (RAG rating based on progress against expectations for 25/26)	
To have **addressed known weaknesses in services** across neighbouring trusts by working together as good bilateral partners	• Positive executive level working together on bilateral basis with a focus on problem solving particularly operational and performance issues in clinical services. Improvements delivered include patient acute cardiology, audiology, NCIC skin and head and neck waits. Focus shifting from addressing issues where one trust is fairing more poorly, to jointly working on areas where overall improvements can be made. Doing collaborative work like the Alliance requires time commitment from already busy executive, clinical and managerial leads and this continues to be a challenge. Focussed support from the Alliance Formation Team in planning and facilitating meetings and discussions found to be very helpful with this. • GHFT board strategic options work clear on renewed priorities for bilateral collaboration, but the bilateral itself stalled for a number of months. QEF transport / logistics support to Newcastle. • Further to go to ensure the existing positive examples of working together at clinical lead and middle manager levels become norm. East coast medical leaders' workshops helpful in building wider clinical engagement and collaboration on priorities. • Alliance strategic intent approved by Boards to 'Work together to deliver excellent tertiary and secondary hospital services, while strengthening neighbourhood care closer to patients' homes'	Green
To have **improved productivity and efficiency** and reduced unwarranted variation in clinical and back office services to become financially sustainable	• This continues to be hard to do but is a recognised purpose of most Alliance work including bilaterals. Alliance benchmarking information on relative cost and efficiency of clinical and back office services shared at exec level and sometimes used at service level. Progress mainly made in clinical pathways around operational and performance issues because that information is readily available, whereas a lack of information and comparable information on outcomes and experience. Some back office opportunities and ideas are surfacing on bilateral basis, as well as at a regional level beyond the Alliance.	Amber
To have **shifted towards community and out of hospital care** and have secured support for our plan to transform care AND have fit for purpose buildings that enable us to deliver efficient high-quality care	• Significant focus in FTs with place-based partners to co-design neighbourhood work with opportunity for shared learning. Each trust at different starting point. • Alliance focus on levelling up FT offers to primary care (including radiology access) and agreeing direction of travel. • ASG supporting Northumbria IHO ambition ahead of wider move to IHO model by other Alliance FTs. • Research commissioned showing no international evidence of impact on inequalities of moving care into community but many other benefits. Results helping local community shift. Follow up research with 2 Community Diagnostic Centres. • Alliance Construction Programme has involved significant market engagement and work with regional and national colleagues to shape the approach. Focus on funded 4 year programme ahead of the longer, as yet, unfunded ambitions. • 4 trust estates teams collaborating on electronics, medical engineering, plans to reduce carbon and capital planning.	Green

Continued (p 2 of 2)

25/26 Priorities	Progress by year end March 2026 (RAG rating based on progress against expectations for 25/26)	
To have **improved our digital services** so that staff find it easier to do their work and we have released back-office costs to reinvest in improving our services	• Joint Chief Information Officer appointed across Northumbria, Gateshead and Newcastle. Current focus on stabilising safe digital foundations ahead of longer-term transformation ambitions. • Collaboration between trusts where significant operational digital incidents arise, eg Gateshead PACS. • Work underway on digital governance and risk structures inside the digital teams and operating model. Opportunities for efficiencies between services being identified. Scale of opportunities outlined in 10 Year Health Plan exceed current resource levels in some areas. • Challenge re ensuring all trusts on same page re scale / share of investment needed to deliver ambition asked for. • Opportunity for LIMS collaboration across NHCT, NCIC and NUTH being progressed.	
To have **deepened our collaboration** and strengthened our shared leadership as the NHS moves to a more decentralised model based on local leadership	• Deepened collaboration and move to decentralised through; bilaterals between FTs; strengthened neighbourhood planning work at place level with partners; east coast medical leaders' workshops. • Shared leadership evidenced by: close working of CEOs; appointment of Shared Chair and Shared CIO across Gateshead, Newcastle and Northumbria; appointment of Trudie Davies within the Alliance as interim CEO at NCIC; lead directors for finance and research and life sciences, role of Alliance director and Alliance Formation Team, collaboration between estates and facilities teams. • It is recognised that each of the 4 FTs are at different starting points and need to respond to different contexts. For example the inclusion of NCIC in the national Improvement Regime with 'Intensive Government Support' and Northumbria's exploration of Integrated Healthcare Organisation / Advanced Foundation Trust potential developments means collaboration will not be a one size fits all model. • Strengthened 'wrap around' Alliance governance with changes to Alliance Steering Group to move to a single joint meeting and appointment of vice chairs onto the group.	

In addition to the 5 strategic priorities a number of milestones for the year were set. Progress on those is shown below.



Milestones for 25/26 delivery	Progress by year end March 2026
CQC Good (or better) x 3	Improvements in performance in many areas. NUTH deescalated from CQC concerns. FT NOF ratings range from 1-4 with NCIC in the intensive recovery programme
Begin comprehensive review of NCIC sub/tertiary specialties with NUTH. Begin phased transfers of any agreed upon specialties	Closer exec level working between NCIC and NUTH, including monthly bilaterals and planned Clinical Summit. Number of service collaborations underway (OMFS, ophthalmology, paeds T&O) with others being identified. Time consuming.
Shared culture principles and leadership programme in place	Culture is becoming much more collaborative but work on specific culture principles for how we will and should work not progressed. Sharing some leadership roles across Alliance. Some cross trust participation in leadership programmes.
Joint recruitment campaigns in place to attract high need areas	Some collaboration specific posts to aid recruitment, mostly between NUTH and NCIC, but also some in other bilaterals.
Clinical framework agreed	Strategic Intent agreed to "Work together to deliver excellent tertiary and secondary hospital services, while strengthening neighbourhood care closer to patients' homes". Clinical Framework Group being established
Medium Term Financial Plan in place	4 Trust medium term financial plans developed in partnership supported by the Alliance and submitted to NHS England. Alliance level planning is mostly an aggregation of 4 FT plans rather than demonstrating impact of Alliance working. Further work to be done on CIP delivery, coding , counting and where services can share to mutual benefit
Analysis of NCICs structural deficit and potential measures	Work undertaken by NCIC. Discussions with DoFs as part of development of medium term finance plan
Deliver significant improvements in quality and access towards recovery of constitutional standards	Significant improvements in areas such as acute coronary syndrome, audiology, head and neck and NCIC skin waits. Overall Alliance performance on each of the main access standards is improving (A&E, RTT, cancer 28 & 62 day, and diagnostics) but remains well below the best levels achieved historically.
Compact written between primary and secondary care	Primary care workstream clarifying offer from secondary care. Supports neighbourhood discussions.
Early adopter integrated Neighbourhood Health Service teams	Significant area of focus within FTs and with place based partners to co-design neighbourhood work.
Specialty Improvement Plans developed	Work taking place at appropriate differing levels, eg bilaterally on skin and vascular / diabetes between NUTH and NHCT; on a 3 way east coast basis via medical directors on stroke, spines, deteriorating child, audiology and urology. Will be major focus of Clinical Framework Group and development of Alliance clinical plan.
Joint research and life science strategy agreed	Work underway with research and innovation focus. Big research conversation and big innovation events held.
Big Build: reviewed top 20 strategic sites for neighbourhood health centres; first FBCs written; joint shared venture developed	Discussion re neighbourhood health centres part of place discussions. Alliance Construction Programme continued market engagement. Longer term ambitions unfunded. 4 FT estate teams discussing greater collaboration
Co-brand all relevant initiatives Trust and Alliance	Examples include cobranding Community Diagnostic Centre, Big Innovation Conversation, Carol Service, website
Review Joint Committee and lead director areas	Review of joint committee arrangements done. Changes approved as set out in 'wrap around governance' paper.
Aligned Staff Survey questions	Deprioritised as a current area of focus within overall workforce programme.

Important work is progressed through bilaterals, such as the one between Northumbria and Newcastle as summarised here

Complete | On track | At risk | Off track | New suggestion

#	Work area		Description of progress and next steps
1	Audiology	At risk	• Encouraging delivery from Bright Charity to support RNIB activity. Risks exist around ongoing affordability and delivery of DM01 position. Last discussed at Bilateral in September. • Concerns and comments from Northumbria Governors and stakeholders still present.
2	Urology	Off track	• Continued challenges despite progress to deliver an improvement plan that has resulted in NHCT looking at out and insourcing. Also reviewing SLA, and a shared approach to workforce issues, including job planning, cost-sharing sickness and leave, and recruitment. Last discussed at Bilateral in September. • Work and discussions have shifted out of bilateral meetings into direct / business as usual forums. Ongoing issues being looked at via NCA re MDT and radiology limitations on MDT impacting on cancer performance
3	Skin and plastics	Off track	• Ongoing discussions to agree approach to tackling high referral volumes across both trusts and changes to DoS; changes have seen drop in referral numbers to NUTH and increase in NHCT. Agreed to have discussions with respective partners, looking at having discussions with primary care, using technology / AI solutions, looking to other national best practice, and then working with ICB and Cancer Alliance across this to support onward commissioning.
4	West patient flows	At risk	• Joint project sub-group set up to look at data from both trusts, separating this from anecdotes. Output coming back to next bilateral board to understand whether there are any options to be developed based on the data.
5	Vascular and diabetes	At risk	• Good early discussion in March bilateral to outline opportunities to improve pathways, patient outcomes and operational pressures from varied demographic issues. Exploring data and forming sub-group to take forward work, reporting to next Bilateral.
6	LIMS	On track	• In principle discussions ongoing around extending NHCT LIMS provision to Newcastle. Procurement risks being assessed and worked through. Taken forward through digital / Joint CIO discussions.
7	Pain management	On track	• Reviewing historic issues and service transfer, exploring where improvements are possible.
8	Other issues	Complete	• Some areas have moved off the Bilateral agenda, either through them not requiring specific focus that warrants discussion, or because they have moved to 'business as usual' type forums – ILD, upper GI, Manor Walks, OMFS, Sterile Services, staff passporting.

Key learning points from the past year

- Bilateral meeting frequency reduced – now c.6-weekly – but duration increased. Single item agendas have been useful to flush out opinions to then focus on solutions.
- Sense from attendees that most recent meetings have been most and increasingly productive. Nature of collaborative options has expanded but still some views raised that are seen as uncollaborative, or seeking to part blame and risk deliverables that are beneficial to patients.
- Discussions increasingly seeking to outline an affordable model of provision that can then be discussed with the ICB to commission but needs to be done prior to any change in pathway to avoid unintended consequences

Important work is progressed through bilaterals, such as the one between North Cumbria and Newcastle as summarised here

Complete | On track | At risk | Off track | New suggestion

#	Work area		Description of progress and next steps
1	Exec to Exec	On track	• Monthly bilaterals continue. Regular and frequent discussions between CEOs, medical directors and COOs, supported by bilateral discussions between estate, finance, nursing and others. Joint executive to executive held.
2	OMFS	At risk	• Services in NCIC currently stabilised with increased input from Newcastle colleagues. Progress slow and relationships could be better. Medical directors and external facilitators working with colleagues in both trust to build relationships around implementing constructive plan.
3	Paeds T&O	At risk	• Issues around medical capacity at NCIC supported by in-reach support from GNCH. Intention to ensure that recruitment of consultant at NCIC is supported by continued and paid sessional input from GNCH consultants.
4	Ophthalmology	Off track	• Services in both trusts challenged with risks around follow up care (e.g. glaucoma) and capacity. Significant medical and wider clinical leadership support provided by Newcastle into NCIC. Discussions currently underway around how best to support and sustain NCIC service in longer term. Given the significance of the risks to NCIC patients it may be necessary to urgently explore options outside the GNHCA footprint if local mitigations can't be identified.
5	Collaboration model	On track	• Draft collaboration model paper developed and discussed. Principles contained within it currently being checked between bilateral peers with the aim of making good progress and potentially adopting as a blueprint for other bilateral relationships within the Alliance.
6	Gastro	Off track	• NCIC have recently asked for help with this specialty due to significant shortfall in consultant capacity. Medical directors bringing together leaders from both trusts to scope the options for collaboration. GNHCA CEOs are aware and supporting clinical leaders to see if any solutions can be reached
7	Research and education	On track	• Medical director dialogue about opportunities linked to new Cumbria Imperial Pears Medical School
8	Clinical summit	On track	• Intention to hold a joint clinical summit of c30 senior clinical leaders to build senior clinical relationships between the 2 trusts, so that as individuals and collectively they (1) share better understanding of each others challenges in providing high quality care, (2) identify ways to work together to improve services for patients and staff, and (3) can more easily work directly in delivering these improvements. Intention to hold in June. Proposal with MDs and DoNs.

Key learning points from the past year

- New NCIC interim CEO and chair have brought Alliance working into greater focus within the Board who are supportive of the Alliance strategic intent direction of travel.
- Need for active day to day executive involvement where fragility of some clinical level relationships can show up in some unexpected developments that can knock back collaborative clinical and managerial working.
- Greater service level managerial and leadership churn than seen in other bilaterals reinforces need for good program governance and reporting in and to bilateral discussions.

Important work is progressed through bilaterals, such as the one between Gateshead and Newcastle as summarised here

Complete | On track | At risk | Off track | New suggestion

#	Work area		Description of progress and next steps
1	Gateshead Board support for closer Alliance working	On track	• Gateshead Board have considered various strategic sustainability options and concluded that strong collaboration via the Alliance is key. • 6 clinical pathways identified for prioritised progress via Alliance with Newcastle in acute oncology, cancer, cardiology, paeds, stroke and urology.
2	Alliance strategic intent	On track	• Both Boards and executive teams have approved Alliance Strategic Intent to 'Work together to deliver excellent tertiary and secondary hospital services, while strengthening neighbourhood care closer to patients' homes'.
3	East Coast Medical Directors' collaboration	On track	• Close medical director collaboration between the two trusts and with Northumbria. Very helpful monthly meetings with progress being made in identifying and taking forward opportunities for collaboration. Gateshead MD to Chair Clinical Framework Group for the Alliance as a whole. • Active engagement from senior clinical leaders from both trusts in 2 east coast medical leaders' workshops that have identified specific areas of focus for collaboration in stroke, spines and paeds. Joint working groups being established.
4	Bilateral meetings	Off track	• Bilateral meetings have lost momentum. Renewed focus required aligned to the clinical pathways identified above with face to face meetings in working time.
5	Paediatric collaboration	At risk	• Positive discussions between senior medical and managerial leaders about opportunities for closer collaboration around acute and community paediatric models of care between Gateshead and Newcastle GNCH. Further two meetings to be arranged with the aim to draft up a proposal for a future model for paediatric care between the two trusts as part of the wider network arrangements.
6	Urology	Off track	• Continued challenges despite numerous discussions at operational management level to improve access for patients. SLA for 26-27 has confirmed a capacity / demand imbalance in relation to Gateshead referrals. • Opportunities considered about changing service model but challenges with stranded costs. Joint update paper being prepared for consideration by executive leaders to look at next steps.
7	CDC	On track	• Collaborative Community Diagnostic Centre opened at Metro Centre providing increased capacity and reducing patient waits. Challenges with different booking and digital systems. Good governance arrangements in place to address operational and strategic issues. • Phase 2 of the CDC successfully supported by NHSE. Facility to be regionally available rather than via a bilateral model. Focus on embedding neighbourhood health within phase 2. • Intention to build on Alliance prevention workstream research into impact of moving care from hospital to community by undertaking follow up study between Metro Centre and Workington CDCs looking at opportunities to reduce inequalities in access etc.

Key learning points from the past year

- Bilateral working requires both Board / executive commitment to the Alliance model and relevant executive director capacity to engage in and drive the work.
- SLA issues need to be brought into bi-lateral discussions.

Examples of progress made during 2025/26 through the Great North Healthcare Alliance

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

- **Stronger working relationships across hospitals:** Staff across the Alliance are working together better than ever before. In places where relationships were once difficult, teams now feel more positive, supportive and aligned. This stronger way of working is helping us make faster decisions and deliver improvements more quickly, supported by regular joint working and strong leadership from our Boards.
- **Faster treatment for heart attack patients:** Patients with acute coronary syndromes are now being transferred to the Freeman Hospital for specialist treatment much more quickly. Average waiting times have been cut from four days to two. This means better outcomes for patients, quicker recovery, and shorter hospital stays.
- **More care available closer to home:** New services and improved care pathways mean more patients can now be diagnosed and treated locally, without unnecessary trips to hospital. Two new Community Diagnostic Centres have opened in Workington and at the Metrocentre. These have helped reduce waits for head and neck services in Cumbria, and for lung disease services in Northumberland and North Tyneside.
- **Quicker access to hearing aid support:** By working with voluntary sector partners, patients can now get hearing aid supplies and repairs more quickly and closer to home. This frees up NHS staff to focus on patients with more complex hearing needs, improving care for everyone.
- **Better recruitment to hard-to-fill roles:** Trusts have worked together to recruit consultants in specialties where staffing has been a challenge. By advertising and recruiting jointly, services are becoming more stable and resilient for patients.
- **Making services more consistent for GP practices and patients:** The Alliance recognised that access to tests and services offered to GPs and patients varied between trusts without clear reasons. Trusts are now working together to align and improve these offers, making it easier for GPs to refer patients and for patients to receive the care they need.
- **Sharing clinical expertise to improve care:** Clinical leaders from different trusts now meet regularly to share learning and solve problems together. For example, in children's services this joint working helped open up more capacity over the winter, supporting safer care for families.
- **Successfully used real-time patient feedback in 4 emergency departments** to build leadership capability, empower teams, and improve patient experience
- **Stepping in to support when problems arise:** When one trust experiences difficulties, others step in to help. For example, when digital radiology systems failed in Gateshead, other Alliance trusts shared staff and expertise so patient care could continue with minimal disruption.
- **Improving care pathways along the east coast:** Senior medical leaders from the three east coast trusts are meeting regularly to improve how services work across organisations. This is helping to smooth patient journeys and make it easier for staff to work together across trust boundaries.
- **A shared vision for the future:** All Alliance organisations have agreed a clear shared ambition: to work together to deliver excellent hospital services while strengthening care closer to people's homes. This shared direction is guiding decisions and future improvements.
- **Using research to reduce inequalities and improve value:** A local university has helped research the impact of moving services from hospitals into the community, particularly on health inequalities. This evidence is shaping how services change, ensuring improvements benefit patients and make best use of public money. Further research is now underway to make the most effective use of Community Diagnostic Centres.

Next steps including refreshed strategic intent

Focus of the refreshed strategic intent – "Working together to deliver excellent tertiary and secondary hospital services, while strengthening neighbourhood care closer to patients' homes."

- Delivering excellent tertiary and secondary hospital services
- Strengthening neighbourhood care closer to patients
- Supporting patient choice and reducing inequalities
- Improving sustainability and financial resilience through collective action

A second phase of work will identify a small number of priority pathways for progression in 2026/27, supported by detailed clinical, financial and engagement work.

Nested approach to clinical planning / strategy

Percentages give an indication of relative scale of work

National health policy 1%

- Creates the context in which local systems plan and organise care

North East and North Cumbria system ~ 4%

- Co-production of plans for regionally provided fragile services linked to Strategic Approach to Clinical Services

Alliance clinical framework 15%

- Alliance FT partners working together to ensure the delivery of excellent tertiary and district general hospital services
- Led by Clinical Framework Group of executives from 4 FTs

Foundation Trust strategies 60%

- Organisational and clinical strategies
- Core of clinical planning done and coordinated through FTs' own organisational strategies and clinical plans

Neighbourhood health 20%

- Neighbourhood and place health & care plans
- Linking primary, community and social care, reflecting where majority of care is provided

Any questions?

8. NHS Staff Survey Results

To be presented by Amanda Venner, Group Director of People and Organisational Development

Report Cover Sheet Agenda Item: 8

Report Title:	**2025 Staff Survey Results**			
Name of Meeting:	Council of Governors – Part 1			
Date of Meeting:	20th May 2026			
Author:	Sam Corcoran, OD Practitioner Sophia Grainger, Head of Staff Experience			
Executive Sponsor:	Amanda Venner, Executive Director of People and OD			
Report presented by:	Amanda Venner, Executive Director of People and OD			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance** ☐	**Information:** ☐
	Enter purpose here			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	1. EMT Monday 12th January 2026 2. Staff Experience and Inclusion Group 15th January 2026 3. Trust Board – Part 2 28th January 2026 4. Board of Directors – Part 1 25th March 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*	This cover sheet accompanies the slide pack which shows the results in more detail. • The staff survey completion rate for 2025 was 42%, down 11% from 2024. As an overall summary compared to 2024, 2% of questions have significantly improved, 53% of questions have had no significant in year change, and 44% have significantly declined. • From wider discussions with staff to contextualise the results, the feedback is that it is reflective of organisational decisions taken in-year, which have had unintended consequences on engagement, which has dropped to 6.5, the lowest engagement score in last 5 years.			

	• Confidence in the organisation has gone down since 2024. Fewer staff would recommend it as a place to work (an 11% drop), and fewer believe patient care is the organisation's top priority (a 9% drop). Staff are telling us that some of the decisions made this year to help the Trust's financial position have unintentionally reduced their confidence and willingness to advocate for the organisation. • Career development is another area which has seen a significant in-year decline, with 'There are opportunities for me to develop my career in this organisation' declining by 10%, and 'Have opportunities to improve my knowledge and skills' declined by 8%. During 24/25 all non-mandatory training was paused, and increased scrutiny on vacancies may have lead staff to feel that progression opportunities either within their current role, or to progress were limited. • Scores related to line managers have also gone down. This is something managers can directly influence within their own teams. We have support and training available to help managers build their skills, and as the results are shared, managers will be reminded that these scores relate to their role and that they need to take responsibility for improving them. As a result of the data, the focus will be to: • **Prioritise Engagement** - Helping staff feel involved, listened to and able to shape how we work. • **Work harder to show staff that patient care is our top priority** – delivering compassionate care every day. This is underpinned by 3 key actions, with a series of deliverables: 1. We will improve opportunities for career development. 2. We will continue to support opportunities for staff to speak up and ensure we close the loop on concerns raised. 3. We will support teams to build cohesion through civility and respect

Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	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.

<table>
<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 care for our people, creating a fair, inclusive and respectful environment where everyone can thrive in their role
• We will grow and develop our people with a focus on celebrating achievements and creating a culture of high performance and innovation
• We will be an employer and training provider of choice within the local workforce recognising our role as an anchor institution</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">4 797 - There is a risk that the Trust does not consistently prevent, identify or address organisational and cultural factors contributing to negative staff experiences, due (but not limited to) inconsistent leadership behaviours, inequitable practices, organisational pressures and working conditions, resulting in colleagues feeling undervalued or unsupported, disengagement, increased turnover, burnout and sickness absence, with potential impacts on staff wellbeing, team cohesion and the quality and safety of patient care. (12)</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>

2025 Staff Survey: Group Results

Council of Governors – Part 1

Amanda Venner

20th May 2026

2024 Objectives

From 2024 staff survey results. 2 key areas of focus were identified….

- **Stop Incivility**
  - Be polite to *each other* and show respect and appreciation
  - Tackle bullying and harassment across all our staff groups, especially those who are under-represented (LGBT, GEM, D-ability)

- **Promote and take positive action on engagement**
  - Have wider visibility on our Health and Wellbeing offer – what's needed, what's already available, how do we access it
  - How can we support our own HWB, access support and stay well

Actions taken:

Stop Incivility:
Awareness session launched, civility toolkit available, consistent messaging promoted, comms campaign limited but training on-going.

Inclusive Environment:
Survey feedback shared with GEM, D-Ability, LGBTQ+ & Women's networks, refreshed EDI reports reporting into new Staff Experience and Inclusion oversight group.

Health & Wellbeing:
Campaigns and weekly features delivered, Wellbeing Ambassador & Mental Health First Aid networks relaunched, Health Needs Assessment completed, new guides and support developed, Better Health at Work Award planned for 2026.

Introduction to 2025 Staff Survey

The 2025 survey approach remains consistent with the surveys from 2021, with the realignment to the NHS People Promise, allowing for a year-on-year comparison.

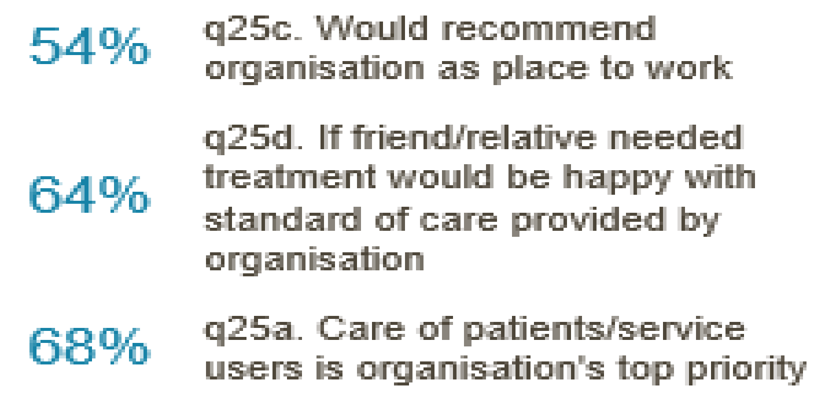
This presentation provides a high-level overview of the group results – this is the first year the QEH & QEF have been combined into one Group survey

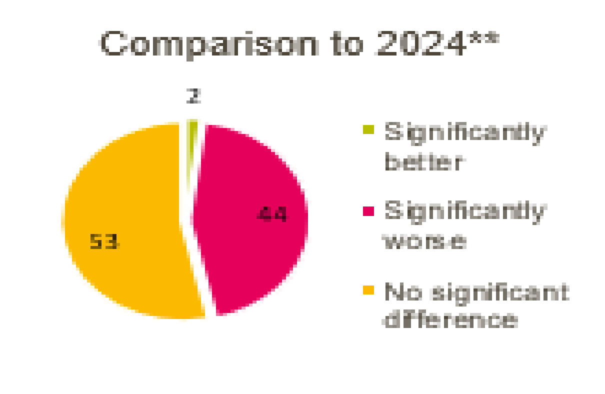
A total of 124 questions were asked in the 2025 survey, of these, 110 can be compared to 2024 and 101 can be positively scored.

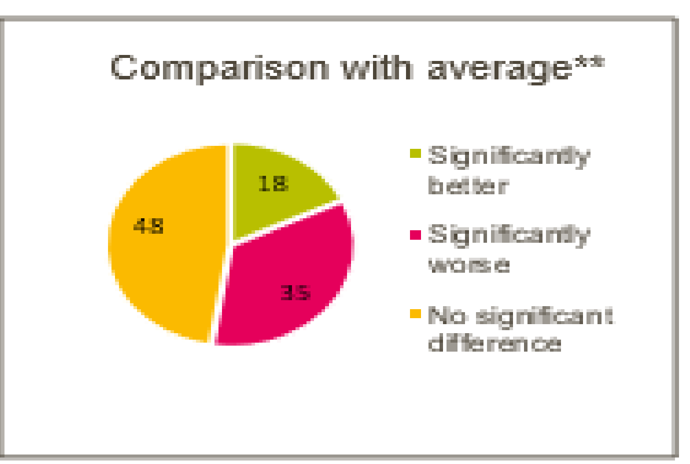
5227 Invited to complete the survey	5094 Eligible at the end of survey	42% Completed the survey (2155)	48% Average response rate for similar organisations	53% Your previous response rate

42% **Group** Completion Rate

Group: Executive Summary







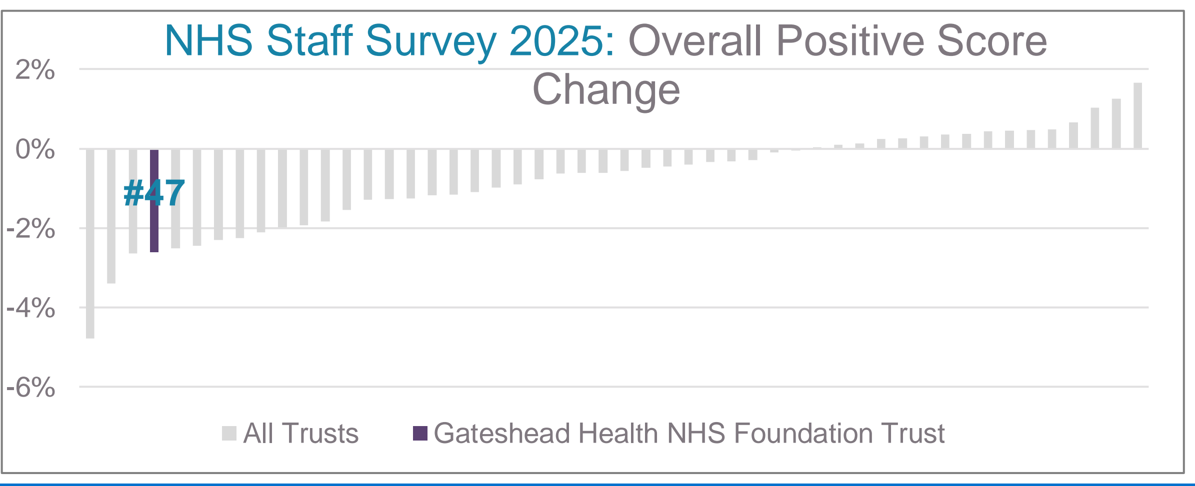
QEH 2024

63%	q25c. Would recommend organisation as place to work
71%	q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation
77%	q25a. Care of patients/service users is organisation's top priority

QEF 2024

58%	q25c. Would recommend organisation as place to work
67%	q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation
67%	q25a. Care of patients/service users is organisation's top priority

The historical league table shows how your overall positive score changed from the previous survey, and how this change compares to other organisations Acute and Acute Community Trusts who ran the NHS Staff Survey 2025 with Picker.



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Executive summary 2025

Top 5 scores vs Organisation Average	Org	Picker Avg
q14a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	81%	75%
q4c. Satisfied with level of pay	36%	32%
q16a. Not experienced discrimination from patients/service users, their relatives or other members of the public	95%	91%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	56%	52%
q25d. If friend/relative needed treatment would be happy with standard of care provided by organisation	64%	60%

Bottom 5 scores vs Organisation Average	Org	Picker Avg
q24b. There are opportunities for me to develop my career in this organisation	43%	50%
q2a. Often/always look forward to going to work	46%	52%
q8c. Colleagues are polite and treat each other with respect	64%	70%
q23d. Appraisal left me feeling organisation values my work	28%	33%
q14d. Last experience of harassment/bullying/abuse reported	49%	54%

Most improved scores	Org 2025	Org 2024
q13d. Last experience of physical violence reported	70%	64%
q13a. Not experienced physical violence from patients/service users, their relatives or other members of the public	88%	84%
q12a. Never/rarely find work emotionally exhausting	25%	22%
q18. Not seen any errors/near misses/incidents that could have hurt staff/patients/service users	68%	65%
q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours	56%	53%

Most declined scores	Org 2025	Org 2024
q24b. There are opportunities for me to develop my career in this organisation	43%	53%
q25c. Would recommend organisation as place to work	54%	63%
q25a. Care of patients/service users is organisation's top priority	68%	77%
q25b. Organisation acts on concerns raised by patients/service users	64%	71%
q24c. Have opportunities to improve my knowledge and skills	63%	71%

Tables are based on absolute % differences, not statistical significance

Trust ***Negative*** scores - questions where we have declined since last year ***and*** are significantly worse than the average

		Historical					External	
		2021	2022	2023	2024	2025	Average	Organisation
q24b	There are opportunities for me to develop my career in this organisation	49%	57%	56%	53%	43%	50%	43%
q25c	Would recommend organisation as place to work	65%	66%	68%	63%	54%	56%	54%
q25a	Care of patients/service users is organisation's top priority	81%	79%	79%	77%	68%	70%	68%
q25b	Organisation acts on concerns raised by patients/service users	77%	73%	73%	71%	64%	67%	64%
q24c	Have opportunities to improve my knowledge and skills	66%	72%	73%	71%	63%	67%	63%
q23d	Appraisal left me feeling organisation values my work	27%	32%	33%	32%	28%	33%	28%

Key Themes:

- Career Development & Learning (q24b, q24c)
- Advocacy & Organisational Confidence (q25a, q25b, q25c)
- Feeling Valued via Appraisal (q23d)

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Trust *Positive* scores - questions where we have increased since last year *and* are significantly better than the average

		Historical					External	
		2021	2022	2023	2024	2025	Average	Organisation
q13a	Not experienced physical violence from patients/service users, their relatives or other members of the public	87%	83%	87%	84%	88%	85%	88%
q13b	Not experienced physical violence from managers	100%	100%	100%	99%	100%	99%	100%
q14a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	76%	76%	79%	79%	81%	75%	81%
q14b	Not experienced harassment, bullying or abuse from managers	91%	93%	92%	92%	92%	91%	92%
q14c	Not experienced harassment, bullying or abuse from other colleagues	84%	85%	84%	83%	84%	82%	84%
q16a	Not experienced discrimination from patients/service users, their relatives or other members of the public	95%	96%	96%	94%	95%	91%	95%
q16b	Not experienced discrimination from manager/team leader or other colleagues	93%	95%	94%	93%	93%	91%	93%

Key Themes:

- Physical Safety & protection (q13a, q13b)
- Inclusive Culture (q16a, q16b)
- Positive Managerial Behaviour (q14b)

Engagement Score vs Picker Average

7.4
7.2
7
6.8
6.6
6.4
6.2
6

7.3 7.3 7.3 7.3 7.3

7

6.9 6.9

6.85

6.8 6.82

6.8

6.7

6.5

2021 2022 2023 2024 2025

Group
Picker Avg
Group Target

2021 – 2025 bullying & harassment scores vs Picker average

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		Historical					External	
		2021	2022	2023	2024	2025	Average	Organisation
q14a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	76%	76%	79%	79%	81%	75%	81%
q14b	Not experienced harassment, bullying or abuse from managers	91%	93%	92%	92%	92%	91%	92%
q14c	Not experienced harassment, bullying or abuse from other colleagues	84%	85%	84%	83%	84%	82%	84%
q14d	Last experience of harassment/bullying/abuse reported	44%	45%	47%	50%	49%	54%	49%
q15	Organisation acts fairly: career progression	-	-	-	-	56%	53%	56%
q16a	Not experienced discrimination from patients/service users, their relatives or other members of the public	95%	96%	96%	94%	95%	91%	95%
q16b	Not experienced discrimination from manager/team leader or other colleagues	93%	95%	94%	93%	93%	91%	93%
q17a	Not experienced unwanted behaviour of a sexual nature from patients/service users, their relatives or members of the public	-	-	91%	91%	93%	92%	93%
q17b	Not experienced unwanted behaviour of a sexual nature from other colleagues	-	-	98%	97%	98%	97%	98%

Bullying & Harassment Experiences Within Staff Groups

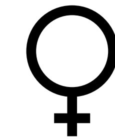
Q	Description	Comparator (Organisation Overall)	Disability Yes	Disability No	White	GEM	Heterosexual / straight	Gay / lesbian, Bisexual, Other	Prefer not to say - sexual orientation	Female	Male
q14a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	80.8%	75.1%	82.7%	81.2%	75.6%	81.1%	78.0%	75.4%	80.4%	82.6%
q14b	Not experienced harassment, bullying or abuse from managers	91.8%	86.4%	93.9%	91.7%	92.2%	92.3%	92.3%	83.2%	92.9%	90.2%
q14c	Not experienced harassment, bullying or abuse from other colleagues	84.1%	76.6%	87.0%	84.9%	76.2%	85.1%	77.8%	73.7%	84.7%	84.7%
q14d	Last experience of harassment/bullying/abuse reported	48.8%	45.1%	50.3%	49.1%	47.8%	49.8%	46.8%	42.9%	53.6%	37.1%
q15	Organisation acts fairly: career progression	55.5%	51.3%	57.3%	56.3%	48.5%	56.2%	57.1%	42.1%	56.9%	55.9%
q16a	Not experienced discrimination from patients/service users, their relatives or other members of the public	95.1%	94.0%	95.5%	96.5%	82.1%	95.4%	93.3%	92.0%	95.3%	95.4%
q16b	Not experienced discrimination from manager/team leader or other colleagues	93.0%	88.1%	95.0%	94.2%	82.7%	93.8%	88.1%	86.6%	93.7%	93.3%
q17a	Not experienced unwanted behaviour of a sexual nature from patients/service users, their relatives or members of the public	92.6%	90.1%	93.5%	92.5%	92.9%	92.8%	90.8%	90.4%	91.2%	96.8%
q17b	Not experienced unwanted behaviour of a sexual nature from other colleagues	97.7%	96.6%	98.2%	97.6%	99.0%	97.9%	94.9%	97.4%	98.0%	97.6%

Overall positive score
Staff with protected characteristics

Yes (570)	No (1541)
54%	62.5%

Heterosexual / straight (1890)	Gay / lesbian, Bisexual, Other (119)	I would prefer not to say (115)
61.1%	57%	48.7%

White (1923)	Mixed/ Multiple ethnic groups, Asian/ Asian British, Black/ African/ Caribbean/ Black British, Other ethnic group (198)
59.9%	63.6%



Female (1543)	Males (498)	Prefer not to say (86)
58%	58.8%	40.3%

Immediate Manager Questions

		Historical					External	
		2021	2022	2023	2024	2025	Average	Organisation
q9a	Immediate manager encourages me at work	69%	75%	74%	74%	**70%**	72%	70%
q9b	Immediate manager gives clear feedback on my work	61%	65%	66%	64%	64%	65%	64%
q9c	Immediate manager asks for my opinion before making decisions that affect my work	57%	61%	63%	59%	56%	59%	**56%**
q9d	Immediate manager takes a positive interest in my health & well-being	67%	72%	73%	73%	**69%**	70%	69%
q9e	Immediate manager values my work	70%	75%	73%	74%	**71%**	72%	71%
q9f	Immediate manager works with me to understand problems	67%	71%	72%	70%	68%	69%	68%
q9g	Immediate manager listens to challenges I face	68%	74%	75%	73%	71%	71%	71%
q9h	Immediate manager cares about my concerns	68%	74%	73%	72%	69%	70%	69%
q9i	Immediate manager helps me with problems I face	66%	70%	70%	68%	66%	67%	66%

These are the most important relationships; between an individual and their immediate manager

Considerations & context

Generally, we have deteriorated, why is that?

- **External Pressures** – NHS-wide challenges
- **Cultural Shifts** – Greater candour, raised expectations
- **Operational Changes** – Restructures, VSS, financial constraints
- **Psychological Factors** – Change fatigue, say-do gap, psychological safety vs danger
- **Workforce Trends** – Generational expectations, turnover and retention
- **Line manager accountability** – Following policies effectively and managing processes

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NHS England requirements

Every NHS board will be expected to use the 2025/26 staff survey findings to commit to:

- a full and **detailed analysis of all free text** comments generated through their staff survey

- identifying, as a minimum, **3 areas** where the data shows the greatest staff dissatisfaction, generating a detailed analysis where those issues impact most within their organisation and developing detailed action plans to resolve those issues within year wherever possible

So what do we do with this information?

Confirm our **key areas of focus** for this year:

Work harder to show you that patient care is our top priority – delivering compassionate care every day

Prioritise Engagement - Helping you feel involved, listened to and able to shape how we work.

Actions:

We will demonstrate that care of patients is a top priority.

We will improve opportunities for career development.

We will continue to support opportunities for staff to speak up and ensure we close the loop on concerns raised.

We will support teams to build cohesion through civility and respect

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Actions in more detail

Action	Sub-Actions to deliver in-year change (Action owner)
Action 1: We will demonstrate that care of patients is a top priority.	Corporate Actions: • Ensure that key business decisions which support both patient care and financial investment are shared and cascaded through corporate messaging. • We will continue to champion high quality patient care in our comms and messaging. • Continue to increase board visibility and share messaging directly in ward and team areas. BU Local Actions: • Care of patients is a top priority has declined, business units to discuss this locally and understand what is driving this decline identify areas of improvement and undertake actions to address. (Clinical Leads and BU Ops Teams)
Action 2: We will improve opportunities for career development.	• Continue to launch the improved learning offer (L&D/OD) • Share positive messaging on opportunities to access funding available (CPD), and ensure its use is strategic, and in line with the Trust aims and objectives. (L&D) • Share messaging via appraisal training and Trust-wide comms that development is wider than just formal training/courses. (L&D) • Work to schedule training for operational teams at a time that works best and look at flexible approaches to delivery (L&D) • Deliver the enhanced rostering consultation and associated headroom to ensure that corporate nursing managers have the space to support and develop their teams via regular 1:1's and team time. (Corporate Nursing) • Work harder to ensure our people are being released to attend learning when they can. (All)

Actions in more detail

Action	Sub-Actions to deliver in-year change (Action owner)
Action 3: We will continue to support opportunities for staff to speak up and ensure we close the loop on concerns raised.	• We will promote the Route Map for raising concerns organisationally and within the BU's (Line Managers) • Where not other routes are available use the FTSU champions to raise concerns locally, and with someone individuals may identify with. (FTSU) • Closing the loop on unsafe clinical practice in a timely manner (Patient Safety/BU Safecare) • We will continue to follow the 'Speak Up, Listen Up, Follow Up' framework for Freedom to Speak up, ensuring closer scrutiny on the follow up. (FTSU) • We will look to close the loop as appropriate from ER cases confidentially with staff involved, to ensure there is a clear outcome following a case. (POD Advisory) • We will actively target Staff networks, whom we know experience more bullying and harassment at work, but may be less likely to report, to understand the barriers, and work with them to share stories/examples of when speaking up has led to a positive outcome, to encourage others to report. (EDI)
Action 4: We will support teams to build cohesion through civility and respect	• We will continue with the successful roll out of civility/team behaviours awareness training which is being positively received and well attended. (OD) • We will develop a follow up module for staff on how to deal with uncivil behaviours they may face. (OD) • We will focus on ensuring role modelling of desired behaviours is a focus at leaders at all levels (Line Managers), promoting this via the Leading Forward Framework. (OD/L&D) • We will target interventions to low-scoring teams/groups, or teams identified via culture and triangulation meeting to ensure resources are being targeted to the right areas to improve civility in the workplace. (OD/HWB) • Leaders and managers to role model good behaviours (Clinical and operational leads)
BU Local Actions	• Clinical leads and managers to speak to their teams about their results to 'sense check' what it means locally • All managers review their staff survey results under 'immediate manager' as those are directly about them, and identify areas of improvement, ensuring that the basics that are expected are in place for their team (Regular 1:1's, annual appraisals, supporting performance, giving feedback, having health and wellbeing conversations, role modelling behaviours in line with the behaviour framework, and tackling poor behaviour, actively seeking information relevant to your team/department and communicating those messages in a timely manner). If managers require development access this via Leading Forward Framework. (Line Manager)

Impact

The actions listed on the previous slides focus on targeting the greatest areas of dissatisfaction to make an in-year improvement.

As these areas are the greatest for dissatisfaction addressing these are likely to have the greatest impact on improving the lowest scoring areas and in-turn impact on our key areas of focus:

- **Engagement** - morale, advocacy and recommending the organisation as a place to work
- **Patient care** - is our top priority.

Measuring success via the quarterly pulse surveys, informal feedback, concerns being raised, FTSU

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Next Steps - Cascade Plan

POD Engagement Workshop	Review survey results and identify three key areas of dissatisfaction to present to the Board, along with practical, in-year improvement proposals, development of any support resources needed to help managers and BUs implement them	January 2026 Complete
Board	For approval of three key priority areas, themes, approach, and headline positioning.	Data released to Board in January Complete
GHLG	Secondary cascade with emphasis on Trust accountability.	January 26 Complete
Executive-led Team Brief (Operation)	Focus on operational interpretation and immediate expectations for all managers and leaders within the Trust. From April the format of Team Brief will change and follow a standardised format. Will include NQPS results, operational priorities and update on each of the 4 strategic objectives:	March 26 Complete
Ops Board	Relevant analysis and allocation of SMART targets; identification of local impact areas.	Feb onwards Complete
Team Level Meetings	It is envisaged that cascading of results to teams will be supported by wrap-around tools and resources for managers, including dashboards, managers guide, OD handbook. To encourage structured team discussions.	Feb Onwards On-going
Corporate Led Staff Engagement & Comms	A number of planned activities to highlight team improvements, embed key survey messages across Trust channels, strengthen leadership visibility (CEO sessions, Exec walkabouts, refreshed Team Brief), and provide regular “You Said, We Did” and pulse survey updates.	March Onwards on-going
Governance	Accountability via POD Steering group into EMT and POD Committee for assurance Monitored via new Performance Oversight meetings	June - September

9. Governor Response to the Quality Accounts

To be presented by Beth Swanson, Interim Chief Nurse

Report Cover Sheet Agenda Item:

<table>
<tr><td>Report Title:</td><td colspan="4">Quality Account 2025/2026</td></tr>
<tr><td>Name of Meeting:</td><td colspan="4">Council of Governors</td></tr>
<tr><td>Date of Meeting:</td><td colspan="4">20th May 2026</td></tr>
<tr><td>Author:</td><td colspan="4">Wendy McFadden – Clinical Effectiveness Lead
Andrew Ward – Senior Analyst – Quality & Patient Safety
Jane Conroy – Head of Quality & Patient Experience
Plus priority leads</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:
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<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">NA</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 Quality Account has been produced in line with the national guidance.

Full detail is provided for each priority for 2025/26 and an overview of next steps where the priority has not been fully achieved.</td></tr>
<tr><td>Recommended actions for this meeting:</td><td colspan="4">To receive the Quality Account for assurance, and to undertake a discussion with a view to producing a</td></tr>
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<table>
<tr><td>Outline what the meeting is expected to do with this paper</td><td colspan="5">collective feedback statement from the Council of Governors</td></tr>
<tr><td rowspan="4">Trust strategic priorities that the report relates to:</td><td>☒</td><td colspan="4">Excellent patient care</td></tr>
<tr><td>☒</td><td colspan="4">Great place to work</td></tr>
<tr><td>☒</td><td colspan="4">Working together for healthier communities</td></tr>
<tr><td>☒</td><td colspan="4">Fit for the future</td></tr>
<tr><td>Trust strategic objectives that the report relates to (2025 to 2030 strategy):</td><td colspan="5">List strategic objective here</td></tr>
<tr><td>Links to CQC Key Lines of Enquiry (KLOE):</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☒</td><td>Effective
☒</td><td>Safe
☒</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):</td><td colspan="5"></td></tr>
<tr><td>Has an Equality and Quality Impact Assessment (EQIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
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Quality Account

Gateshead Health NHS Foundation Trust

2025/26

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Part 1

Quality Account – Chief Executive's Statement

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Statement on Quality from the Chief Executive – *with Sean for review*

Signed Date:

Chief Executive

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What is a Quality Account?

Quality Account is an opportunity to be open about the care we provide, reflect on the progress we have made over the last year and share where we know we still need to improve.

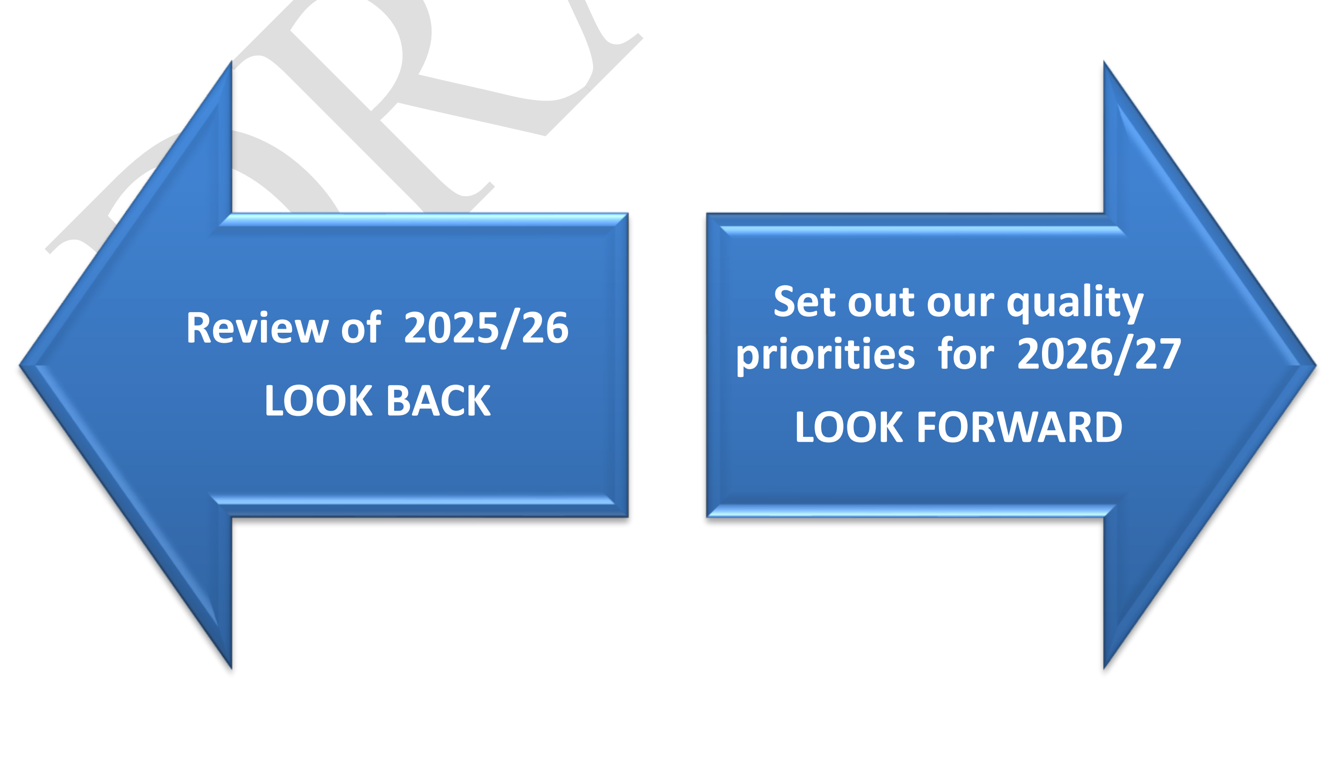
At Gateshead Health, we are proud of the care our teams deliver every day and equally proud of the culture of learning, honesty and continuous improvement that sits behind it. This report allows us to celebrate the achievements of our staff, recognise the experiences of our patients and communities, and demonstrate how feedback, learning and quality improvement continue to shape our services.

The Quality Account looks back on the quality priorities and objectives we set ourselves for 2025/26, outlining the progress made and the impact this has had on patient care, safety and experience. It also looks ahead to our priorities for 2026/27 and the areas where we will continue to focus our efforts to improve outcomes and experiences for the people who use our services.

Quality Accounts are published annually by all NHS organisations as part of our commitment to openness and transparency in healthcare. They provide an important opportunity for patients, carers, staff and partners to understand how we are performing as an organisation and how we are continuing to improve the quality of care we provide

The dual functions of a Quality Account are to:

- Summarise our performance and improvements against the quality priorities and objectives we set ourselves for 2025/26.
- Outline the quality priorities and objectives we set ourselves going forward for 2026/27.



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About us and the service we provide

Gateshead Health NHS Foundation Trust provides a wide range of acute and community health services to people across Gateshead and surrounding areas, serving a population of around 200,000 people.

Our services are delivered from the Queen Elizabeth Hospital in Gateshead, community bases across the borough, and in people's own homes. We provide emergency care, elective and day case surgery, outpatient services, diagnostics, maternity and neonatal care, children and young people's services, therapies, community nursing and a range of specialist services.

The Queen Elizabeth Hospital is one of the busiest hospitals in the North East and is recognised regionally for a number of specialist services including gynae-oncology, women's health, diagnostics, stroke care, breast screening, orthopaedics and vascular access. Alongside our acute hospital services, we provide extensive community services which support people to remain independent, recover closer to home and avoid unnecessary hospital admissions wherever possible.

We are proud to be a teaching Trust with strong partnerships across the NHS, local authorities, universities and the voluntary and community sector. Research, innovation and continuous improvement are increasingly important parts of how we deliver care and improve outcomes for the communities we serve.

During 2025/26 we have continued to work closely with our Great North Healthcare Alliance partners and the wider North East and North Cumbria Integrated Care System to improve access to services, reduce health inequalities and strengthen neighbourhood and community-based models of care. This has included collaborative work across urgent and emergency care, discharge and flow, maternity services, digital transformation and workforce development.

The Trust employs over 4,500 staff across a wide range of professional groups, all of whom play an important role in delivering safe, compassionate and high-quality care. We recognise that the experience of our patients is directly linked to the experience of our staff and we remain committed to creating an inclusive culture where people feel valued, supported and able to thrive.

Over the last year we have continued to see examples of innovation, improvement and compassion across our services. These include ongoing digital developments to support safer care, improvements in patient flow and emergency care performance, continued investment in workforce development, and national recognition for the quality of our maternity services. We have also strengthened our focus on listening to patients, carers and staff so that their experiences directly inform how services develop and improve.

As an anchor institution within Gateshead and the wider North East, we are committed not only to delivering high-quality healthcare services, but also to improving the wider health and wellbeing of our communities. We will continue to work with patients, carers, staff and partners to ensure services remain safe, effective, responsive and sustainable for the future.

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121,113
A&E
Attendances

62,396
Inpatient Spells

1,817
Births

15,587
Same Day
Emergency Care
(SDEC) Attendances

282,811
Outpatient
Attendances

Local Population
over **200,000**

Employ
around
4,500 staff

Part 2

Quality Priorities

2. Priorities for Improvement

2.1 Reporting back on our progress in 2025/26

In our 2024/25 Quality Account we identified eight quality priorities that we would focus on. This section presents the progress we have made against these:

PATIENT SAFETY:

Priority 1: We will strive to eliminate unnecessary waits, to ensure patients receive timely care and experience better outcomes

What did we say we would do?

- Reduce non-elective length of stay
- Reduce the percentage of patients who remain in our Emergency Department for over 12 hours (type 1 – this is Queen Elizabeth Hospital Emergency Department)
- Access to diagnostics (DM01 percentage of monthly patients who are waiting less than 6 weeks for a diagnostic test)
- Reduce general and acute bed occupancy rate
- Time for diagnosis (Cancer 28-day Faster Diagnosis Standard)

Impact for patients

Timely access to urgent, diagnostic and cancer care is essential to patient safety and patient experience. Long waits in emergency departments, delays in diagnostics and extended waiting times for treatment can lead to deterioration in patients' conditions, increased anxiety for patients and families, delayed diagnosis, and poorer health outcomes. By focusing on reducing unnecessary waits, improving patient flow through the hospital, and increasing timely access to diagnostics and treatment, the Trust aims to ensure patients receive the right care at the right time, in the right place. This priority supports safer care, earlier diagnosis and intervention, reduced overcrowding, shorter hospital stays, and an improved overall experience for patients accessing services across the Trust.

Did we achieve this?

- 2.5% of patients spent >12 hours in ED across 25/26. This is a % improvement on the previous year of 4.68%.
- Achieved an average performance of just below 70% throughout 25/26 for patients waiting 62 days for treatment on a cancer pathway.
- Unfortunately, the standard was not achieved. Overall performance in March 2026 was 95.21%, which is below the 99% national standard, but represents a significant improvement from earlier in the year (75.8%).
- Performance against the 4-hour standard reporting an average 76.2% against a target of 78%.
- 18 (TBC) patients waiting greater than 52 weeks for their treatment by end of March.
- Unfortunately, performance is not expected to meet trajectories, 62 days' time to first treatment for patients with cancer for no less than 64.7% of patients.

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How we achieved it:

The Trust has significantly reduced the number of patients waiting in ED more than 12 hours, this has been through a dedicated improvement programme examining flow, bed occupancy, timeliness of diagnostics, discharge and clinical decision making. This clinically led programme has focused on ensuring that patients are admitted promptly to a bed if required and those who do not require admission are discharged in a reasonable time frame.

Evidence of achievement:

Evidence of achievement: Patients in ED over winter period who waited more than 12 hours reduced by half (to around 1700 from 3400)

Next steps:

- The Trust has a dedicated improvement programme set up for 26/27 there are three key workstreams which will contribute to this - Urgent and Emergency Care, Discharge and Flow and Community.
- This Quality Account Priority will be rolled forward to 2026/27

Access to diagnostic (DM01 - % waiting <6 weeks)

- Targeted improvement plans continue in underperforming specialties and report through the Operational Delivery Programme Board
- Workforce challenges remain a key constraint in:
  - Audiology
  - Echocardiography
    - Focus on recruitment, retention, and alternative workforce models
- Urology / Cystoscopy pathway review:
  As this is not a service delivered by GHFT, ongoing discussions with The Newcastle upo Tyne Hospitals NHS Foundation Trust are in place. Aim to agree a sustainable delivery model to improve access and performance
- Further reduction of 6–13 week waits to move towards the 99% standard
  - Continued weekly performance grip and escalation

Cancer Performance Overview

- A breast recovery plan has been approved, including both a short-term (Q1) recovery plan and a longer-term sustainable service model.
- Pathway improvement work has commenced across key challenged areas, including Breast, Urology, Gynaecology and Lower GI and reported through the Operational Delivery Programme Board
- Service Development Funding has been allocated to strengthen tracking and cancer pathway navigation capacity.
- Continued weekly performance grip and escalation.

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Priority 2: We will implement the Maternity and Neonatal Three-Year Delivery Plan, to improve safety, equity, and the quality of care for women, babies and families

What did we say we would do?

We will implement a delivery plan based on national guidance which sets out how the NHS will make Maternity care safer, more personalised and more equitable, with twelve objectives identified based on four nationally mandated high level themes:

• listening to women and families with compassion.
• supporting our workforce to develop their skills and capacity,
• developing and sustaining a culture of safety, and
• meeting and improving standards and structures

Impact for patients

Safe, compassionate and personalised maternity and neonatal care has a significant impact on the health and wellbeing of women, babies and families. High-quality maternity services help to reduce the risk of avoidable harm, improve outcomes for mothers and babies, and ensure families feel listened to, respected and supported throughout pregnancy, birth and the postnatal period. Focusing on equity and personalised care also helps address inequalities in outcomes and experience for different communities. By strengthening workforce skills, embedding a culture of safety, improving governance and listening to the voices of women and families, the Trust aims to provide consistently safe, responsive and family-centred care that improves both clinical outcomes and patient experience across maternity and neonatal services.

Did we achieve this?

- The service has improved in the annual CQC Maternity Survey rating from 8th (2022), 5th (2023) to 1st in 2024 & 2025 (Picker)
- In 2024/25, the service commenced a Pelvic Health offer supported by a specialist midwife, physiotherapist and Obstetric Consultant
- The midwifery workforce is compliant with the latest Trust Birthrate+ workforce recommendations with additional administrative support in place to free up clinical time. All labour ward coordinators, ward managers & midwifery leads have been supported with appropriate leadership training opportunities
- We maintained >90% compliance with the North East & North Cumbria agreed Training Needs Analysis which meets the requirements of the Core Competency Framework and Safety Action 8 of the Maternity Incentive Scheme (MIS). The Gateshead team contributed significantly to the development of regional resources for the agreed training plan
- The monthly Integrated Oversight Report (IOR) reports minimum Perinatal Quality Surveillance Measures directly to Trust Board or Quality Governance Committee.
- We have fully embedded the Saving Babies Lives Care Bundle, with the new Year 8 Maternity Incentive Scheme standards moving towards this as "business as usual".
- The new national neonatal early warning track and trigger observation tool (NEWTT2) has been implemented into the neonatal care pathways

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- We work in co-production with our Maternity & Neonatal Voices Partnership & safety champions in governance processes, 15-steps walkabouts & reaching out to hear service user voices in the community
- The multi-disciplinary workforce & our trainees are supported by retention & recruitment midwife, practice placement support, educational supervisors & practice development team
- The Maternity Patient Safety Champions are key to providing oversight and assurance of the quality and safety of the maternity and neonatal service, with monthly meetings and walkabouts. All Safety Champions are in post including executive (Chief Nurse) and Non-Executive Director, as well as clinical champions for midwifery, obstetrics and neonates and MNVP leads.
- Maternity and Neonatal services have an embedded full electronic patient record (Badgernet), and digital midwifery support closely aligned with LMNS and Gateshead Health digital teams.

Evidence of achievement:

- Co-developed patient information leaflets, service improvement, social media messaging & enhanced patient environments including murals, birth stats & refurbishment of patient areas
- Full compliance with the Maternity Incentive Scheme Safety Standards for each year
- Submission of application for UNICEF Stage 1 Baby Friendly accreditation for the Neonatal service & progression of work towards Stage 3 Maternity accreditation
- Staff survey, student midwifery feedback and the trainee feedback survey all report favourably with sustained positive reports from the Annual Deanery Quality Meeting. SLEC (Safe Learning Environment Charter) is embedded within the service.
- Triangulation of safety & quality metrics within the monthly IOR including workforce, patient safety & experience data, and supplemented by benchmarking data from national sources including the Maternity Health Inequalities dashboard, MBBRACE & NNAP reports and regional heatmap tools/

Next steps:

- Embed the Pelvic Health service including a self-referral portal, outpatient clinics and data collections processes to demonstrate outcomes.
- Roll-out of Maternal Mental Health Service to provide specific psychological support pathways in line with the national service specification including birth trauma, bereavement & tokophobia
- Continue working towards the stages of UNICEF BFI accreditation for Maternity & Neonatal services
- Continue working towards development of a Nursing and Midwifery Workforce Strategy which includes a focus on Equity and Inclusion
- Establish a new Perinatal Quality & Safety Group to provide additional focussed oversight & assurance of all perinatal metrics
- Work towards full compliance with the MIS Year 8 standards
- Be ready to implement the recommendations from future national reviews including the Thirwell report and the National Maternity & Neonatal Services review (by Baroness Amos)

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PATIENT EXPERIENCE:

Priority 3: We will improve the timeliness for responding to complaints and concerns, so that people feel heard, issues are resolved quickly, and trust in our services is strengthened.

What did we say we would do?

- We will implement a new complaints training package.
- We will review the effectiveness of our new Complaints and Concerns policy.

Impact for patients

Responding to complaints and concerns in a timely, compassionate and effective way is essential to maintaining patient confidence and improving the quality and safety of care. When patients, families and carers feel listened to and their concerns are addressed promptly, it helps build trust, improves communication and demonstrates openness and accountability. Delays in responding to complaints can increase frustration and anxiety for those involved and may result in missed opportunities to learn from patient feedback and improve services. By strengthening complaints handling processes, improving staff confidence and increasing accountability for response times, the Trust aims to ensure patients and families feel heard, valued and reassured that their experiences are used to drive meaningful improvements in care.

Did we achieve this?

- We have completed both elements; however, this has not yet resulted in a measurable improvement in the timeliness of responses to complaints. While foundations for improvement are now in place, further work is required to translate these into consistent operational impact.

How we achieved it:

- We implemented a new complaints training package during 2025/26. Six half-day training sessions were delivered, with strong multidisciplinary attendance from across the Trust, including clinical, administrative and managerial staff.
- In addition, a review of the Complaints and Concerns Policy was undertaken to assess clarity, accessibility and alignment with best practice, with a new policy developed and ratified. Feedback from staff and complaints handling teams informed minor revisions and also highlighted areas requiring further support, particularly around response timescales and ownership.

Evidence of achievement:

- Delivery of six structured training sessions with positive participant feedback, indicating increased confidence in handling complaints.
- High levels of attendance across multiple staff groups, demonstrating organisational engagement with the complaint's improvement agenda.
- Completion of a policy review, with identified actions to strengthen guidance on timeliness and accountability which resulted in the development and ratification of a new complaints policy.
- Baseline data indicates that, despite these interventions, response time performance has remained static.

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Next steps:

- Introduce further robust monitoring and reporting of complaint response times at service and divisional level, with clear accountability.
- We will introduce enhanced monitoring of complainant dissatisfaction such as the number of complaint responses that are queried further or complaints that subsequently are referred to the Parliamentary and Health Service Ombudsman (PHSO) as a measure for people feeling heard.
- Implement targeted support for teams with the greatest delays, including coaching and case reviews.
- Strengthen escalation processes for overdue complaints to ensure timely senior oversight.
- Embed complaints handling expectations into performance management frameworks.
- Review the impact of training at 6 and 12 months, with consideration of refresher sessions or more targeted training where required.

Priority 4: We will strengthen our working with voluntary and third sector organisations, to better meet the needs of our communities, support more holistic care, and help secure the long-term sustainability of our services.

(Nicola Bruce will need to add to part of this)

What did we say we would do?

- We are an anchor institution and will work with voluntary and third sector organisations
- We will invite key partners to the Patient Experience Group to share insights, align priorities and build trust.
- We will develop a clear mapping of the voluntary and community sector (VCS) landscape in Gateshead by working with the Integrated Care Board (ICB).

Impact for patients

Working closely with voluntary and third sector organisations helps the Trust provide more joined-up, person-centred care that better reflects the wider needs of patients and communities. Many patients require support that goes beyond clinical treatment alone, including help with mental wellbeing, social isolation, financial pressures, housing, carers' support and long-term condition management. Strong partnerships with community and voluntary organisations can improve access to this support, reduce inequalities and help patients remain independent and well for longer. By strengthening collaboration with local partners, the Trust aims to improve patient experience, support more holistic care, and ensure services are better connected to the needs of the communities they serve, contributing to improved outcomes and more sustainable healthcare services.

Did we achieve this?

- We have made good progress against this priority. Key partnerships have been strengthened, and there has been increased engagement with VCS organisations. While this work is still developing, early indications suggest improved collaboration and stronger foundations for more integrated, community-focused approaches.

How we achieved it:

- We actively engaged with VCS partners throughout 2025/26, recognising our role as an anchor institution. Key VCS representatives were invited to attend the Patient Experience Group, enabling shared learning, improved understanding of community needs, and more aligned priorities.

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- In partnership with the ICB, we began mapping the VCS landscape across Gateshead to better understand available services, identify gaps, and support more effective signposting and collaboration. This has supported stronger relationships between Trust services and community organisations and increased awareness of the role VCS partners play in supporting patient outcomes.

- Evidence of achievement:
- Increased number of VCS organisations engaged in service planning and patient experience discussions.
- Attendance and contributions from VCS partners at Patient Experience Group meetings.
- Initial development of a VCS mapping resource in collaboration with the ICB.
- Positive feedback from partners indicating improved collaboration and communication.
- Patient and community feedback (including via Healthwatch and local engagement platforms such as Our Gateshead) indicating improved awareness of joined-up, community-based support.

- Next steps:
- Complete and regularly update the VCS mapping to ensure it remains a useful and accessible resource for staff and partners.
- Further embed VCS involvement in service design, co-production, and decision-making forums.
- Strengthen mechanisms for capturing and evidencing the impact of VCS collaboration on patient outcomes and experience.
- Increase visibility of VCS support options for patients and staff to enable more holistic, person-centred care.

STAFF EXPERIENCE:

Priority 5: We will listen to staff, to shape a culture where everyone feels valued, supported and able to deliver their best for patients.

- What did we say we would do?
- We will improve communication and issues of communication moving concerns both up and down
- We will develop and implement an improvement plan based on the themes that emerge from our staff survey results

Impact for patients and staff

Listening to and supporting staff is essential to delivering safe, high-quality and compassionate patient care. Staff who feel valued, respected and able to speak up are more likely to be engaged, motivated and empowered to provide the best possible care for patients. Positive staff experience is closely linked to improved patient safety, better communication, stronger teamwork and higher levels of patient satisfaction. Conversely, poor staff experience can affect morale, wellbeing and the ability to deliver consistently high standards of care. By strengthening communication, promoting a culture of respect and inclusion, and responding to staff feedback, the Trust aims to create a supportive working environment where staff can thrive and continue to deliver safe, effective and person-centred care for patients and families.

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Did we achieve this?

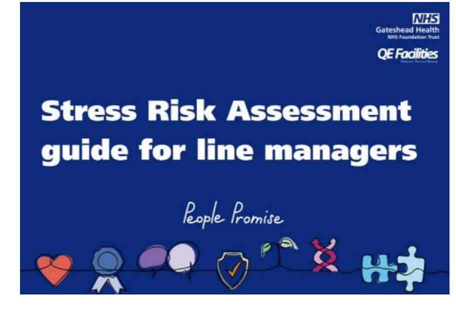
- Partially achieved – mechanisms to listen to staff were strengthened and used extensively, but survey results show that staff confidence, engagement and advocacy declined during 2025, indicating that further improvement is required.

How we achieved it:

- Consistent, structured messaging through existing internal channels
- Empower managers to share and gather information in two-way conversations, with regular reinforcement through team briefings, CEO updates and Gateshead Health Weekly
- Stopping incivility programme of work – encouraging politeness, respect, and tackling bullying and harassment, working closely with our staff networks, Staff Side partners and FTSU Guardian to promote a culture of civility and respect
- Promoting engagement programme of work – raising awareness of Health and Wellbeing (HWB) support and helping staff stay well.
- Used the “You Said, We Did” approach to respond to feedback received within the staff survey communications plan.
- Used the recently launched Staff Experience and Inclusion Oversight Group to review staff feedback, monitor actions, and coordinate cross-Trust responses to issues raised.
- Implemented the culture triangulation meeting, to ensure that various people data sources are being effectively triangulated and escalated where concerns are raised.

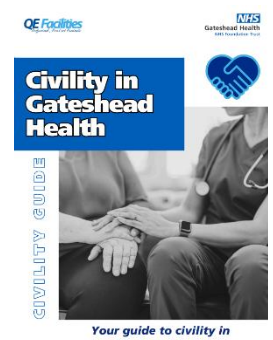
Evidence of achievement:

- Intranet visits have doubled over the year, peaking at over 60,000.
- CEO updates and Gateshead Health News continue to provide a stable and reliable baseline of engagement, with spikes during key organisational moments
- Team Brief attendance has remained consistent, with the principles of this platform to support line managers to share and reinforce messages locally
- Civility work is now embedded within several Trust programmes including corporate induction, team development, and leadership Development. This was supported with the introduction of a civility guide.
- A Health Needs Assessment completed to inform a new HWB approach.
- Absence Taskforce launched to ensure data-led and accessible support.
- Commendation received for wellbeing integration in SEQOHS accreditation, and “Better Health at Work Award” Continuing Excellence accreditation attained.
- New Stress at work guidance, including an updated Stress Risk Assessment launched



Next steps:

- Continue focus on engagement and closing the feedback loop, responding areas of concern highlighted within the staff survey.
- Embed local ownership of survey results through manager support.
- Further strengthen civility programme of work, building on 2025/26 foundations.



Priority 6: We will strive to have the right staff in the right place at the right time, to enhance patient care and support a sustainable, high-performing workforce.

➢ What did we say we would do?

- ➢ We will review our staffing models

Impact for patients

Having the right staff in the right place at the right time is fundamental to delivering safe, effective and compassionate care. Appropriate staffing levels help ensure patients receive timely assessments, treatment and support from skilled professionals who are able to meet their individual needs. Safe staffing is closely linked to improved patient outcomes, reduced risk of harm, better patient experience and higher standards of care quality. It also supports staff wellbeing and retention, helping to maintain a stable and sustainable workforce. By reviewing and improving staffing models across the Trust, the organisation aims to ensure services are responsive to patient demand, staff have the capacity to provide high-quality care, and patients receive safe and consistent care at all times

➢ Did we achieve this?

- ➢ Yes, we have done this for our Nursing adult in-patient areas. This work was reviewed in line with a full review of our rostering practices.
- ➢ Yes we further reviewed this from a medical perspective with a review of the Tier 1 Resident Doctors rota in Medicine.

➢ How we achieved it:

- ➢ We undertook an evidence-based review using the Safer Nursing Care Tool (SNCT) and professional judgement to assess and redesign staffing models.
- ➢ By aligning this with a comprehensive roster review, we were able to identify areas requiring uplift and invest in nursing workforce capacity.
- ➢ This ensured that staffing levels are better aligned to patient acuity, dependency, and service need, supporting the delivery of safe, high-quality care.

➢ Evidence of achievement:

- ➢ We have developed monthly monitoring of key quality outcomes and built this into our governance structure, including staffing fill rates, patient safety indicators, and nurse-sensitive outcomes, to demonstrate the positive impact of the revised models.
- ➢ Trends from this monitoring aim to provide assurance that the staffing changes are supportive of improved care delivery and safer staffing.

➢ Next steps:

- ➢ We will extend Nursing staffing model reviews to additional service areas across the Trust, including but not exclusive to:
- ➢ Paediatrics
- ➢ Outpatient Services
- ➢ Maternity
- ➢ This will ensure a consistent, Trust-wide approach to safe and sustainable staffing.
- ➢ We will continue to progress reviewing Resident Doctor rota's across the Trust.

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CLINICAL EFFECTIVENESS:

Priority 7: We will drive our digital developments to enable more time to care, and therefore a better patient experience

- What did we say we would do?
- Care planning
- Record keeping/noting
- Observations

Impact for patients

Digital innovation can improve both the safety and quality of patient care by enabling staff to spend more time caring for patients and less time on manual processes and paperwork. Effective digital systems support more accurate and timely record keeping, improve communication between clinical teams, and help ensure important information is available when and where it is needed. This can reduce the risk of errors, support faster clinical decision-making and improve continuity of care for patients. Digital tools such as electronic care plans and observation systems also help staff monitor patients more effectively and respond quickly to signs of deterioration. By continuing to develop digital solutions across the Trust, the organisation aims to improve patient safety, enhance patient experience and support more efficient, responsive and person-centred care.

- Did we achieve this?
- Yes

- How we achieved it:
- Digital care planning rolled out to all in scope areas.
- Digital Clinical noting programme has been started. Is in in early phase of scoping.
- Neuro observation model has been implemented across inpatient areas and the Emergency department

- Evidence of achievement:
- Daily use of digital Care plans on NerveCentre and Audit programme has been developed and signed off by the clinical audit and effectiveness Group.
- Neuro observation model is available and used when clinical care dictates and is evidenced on NerveCentre.
- The clinical noting programme of work has been established and reports via digital governance routes.

- Next steps:
- Undertake the care plan audit and report back to clinical audit and effectiveness committee one a quarterly basis.
- Continue to develop the ongoing clinical noting programme ensuring adequate stakeholder involvement and progress aligned with the project implementation document.

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Priority 8: We will implement and deliver on a programme to address health inequalities, so that all communities can access fair, high-quality care and achieve better health outcomes.

- What did we say we would do?
- Making every contact count (MECC) - To deliver a systematic and sustainable Trust-wide roll-out of MECC that is clearly aligned with regional and national implementation frameworks, with a deliberate focus on clinical areas where the greatest population health impact can be achieved.

- Health literacy - we aimed to improve organisational understanding of health literacy and embed principles in information shared with patients and carers in order to improve patient engagement with health services and empower patients as partners in their care
- Reasonable adjustment flags - Implement RAFs across the parent patient administration systems (Careflow and Emis) inline for implementation month of September 2026. Reasonable adjustment flags support patient experience when accessing services and should reduce rates of non-engagement.
- Equitable elective recovery - to ensure that as we recover our elective performance in clinical services with long waits we did so with due regard to the health inequalities experienced by our patients seeking to reduce health inequalities where possible

Impact for patients

Addressing health inequalities is essential to ensuring that all patients have fair access to safe, effective and high-quality healthcare, regardless of their background, circumstances or individual needs. Some communities experience poorer health outcomes, barriers to accessing services, or difficulties understanding health information, which can lead to delays in treatment, reduced engagement with care and widening inequalities. By improving health literacy, supporting personalised approaches through reasonable adjustments, and using every patient contact as an opportunity to promote health and wellbeing, the Trust aims to reduce these barriers and improve outcomes for all communities. This work will help patients better understand their care, access services more equitably, feel more supported in managing their health, and experience care that is inclusive, accessible and responsive to their individual needs.

- Did we achieve this?
- MECC - Yes, and this work is ongoing and accelerating. The MECC Lead has completed both the Core and Train-the-Trainer programmes and is proactively leading the delivery of high-quality, evidence-based training.

- Health Literacy - we have achieved the elements we set out in delivering the health literacy element of this priority over the last 12 months, noting that this is a multiyear programme of work. Key foundations have been established, including improvements to patient-facing information and the development of internal capability to support sustainable implementation.

- RAFs – Yes, the digital nursing team are on track for the flags to be live ahead of the on track for September deadline.

- Equitable Elective Recovery – Not yet, work was delayed but has now has started with a focus on rates of non-attendance in Trauma and Orthopaedics, this specialty was chosen

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due to its high volume and rates of non-attendance. We are supported in this by a public health resident doctor in placement at Gateshead Local Authority.

➢ How we achieved it:

- MECC - Implementation has been formally approved within the pilot areas, with comprehensive training delivered across all sites to both clinical and non-clinical patient-facing staff. In parallel, collaborative work continues with the MECC Regional Lead to support the implementation of a standardised MECC training programme for patient-facing staff across pilot areas, with the clear long-term aim of improving consistency, strengthening workforce confidence, and delivering improved health outcomes for patients and communities.

  Health Literacy - We focused on both practical application and organisational development. A pilot within the lung cancer pathway was used to embed health literacy principles into patient communications. The Lung Cancer Specialist Nurse leaflet was reviewed by the regional health literacy team and confirmed to already meet recognised standards, providing assurance of good practice.
  CT appointment letters and supporting patient leaflets were revised (draft format) in collaboration with the regional team to improve clarity, accessibility, and patient understanding. These now act as exemplars of health literate communication.
  Alongside this, we strengthened organisational capability through a Health Literacy Strategic Meeting, which brought together key operational and managerial leads. This enabled access to regional resources, including health literate templates, training opportunities, and tools to embed health literacy into existing document approval processes.
  Training and workforce development have also been prioritised, with staff attending health literacy awareness sessions and "Writing Simply" training and plans in place to develop internal trainers through a Train the Trainer programme.

- RAFs - Scoping, development, and education plans have been submitted to the health inequalities group. ESR training from the National team is available to staff.

➢ Evidence of achievement:

- MECC - To date, approximately 80 patient-facing staff have completed MECC Core Training, demonstrating strong early engagement with the pilot. This number is expected to increase further as the remaining pilot sessions conclude in March, supporting the Trust's aim to embed MECC as a routine, sustainable approach to patient care.
  Pre- and post-MECC training surveys have been reviewed and consistently demonstrate a positive response from participants. Notably, confidence in initiating MECC conversations has increased, indicating that MECC is more likely to be formally and consistently implemented in practice compared with pre-training baseline within the pilot areas.

- Health Literacy - Lung Cancer Specialist Nurse leaflet reviewed and confirmed as meeting health literacy standards and formally approved by the Trust.
  Positive external feedback on patient information from learners at Tyne Coast College.
  Revised CT letters and patient leaflets demonstrating clear, accessible communication and acting as best practice examples.
  Establishment of a Health Literacy Strategic Group with improved multidisciplinary representation.

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Access secured to regional health literacy resources, including toolkits, templates, and training materials.
Staff attendance at health literacy training and participation in Train the Trainer programmes to support sustainability.

- RAFs - regular updates have been provided to the Health Inequalities Group to demonstrate progress against the deadline. This has been co-ordinated with plans to launch the reasonable adjustments flag as part of a wider launch of the Health Inequalities Staff Zone page.

- Next steps:
- MECC - Focusing on areas where staff have completed MECC training, the primary purpose is to strengthen and evidence effective implementation by identifying what works well and systematically replicating successful approaches across the organisation. Using the NHS Standard for Creating Health Content, the baseline position of patient-facing communications will be evaluated to inform clear, prioritised plans for improvement.
The overarching intent is to demonstrate the impact and value of MECC through measurable, meaningful outcomes.
Further feedback sessions are planned, with findings to be collated and reviewed ahead of wider organisational roll-out.
A clear and structured evaluation plan for the MECC programme will be developed.
'Train the Trainer' sessions are being explored, with ongoing support from the MECC Lead.
Work is underway with the Communications Team to develop a screensaver and utilise Trust social media formats, supporting the launch of the HI Staff Zone page. This page will highlight 'all' of the key HI priorities, with the anticipated launch of the HI webpage planned for mid-May 2026.

- Health Literacy - Embed health literacy principles consistently across all patient information, using lung cancer pathway documents as exemplars.
Roll out health literacy training more widely, including Advanced Writing Simply training for staff responsible for developing and approving patient information.
Develop internal training capacity through the Train the Trainer programme to ensure sustainability beyond regional support.
Finalise and implement a standardised approach to reviewing and approving patient information in line with health literacy standards.
Progress development of accessible communication tools, including navigator letters, to support patient understanding and engagement.
Strengthen leadership visibility and organisational commitment to health literacy to support long-term cultural change.

- RAFs - - Launch Reasonable Adjustment Flags into the organisation through a structured communication plan including the launch of the Health Inequalities Staffzone page. This will be coordinated with an education package enabling implementation ahead of September 2026.

- Equitable elective recovery - Health Inequalities' as experienced by colleagues – we will work with our Health and Wellbeing manager to ensure a joined up approach to health inequalities across our patients and our colleagues built on the knowledge that may colleagues live in the local community and may experience health inequalities themselves.

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2.2 Our Quality Priorities for Improvement 2026/27

The following priorities have been agreed by Gateshead Health NHS Foundation Trust for 2026/27. These priorities reflect the areas where we believe focused improvement activity will have the greatest impact on patient safety, patient experience, clinical outcomes and staff experience.

Progress against these priorities will be monitored throughout the year through the Trust's governance structure, including the Patient Experience Group, SafeCare Steering Group and Quality Governance Committee, providing oversight, challenge and assurance around delivery, improvement and impact. Updates will also be reported through divisional governance arrangements and escalated through Trust governance processes where required.

The priorities have been developed through engagement with staff, patients, carers, governors and partners, alongside review of organisational intelligence, quality data and areas of emerging risk or opportunity. A range of information sources were used to help identify the priorities for 2026/27, including:

- Patient, carer and community feedback
- Friends and Family Test responses
- Complaints, concerns and PALS themes
- Staff survey feedback and workforce intelligence
- Clinical audit findings and effectiveness data
- Learning from incidents, PSIRF reviews and mortality reviews
- National and local performance data
- Benchmarking information and GIRFT recommendations
- Care Quality Commission (CQC) insight reports and regulatory feedback
- Feedback from Healthwatch, governors and system partners
- Emerging themes identified through governance and assurance processes

The Trust recognises that quality improvement is continuous and that meaningful improvement relies on listening, learning and working collaboratively with patients, staff and partners. Throughout 2026/27 we will continue to monitor progress against these priorities to ensure that improvement activity results in measurable and sustainable benefits for the people and communities we serve.

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Priority 1 – Patient Experience

We will strengthen patient and community engagement so that services are co-designed, inclusive and responsive to the needs and experiences of our population.

Why is this a priority?

Listening to patients, carers and communities is essential to delivering safe, effective and compassionate care. We know people's experiences and outcomes improve when they are actively involved in decisions about their care and when services are designed alongside the communities who use them.

We also recognise that some groups within our community's experience barriers to accessing healthcare or do not always feel heard through traditional engagement approaches.

Strengthening how we listen, involve and work alongside our population will help us better understand local needs, reduce inequalities and ensure services remain responsive, inclusive and person centred.

As an anchor organisation within Gateshead and the wider North East, we want to build stronger relationships with patients, carers, local communities and partner organisations so that improvement is shaped by lived experience as well as organisational priorities.

What are our aims for 2026/27?

- Improve how patients and communities are involved in service design and improvement
- Strengthen approaches to co-production and personalised care
- Improve accessibility of information and communication
- Increase engagement with communities whose voices are currently underrepresented Ensure patient feedback directly informs quality improvement and decision making

What will we do?

- Establish and develop a Gateshead Patient Forum to strengthen patient voice and involvement
- Increase patient and public representation within governance groups and improvement programmes
- Work with community, voluntary and third sector partners to improve engagement and reduce barriers to care
- Improve the accessibility of patient information, including the use of easy read, digital and translated materials
- Continue to use patient stories, feedback and lived experience within Trust meetings and improvement work
- Develop clearer feedback loops so patients and communities can see how their involvement has influenced change

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Priority 2 – Patient Safety

We will strengthen patient safety through data triangulation and learning so that risks are identified earlier, insights drive improvement and avoidable harm is reduced.

Why is this a priority?

Creating a strong culture of patient safety remains one of the Trust's highest priorities. We know that improving safety relies on more than reviewing incidents in isolation. To identify themes early and reduce avoidable harm, we need to bring together learning from incidents, complaints, claims, patient feedback, mortality reviews, audits and staff concerns.

By strengthening how information is reviewed across the organisation, we will improve our ability to identify emerging risks earlier, support learning across teams and ensure improvement actions are targeted where they will have the greatest impact.

This work also supports the continued development of our Patient Safety Incident Response Framework (PSIRF) approach, helping to create a culture focused on learning, improvement and openness

What are our aims for 2026/27?

- Improve how safety information is triangulated and reviewed across the organisation
- Strengthen organisational learning and sharing of improvement actions
- Support earlier identification of risks and emerging themes
- Embed a more proactive and intelligence-led approach to patient safety
- Reduce avoidable harm and improve patient outcomes

What will we do?

- Strengthen governance processes to ensure data from multiple sources is reviewed collectively
- Develop improved dashboards and reporting mechanisms to support earlier identification of risks and trends
- Continue to embed PSIRF principles and systems-based learning approaches
- Support divisions to use safety intelligence to inform local improvement plans
- Explore opportunities to improve digital reporting systems and data integration
- Increase visibility of learning and improvement actions across the organisation

Priority 3 – Clinical Effectiveness

We will strengthen clinical effectiveness through the use of outcomes data, evidence and research so that patient outcomes improve and unwarranted variation is reduced

Why is this a priority?

Delivering clinically effective care means ensuring patients consistently receive care that is safe, evidence based and achieves the best possible outcomes. Understanding variation in

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outcomes across services allows us to identify opportunities for improvement and ensure patients receive high-quality care regardless of where they access services.

Using outcomes data more effectively will support better decision making, improve transparency and help clinical teams focus improvement efforts where they are most needed. Alongside this, research and innovation continue to play an increasingly important role in improving treatment options, patient experience and long-term outcomes.

By strengthening the use of evidence, audit, benchmarking and research, we aim to support continuous improvement and deliver better outcomes for the communities we serve.

What are our aims for 2026/27?

- Improve the use of outcomes data within clinical governance and improvement work
- Reduce unwarranted variation in care and outcomes
- Strengthen evidence-based practice across services
- Increase participation in research and innovation
- Improve patient outcomes through targeted improvement activity

What will we do?

- Develop and standardise key clinical outcome measures across services
- Strengthen the routine review of outcomes data within divisional governance structures
- Use benchmarking, GIRFT reviews and audit findings to identify variation and improvement opportunities
- Support targeted improvement work in areas of greatest risk or variation
  Increase opportunities for staff and patients to participate in research studies
- Continue to strengthen multidisciplinary learning, review and shared decision making

Priority 4 – Staff Experience

We will improve opportunities for career development so that our people have clear, equitable pathways to progress and can reach their full potential.

Why is this a priority?

Our staff are our greatest asset and play a vital role in delivering safe, compassionate and high-quality care. We know that staff who feel valued, supported and able to develop are more likely to remain within the organisation, feel engaged in their work and provide better experiences for patients.

We also recognise that access to development opportunities can vary across staff groups and services. Creating clearer and more equitable opportunities for progression will help us build a sustainable workforce for the future while supporting wellbeing, retention and inclusion.

Investing in our people is essential if we are to continue developing services, responding to future challenges and delivering high standards of care.

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What are our aims for 2026/27?

- Improve access to learning, development and career progression opportunities
- Strengthen equitable development pathways for all staff groups
- Improve staff experience and retention
- Support managers to create positive learning cultures within teams
- Increase staff confidence in opportunities for growth and progression

What will we do?

- Continue to develop and promote the Trust learning and development offer
- Improve access to protected learning time and development opportunities
- Strengthen communication around career pathways, apprenticeships and funded development programmes
- Support managers to embed regular wellbeing and development conversations within teams
- Continue work to improve rostering and workforce models to support supervision and team development
- Promote inclusive leadership and equitable access to opportunities across the organisation

Priority 5 – Women's Health

We will raise awareness of the importance of women's health and make it easier for women and girls to access services.

Why is this a priority?

Women and girls can experience significant inequalities in health outcomes, access to services and experiences of care. Nationally and locally, there is growing recognition that women's health needs have not always been consistently prioritised and that barriers remain in accessing timely support, diagnosis and treatment.

Improving women's health is an important part of our wider strategic ambition to reduce inequalities, improve prevention and support earlier intervention. We want women and girls to feel informed, listened to and able to access services that are responsive to their individual needs across all stages of life.

By raising awareness and strengthening pathways of care, we aim to improve experiences, reduce stigma and support better health outcomes for women across our communities

What are our aims for 2026/27?

- Improve awareness and understanding of women's health issues
- Improve access to information and services for women and girls
- Strengthen partnership working across services and organisations
- Support earlier intervention and prevention
- Improve experiences of care for women accessing Trust services

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What will we do?

- Promote women's health awareness through campaigns, engagement and education
- Strengthen pathways linked to areas such as pelvic health, menopause, menstrual health and maternal wellbeing
- Improve signposting and access to support services and community resources
- Work collaboratively with system partners to improve joined-up approaches to women's health
- Continue to listen to women's experiences to inform service improvement and development
- Support staff awareness and understanding of women's health needs across services

Priority 6 – Timely Access to Care

We will strive to eliminate unnecessary waits, to ensure patients receive timely care and experience better outcomes.

Why is this a priority?

Timely access to healthcare has a significant impact on patient safety, experience and outcomes. Long waits for assessment, diagnostics or treatment can lead to deterioration in patients' conditions, increased anxiety and poorer overall experiences of care.

Like many NHS organisations, the Trust continues to face operational pressures across urgent and emergency care, diagnostics and elective pathways. Improving patient flow and reducing delays across the system remains essential to ensuring patients receive the right care, in the right place, at the right time.

Reducing unnecessary waits also supports safer care environments, improves patient experience and helps staff deliver care more effectively.

What are our aims for 2026/27?

- Reduce unnecessary waits across urgent, elective and diagnostic pathways
- Improve patient flow and discharge processes
- Improve access to diagnostics and treatment
- Reduce overcrowding and delays within urgent and emergency care
- Improve patient experience and outcomes through more timely care

What will we do?

- Continue to progress improvement programmes focused on urgent and emergency care, discharge and flow
- Strengthen collaborative working with community and system partners to support timely discharge and admission avoidance
- Continue pathway improvement work across key specialties and services
- Improve operational oversight and escalation processes to support timely access to care
- Focus on reducing long waits for diagnostics and treatment
- Continue to develop workforce and digital solutions that support more efficient patient pathways

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2.3 Statements of Assurance from the Board

During 2025/26 the Gateshead Health NHS Foundation Trust provided and/or sub-contracted 32 relevant health services. The Gateshead Health NHS Foundation Trust has reviewed all the data available to them on the quality of care in 100% of these relevant health services. The income generated by the relevant health services reviewed in 2025/26 represents 92% of the total income generated from the provision of relevant health services by Gateshead Health NHS Foundation Trust for 2025/26.

Participation in National Clinical Audits 2025/26

During 2025/26, 37 National Clinical Audits and TBC National Confidential Enquiries covered relevant health services provided by Gateshead Health NHS Foundation Trust.

During that period Gateshead Health NHS Foundation Trust participated in 92% of National Clinical Audits which it was eligible to participate in.

The National Clinical Audits and National Confidential Enquiries that Gateshead Health NHS Foundation Trust participated in, and for which data collection was completed during 2025/26, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audit title	Participation	% of cases submitted/number of cases submitted
National Audit - Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	200 Cases submitted up to Feb 26 – no minimum requirement
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	6 Cases submitted – no minimum requirement
National Audit - National Emergency Laparotomy Audit (NELA)	Yes	TBC Cases submitted – no minimum requirement
National Audit - Elective Surgery (PROMS)	Yes	No minimum requirement HIP -237 Cases submitted Knees -430 Cases submitted
National Audit - Falls & Fragility Fractures Audit Programme (FFFAP) Inpatient Falls	Yes	43 Cases submitted – no minimum requirement
National Comparative Audit of Bedside Transfusion Practice	Yes	16 Cases submitted – no minimum requirement
National Audit - National Pulmonary Rehabilitation	Yes	338 Cases submitted – no minimum requirement
National Audit - National Cardiac Rehabilitation	Yes	680 Cases submitted – no minimum requirement
National Audit - National Pregnancy in Diabetes Audit	Yes	Data for 2025/26 not published as yet. Submission Deadline 31st May
National Audit - National Joint Registry (NJR)	Yes	Data for 2025/26 not published as yet.(mid-May)

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National Major Trauma Registry (NMTR) / (TARN)	Yes	Data for 2025/26 not published as yet. Submission Deadline 31st July
UK Parkinson's Audit	Yes	88 Cases submitted – no minimum requirement
National Audit - Case Mix Programme (ICNARC)	Yes	812Cases submitted – no minimum requirement
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	40 Cases submitted – no minimum requirement
National Audit - National Breast Cancer Audit	Yes	794 Cases submitted – no minimum requirement
National Audit - National Kidney Cancer	Yes	4 Cases submitted (not inc. Qtr4 data not available) – no minimum requirement
National Audit - Non-Hodgkin Lymphoma	Yes	51 Cases submitted (not inc. Qtr4 data not available) – no minimum requirement
LeDeR	Yes	8 Cases submitted – no minimum requirement
National Diabetes Inpatient Safety Audit (NDISA)	Yes	Only one case submitted due to the difficulty in identifying cases to participate in the audit.
National Audit of Care at the End of Life (NACEL)	Yes	84 Cases submitted – no minimum requirement
National Audit - Prostate Cancer	Yes	242 Cases submitted – no minimum requirement
National Audit - Neonatal Intensive and Special Care (NNAP)	Yes	100% of Cases were submitted
National Audit - Maternity and Perinatal Audit (NMPA)	Yes	100% of Cases were submitted
National Audit - National Audit of Dementia	Yes	Not open for submissions during 25/26
National Audit - National Cardiac Arrest Audit	Yes	60 Cases submitted – no minimum requirement
National Audit - National Lung Cancer Audit	Yes	204 Cases submitted – no minimum requirement
National Audit - Chronic obstructive pulmonary disease (Secondary Care)	Yes	555 Cases submitted – no minimum requirement
National Audit - National Heart Failure Audit	Yes	369 Cases submitted – no minimum requirement
National Audit - Oesophago-gastric cancer (NAOGC)	Yes	10 Cases submitted – no minimum requirement
National Audit - National Hip Fracture Database	Yes	318 Cases submitted – no minimum requirement
National Audit - Cardiac Rhythm Management	Yes	98 Cases submitted – no minimum requirement
National Audit - Paediatric Diabetes (NPDA)	Yes	138 Cases submitted – no minimum requirement
National Audit - Bowel Cancer (NBOCAP)	Yes	134 Cases submitted – no minimum requirement

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Sentinel Stroke National Audit Programme (SSNAP)	Yes	258 Cases submitted– no minimum requirement
Inflammatory Bowel Disease Audit IBD Registry	No	*Benefits of the audit did not outweigh the cost to participate.*
National Audit - Diabetes Foot Care	No	*Due to clinical commitments at present the teams do not have the admin support to enable data submission.*
Mental Health (self-harm) (Care in Emergency Departments)	No	*CNTW info collaboration was required, information governance sharing issues, Dept decided to save the cost or participation.*

The Trust utilises clinical audit as a process to embed clinical quality at all levels in the organisation and create a culture that is committed to learning and continuous organisational development. Learning from clinical audit activity is shared throughout the organisation.

The reports of TBC national clinical audits were reviewed by Gateshead Health NHS Foundation Trust in 2025/26, and Gateshead Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

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The Case Mix Programme (CMP)
The CMP is an audit of patient outcomes from adult and general critical care units (intensive care and combined intensive care/high dependency units) covering England, Wales, and Northern Ireland. It is run by the Intensive Care Audit and Research Centre (ICNARC). Data is collected on all patients admitted to the Critical Care Unit. Data on various outcomes and process measures are then compared with the outcomes from other Critical Care Units in the UK.
In the past 12 months the Critical Care Unit has uploaded data on 812 patients to the CMP. Data uploads (via Platform X) are being performed on an approximately weekly basis. CMP/ICNARC continue to publish Quarterly Quality Reports (QQR) for each individual critical care unit. Our most recent QQR, including data for Q3 25/26 shows good performance in all areas, with no measures showing performance worse than comparable units, and strong performance in some areas including potential mis triage to the ward, unplanned readmissions, delayed admissions, and non-clinical transfers to other units. Our overall standardised mortality rate was as expected (observed 16.8% v expected 15.6%), and mortality for patients with a low predicted mortality was very low.
We continue to use Medicus software for data collection and this continues to be update when required. In the past year, a new 'Infections' tab has been added which is being used to collect data for submission to PHE bloodstream infection audit.
Our data completeness remains excellent, with around 100% data completeness for all quality measures and very high levels of completeness for patient data. Our timeliness of data submission to ICNARC also remains excellent.
We continue to contribute data to the ICNARC Cardiogenic Shock Module which is a separate data entry system focusing on patients admitted with cardiogenic shock. We have not received any performance data on this as of yet.
We continue to submit our ICNARC data into the North of England Critical Care Network. The Network has a centralised server collecting anonymised data from all critical care units in the Network and are using this to produce unit and network reports on a monthly basis which mirror the ICNARC Quality reports but are available much more quickly. We continue to be heavily involved in the development of these reports by sense-checking the data and suggesting changes. Our ICU data clerk and Consultant lead for ICNARC are both heavily involved in the Network Data group which focusses on ICNARC data submission and quality, and the Consultant Lead has been appointed Co-Chair of the group in the past year.
Action Points:

- Continue to collect and submit data to the Intensive Care National Audit and Research Centre (ICNARC)/CMP and to the Cardiogenic Shock Module.
- Ongoing education of ward clerks and Nursing/Medical staff regarding the correct entry of data, assisted by the ICNARC data clerk.
- Continued consideration of the ICNARC data clerk role becoming a full-time role to allow more data collection to occur e.g., quality measure data, etc.
- Use the QQR to ensure timely identification of any areas of deterioration in performance and address these when they occur.
- Continue to share QQR and other CMP/ICNARC data with relevant teams within the Trust.
- Work with the Critical Care Network to ensure quality of Network reports.
- Continue to contribute to the Critical Care Network data group.
- Explore data collection for Outreach team once this is established (using Medicus Outreach Module).
- Explore data collection within Medicus for Critical Care Rehab team.

Myocardial Ischaemia National Audit Programme (MINAP)
This audit reviews the quality of care and management of patients who present with pain chest that is deemed to be cardiac in origin (Acute Coronary Syndromes). We continue to contribute to this audit on a monthly basis ensuring that the targets set within the audit are achieved.

Action Points:

- Ensure consistency of input to the MINAP proformas, collaborating with the IT and the Careflow system who advise of any concerns which are then reviewed. This is maintained by the Cardiology team and the value of this information can be cascaded to other members of the Cardiology team. The Cardiology Team within cardiology ward works hard to ensure smooth patient flow and appropriate placement within the hospital, thus ensuring appropriate evidenced based care. Information within the proformas is easily accessible to all and can therefore help with patient care. We will continue to participate in the annual data collection programme

National Joint Registry (NJR)
The Trust continues to contribute to the NJR. Data is entered regarding all hip, knee, ankle, elbow and shoulder replacement operations, enabling the monitoring of the performance of joint replacement implants and the effectiveness of different types of surgery.

Action Points:

- The Trust will continue to contribute to these audits and was awarded the Gold Quality Data Provider Award for 2025.

Patient Reported Outcome Measures (PROMS) National Audit
The Trust have continued to ask patients having elective hip and knee replacement to complete health score questionnaires before surgery then three months after surgery.

Action Points:

- Continue to collect and submit data to the national proms audit programme.
- Continue to share our data with relevant teams within the Trust.

National Hip Fracture Database (NHFD)
The Trust continues to input data into the NHFD which records several clinical parameters for patients admitted with a fracture of either the neck or shaft of Femur. We continue to collect data for the NHFD but in the current audit period we faced significant challenges in data collection due to staff sickness.

Action Points:

- We have also been asked to collect new data sets on pelvic fractures as part of the ongoing audit.
- This is also proving a challenge as the majority of these patients do not get admitted under the orthopaedic team and hence identifying them is a challenge.

National Cardiac Arrest Audit
The Trust continues to provide data on a monthly basis to NCAA as part of our commitment to the scheme. Changes in data collection method introduced last year by NCAA have resulted in a more in-depth analysis of the types of arrests the team attend. The new dataset will allow NCAA to produce higher quality data relating to local and national cardiac arrest outcomes.

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Action Points:

- The trust will continue to participate in this project and upload the new required dataset.

National Sentinel Stroke Audit (SNNAP)
We aim to process a dataset in the national audit database (SSNAP) for every Stroke patient at the QE.

Prior to recalibration of scoring, Queen Elizabeth scored C (A to E scoring). SSNAP recalibrated their scoring when they changed the format of their dataset in October 2024 and they did not produce results for a period of adjustment –

- **July 2025:** Key indicator performance metrics for Jan–March 2025 (without ratings) were made public.
- **October 2025:** The first public, updated A to E ratings for providers (reporting on April–June 2025 care) were published.

In the 3 quarters that are available from the new scoring system, Queen Elizabeth Hospital has consistently scored a D overall.
However as a team we have improved since the first production of the new figures and for the latest period (Oct-Dec25), the QE scored as follows in the 4 team-centred domains in which we are rated –
Specialist pathway – B
Therapy intensity – C (dropped from A in Jul-Sept)
Therapy frequency – C
Standards by discharge - C (improved from D in July-Sept)
In addition, we consistently score an A in both Case Ascertainment & Audit Compliance.
Action Points:

- As a team we are constantly discussing ways to improve our results, and currently we are carrying out a piece of work focusing on the patients' first 72 hours. The therapy team have also been exploring ways to improve frequency and intensity of rehabilitation with current staffing, and last year the Stroke Team won an Innovation Award at the Trust Awards for this work.

National Audit of Care at the End of Life
The trust continues to participate in the Annual comparative audit of quality/outcomes of end of life care during the last admission leading to death. Monitors progress against: Five Priorities for Care (One Chance to Get It Right) and relevant NICE guidance/quality standards. 8th round since 2014; questions/indicators refined each year (limits deep year-on-year comparisons).
Action Points:

- Share NACEL 2025 findings Trust-wide (Board to frontline): celebrate strengths, focus on persistent gaps
- Strengthen education as core requirement (induction, mandatory role-based training, advanced skills for senior staff); monitor compliance
- Prioritise digital prompts/tools to support individualised end of life care plans (e.g., embed Caring for the Dying Patient document in digital noting)
- Prioritise digital solutions to record/share advance care planning and treatment escalation planning across settings
- Implement and roll out Careflow chaplaincy clinical note to strengthen evidence of spiritual care
- Agree next steps to address the gap in 8-hours/day, 7-days/week face-to-face specialist palliative care (building on 2023 pilot/business case)
- Continue development of an end-of-life volunteer workforce (clear roles, training, governance).

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The reports of TBC local clinical audits were reviewed by Gateshead Health NHS Foundation Trust in 2025/26, and Gateshead Health NHS Foundation Trust intends to take actions to improve the quality of healthcare provided. Below are examples from across the Trust that demonstrate some of the actions taken to improve the quality of our services:

Business Unit	Speciality	Actions identified
Nursing & Midwifery	Safeguarding Adults	Domestic Abuse Risk Assessment and Referral Form Quality Audit Though only signature and date missing, it's important for staff to remember these forms could be used in legal cases Staff will continue to be reminded via training and individual feedback of importance in relationship to risk assessment and safety planning and Multiagency Risk Assessment Conference (MARAC) referral; especially if referred/passed to other agencies. Similar results to last audit (minor adjustments). Overall pleased with staff's completion of paperwork. A few of criteria decreasing and staying same will prove positive once staff trained to complete 'all' forms. • Additional Training has been offered to assist staff in completing paperwork
Nursing & Midwifery	Safeguarding Adults	Enhanced Care and DoLS compliance audit The audit demonstrated a significant increase in the recording of enhanced care, rising from 397 uses in the first six months of the year, up to 1483 uses within the six months of the year covered by this current audit. There was a substantial rise in the use of DoLS applications, from 220 in the previous audit, up to 406 uses within this audit. • The audit was reported to the safeguarding group- concerns regarding the significant increase in reporting of enhanced care usage were expressed. A separate meeting was arranged to look into this matter. • The audit was circulated, to feedback to ward teams. • Work is ongoing with the digital team to develop a digital mental capacity assessment and DoLS screening tool to better identify those patients who require a DoLS application
Clinical Support & Screening	Radiology	Review of outside worker and secondary employment documentation and training Outside workers – Equipment training – 100% compliance. Provided evidence of IR(ME)R training – 100% compliance. 297 Level 2 Radiation Awareness Training – 100% compliance. Read local rules and signed the declaration – 100% compliance. Read Employers Procedures and signed the declaration – 87.5% compliance. Record of Ionising Radiations Regulations (IRR) 17 Outside Worker Arrangements – 87.5% compliance

		• Documentation requires completion by main employer, host trust and the employee. Radiation Protection Adviser (RPA) are now involved to ensure documentation can be completed. • New secondary employment have been identified; contact has been made with their secondary employer and documentation completed. • Re circulate Employers procedure declarations. • Record of outside worker arrangement has been escalated to RPA who is contacting the main employers RPA
Medicine	Mental Health	Physical health monitoring for patients on lithium in the community Calcium and thyroid function are commonly missed or late when undergoing physical health checks of those on lithium. Other physical health checks, such as lipid panels, blood pressure and weight were very often checked in accordance with guidelines. • This has been discussed with the ICE pathology team who will set up a lithium panel, which includes all of the required laboratory investigations and the recommended time frames in which they should be monitored.
Medicine	Emergency Assessment Unit	Improving Skin Eruptions Management and Enhancing Dermatology Referral Practices Many practitioners showed keen interest on dermatological topics and demonstrated desire to improve. We managed to collect useful insightful issues faced by the practitioners to work on. Lack of formal guidance on dermatological conditions and referral pathways. Lack of guidance on describing skin rashes. • A formal guidance is needed to aid clinicians to accurately describe skin rashes, initiate investigations and managements when encountering acute dermatological conditions. • Teaching sessions have been conducted to raise awareness on this and address the knowledge gap identified to ensure safe patient care.
Clinical Support & Screening	Bowel Screening	Bowel Prep interim Audit Since change in prep there has been a slight decrease, but it was better than expected. There seems to be improvement in scores with addition of Senna. • Gathering data on patients who vomit prep and require cancellation. • Asking patients who have poor prep during procedure about diet and fluid intake. • Extended bowel preparation policy in development.

		• Agreement to have Moviprep and Senna for Extended prep, therapeutic and EMR/ESD polypectomy cases. • Bowel prep task and finish group set up to look at all areas that could impact the quality of preparation. • Education sessions with preceptorship and Nursing students.
Surgery	Maternity	Newborn Apgar Score There were no patient safety concerns flagged with the cases reviewed against relevant neonatal outcome criteria, including unavoidable admissions to the SCBU, low cord gases or HIE rates. The Trust believes that had the correct scoring been applied in all cases, the service would not flag as an outlier for this measure. This retrospective low Apgar deep dive demonstrated data quality issues with 38% of cases containing incorrect classification of Apgar score at 5 minutes. This is line with the finding of other Trusts within NENC • Development of a regional “safety alert” to focus on correct scoring. • Sustained emphasis on NLS training and a development of the documentation used to record the APGAR score.
Surgery	Critical Care	Pain Assessment in Critical Care The sedated patients and those admitted for medical reasons (rather than surgical) do not receive regular or frequent pain assessment. Surgical patients receive the highest frequency of pain assessment due to protocolised pain assessment (local anaesthetic or PCA pain assessment and management forms) and the ease of usage of the numerical rating scale of the nursing staff. • Discussed with CCD Clinical Lead. • There needs to be training on CPOT as a BPAT for sedated/ventilated patients for both nurses and doctors in training. We need to include CPOT assessments on the Critical Care Observation Charts. • Pilot testing CPOT on Level 3 patients done by Pain link Band 6 nurse.

Participation in National Confidential Enquiries 2025/26

Enquiry	Participation	% of cases submitted
Data awaited		

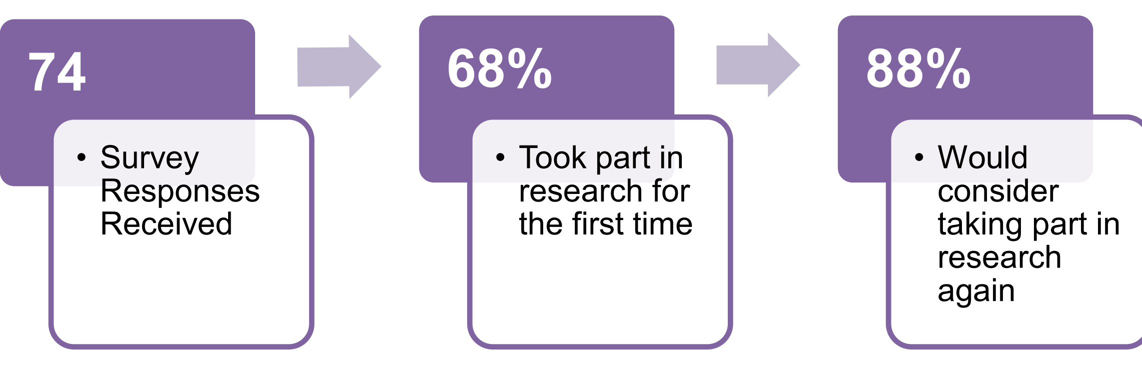
Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Gateshead Health NHS Foundation Trust in 2025/2026 that were recruited during that period to participate in research approved by the Health Research Authority (HRA) was **931**.

Recruitment by Managing Specialty	Total
Ageing	20
Anaesthesia, Perioperative Medicine and Pain Management	10
Cancer (Including Gynae Oncology)	60
Critical Care	37
Dementias and Neurodegeneration	32
Dermatology	10
Diabetes, Metabolic & Endocrine (DME)	4
Gastroenterology & Hepatology	78
Haematology	1
Imaging	12
Infection	113
Musculoskeletal & Orthopaedics	13
Reproductive Health and Childbirth	412
Respiratory	26
Stroke	17
Surgery	10
Trauma and Emergency Care	76
Total	**931**

In line with the Research Strategy, Gateshead Health NHS Foundation Trust remains a research active organisation, which ensures that our patients have access to the very latest treatments and technologies. Evidence shows that clinically research active hospitals have better patient care outcomes.

Each year the Patient Research Experience Survey (PRES) gathers feedback from our patients about their research experiences.



The feedback shows that a high proportion of our patients had a good experience of taking part in research and would be happy to take part again. This shows that our patients trust and support research at Gateshead Health NHS Foundation Trust.

The survey also found:-

96% of participants agreed they were treated with kindness, courtesy & respect.

88% of participants agreed that the information they received before taking part, prepare them for their research experience.

93% of adults felt valued by researchers for their participation.

Top 5 Recruiting Studies

INGR1D2 **INGR1D2 - INvestigating Genetic Risk for type 1 Diabetes (2)**

Type 1 diabetes is a common chronic disease in childhood and is increasing in incidence. The clinical onset of type 1 diabetes is preceded by a phase where the child is well but has multiple beta-cell auto-antibodies in their blood against insulin-producing beta cells, which are present in the pancreas.

Neonates and infants who are at increased risk of developing multiple beta cell auto- antibodies and type 1 diabetes can now be identified using genetic markers. This provides an opportunity for introducing early therapies to prevent beta-cell autoimmunity and type 1 diabetes.

The objective of INGR1D2 is to determine the percentage of children with genetic markers putting them at increased risk of developing type 1 diabetes, and to offer the opportunity for these children to be enrolled into phase II b primary prevention trials.

INGR1D2 has recruited a total number of 362 participants.

POS-cUTI - Perpetual Observational Study on Complicated Urinary Tract Infections

POS-cUTI is an observational data collection study looking at Complicated urinary tract infections (cUTI), which are associated with significant morbidity and mortality. Due to the high frequency of UTI, they have a major impact on antibiotic use and the antibiotic resistance of prominent UTI bacteria is of recognised importance. Therefore, UTIs, and particularly cUTIs, are a target for repurposing of old and neglected drugs, new drug development and non-antibiotic therapeutic and preventive approaches.

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The aim of the study is to describe the variations in current practices in treating cUTIs at study sites, the patient population they occur in and the microbiological causes of cUTI at study sites, to determine:-

- The incidence of treatment failure in patients with cUTI and identify modifiable and non-modifiable risk factors for treatment failure.
- The rate of recurrences and superinfections, and those caused by multidrug-resistant bacteria
- The mortality and its predictors in patients with cUTI
- The length of hospital stay after cUTI

POS-cUTI has recruited a total number of 231 participants.

POS-ARI-ER - Perpetual Observational Study of Acute Respiratory Infections presenting via Emergency Rooms and Other Acute Hospital Care Settings

POS-ARI-ER - is a perpetual, observational study (POS), designed to provide data for clinical characterisation of acute respiratory infections (ARIs) in adults presenting to hospital settings across Europe

Every year, respiratory infections such as colds, flu, pneumonia and now, Covid-19, affect millions of people globally and are one of the main reasons for needing hospital care. New or changing viral respiratory infections also have the potential to cause large outbreaks or pandemics. Understanding respiratory infections, and the best ways to diagnose and treat them in hospital, is therefore of high public health importance.

POS-ARI-ER has recruited a total number of 264 participants.

COLO-FC - Barriers to Faecal Immunochemical Test (FIT) completion amongst patients with symptoms of possible colorectal cancer

Recent UK guidance recommends that almost all patients who see their GP about symptoms of possible bowel cancer should complete a faecal immunochemical test (FIT). FIT is a test that patients do at home, to look for traces of blood in their poo (faeces).

A positive FIT result means there is a somewhat greater chance that their symptoms are due to bowel cancer. GPs use FIT to help decide whether patients should be referred to hospital for investigation and, if so, how urgently. (The earlier bowel cancer is diagnosed, the greater the chance of cure).

New data suggest that 10-20% of patients asked to complete FIT, do not do so.

COLO-FC will use a brief survey and interviews to investigate these issues to identify which patients might need more support to complete FIT and what that support could be. Addressing what hinders FIT completion amongst patients with symptoms of possible bowel cancer could help diagnose cancers earlier and increase chances of survival. (The earlier bowel cancer is diagnosed, the greater the chance of cure).

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COLO-FC has recruited a total number of 60 participants.

Risk of Cancer and Hyperplasia in Thickened Endometrium Without PMB

RiCH aims to determine the womb lining thickness that might suggest cancer or precancer in women after menopause who have no vaginal bleeding, but the internal scan showed that the womb lining to be thicker than 4 mm.

It is well established that women who bleed after the menopause require further investigations if the internal scan shows a womb lining thickness of more than 4mm; although, it is uncertain as at what womb lining thickness postmenopausal women without bleeding should be offered further intervention.

Cancer of the lining of the womb is the fourth most common cancer in females in the United Kingdom. Although women with postmenopausal bleeding are the most vulnerable, sometimes it develops in postmenopausal women with no bleeding.

Many postmenopausal women without vaginal bleeding have internal scans for symptoms such as tummy pain or urinary problems. Some NHS hospitals offer a biopsy from the womb lining with or without a womb telescope test (hysteroscope) when the thickness is more than 4 mm while others use various thresholds up to 10mm. Some doctors do nothing and wait to see if the woman starts bleeding. The practice varies in different hospitals, hence the need for the RiCH study.

RiCH has recruited a total number of 23 participants.

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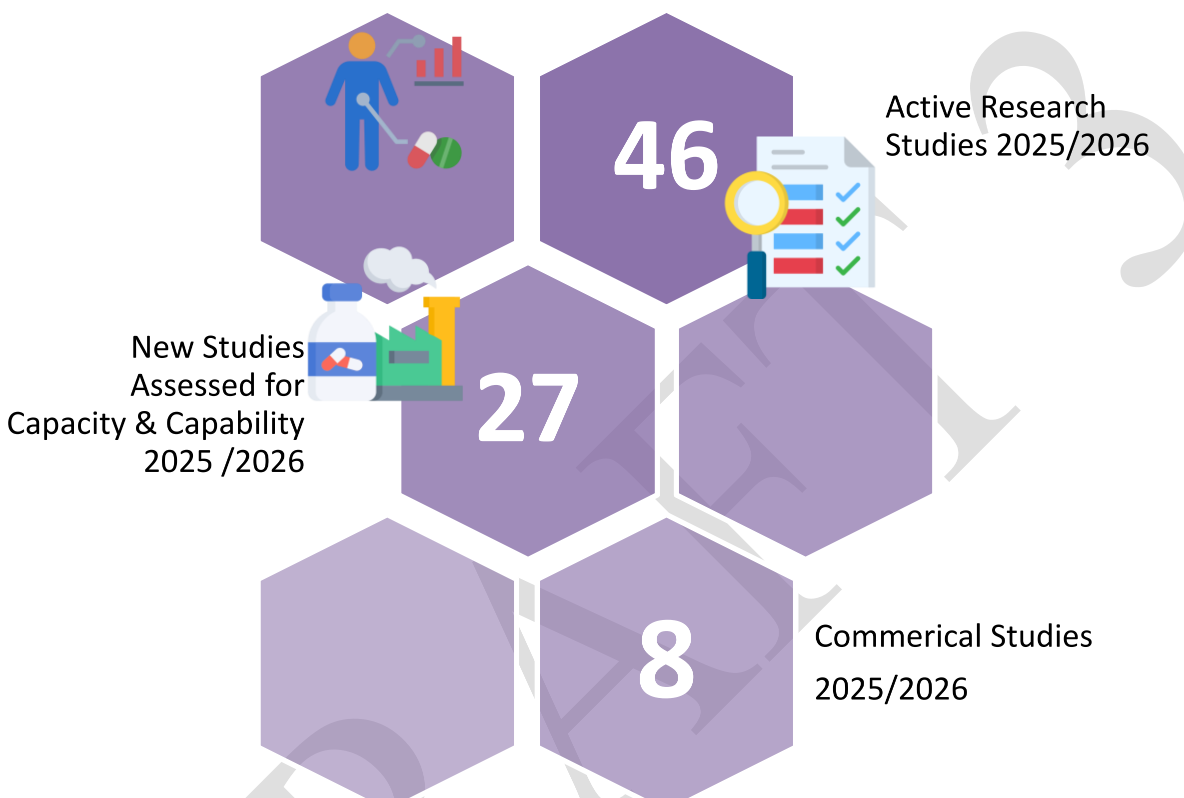
Performance

Under the UK Government's 10 Year Health Plan all NHS Trusts and organisations will need to submit data on the number of trials that are open and actively recruiting. This data will show which Trusts are performing well in clinical trials and which are not. The data will also show the number of hosted trials sponsored by commercial sponsors.

Government investment going forward, will only be prioritised for NHS Trusts and organisations that are performing well and can prove that they can support the NHS to deliver the treatments of tomorrow.



The following hosted studies are commercially sponsored – 5 are actively recruiting, 4 are awaiting the "Sponsor Green Light" to allow recruitment to commence.

Study Title:	Speciality:	Commercial Co.	Status:
PERLE	Cancer	Nagor Ltd	Awaiting Green Light
C3206	DME	BSN Medical	Actively Recruiting
AZURE-Outcomes	DME	Astra Zeneca	Actively Recruiting
Plant Protein Dominant Feed	Gastro	Nutricia Ltd	Actively Recruiting
Ellele-02	Gynae-Oncology	Ellele Health Ltd	Awaiting Green Light
BRAMble	Haematology	BeOne Medicines	Awaiting Green Light
PRIME	Musculoskeletal	UCB BioPharma	Actively Recruiting
RADICAL -React	Respiratory	Sierra Medical Ltd	Awaiting Green Light

Conclusion

In summary, the Trust continues to demonstrate strong performance in research, consistently meeting National time-to-target requirements for confirming capacity and capability for new hosted studies. This is reflected in the Trust's current ranking of 98th out of approximately 215 NHS organisations participating in research across the UK.

Sustained funding will enable continued reinvestment into research infrastructure, particularly staffing, which will help to support the growth of research activity and allow research to expand into new speciality areas, further embedding research within routine clinical practice and patient care. Ensuring this stability will be key to maintaining momentum and realising the full benefits of research for our patients and the organisation.

Use of the Commissioning for Quality and Innovation Framework (CQUIN)

In 2025/26, the CQUIN framework is integrated directly into the NHS Payment Scheme (NHSPS) tariff rather than operating as a separate, conditional payment scheme.

Registration with the Care Quality Commission (CQC)

Registration with the Care Quality Commission (CQC) Gateshead Health NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against Gateshead Health NHS Foundation Trust during 2025/26.

Gateshead Health NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

There were no announced or unannounced inspections by the CQC during 2025/26.

There has been one Mental Health Act (1983) Monitoring visits during 2025/26, on Cragside in January 2026.

Positive feedback was received verbally, with CQC stating they were impressed with the following:

- Quality of patient care
- Patients were happy and engaged
- Patient feedback was amazing and very complimentary about the team. All patients said they wanted to remain on the ward.
- Care plans, in particular how person-centred they are and that there was evidence of involvement of the patient in their care plan and review of this.
- Covert care plan showed good evidence of engaging with the family in coming to the decision to use, and this was well documented within the care plan documentation. MCA 1& 2 was in place for this.

The Trust is currently awaiting the formal report to the Chief Executive.

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Data Quality

Gateshead Health NHS Foundation Trust recognises that it is essential for an organisation to have good quality information to facilitate effective delivery of patient care, and this is essential if improvements in the quality of care are to be made.

Gateshead Health NHS Foundation Trust submitted records during 2025/26 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data is shown in the table below:

Which included the patient's valid NHS Number was:	Trust %	National %
Percentage for admitted patient care*	99.9%	99.8%
Percentage for outpatient care*	100.0%	99.8%
Percentage for accident and emergency care†	99.5%	98.5%

Which included the patient's valid General Medical Practice Code was:	Trust %	National %
Percentage for admitted patient care*	100.0%	99.4%
Percentage for outpatient care*	100.0%	99.6%
Percentage for accident and emergency care†	100.0%	99.0%

* SUS+ Data Quality Dashboard - Based on data submitted to SUS before 5.00pm on Wednesday 18th March 2026 for activity up to and including Saturday 28th February 2025, for M11 2025-26
†ECDS DQ Dashboard based on data submitted before 5.30pm on Saturday 18th April for activity from Tuesday 1st April 2025 up to and including Saturday 18th April 2026

Key

Colour	Meaning
Green	The Trust % is equal or greater than the National % valid
Amber	The Trust is up to 0.5% below the National % valid
Pink	The Trust % valid is more than 0.5% below the National % valid

Information Governance Toolkit

Gateshead Health NHS Foundation Trust successfully submitted the Data Security and Protection Toolkit (DSPT) for 2024/25 (version 7) on 30 June 2025. The Trust received a certificate confirming that standards were met, which remains valid until 30 June 2026. Additionally, the baseline submissions for the Cyber Assessment Framework (CAF) DSPT 2025/26 (version 8) were completed punctually, both on 24 and 29 December 2025. These timely submissions reflect the Trust's ongoing commitment to maintaining robust data security and protection measures. Looking ahead, an external audit of the Trust's DSPT progress is scheduled for March 2026, with the intention of upholding the high standards previously achieved.

Standards of Clinical Coding

Gateshead Health NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2025/26 by the Audit Commission.

Gateshead Health NHS Foundation Trust will be taking the following actions to improve data quality:

Our data quality strategy is in place to support the continual improvement of data entry/quality/validity and, therefore, ensuring that Trust decision making is based on clean and accurate information. Reports are circulated to elicit action where data quality issues have

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been identified, and the organisation's data quality is discussed at the quarterly Digital Data & Technology Performance & Assurance Group Meeting to provide assurance over its ongoing position.

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3.3 Learning from Deaths

During 2025/26, there were 1,134 patient deaths within Gateshead Health NHS Foundation Trust. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 317 in the first quarter.
- 234 in the second quarter.
- 292 in the third quarter.
- 291 in the fourth quarter.

Seasonal increases in mortality are seen each winter in England and Wales.

In early April 2025, 1,103 case record reviews (Medical Examiner scrutiny) and 54 investigations (Mortality Council reviews) have been carried out in relation to 1,133 of the deaths included above.

In 53 cases a death was subjected to both a case record review and an investigation.

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 310 in the first quarter.
- 230 in the second quarter.
- 281 in the third quarter.
- 282 in the fourth quarter.

0 deaths representing 0% of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 0 representing 0.0% for the first quarter.
- 0 representing 0.0% for the second quarter.
- 0 representing 0.0% for the third quarter.
- 0 representing 0.0% for the fourth quarter.

These numbers have been estimated using the Trust's 'Learning from Deaths' policy. Reviewed cases are graded using the Hogan preventability score and National Confidential Enquiry into Patient Outcome and Death (NCEPOD) overall care score following case note review.

58 case record reviews (ward reviews) and 111 investigations (mortality council reviews) were completed after 1st April 2025 which related to deaths which took place before the start of the reporting period. 2 deaths representing 1.8% (2/111) of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

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Summary of learning/Description of Actions/Learning themes identified:

Good Practice Identified:

Person-Centred and Inclusive Care
- Collaborative working with carers, enabling familiar faces to assist with meals and care
- Proactive identification and support of patients with a learning disability via electronic system alerts
- Detailed care plans provided by care homes, with reasonable adjustments implemented
- Appropriate Mental Capacity Act assessments undertaken
- Continuity of care maintained throughout the patient journey

Clinical Responsiveness and Patient Safety
- Rapid response to patient deterioration
- Timely cross-specialty reviews completed and clearly documented
- Risk assessments completed appropriately
- AFLOAT tool embedded and used alongside the Safer Nursing Care Tool
- Rapid adaptation of anaesthetic plans to minimise risk

Leadership, Teamwork and Multidisciplinary Working
- Clear leadership and strong teamwork highlighted in national investigation report
- Outstanding performance from Emergency Department registrar
- Effective multidisciplinary collaboration, including visiting specialties
- Hot debriefs undertaken to support learning and improvement

Communication and Information Sharing
- Good communication with families throughout care episodes
- Clear explanation of decision-making, risks and care provided
- Excellent documentation from visiting specialties
- High standard of record-keeping, including documentation of all resuscitation attempts

End of Life and Palliative Care
- Excellent support provided by the Palliative Care team
- High-quality end of life care provision
- Positive bereavement support for families

Operational Effectiveness and Escalation
- Proactive management of technical issues, including escalation of image transfer delays
- Alternative arrangements made (e.g. blue light ambulance transfer of images) to avoid treatment delays

Learning Identified and actions taken:

Supporting vulnerable patients:
People with learning disabilities and complex needs were disproportionately affected during periods of reduced specialist capacity. Improvements are focused on strengthening awareness, decision-making, safeguarding, and access to fundamental care.

Patient safety and clinical pathways:
Learning from falls, high-risk emergency presentations, and medication safety has informed Trust-wide improvement work, including clearer assessment processes, faster access to diagnostics, and updated clinical guidance.

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Staffing, continuity, and basic care:
Staffing pressures, particularly during winter escalation and weekends, impacted continuity of care, rehabilitation, personal care, and mealtime support. These risks are being addressed through workforce planning and organisational oversight.

Communication and compassion:
Communication with patients and families, especially in complex conditions and at the end of life, was a recurring theme. Training and support are being strengthened to ensure care is compassionate, clear, and person-centred.

Documentation and information sharing:
The use of multiple record systems creates challenges for staff and potential risks for patients. This has been formally recognised and work is ongoing to improve access, clarity, and consistency of information.

Training and organisational learning:
Several core areas—such as mental capacity, safeguarding, and end-of-life care—require ongoing reinforcement through induction and mandatory training. Learning from reviews is being embedded into Trust-wide programmes and governance structures to support sustained improvement.

To ensure triangulation and learning these outcomes will be fed into the revised Patient Investigation Response Plan currently under development.

2.5 Seven Day Hospital Services

The Trust has fully implemented priority standards five (access to diagnostics) and six (access to consultant directed interventions) from the ten clinical standards as identified via the seven-day hospital services NHS England recommendations. Across the remaining eight standards there are elements that have been implemented.

The Covid-19 pandemic delayed further work around this agenda, and we had to temporarily adapt our ways of working considerably during this time. As we came out of the pandemic, we reviewed and changed our model of care, concentrating on patient flow especially around non-elective care. The original NHS England recommendations around seven-day hospital services are a number of years old and need to be reconsidered in light of new models of care (both locally and nationally). The priority for the Trust moving forward will be to improve the quality of care through consistent achievement of the NHS constitutional standards, reducing length of time in our Emergency Department and reducing length of in-patient stay through better use of clinical pathways including a shift to care delivered in the community. The original NHSE recommendations may need to be revised given the national shifts from digital to analogue, hospital to community and treatment to prevention and the standards redefined.

2.6 Freedom to Speak Up

As a result of Sir Robert Francis QC's follow up report to his Mid Staffs Report, all NHS Trusts are required to have a Freedom to Speak Up Guardian (FTSUG). Gateshead Health NHS Foundation Trust is committed to achieving the highest possible standards/duty of care and the highest possible ethical standards in public life and in all its practices. We are committed to promoting an open and transparent culture to ensure that all members of staff feel safe and confident speaking up. The FTSUG is employed by the Trust but is independent and works

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alongside Trust leadership teams to support this goal. The Trust has shown their commitment to FTSU by supporting the role as a full-time permanent position.

The FTSUG reports information on themes and trends of concerns, improvement work to support an open and honest culture and learning from concerns to the Board of Directors Bi-annually, the Quality Governance Committee and the People & OD Committee quarterly. Externally FTSUG reports to the National Guardian Office data collection for all concerns on a quarterly basis.

Our FTSUG supports the delivery of the Trust's corporate strategy and vision as captured in our ICORE values. As well as via FTSUG, staff may also raise concerns with their trade union or professional organisations' as per our FTSU Policy. There is a Roadmap which has been developed for staff to make it easier for staff to know who and where they can get support when they have concerns, they need to raise which supports the FTSU Policy. When concerns are raised via the FTSUG, the Guardian commissions an investigation with the most appropriate manager / leader and feeds back outcomes and learning to the person who has spoken up. The FTSUG is actively engaged in profile raising and education in relation to this role and is an active member of the Trust's Culture Board Program. The FTSUG now reports directly to the Chief Nurse / Deputy Chief Executive and can escalate to the Chief Executive Officer when required and has regular meetings with the Director of People and OD and the Non-Executive Director (NED) responsible for FTSU.

2.7 NHS Doctors and Dentists in training

The Trust Board via the People and Organisational Development Committee receives quarterly reports from the Guardian of Safe Working summarising identified issues, themes, and trends. In line with exception reporting reforms, high level exception reporting data is scrutinised by the Medical Workforce Group with representation from all business units and actions to support areas and reduce risk/incident levels identified on a quarterly basis. These actions are escalated to the People and Organisational Development Committee by exception when it is deemed necessary due to difficulty in reaching local resolution.

The Trust Board via the People and Organisational Development Committee receives an annual report from the Guardian of Safe Working which includes a consolidated report on rota gaps and actions taken by the Medical Workforce Group. This report is provided to the Local Negotiating Committee (LNC) by the Guardian of Safe Working and at the Medical Workforce Group.

The Medical Workforce Group meets bi-monthly and reviews Medical Workforce Metrics with representation from the Business Units. The Trust Medical Staffing Team are now established and manage a proportion of the Trusts medical rotas on a day-to-day basis to ensure to compliant rotas and safe medical staffing cover. The Medical Staff Team provide support for rotas which are still managed in the business units. Management of gaps on the rota is proactive to ensure full rota compliance. The Associate Director of Medical Staffing has worked with colleagues in his team, finance and the leadership triumvirate in the Division of Medicine to develop a new pilot rota model starting in August 2025 for Tier 1 resident doctors. Outcome measures of the effectiveness of that pilot will include reduction in exception reporting and reduction in run rate spend. A review of the pilot has shown delivery of these benefits, and further review and efficiency work has been completed to deliver more resilience on the rota from August 2026. An e-rostering system has been procured which will further support the medical staffing team to operationalise the rota effectively with a positive impact on rota gaps and exception reporting, and implementation is planned for 2026 for medical e-rostering.

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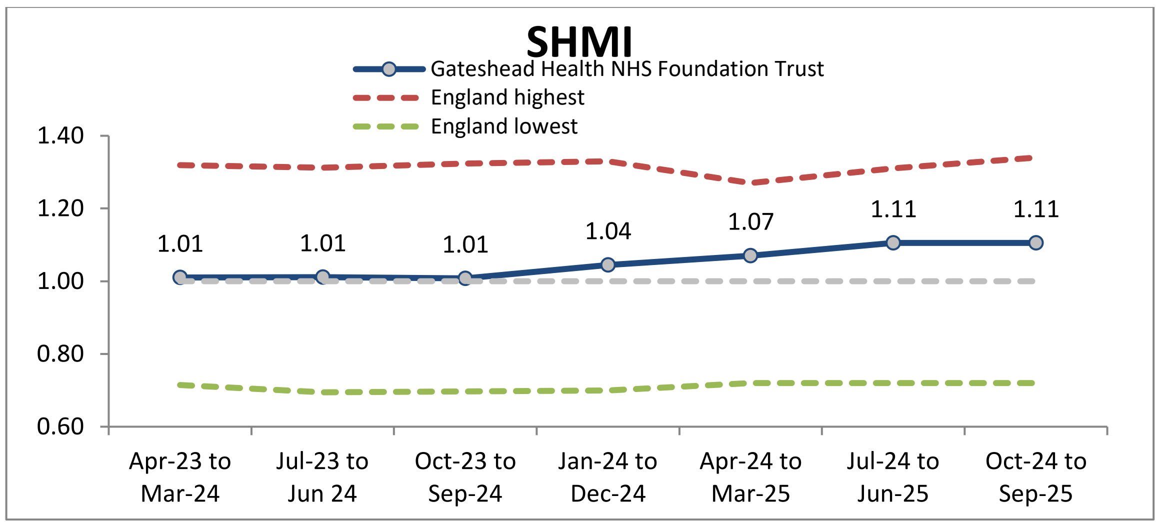
2.8 Mandated Core Quality Indicators

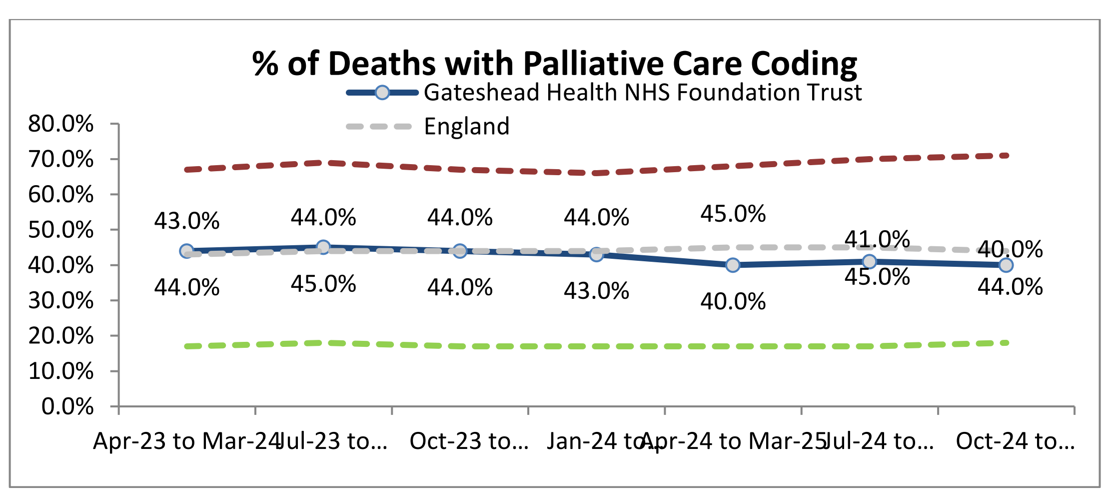
(a) SHMI (Summary Hospital-level Mortality Indicator)

SHMI	Apr-23 to Mar-24	Jul-23 to Jun 24	Oct-23 to Sep-24	Jan-24 to Dec-24	Apr-24 to Mar-25	Jul-24 to Jun-25	Oct-24 to Sep-25
Gateshead Health NHS Foundation Trust	1.01	1.01	1.01	1.04	1.07	1.11	1.11
England highest	1.32	1.31	1.32	1.33	1.27	1.31	1.34
England lowest	0.71	0.69	0.70	0.70	0.72	0.72	0.72
Banding	2	2	2	2	2	2	2



(b) The percentage of patient deaths with Palliative Care coded at either diagnosis or specialty level

% Deaths with palliative coding	Apr-23 to Mar-24	Jul-23 to Jun 24	Oct-23 to Sep-24	Jan-24 to Dec-24	Apr-24 to Mar-25	Jul-24 to Jun-25	Oct-24 to Sep-25
Gateshead Health NHS Foundation Trust	44.0%	45.0%	44.0%	43.0%	40.0%	41.0%	40.0%
England highest	67.0%	69.0%	67.0%	66.0%	68.0%	70.0%	71.0%
England lowest	17.0%	18.0%	17.0%	17.0%	17.0%	17.0%	18.0%
England	43.0%	44.0%	44.0%	44.0%	45.0%	45.0%	44.0%



Gateshead Health NHS Foundation Trust considers that this data is as described for the following reasons:

- The Summary Hospital-level Mortality Indicator (SHMI) reports death rates (mortality) at a Trust level across the NHS in England and is regarded as the national standard for monitoring of mortality.
- For all SHMI calculations since October 2011, mortality for the Trust has been banded 'as expected' or 'Lower than expected'. For the latest period the SHMI is 'as expected'.
- The Trust monitors its SHMI monthly via the Trusts Quality and Safety Report and reviews and discusses the SHMI at the quarterly Mortality and Morbidity Steering Group.
- From May 2024 onwards, Trusts began to remove recording Same Day Emergency Care (SDEC) activity from the Admitted Patient Care dataset (APC) to the Emergency Care Data Set (ECDS) as Type 5 A&E activity. The SHMI is calculated using APC data. Trusts with SDEC activity removed from the SHMI data have seen an increase in their SHMI value. Currently 55 of 118 Trusts are submitting SDEC data to ECDS. It was expected that all Trusts would transition to recording SDEC activity in the ECDS, however transitioning Trusts have been asked to pause whilst the varying approaches to recording are considered. Trusts are awaiting further guidance.
- The Trust SHMI has stabilised in recent months as all SDEC activity is no longer reported in the SHMI (following an upward trend during the transition).

Gateshead Health NHS Foundation Trust has taken the following actions to improve the indicator and percentage in (a) and (b), and so the quality of its services, by:

- The Trust reviews cases for individual diagnosis groups where the SHMI demonstrates more deaths than expected or an alert is triggered for a diagnosis group. The Trusts mortality review process can be used to review the Hogan preventability score & NCEPOD quality of care score and interrogate the narrative from the review to identify specific learning or learning themes.
- The Trust reviews the clinical coding for alerting diagnosis groups when required to determine whether the appropriate diagnosis was assigned and to refine the coding where appropriate.
- The Trust continues to review palliative care coding to ensure palliative care is recorded for all cases where this is appropriate. Palliative care coding is higher than the national level at 3.0% of provider spells compared to 2,1% nationally in the most recent publication (March 2026). The model does not risk adjust for palliative coding.

Patients on Care Programme Approach (CPA) who were followed up within seven days after discharge from psychiatric inpatient care.

- In March 2020, the collection was suspended due to the coronavirus illness (COVID-19) and the need to release capacity across the NHS to support the response. This indicator is not included because of the suspension and has not yet been reinstated.

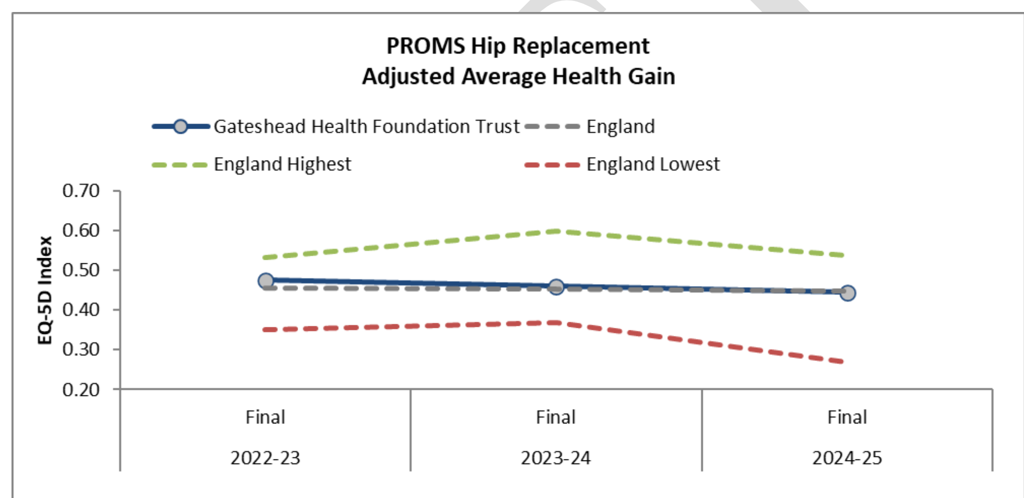
PROMs (Patient Reported Outcome Measures) for Hip Replacement and Knee Replacement:

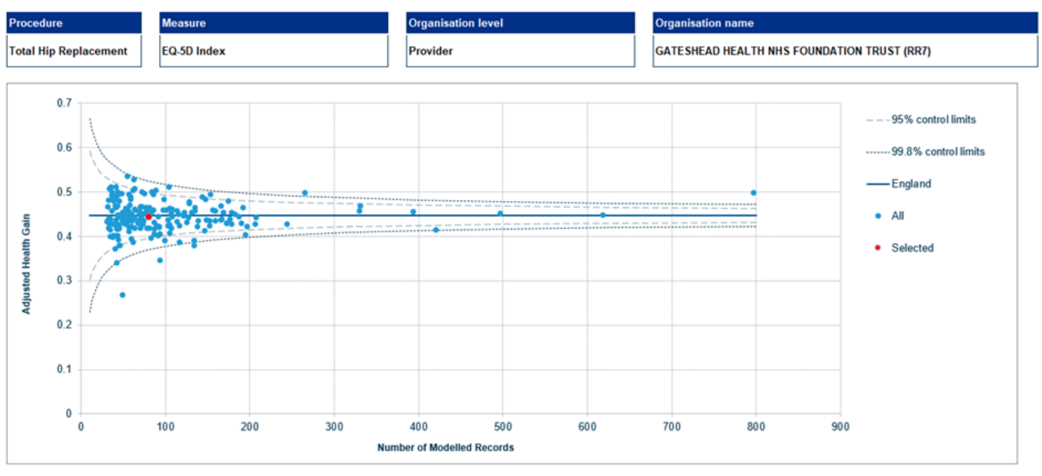
Hip Replacement Adjusted average health gain EQ-5D index	2022-23 Final	2023-24 Final	2024-25 Final
Gateshead Health Foundation Trust	0.48	0.46	0.44
England	0.45	0.45	0.45
England Highest	0.53	0.60	0.54
England Lowest	0.35	0.37	0.27

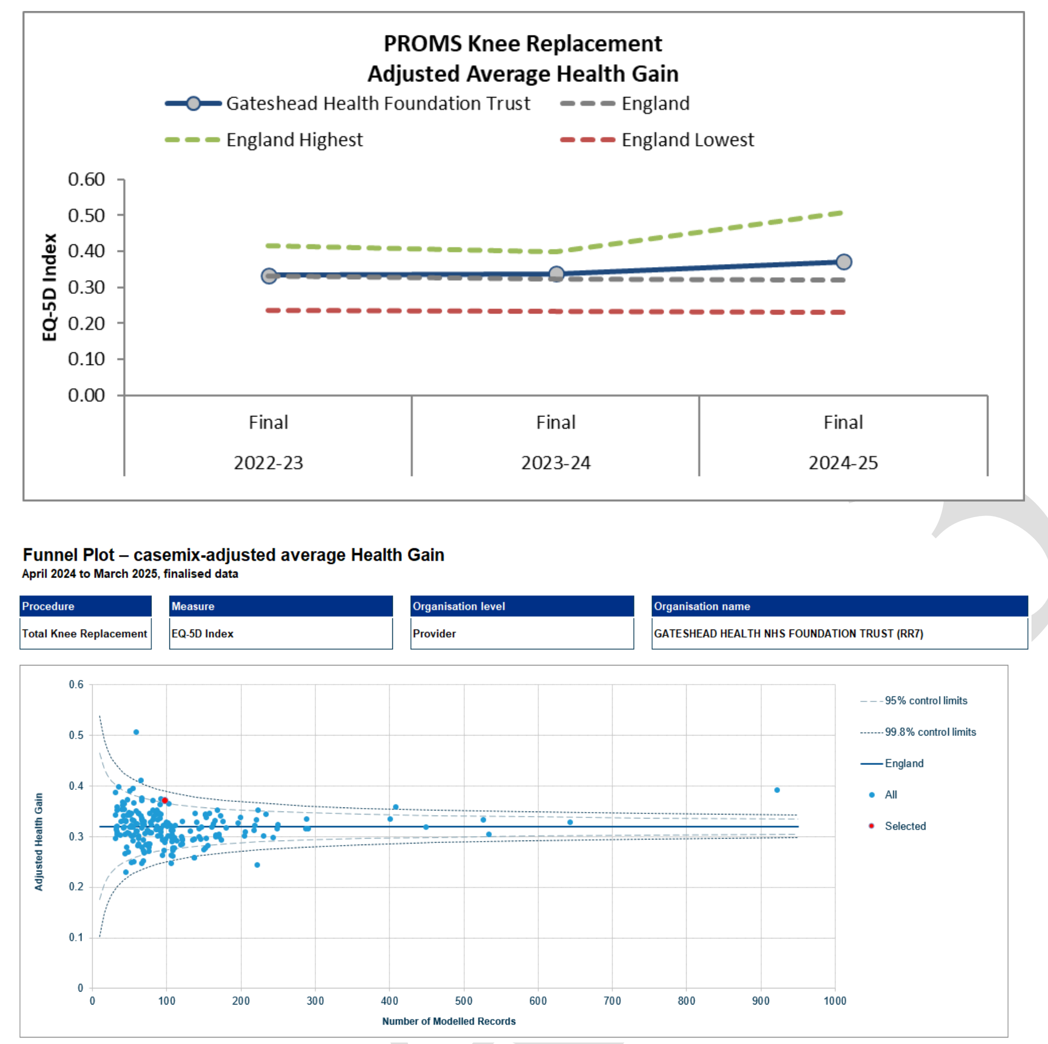
Source: https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms

Knee Replacement Adjusted average health gain EQ-5D index	2022-23 Final	2023-24 Final	2024-25 Final
Gateshead Health Foundation Trust	0.33	0.34	0.37
England	0.33	0.32	0.32
England Highest	0.42	0.40	0.51
England Lowest	0.24	0.23	0.23

Source: https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms







Gateshead Health NHS Foundation Trust considers that the outcome scores are as described for the following reasons: *Awaiting sign off / amendments*

- The Trust performance for PROMS score in 2024-25 remain above the national average for knee replacements, and in line with the England average for hip replacements. The Trust scores are within common cause variation from the England average for hip replacements indicating outcomes are no better or worse that other providers, and above the 95% control limit for knee replacements indicating better outcomes when compared to other providers.

Gateshead Health NHS Foundation Trust has taken the following actions to improve these outcome scores, and so the quality of its services, by: *Awaiting sign off / amendments*

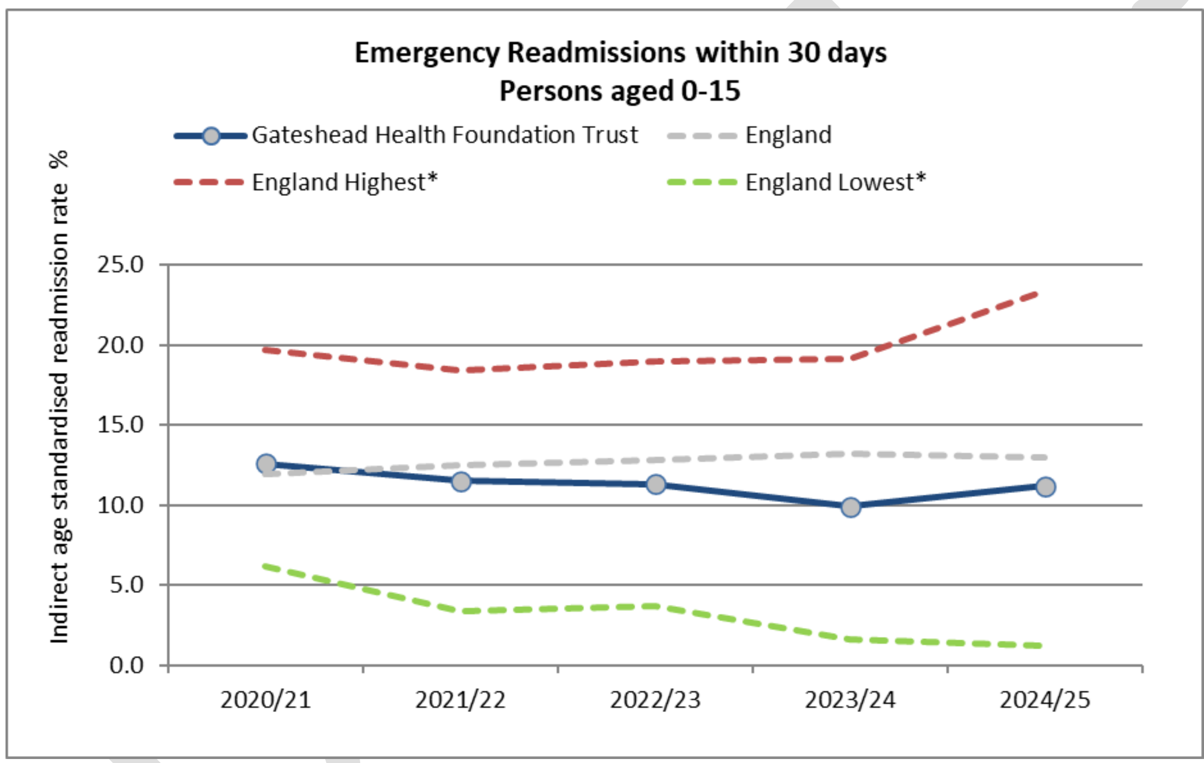
- Data continues to be shared and discussed in the regional Orthopaedic Alliance group as part of a Getting it Right First Time (GIRFT) review across all regional providers.
- The trust is an integral part of the newly formed North-East and North Cumbria orthopaedic alliance as part of the pandemic recovery programme and is working within this group to achieve a centrally agreed shared data set for the group to develop shared learning and reductions in unwarranted variation.

Emergency Readmissions within 30 Days

- Aged 0 – 15yrs

Emergency readmissions within 30 days of discharge from hospital Persons aged 0-15	2020/21	2021/22	2022/23	2023/24	2024/25
Gateshead Health Foundation Trust	12.6	11.5	11.3	9.9	11.2
Banding	W	W	W	B1	B5
England	11.9	12.5	12.8	13.2	13
England Highest*	19.7	18.4	19	19.1	23.4
England Lowest*	6.2	3.4	3.7	1.6	1.2

W = National average lies within expected variation (95% confidence interval)
B5 = Significantly lower than the national average at the 95% level but not at the 99.8% level
B1 = Significantly lower than the national average at the 99.8% level
*Excluding caution in interpretation of data records. Numbers of patients discharged too small for meaningful comparisons (i.e. below 200).



Gateshead Health NHS Foundation Trust considers that the data is as described for the following reasons:

- Emergency readmission rates have increased slightly in 2024/25, however remaining significantly lower or within than the national average in each of the last five years.

Gateshead Health NHS Foundation Trust has taken the following actions to improve these outcomes, and the quality of its services, by:

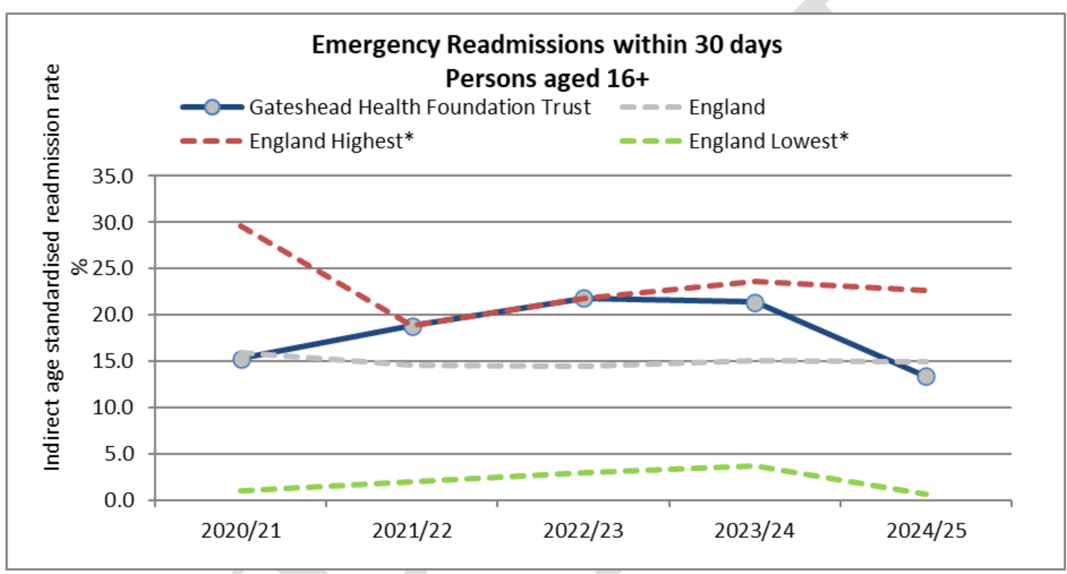
- The Trust will continue to monitor performance and undertake further investigations/actions should the rate increase.

Emergency Readmissions within 30 Days

➢ Aged 16 years or over

Emergency readmissions within 30 days of discharge from hospital Persons aged 16+	2020/21	2021/22	2022/23	2023/24	2024/25
Gateshead Health Foundation Trust	15.3	18.8	21.8	21.4	13.4
Banding	W	A1	A1	A1	B1
England	15.9	14.6	14.4	15.1	14.9
England Highest*	29.6	18.8	21.8	23.6	22.6
England Lowest*	1	2	3.0	3.7	0.6

A1 = Significantly higher than the national average at the 99.8% level.
W = National average lies within expected variation (95% confidence interval)
B1 = Significantly lower than the national average at the 99.8% level
*Excluding caution in interpretation of data records. Numbers of patients discharged too small for meaningful comparisons (i.e. below 200).



Gateshead Health NHS Foundation Trust considers that the data is as described for the following reasons:

➢ Emergency readmission rates have continued to reduce and are lower than the national average during 24/25. Part of this change relates to how data is captured nationally rather than changes to clinical practice. From May 2024 SDEC activity was removed from the admitted patient dataset and recorded as Type 5 A&E attendances. resulting in fewer activities that would appear as 30-day readmissions.

Gateshead Health NHS Foundation Trust has taken the following actions to improve these outcomes, and the quality of its services, by:

➢ Local monitoring of readmissions by ward and speciality to ensure that there is oversight of outlying areas.
➢ Reviews of readmissions that highlight failed / inappropriate discharges to better understand where practices can be improved and help ensure lessoned are learned.
➢ Returned responsibility for discharge to the Clinical teams on the wards to ensure that this is overseen from a medical and nursing stance.

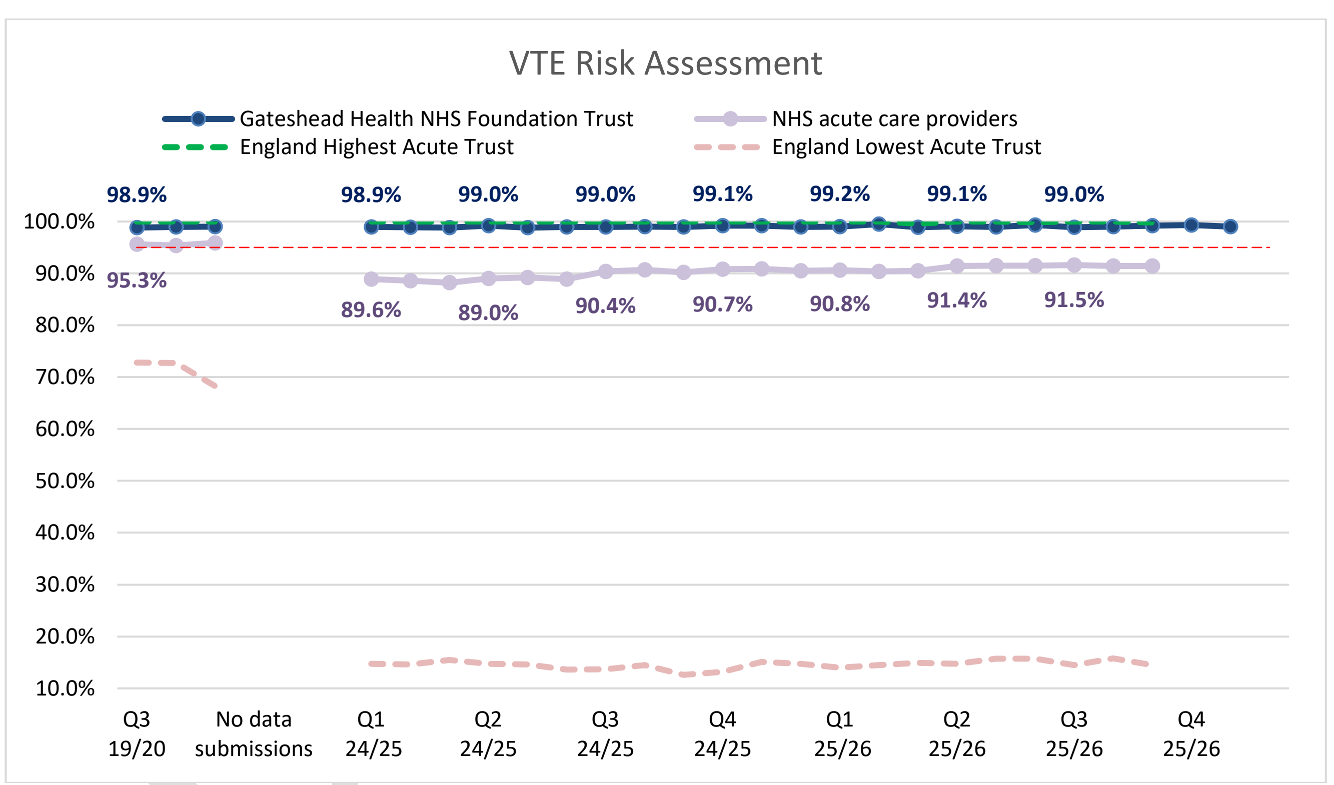
Trust's responsiveness to the personal needs of its patients

Following the merger of NHS Digital and NHS England on 1st February 2023, future presentations of the NHS Outcomes Framework indicators were to be reviewed. Annual publications which were due to be released were delayed and have to date not been forthcoming.

Percentage of staff employed by, or under contract to the Trust who would recommend the Trust as a provider of care to their family or friends

- This information is now captured by the Peoples Pulse collection please refer to Section 3.5 Focus on Staff for further information.

Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism



The Gateshead Health NHS Foundation Trust considers that these percentages are as described for the following reasons:

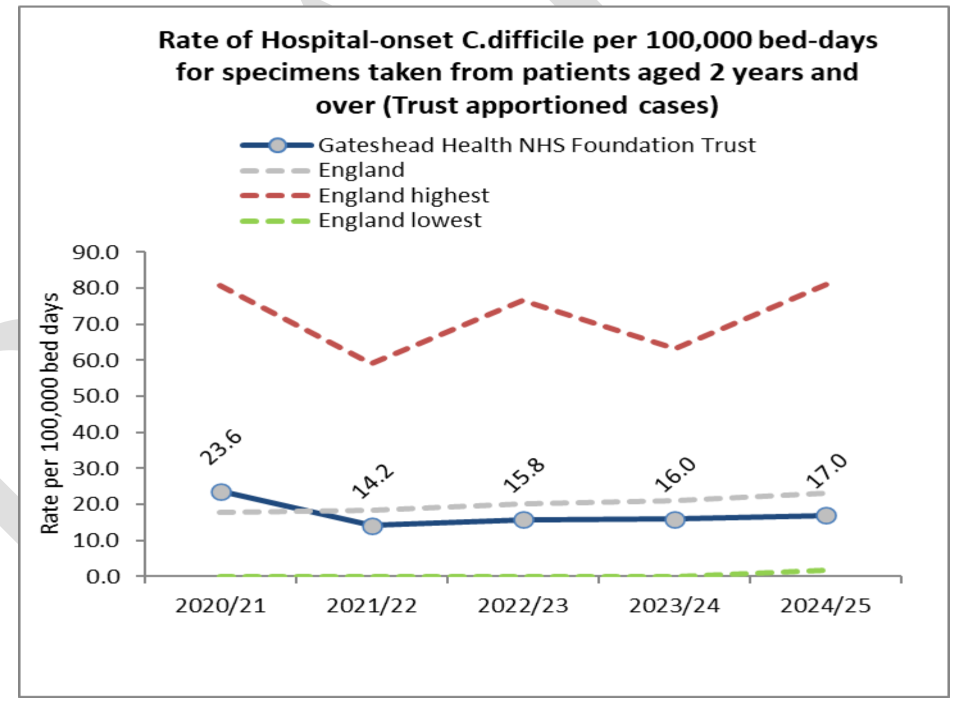
- Gateshead Health NHS Foundation Trust Compliance with DVT risk assessment has reached 95% in all areas of the hospital which use the JAC prescribing site and reassurance has been gained regarding a robust assessment in Critical Care which use a paper documentation.
- VTE Risk assessment continued to be monitored by the Trust during the suspension of the national submission. Performance continues to exceed the 95% national objective.

The Gateshead Health NHS Foundation Trust intends to take the following actions to improve these percentages, and so the quality of its services, by:

- Work on VTE will become part of the Audit & Effectiveness Group's agenda, who will be responsible for updating all guidelines and raising awareness of deep vein thrombosis and pulmonary embolism and the impact on health. Education of junior doctors and nursing staff have been commenced with regular sessions in the Clinical Leads Nursing meeting and SafeCare meetings. The intranet has been updated with these guidelines and an e-learning module for this has been set up with the help of the Practice and Development Team.
- All new NICE guidelines are monitored on a monthly basis and the relevant updates sent to the respective teams.
- The Trust hospital acquired thrombosis data is also shared with GIRFT.

The rate per 100,000 bed days of cases of *Clostridium difficile* infection (CDI) reported within the Trust amongst patients aged 2 or over.

Rate of Hospital-onset C.difficile per 100,000 bed-days for specimens taken from patients aged 2 years and over (Trust apportioned cases)	2020/21	2021/22	2022/23	2023/24	2024/25
Gateshead Health NHS Foundation Trust	23.6	14.2	15.8	16.0	17.0
England highest	80.6	59.0	76.6	63.1	81.0
England lowest	0.0	0.0	0.0	0.0	1.8
England	17.7	18.3	20.2	20.9	23.3



Gateshead Health NHS Foundation Trust considers that these percentages are as described for the following reasons:

- Clostridium difficile infection (CDI) remains an unpleasant, and potentially severe or even fatal, infection that occurs mainly in elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment. Reduction of CDI continues to present a key challenge to patient safety across the Trust, therefore ensuring preventative

measures and reducing infection is very important to the high quality of patient care we deliver.

- The Trust reports Healthcare associated CDI cases to PHE via the national data capture system against the following categories:
  - Hospital onset healthcare associated (HOHA): cases that are detected in the hospital 2 or more days after admission (where day of admission is day 1)
  - Community onset healthcare associated (COHA): cases that occur in the community (or within 2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks.
- Nationally the financial sanctions for CDI have been removed and the 'appeals' process no longer in use, and the expectation that organisations will perform local review of cases.
- The Trust is required under the NHS Standard Contract 2025/26 to minimise rates of Clostridioides difficile (C. difficile) so that it is no higher than the threshold level set by NHS England and Improvement.
- For 2025/26 we reported forty-seven (47) cases of healthcare associated CDI against the threshold of thirty-six (36). Thirty (30) hospital onset healthcare associated, and seventeen (17) community onset healthcare associated cases.
- The Trust has reported a reduction in CDI cases of 2% for 2025/26 in spite of increased activity compared to 2024/25. The threshold for CDI's, which is calculated by Public Health England (PHE) from November to October was reduced by 2% for 2025/26 which made the threshold challenging.

Gateshead Health NHS Foundation Trust has taken the following actions to improve these percentages, and so the quality of its services by using the following approaches:

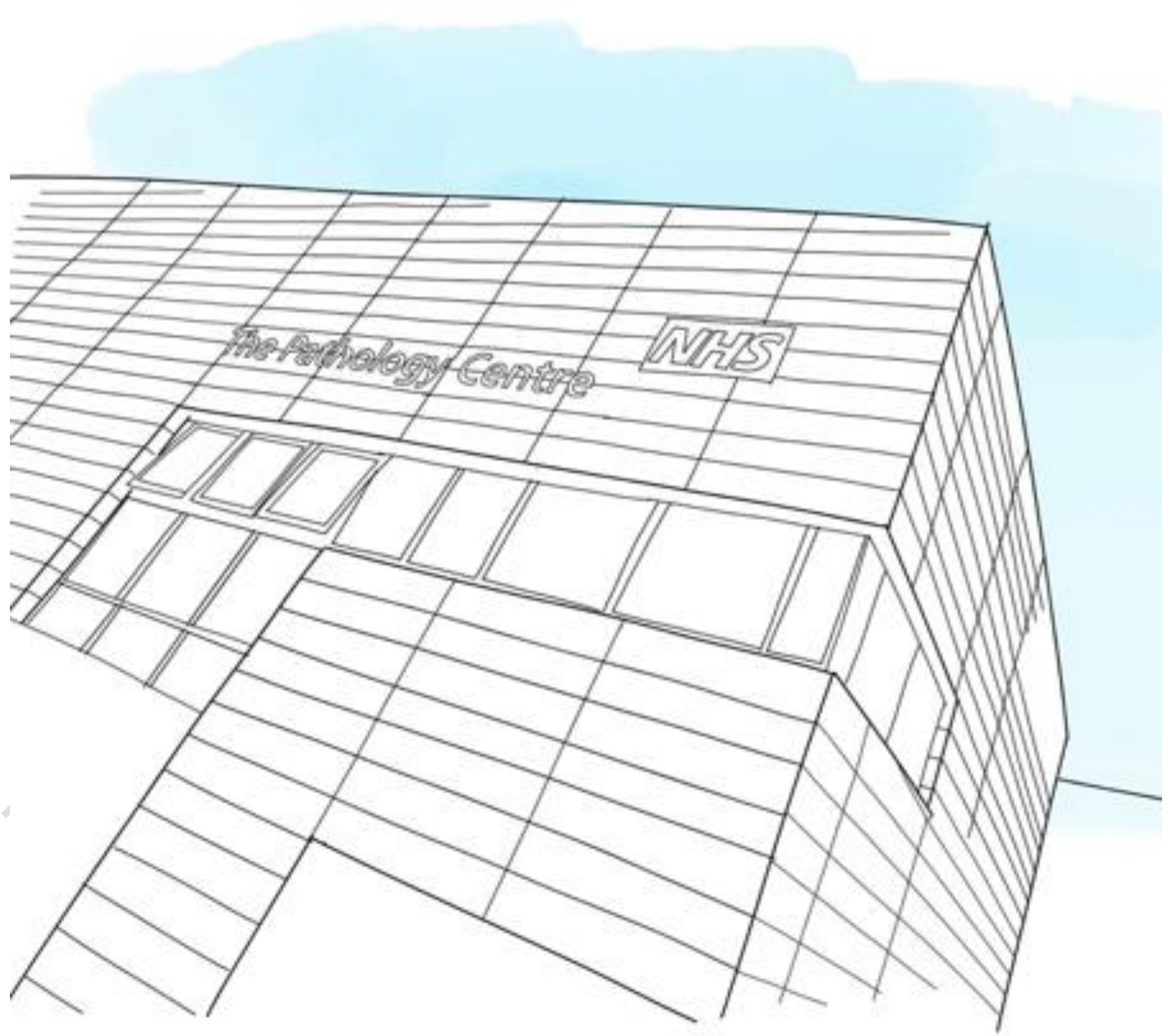
- An internal review is held for all healthcare associated CDI cases, supported by the PSIRF framework and internal safety triangulation review as necessary, where good practice and lessons learnt can be identified. The learning is then linked, if appropriate, to the key themes of sample submission, antimicrobial prescribing, documentation, patient management and human factors. The good practice and lessons learnt are then cascaded back through the internal safe care mechanisms.
- An action plan was devised to help with this ambitious target, these included; education and awareness around hand washing, increased audit surveillance on clinical areas, clearer definitions on cleaning terminology, clearer signage on wards, refresh of IPC intranet page and implementation of PSIRF.
- Where there is an increased incidence of CDI associated with a particular clinical area, a multidisciplinary meeting will review all the cases collectively, consider if any cross infection may have occurred then formulate and enable an action plan to address any shortcomings identified.
- When there is an increased incidence of CDI cases associated with a particular clinical area Ribotyping can be arranged with the Clostridium difficile Ribotyping Network (CDRN) to determine if cross infection has taken place.

The number and rate of patient safety incidents per 1,000 bed days reported within the Trust.

- NHS England have paused the annual publishing of this data while they consider future publications in line with the current introduction of the Learn from Patient Safety Events (LFPSE) service to replace the NRLS. This remains the same for 25/26.

Part 3

Review of Quality Performance



Review of quality performance

2025/26 has been a successful year in relation to the three domains of quality:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

The Council of Governors has a key role in our assurance processes – both representing the interests of members, the public, staff and stakeholders, as well as holding our Non-Executive Directors to account for the performance of the Board. As part of the Council of Governors meetings, our Chief Executive delivers an overview of our performance against key quality metrics, with opportunities to question our Board Members on this. Two Governors are also nominated observers of our Quality Governance Committee, and we have put in place new structures to support representatives to share feedback on the quality of debate and contributions with the rest of the Council. This provides further opportunities for Governors to seek assurance and hold our Non-Executive Directors to account in respect of quality.

The following sections provide details on the Trust's performance on a range of quality indicators. The indicators themselves have been extracted from NHS nationally mandated indicators, and locally determined measures. Trust performance is measured against a mixture of locally and nationally agreed targets. The key below provides an explanation of the colour coding used within the data tables.

Colour	Meaning
Green	Target achieved
Amber	Although the target was not achieved, it shows either an improvement on previous year or performance is above the national benchmark
Red	Target not achieved but action plans are in place

Where applicable, benchmarking has been applied to the indicators using a range of data sources which are detailed in the relevant sections. The Trust recognises that benchmarking is an important tool that allows the reader to place the Trust performance into context against national and local performance. Where benchmarking has not been possible due to timing and availability of data, the Trust will continue to work with external agencies to develop these in the coming year.

3.1 PATIENT SAFETY

The Trust continues to monitor a comprehensive suite of patient safety indicators as part of its commitment to delivering safe, reliable and high-quality care. Whilst a number of indicators remain within expected thresholds, there are emerging areas of variation and deterioration which require focused attention and have been identified as key considerations within the ongoing review of the Patient Safety Incident Response Plan (PSIRP).

Reducing Harm from Deterioration:

Safe Reliable care	2023-24	2024-25	2025-26	Target
SHMI Period	Apr-23 to Mar-24	Apr-24 to Mar-25	Jan-25 to Dec-25	

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SHMI	1.01	1.07	1.08	<=1
SHMI Banding	As Expected	As Expected	As Expected	As expected or lower than expected
SHMI - Percentage of provider spells with palliative care coding(contextual indicator)	2.6%	2.8%	3.0%	N/A
Crude mortality rate taken from CDS	1.79%	1.77%	1.65%	<1.99%
Number of calls to the CRASH team	134	165	165	N/A
Number of calls to the CRASH team that were cardiac arrests	51	70	71	N/A
Of the calls to the arrest team what percentage were actual cardiac arrests	38.1%	42.4%	43.0%	N/A
Cardiac arrest rate (number of cardiac arrests per 1000 bed days)	0.28	0.40	0.42	N/A
Hospital Acquired Pressure Damage (grade 2 and above)	119	105	85	Year on year Reduction
Community Acquired Pressure Damage (grade 2 and above)	TBC	TBC	TBC	N/A
Number of Patient Slips, Trips and Falls	1344	1478	1615	N/A
Rate of Falls per 1000 bed days	7.77	8.38	**9.46**	Reduction (<8.5)
Number of Patient Slips, Trips and Falls Resulting in Harm	464	682	742	N/A
Rate of Harm Falls per 1000 bed days	2.68	3.87	**4.35**	Reduction (Less than <2.25)
Harm Falls Rate Change	23.6% Increase	44.3% Increase	12.4% Increase	N/A
Ratio of Harm to No Harm Falls (i.e. what percentage of falls resulted in Harm being caused to the patient)	34.5%	46.1%	45.9%	Year on Year reduction

Reducing Avoidable Harm:

Reducing Avoidable Harm		2023-24	2024-25	2025-26	Target
Medication Incidents	No Harm	671	583	870	N/A
	Low Harm	139	178	206	N/A
	Moderate Harm	2	9	1	<8
	Severe Harm	0	1	**1**	0

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	Death	0	0	0	0
	Total	812	771	1078	N/A
Never Events		1	1	1	0
Patient Incidents per 1,000 bed days		37.0	39.5	46.9	N/A
Rate of patient safety incidents resulting in severe harm or death per 100 admissions		0.07	0.04	0.07	N/A

Source: Trust incident reporting system -InPhase

Infection Prevention and Control:

Infection Prevention & Control	2023-24	2024-25	2025-26	2025-26 Threshold
MRSA bacteraemia apportioned to acute trust post 48hrs	0	1	1	0
MRSA bacteraemia rate per 100,000 bed days	0	0.49	0.49	0
Healthcare Associated *Clostridium difficile* Infections (CDI) post 72hr cases	37	48	47	<36
Healthcare Associated *Clostridium difficile* Infections (CDI) rate per 100,000 bed days	18.7	23.6	23.1	-

Infection Prevention & Control	2023-24	2024-25	2025-26
Hospital Onset Healthcare Associated C.difficile count	27	29	30
Hospital Onset Healthcare Associated C.difficile per 100,000 occupied overnight beds	15.97	16.96	17.54
Community Onset Healthcare Associated C.difficile count	10	19	17
Community Onset Healthcare Associated C.difficile per 100,000 occupied overnight beds	5.06	9.34	8.36

Other Indicators:

Other Indicators	2023-24	2024-25	2025-26	Target
Percentage of Cancelled Operations from FFCE's†	0.29%	0.30%	0.26%	0.80%
Percentage of Patients who return to Theatre within 30 days (Unplanned / Planned / Unrelated)	4.21%	4.17%	4.35%	Improve Year on Year
Fragility Fracture Neck of Femur operated on within 48hrs of admission / diagnosis	91.9%	93.7%	90.8%	90%

Proportion of patients who are readmitted within 28 days across the Trust*	13.57%	7.70%	7.52%	Improve year on year
Proportion of patients undergoing knee replacement who are readmitted within 30 days*	8.77%	4.22%	**6.05%**	Improve Year on Year
	25 patients readmitted	14 patients readmitted	15 patients readmitted	
Proportion of patients undergoing hip replacement who are readmitted within 30 days*	9.03%	5.80%	**6.22%**	Improve Year on Year
	28 patients readmitted	17 patients readmitted	14 patients readmitted	

* Figures taken from Healthcare Evaluation data (HED) and provide full financial years for 2023-24, 2024-25 and April to December 2025-26
† FFCE's refer to First Finished Consultant Episodes. A patient's treatment or care is classed as a spell of care. Within this spell can be a number of episodes. An episode refers to part of the treatment or care under a specific consultant, and should the patient be referred to another consultant, this constitutes a new episode

Linking these Patient Safety metrics to PSIRP and our future Quality Account priorities
These emerging trends and areas of variation are being actively considered as part of the Trust's review of its Patient Safety Incident Response Plan (PSIRP), which is a designated Quality Account priority for 2026/27. The PSIRP review provides an opportunity to ensure that future patient safety priorities are aligned to areas of greatest risk, harm, and variation in performance, with a focus on strengthening system learning, prevention of deterioration, and reduction of avoidable harm.

The finalised PSIRP priorities will be informed by triangulation of these metrics with incident learning, thematic reviews, patient feedback and clinical engagement, ensuring a data-driven and clinically meaningful approach to patient safety improvement.

In addition, cancer performance metrics continue to be closely monitored through existing governance arrangements. Where variation has been identified, these are already subject to targeted recovery and improvement plans. These metrics will be formally carried forward as a Quality Account priority into 2026/27, ensuring sustained executive oversight and continued focus on timely diagnosis, treatment performance and pathway optimisation

Safeguarding Children and Adults

The Adult and children's safeguarding teams are committed to ensuring that effective safeguarding arrangements are in place, to prevent and protect adults, young people and children from harm or abuse. Safeguarding is firmly embedded within the organisation as being everyone's responsibility. Leads for both adults and children ensure that a think family approach is evident across the Trust.

Both safeguarding teams have worked in partnership with key partners to address safeguarding priorities in Gateshead.

Within the quarterly Safeguarding Group, we bring the lived experiences of service users by sharing patient stories and any learning at every meeting.

The children and adult teams have continued to work together to further raise awareness of the trusts Safeguarding Exploitation Grooming and Risk Identifier tool (SEGRI) to include both

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vulnerable adults and children at risk sexual exploitation, criminal exploitation, and modern-day slavery.

In response to what staff have told us the safeguarding children team have worked with the Gateshead Safeguarding Children Partnership and have facilitated on site level 3 safeguarding training. This has been well received, and compliance is good. Training has been targeted at gambling related harm, safeguarding babies, level 3 multi agency training, neglect, knife crime and sexual exploitation.

The safeguarding children team have contributed to single and multi-agency audits to identify areas of good practice and service developments. The Children in Care team have embedded the use of Careflow and docstore as the child's record. Additional funding has been secured from the ICB in response to growing numbers of children coming into care . An additional full-time specialist nurse and team administrator support are now in post.

The Named Nurse Safeguarding Children retired from her post in March, and a nurse advisor also left the Trust in February. Safeguarding children staffing is currently on the risk register however both posts have been appointed to, and individuals are progressing through the recruitment process. Experienced bank staff are offering support within the team.

During the past twelve months the children and adult safeguarding teams have continued to deliver a comprehensive safeguarding service. Despite staffing pressures, the team have continued to support staff to safeguard some of the most vulnerable people in society.

The Safeguarding children team have worked with Gateshead Safeguarding Children Partnership contributing to a Joint Targeted Area Inspection JTAI on the theme of child sexual abuse in the family environment. The final report following the inspection is expected in May 2026.

The Adults team continue to prioritise and deliver capacity training in line with Mental Capacity Act legislation.

The joint adult and children Safeguarding Link Meetings have been successful and continue via MS Teams with an emphasis on promoting a "Think Family" approach to Safeguarding. This has proved to be a successful forum for education, sharing knowledge, and for staff to discuss individual safeguarding case studies.

The adults and children's safeguarding teams continue to provide regular news bulletins within the QE Weekly providing valuable updates on current safeguarding issues and promoting training opportunities.

The adult and children team continue to use InPhase to report safeguarding concerns and to provide assurance to the safeguarding group. The adult team, work in partnership with Gateshead Safeguarding Adult Board in supporting challenge and change, and to lead and support the development and implementation of safeguarding practices and procedures within the organisation to protect adults with care and support needs. The adult team contribute to Safeguarding Adult Reviews (SARs) to support identifying any lessons that can be learned from complex cases and to implement changes to improve services, and to share any learning.

The Adult team continue to prioritise safeguarding and prevent training, including monitoring the compliance levels to ensure staff are preventing any harm, ensuring safety by preventing

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abuse and neglect, sharing any learning and to ensure the health and well-being of our patients and colleagues.

Adult safeguarding team have continued to see a steady increase in concerns during the last 12 months with the main categories being neglect, self-neglect, domestic abuse, and financial. This reflects the information shared from partner agencies. These concerns also include the community teams, where we continue to offer support and advice, and attend team meetings to share any updates or learning. The adult team continue to receive provider concerns in relation to care homes and domiciliary care providers. We have recently seen an increase in concerns being raised by community staff which have been escalated appropriately. We continue to liaise and share these concerns with the Local Authority, ICB and within the provider Information sharing meetings. The adult team continue to receive complex domestic abuse referrals, including staff members that are supported and signposted. The team continue to work with departments and partner agencies to support and safeguard people who are at risk of harm, including domestic abuse. The team work closely with managers, security, and HR to ensure the safety and wellbeing of staff.

3.2 CLINICAL EFFECTIVENESS

Getting it Right First Time (GIRFT) – to be finalised

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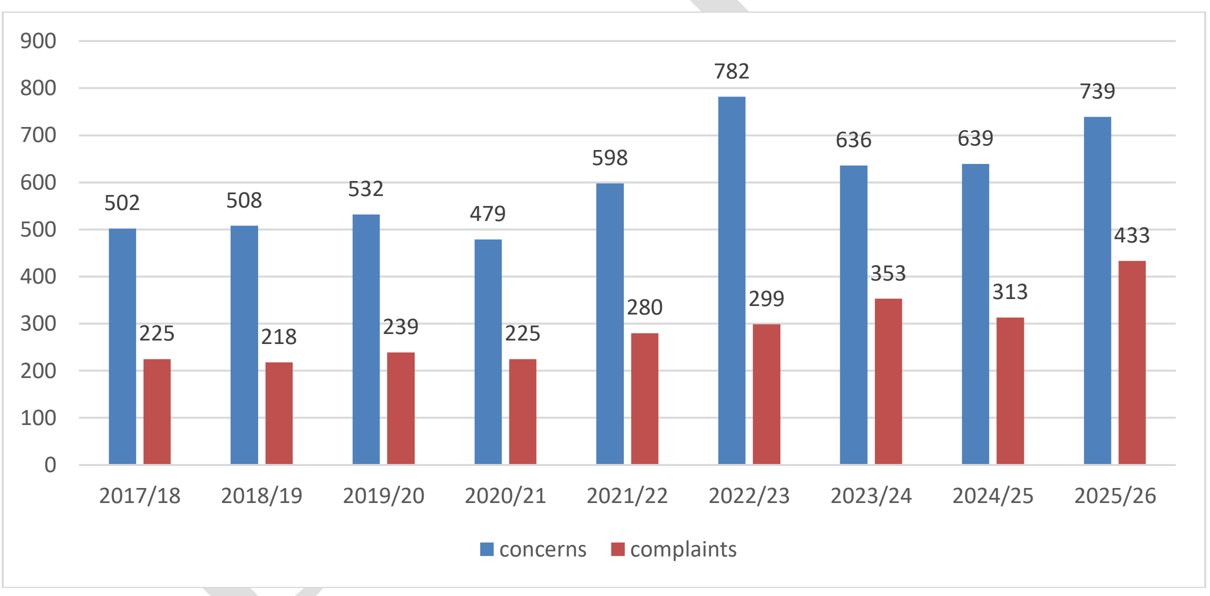
3.3 PATIENT EXPERIENCE

Listening to Concerns and Complaints, Compliments

The Trust acknowledges the value of feedback from patients and visitors and continues to encourage the sharing of personal experiences. This type of feedback is invaluable in helping us ensure that the service provided meets the expectations and needs of our patients through a constructive review.

For the year 2025/26 we received a total of 433 formal complaints. Promoting a culture of openness and truthfulness is a prerequisite to improving the safety of patients, staff, and visitors as well as the quality of healthcare systems. It involves apologising and explaining what happened to patients who have been harmed as a result of their healthcare treatment when inpatients or outpatients of the Trust. It also involves apologising and explaining what happened to staff or visitors who have suffered harm. It encompasses communication between healthcare organisations, healthcare teams and patients and/or their carers, staff and visitors and makes sure that openness, honesty, and timeliness underpins responses to such incidents. The Patient Advice and Liaison Service (PALS) offer confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and carers.

Complaints and Concerns 2017 to 2026



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Complaints performance indicators	Total 2025/26
Complaints received	433
Acknowledged within three working days	433
Complaints closed	393
Closed with agreed timescale	246
Number of complaints upheld	181
Number of complaints partially upheld	128
Concerns received by PALS	739

Complaints Indicators	Total 2025/26
Number of closed complaints reopened	34
Number of closed complaints referred to Parliamentary & Health Service Ombudsman (PHSO)	12

Outcomes of complaints referred to PHSO	Total 2025/26
Considering whether to investigate	5
Currently investigating	1
Complaints upheld	0
Part upheld	0
Declined to be investigated	6
Agreed actions with Trust (incl as a result of learning	0

In the year 2025/26 34 closed complaints were reopened. This compares to 40 in 2024/25. Reasons for reopening cases include where the complainant has additional questions/concerns following receipt of the Trust's complaint response letter.

During 2025/26 the top four main reasons to raise a formal complaint were in relation to:

- Implementation of care
- Communication, confidentiality and consent
- Access, admission and discharge
- Clinical Assessment

As a result of complaints and concerns raised over the past year a number of initiatives have been implemented, of which a small number of examples are shared below.

- In response to a complaint regarding Medicine, a new vascular access pathway was introduced.

- In response to a complaint regarding Radiology (MRI), the MRI protocol has been revised as follows:

    - Whenever a scan cannot proceed due to safety or image-quality concerns, the MRI team will now provide a direct verbal explanation to the requesting clinician, rather than relying solely on an automated message that may be misinterpreted.

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- The MRI Lead has updated the patient paperwork regarding piercings to clarify, for both staff and patients, the necessary requirements before scheduling an MRI scan.

- In response to a complaint regarding Old Age Psychiatry Outpatients, the complaint has been shared directly with the clinical team involved for reflection. It will also be discussed at the department's team meeting to ensure that the following lessons are taken forward:

  - That provisional or uncertain diagnoses are clearly and compassionately explained to patients and relatives especially when the word 'cancer' is involved.
  - That patients and relatives know who to speak with on the ward if they have any questions related to a recent diagnosis or any uncertainty about diagnosis.
  - That staff remain acutely aware of the sensitivity involved in communicating with and about patients who have cognitive impairments like dementia.

- In response to a complaint regarding Endoscopy, as part of the learning from the concerns, the training lead for the Endoscopy department is currently carrying out refresher training to staff about the administration of numbing spray.

- In response to a complaint regarding Maternity:

  - PAU guidelines require updating, to assist staff in identifying less common medical complications that can occur in pregnancy. This will include a "red flag" system, whereby midwives will now be prompted to escalate concerns to a doctor if a patient attends the PAU with the same symptoms on 2 or more occasions, to ensure timely review, management and ongoing care planning.

- In response to another complaint regarding Maternity:
  - We have introduced new customer care training for all maternity staff. This training focuses on empathy, communication and creating a supportive environment and we are confident it will help us to provide more consistent, person-centred care.
  - The Matron and the Ward Manager have also reviewed the information that we give to families before admission. They recognised that although our enhanced recovery leaflet explains what to expect from the enhanced recovery pathway, it does not fully describe how the postnatal ward works or who will be providing care. This is now being addressed, and a more detailed information leaflet is being developed to give families clearer expectations and reassurance.

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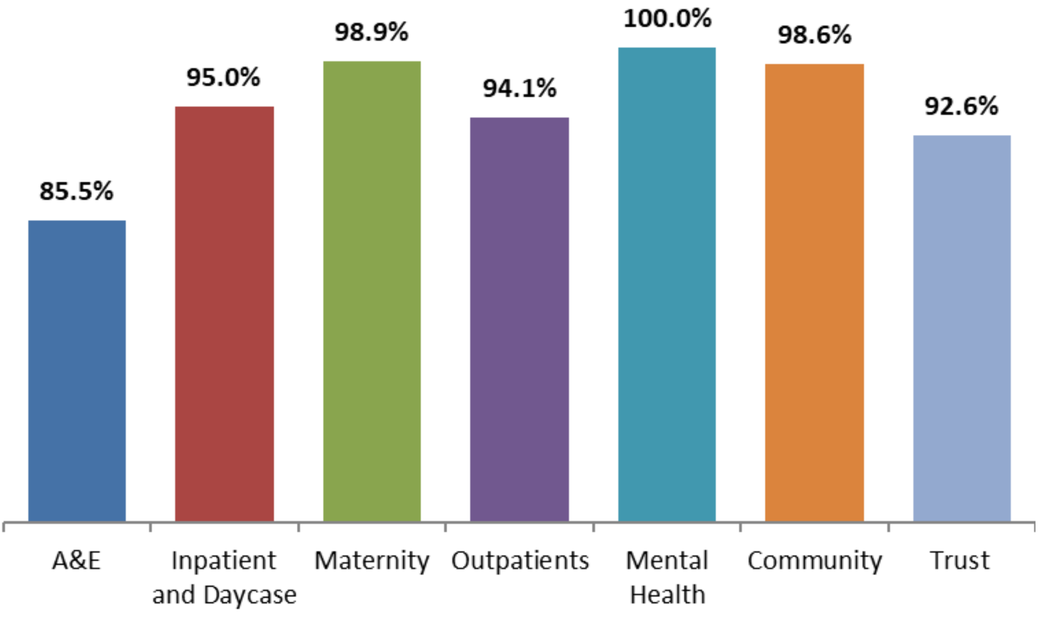
Friends & Family Test

Listening to our patients and service users remains central to how we evaluate and improve the care we provide. The Friends and Family Test (FFT) continues to be one of the key tools we use to understand how patients feel about their experiences with Gateshead Health NHS Foundation Trust. It offers valuable, real-time feedback from those who use our services, helping us to celebrate what we're doing well and identify areas where we can improve.

Over the past 12 months, we are proud to report a strong and consistent level of positive feedback across the Trust. Our overall Trustwide average for the year was 92.6%, reflecting the high quality of care and compassion our teams deliver every day. In particular, our Maternity services received exceptional praise, with a rate of 98.9%, a testament to the dedication of our Midwifery teams and their focus on personalised and safe care for women and families. Similarly, our Mental Health services scored an impressive 100%, and our Community Services were close behind at 98.6%, both of which highlight the importance of continuity, accessibility and compassionate engagement in these areas.

Inpatient and day case services also performed very strongly, with a positive score of 95%, showing that patients consistently feel well cared for and supported throughout their hospital stays. Our Emergency Department, while operating under the pressure of increasing demand, achieved a solid 85.5% rate. We recognise that A&E can be a challenging environment for patients and staff alike, and we are continuing to explore improvements in communication, waiting times and care pathways to further enhance the patient experience.

We remain committed to acting on the feedback we receive through FFT and ensuring that every voice contributes to shaping our services. Whether the response is one of gratitude or highlights an opportunity to do better, each comment matters and drives our ambition to deliver the highest possible standard of care.



3.4 Good News Stories

Year in Highlights

Celebrating Achievement, Innovation and Impact

Celebrating staff achievement, recognition, and service milestones across the Trust.

🏆 Recognition & Awards

Trust teams received national recognition throughout the year, including finalist positions at prestigious professional awards. Specialist staff were acknowledged for outstanding contributions to community care, reflecting excellence, leadership, and innovation across services.

🚀 Innovation & Service Development

Key services were formally launched and expanded, introducing innovative models of care that enhanced access, efficiency, and patient outcomes. Staff embraced new ways of working to support continuous improvement across the organisation.

❤️ Patient Experience & Quality

Services received excellent patient feedback through national surveys, with high ratings for quality, compassion, and effectiveness. Patient insight continues to shape improvements and future developments.

Together, these highlights reflect a year of strong performance, innovation, and recognition, demonstrating the Trust's ongoing commitment to excellence for patients, communities, and staff.

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3.5 Focus on staff – Data awaited

3.6 National targets and regulatory requirements

The following indicators are all governed by standard national definitions

TO BE UPDATED to include February and March positions before final report

Indicator		2023/24	2024/25	2025/26	Plan Target 25/26	Constitutional standard	National Average / Benchmark
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway		68.80%	69.90%	**71.6%****	75.0%	92.0%	61.5%*
A&E – maximum waiting time of four hours from arrival to admission / transfer / discharge		71.10%	71.70%	76.2%	79.4%	95.0%	74.1%**
Cancer Faster Diagnosis Standard	Faster diagnosis standard (FDS): Maximum 28-day wait to communication of definitive cancer/not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening	77.30%	80.00%	**55.2%****	82.7%	92.0%	72.8%*
	Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients	99.60%	99.40%	**99%****	99.5%	96.0%	89.8%*
	Maximum two-month (62-day) wait to first treatment from urgent GP referral (including for breast symptoms) and NHS cancer screening	66.50%	74.90%	**63%****	75.5%	85.0%	68.4%*
Maximum 6-week wait for diagnostic procedures		90.90%	85.20%	**98%****	99.3%	99.0%	75.3%*

* January 2026 position

** February 2026 position

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Annex 1: Feedback on our 2025/26 Quality Account – to add once received

4.1 Gateshead Overview and Scrutiny Committee

4.2 Northeast and North Cumbria Newcastle Gateshead Integrated Care Board

4.3 Gateshead Healthwatch

4.4 Council of Governors

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Annex 2: Statement of directors' responsibilities in respect of the quality account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2021/22 and supporting guidance.
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2025 to March 2026
    - papers relating to quality reported to the board over the period April 2025 to March 2026
    - feedback from Northeast and North Cumbria Newcastle Gateshead Integrated Care Board dated - TBC
    - feedback from governors dated - TBC
    - feedback from local Healthwatch organisations dated – TBC
    - feedback from Overview and Scrutiny Committee dated – TBC
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 – not yet published
    - the 2024 national patient survey – TBC
    - the 2024 national staff survey – TBC
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated – TBC
    - CQC inspection report dated CQC Inspections and rating of specific services dated – 14/08/2019

- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered

- the performance information reported in the Quality Report is reliable and accurate

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts

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regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

Date: Chairman:

Date: Chief Executive:

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Glossary of Terms

Care Quality Commission (CQC)
The CQC is the independent regulator of all health and adult social care in England. The CQC aim is to make sure better care is provided for everyone, whether that's in hospital, in care homes, in people own homes, or elsewhere.

Clinical Audit
Clinical audit measures the quality of care and service against agreed standards and suggests or makes improvements where necessary.

***Clostridium difficile infection* (CDI)**
Clostridium difficile is a bacterium that occurs naturally in the gut of two-thirds of children and 3% of adults. It does not cause any harm in healthy people; however, some antibiotics can lead to an imbalance of bacteria in the gut and then the Clostridium difficile can multiply and produce toxins that may cause symptoms including diarrhoea and fever. This is most likely to happen to patients over 65 years of age. The majority of patients make a full recovery however; in rare occasions it can become life threatening.

Commissioning for Quality and Innovation (CQUIN)
The CQUIN framework was introduced in April 2009 as a national framework for locally agreed quality improvement schemes. It enables commissioners to reward excellence by linking a proportion of English healthcare provider's income to achievement of local quality improvement goals.

Commissioners
Commissioners are responsible for ensuring that adequate services are available for their local population by assessing need and purchasing services.

Council of Governors
Our Council of Governors represent our staff, stakeholders and our local communities in the running of the Foundation Trust, under the terms of the Trust's constitution. The Council of Governors' statutory duty includes the appointment and removal of the Chairman and Non-Executive Directors, the appointment of the Trust's auditors and the approval of changes to the constitution of the Trust. They also hold to account the Trust Board for its management of the Trust. The Council of Governors are involved in a number of initiatives within the organisation, including 15 steps challenge visits and PLACE visits.

Foundation Trust
A Foundation Trust is a type of NHS organisation with greater accountability and freedom to manage themselves. They remain within the NHS overall, and provide the same services as traditional Trusts, but have more freedom to set local goals. Staff and members of the public can join the board or become members.

Friends and Family Test (F&FT)
The Friends and Family Test is an important feedback tool that supports the principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses.

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Getting It Right First Time (GIRFT)
Getting It Right First Time is a national programme designed to improve the quality of care within the NHS by reducing unwarranted variations. By tackling variations in the way services are delivered across the NHS, and by sharing best practice between trusts, GIRFT identifies changes that will help improve care and patient outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings.

Hospital Standard Mortality Ratio (HSMR)
The HMSR is an indicator of healthcare quality that measure whether the death rate at a hospital is higher or lower than would be expected.

Healthwatch
Healthwatch is an independent arm of the CQC who share a commitment to improvement and learning and a desire to improve services for local people.

Healthcare Evaluation Data (HED)
HED is an online benchmarking solution designed for healthcare organisations. It allows healthcare organisations to utilise analytics which harness Hospital Episode Statistics (HES) national inpatient and outpatient and Office of National Statistics (ONS) Mortality data sets.

Hospital Episode Statistics (HES)
HES is a data warehouse containing a vast amount of information on the NHS, including details of all admissions to NHS hospitals and outpatient appointments in England. HES is an authoritative source used for healthcare analysis by the NHS, Government, and many other organisations.

Integrated Care Board (ICB)
A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the Integrated Care System (ICS) area.

Integrated Care System (ICS)
Integrated care systems are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.

Joint Consultative Committee (JCC)
JCC is a group of people who represent the management and employees of an organisation, and who meet for formal discussions before decisions are taken which affect the employees.

Just Culture
The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame. Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated.

Methicillin Resistant *Staphylococcus aureus* (MRSA)
MRSA is a bacterium responsible for several difficult to treat infections in humans. MRSA is, by definition, any strain of *Staphylococcus aureus* bacteria that has developed resistance to antibiotics. It is especially prevalent in hospitals, as patients with open wounds, invasive devices and weakened immune systems are at greater risk of infection than the general public.

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National Confidential Enquiries
These are enquiries which seek to improve health and healthcare by collecting evidence on aspects of care, identifying any shortfalls in this, and disseminating recommendations based on these findings. Examples include Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK (MMBRACE) and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).

National Confidential Enquiry into Patient Outcome and Death (NCEPOD)
NCEPOD's purpose is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public by reviewing the management of patients. This is done by undertaking confidential surveys and research, and by maintaining and improving the quality of patient care and by publishing the results.

National Patient Survey
The NHS patient survey programme systematically gathers the views of patients about the care they have recently received because listening to patients' views is essential to providing a patient-centred health service.

NerveCentre
NerveCentre is an electronic clinical application used to record a variety of patient observations and assessments.

NHS England (NHSE)
NHS England leads the National Health Service (NHS) in England. They set the priorities and direction of the NHS and encourage and inform the national debate to improve health and care.

Overview and Scrutiny Committee
The Overview and Scrutiny Committees in local authorities have statutory roles and powers to review local health services. They have been instrumental in helping to plan services and bring about change. They bring democratic accountability into healthcare decision-making and make the NHS more responsive to local communities.

Patient Advice and Liaison Service (PALS)
PALS is an impartial service designed to ensure that the NHS listens to patients, their relatives, their carers, and friends answering their questions and resolving their concerns as quickly as possible.

Pressure Ulcers
Pressure ulcers are also known as pressure sores or bed sores. They occur when the skin and underlying tissue becomes damaged. In very serious cases the underlying muscle and bone can also be damaged.

Research
Clinical research and clinical trials are an everyday part of the NHS and are often conducted by medical professionals who see patients. A clinical trial is a particular type of research that tests one treatment against another. It may involve people in poor health, people in good health or both.

Risk
The potential that a chosen action or activity (including the choice of inaction) will lead to a loss or an undesirable outcome.

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Special Review
A special review is carried out by the Care Quality Commission. Each special review looks at themes in health and social care. They focus on services, pathways, and care groups of people. A review will usually result in assessments by the CQC of local health and social care organisations as well as supporting the identification of national findings.

Standard Operating Procedure
A Standard Operating Procedure is a set of step-by-step instructions compiled to help workers carry out complex routine processes.

Trust Board
The Trust Board is accountable for setting the strategic direction of the Trust, monitoring performance against objectives, ensuring high standards of corporate governance, and helping to promote links between the Trust and the community. The Chair and Non-Executive Directors are lay people drawn from the local community and are accountable to the Secretary of State. The Chief Executive is responsible for ensuring that the Board is empowered to govern the organisation and to deliver its objectives.

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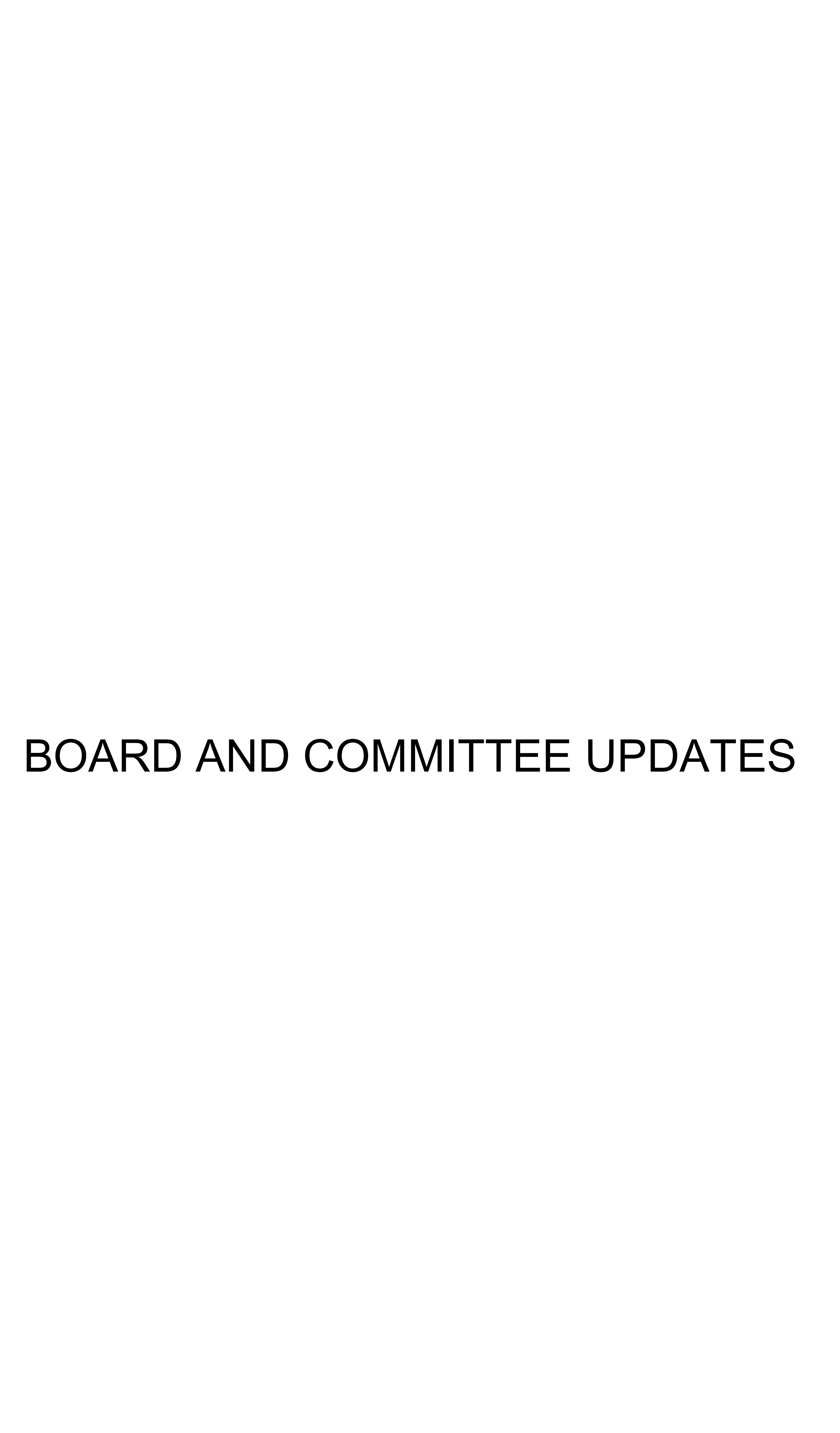

BOARD AND COMMITTEE UPDATES

10. Acting Chief Executive's update

i) Strategic report

ii) Finance Report

iii) Governor Dashboard

iv) Questions received in advance from Governors

Acting Chief Executive's Strategic Report to the Council of Governors

Dr Sean Fenwick, Acting Chief Executive

20th May 2026

Gateshead Health
NHS Foundation Trust

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.

NHS Oversight Framework (NOF) Quarter 3 2025/26 ratings published in March 2026 – Gateshead ranked 65, which is not statistically significant to the previous quarter (62)

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

King's Fund and Nuffield Trust's British Social Attitudes survey shows the biggest drop in dissatisfaction in the NHS since 1998. There has been a 5.6% increase in satisfaction, the first increase since 2019.

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.

National performance headlines

National performance – February and March 2026

77.1% of patients in A&E seen within 4 hours (March) – the best performance since July 2021 despite the highest attendance levels since records began in August 2010 (2.43 million A&E attendances). This is just below the 78% target.

In March for types 1 and 2 only 4 hour performance was 64.7%, which is lower than the overall 4 hour performance (note Gateshead does not have type 2).

On average in March 59.7% of patients who no longer met the criteria to reside remained in hospital compared to 58.7% in March 2025 – i.e. there is deterioration in the position.

9% of patients spent more than 12 hours in A&E in March, below the threshold of 10% outlined in the Urgent and Emergency Care Delivery Plan.

68.6% of referrals met the 62-day cancer standard in February, a slight improvement on last year (67.2%), but below the 75% target outlined in the 2025/26 planning guidance.

In February 80.5% of patients with an urgent referral were told they have cancer, or it was excluded within 28 days. This is consistent with the prior year (80.2%) and in line with the target of 80% outlined in the 2025/26 planning guidance.

In February 20.2% of patients were waiting 6 weeks or more for diagnostic tests, which is a deterioration from the previous year (17.5%). In February 2026 the waiting list reached 1.86 million, the highest figure since records began in January 2006.

Waits within 18 weeks are equivalent to 62.6% of all waits (Feb), with progress needed to meet the aim for 65% of treatments to be waiting no longer than 18 weeks by March 2026. Waits over 52 weeks accounted for 1.7% of all waits, above the threshold of 1%.

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Our performance

Metric	Target	Jan 25	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	Ass/Var
Achievement of the A&E 4 hour standard	>78%	71.2%	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%	
12 hour trolley waits (DTA to left department)	0	0	0	2	0	1	2	1	0	2	21	6	2	12	1	1	
% of ED attendances > 12 hours in department (Type 1) *Reset April 2025 to align with 2025/26 operational guidance definitions*	0.2%	5.2%	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%	
Ambulance handover delays 30-60 minutes	0	21	4	6	11	4	16	5	1	8	21	7	23	72	15	27	
Ambulance handover delays over 45 minutes	0				3	1	5	0	0	0	8	1	15	37	6	15	
Ambulance handover delays 60 minutes +	0	14	0	7	1	0	0	0	0	0	3	0	9	19	1	9	
Achievement of the RTT 18 week standard	>92%	70.6%	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%	77.0%	
Achievement of the 52 week RTT standard	0	83	66	0	16	1	18	35	55	52	41	33	25	20	26	16	
Achievement of the 6 week diagnostic standard (DM01)	>95%	81.4%	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%		
Achievement of the Cancer 28 day standard *Reset April 2025 to align with 2025/26 operational guidance standard*	>80%	77.0%	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%	59.7%	
Achievement of the Cancer 31 day standard	>96%	99.4%	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%		
Achievement of the Cancer 62 day standard *Reset April 2025 to align with 2025/26 operational guidance standard*	>75%	80.2%	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%		

Our key operational performance headlines

- In March 2026 Urgent and Emergency Care (UEC) performance was challenging. **A&E 4-hour performance** was 75.1% against the national target of 78%, although performance significantly improved towards the end of the month. Ongoing high volumes of attendances and availability of beds across the Division of Medicine with Infection Prevention and Control (IPC) issues have contributed to the position.
- The total Type 1 A&E attendances spending **greater than 12 hours in the department** in March was 5.13%, which is above our plan of 0.2%. Additionally, there was one 12 hour trolley wait during the month, which was consistent with the previous month and lower than the months preceding this.
- We experienced some challenges in relation to **ambulance handover** delays with 27 handover delays of 30-60 minutes in March and 9 delays over 60 minutes against a threshold of 0 for both measures. Both figures were higher than February, but still an improvement on January.
- The number of patients waiting **over 52 weeks** reduced to 16 at the end of March 2026 (data awaiting validation). This represents a decrease in the number of patients waiting over 52 weeks for treatment with almost all patients awaiting Urology care. We have utilised sprint NHS England monies in Q4 to improve the position, but this arrangement ceased at the end of March. 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 Great North Healthcare Alliance.
- The average **length of stay** for non-elective patients increased to 8.25 days compared to 7.92 days in February. This is above our threshold of 4 days and this reflects ongoing challenges with patients for whom a suitable out of hospital placement has been difficult to source, particularly those with complex ongoing needs. There were significant positive gains on the ward which implemented the NHS England discharge sprint initiative and this work is now being rolled out to a second ward.
- **Cancer constitutional standards** remain an area of concern. The 28 day faster diagnosis standard has been particularly impacted by the demand and capacity mismatch within breast services (further information is contained later in this report). 59.7% of patients were seen within 28-days but this remains well below the 80% standard. Some improvements can be seen in the 62 day performance (63%) but this remains below the 75% standard.
- Further information on quality and people performance metrics can be found within the *Governor Dashboard* agenda item.
- In addition Governors can refer to the Board's performance report for more detailed information on all aspects of performance (this is sent to Governors as part of the Board papers).

Excellent patient care

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- 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.
- 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.
- 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..

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.

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

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- 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.
- 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.
- Finally, we would like to record our sincere thanks to **Gavin Evans**, QE Facilities Managing Director, and **Jo Halliwell**, Chief Operating Officer, who will both be leaving us shortly to commence new positions with our Alliance partner North Cumbria Integrated Care NHS Foundation Trust. Both Gavin and Jo have made a significant contribution to the Group and we wish them every success in their new roles.

Report Cover Sheet Agenda Item: 10ii

<table>
<tr><td>Report Title:</td><td colspan="4">Finance Report 2025-26</td></tr>
<tr><td>Name of Meeting:</td><td colspan="4">Council of Governors</td></tr>
<tr><td>Date of Meeting:</td><td colspan="4">20 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:
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<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 had an original approved 2025-26 planned deficit of £8.621m before adjustments for donated asset depreciation, and £8.381m after.

Following the allocation of non-recurrent deficit support funding by NHS England in March the trust has been allocated an additional £3.276m resulting in a revised planned deficit of £5.345m before adjustments for donated asset depreciation, and £5.105m after.

As of March 2026, subject to external audit review, the Trust has reported an actual deficit of £5.048m after adjustments for donated asset depreciation. This is a favourable variance of £0.057m from the planned deficit for reasons detailed in the body of this report.

After all additional capital awards the Trust revised 2025-26 capital plan totalled £28.218m including £20.521m PDC funded schemes and £0.092m charitable funds. Capital spend for 2025-26 totalled £27.538m. This is an under-spend of £0.680m</td></tr>
</table>

	from the capital plan for the reasons detailed in the body of this report. Cash balances are £30.929m at 31st March 2026 which is £28.140m above planned levels for the reasons detailed in the body of this report.
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The recommendation to the Council of Governors is to receive the report, and record full assurance for the achievement of its 2025-26 planned financial targets.
Trust strategic priorities that the report relates to:	☐ Excellent patient care ☐ Great place to work ☐ Working together for healthier communities ☒ Fit for the future
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	We will ensure efficient and effective use of our resources, identifying opportunities to improve productivity and ensure best use of public money.
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☐ | Responsive ☐ | Well-led ☒ | Effective ☐ | Safe ☐
Risks / implications from this report (positive or negative):	
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐ | **No** ☐ | **Not applicable** ☒

2025/26 Background

The Trust approved its financial plan and submitted to NHS England in March 2025. The plan included:

- A £8.621m revenue deficit after allowing for donated asset depreciation. Following the allocation of additional non-recurrent deficit support funding this was reduced to £5.105m
- A Cost Reduction Plan (CRP) totaling £32.872m;
- An in year £20.076m capital plan, of which £9.008m funded by public dividend capital (PDC) allocation. After additional capital awards this was revised to £28.218m
- A cash plan that reduces to £2.789m by March 2026.

2025/26 Performance (April 25 to March 26)

Revenue financial performance at 31st March 2026 was a deficit of £5.048m, which is marginally better than plan by £0.057m; this is mainly due to underspends on pay across most staff groups as well as additional income received in Q4. This underspend has enabled the Trust to offset unplanned cost pressures including unfunded pay pressures and the cost of unfunded insulin pumps.

CRP savings at 31st March 2026 were £32.873m and on plan, of which £14.756m has been achieved on a recurrent basis.

Capital performance at 31st March was £27.538m against a revised plan of £28.216m, an underspend of £0.680m.

Cash balances were £30.929m at 31st March 2026, which was £28.140m more than plan largely due to an increase in trade and other payables.

Key issue: Revenue

Net revenue expenditure was £0.057m better than plan.

The Trust actual spending was a £0.057m underspend against planned level, however, at year-end was less than plan for pay costs and income and more for non-pay costs.

Expenditure on bank and agency staffing was above planned levels for the year due to the impact of site pressures and the opening of ward 11, industrial action and staff sickness; however, underspends against substantive posts helped to offset this and the trust also received additional income from NHSE in Q4 to help cover the costs of the industrial action.

The position for 2025-26 was challenging as evidenced by the required cost improvement target of £32.871m. To respond to the challenge the Trust established Cost Reduction

Planning Steering Group that supports and monitors work streams focused on tackling underlying deficits and targeting medium term savings. In addition, the Financial Accountability Framework requires overspending business units to develop financial recovery plans. Whilst the CRP plan was delivered £18.115m was on a non-recurring basis resulting in challenges for 2026-27 financial year.

Key issue: Capital

Capital expenditure was below the revised plan by £0.680m

Capital spend for the year was £27.538m following the allocation of additional funding in year. This represents an underspend against the revised plan of £0.680m comprising of a £0.008m overspend against Trust CDEL and £0.688m slippage against a PDC award relating to the Medicines Manufacturing Centre due to a delay in NHS England approving the transfer of this slippage to Northumbria Healthcare Foundation Trust by 31st March 2026.

Key issue: Cash

The closing cash balance at the end of March was £30.929m which was £28.140m above planned levels mainly due to by trade and other payables being £17.829m higher than planned.

Key issue: CRP Delivery

CRP requirements in 2025-26 were to achieve a £32.871m target on a recurring basis to improve the Trusts underlying deficit.

The Trust delivered CRP of £32.873m in 2025-26, which is in line with the target. At year-end the Trust transacted £14.756m CRP schemes on a recurring basis which represents 45% of the target carrying forward a shortfall of £18.115m which represents a risk to achieving the financial plan for 2026-27 financial year and the overall trust's financial sustainability.

As part of its financial sustainability, work the Board aims to ensure that the future programme identifies a higher proportion of recurrent, sustainable schemes. Key steps to date include the establishment of a CRP Steering Group focused on working at pace with business units to develop ideas into fully worked up schemes, a baseline financial assessment of opportunities via our internal and Great North Healthcare Alliance costing data as well as Model Hospital and corporate benchmarking tools.

Governor Dashboard

Key Messages

May 2026

Top Organisational Risks

Financial Sustainability

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

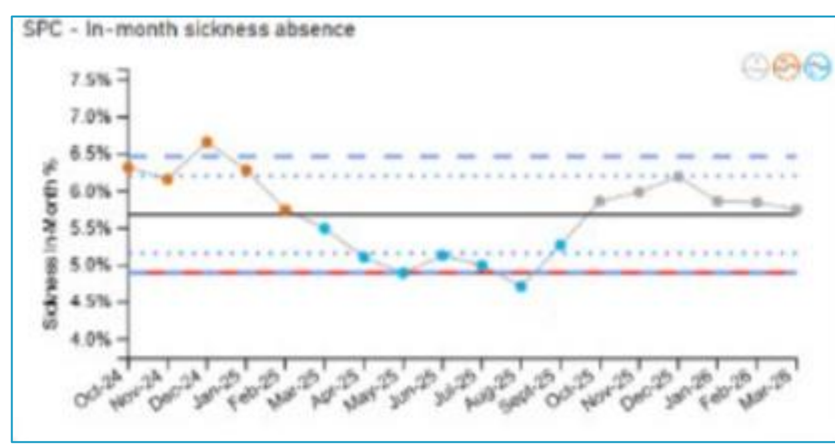
Estates

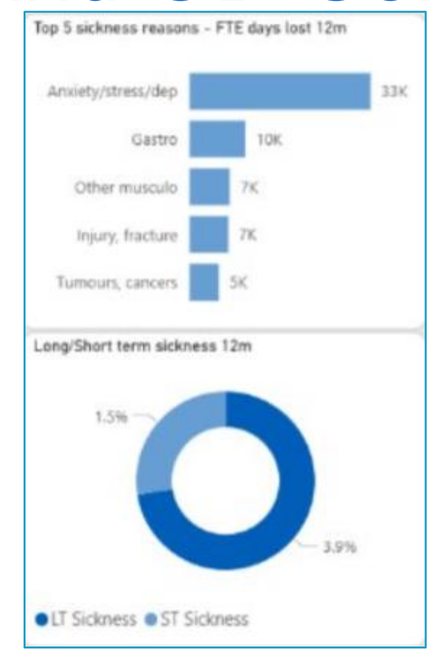
Risk to sustainability of core infrastructure and to invest in clinical advances and the working environment for our staff.

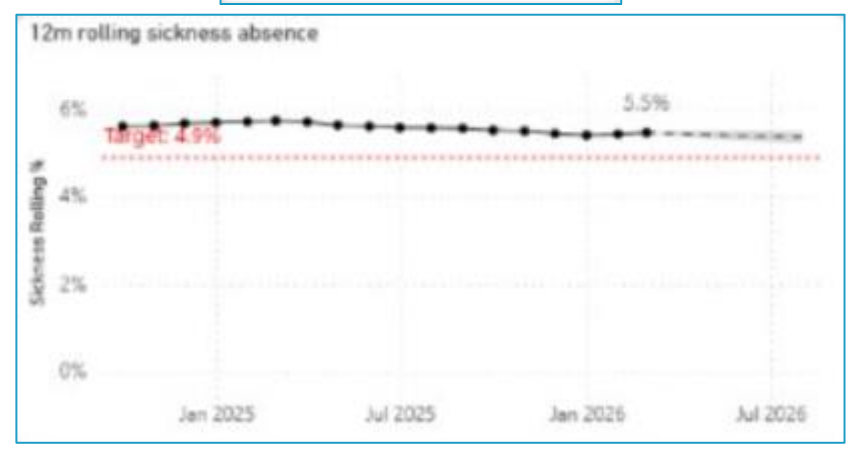
Digital

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.

People metrics – sickness absence (March 26 – as reported to the People and OD Committee)



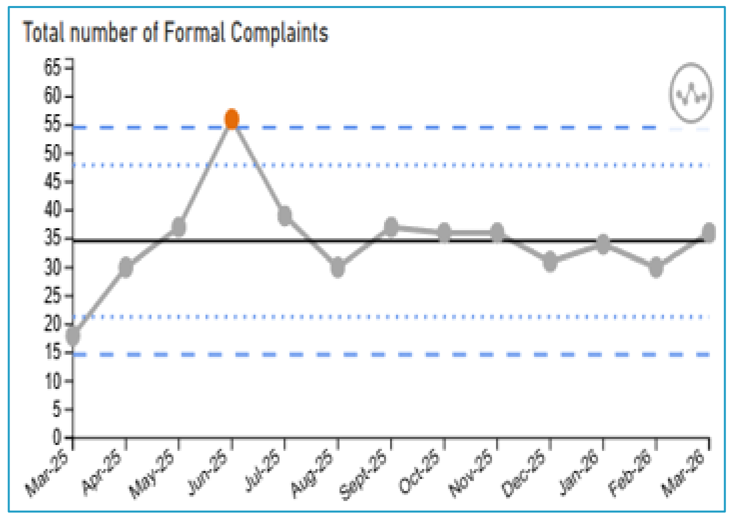


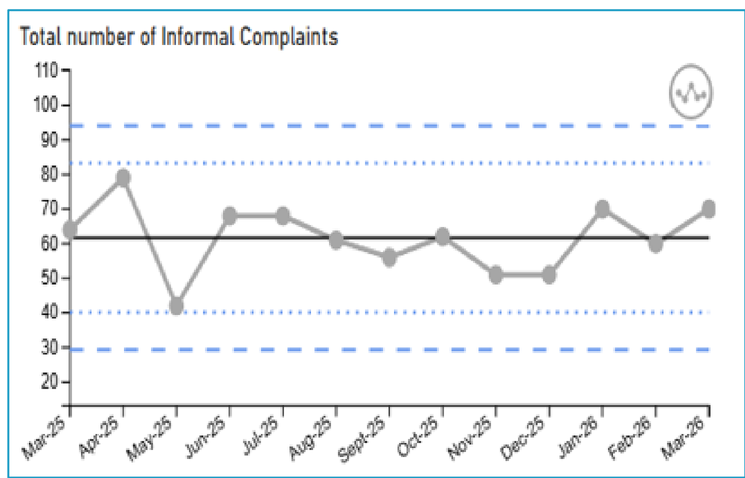


<u>What does this data tell us?</u>

- From April 2025 to January 2026 there was an increasing downwards trend in relation to sickness absence, with a low in January of 5.41%.
- February and March 2026 have seen slight increases, with a figure of 5.46% in March 2026 against the target of 4.9%.
- The Trust ranks second lowest for rolling sickness absence in the ICS area and below the median average across the whole of the North East and Yorkshire.
- Estimated cost of sickness over the past 12 months is £10m.
- Anxiety, stress and depression continues to be the top reason for absence.
- Long term absence continues to makes up 3.9% of the absence in the past 12 months in comparison to 1.5% short term absence.

Patient experience – March 26 data (reported to Quality Governance Committee)





Complaints breakdown – 36 formal complaints reported

Implementation of Care (20)
- Quality of care (20)

Communication, Confidentiality and Consent (8)
- Verbal (5)
- Written (1)
- Staff attitude (2)

Clinical Assessment (3)
- Diagnosis delay (1)
- Scan / x-ray / specimen issue (1)
- Diagnosis incorrect (1)

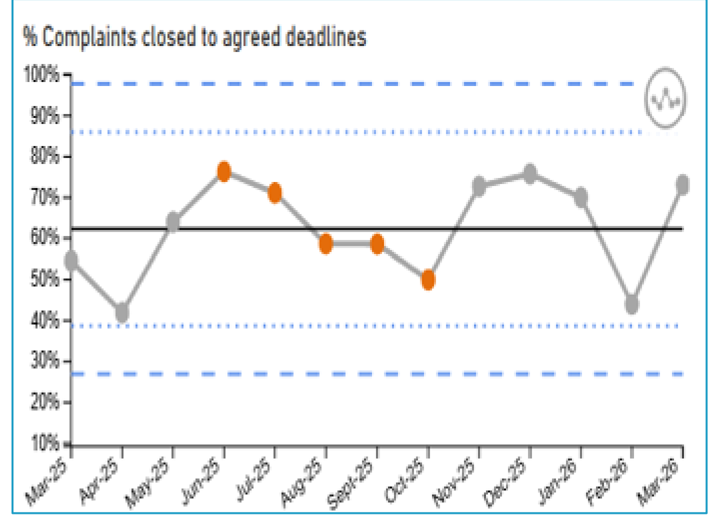
Access, Admission and Discharge (4)
- Premature / inappropriate discharges (1)
- Delays in appointments (2)
- Referral issue (1)

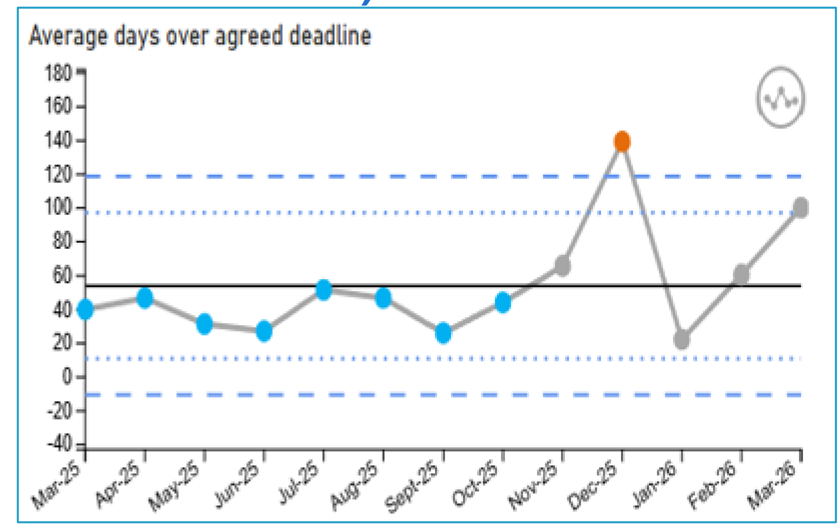
Security (1)

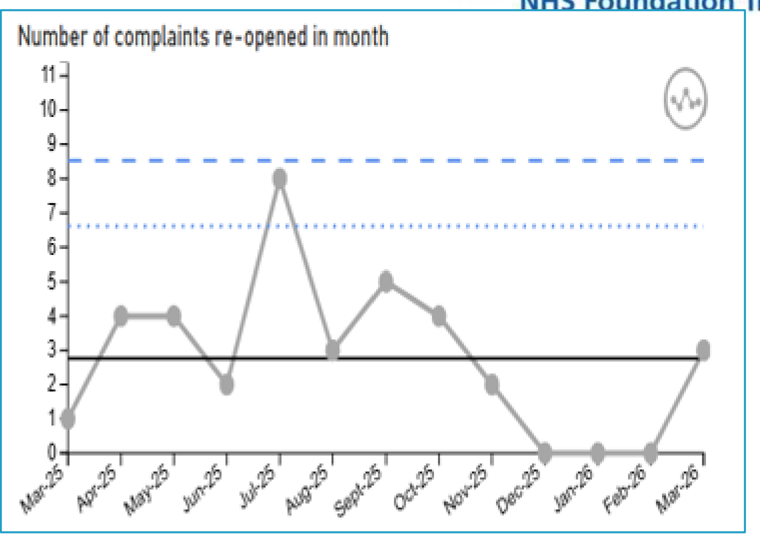
Themes remain consistent with previous months, with implementation of care and communication continuing to be the most prominent drivers. The concentration of concerns relating to quality of care should remain a focus through divisional governance and quality improvement processes.

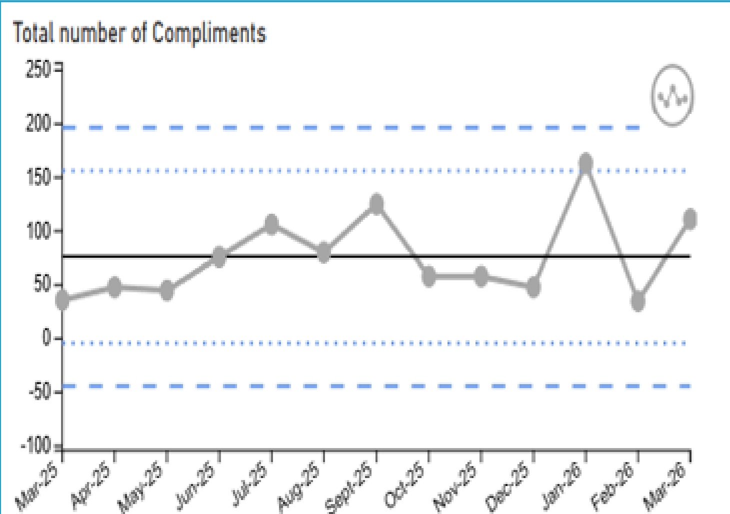
Formal complaints
- 28 formal complaints closed in March 2026
- 8 upheld
- 14 partially upheld
- 2 not upheld
- 2 withdrawn
- 100% of complaints acknowledged in 3 days
- 19 complaints closed were responded to within the agreed timescale (67.9% of the complaints closed)
- 20 complaints were overdue at the month end:
  - Medicine 9
  - Surgery 11
- Complaints are signed off by the Acting Chief Executive.

Patient experience – March 26 data (reported to Quality Governance Committee)





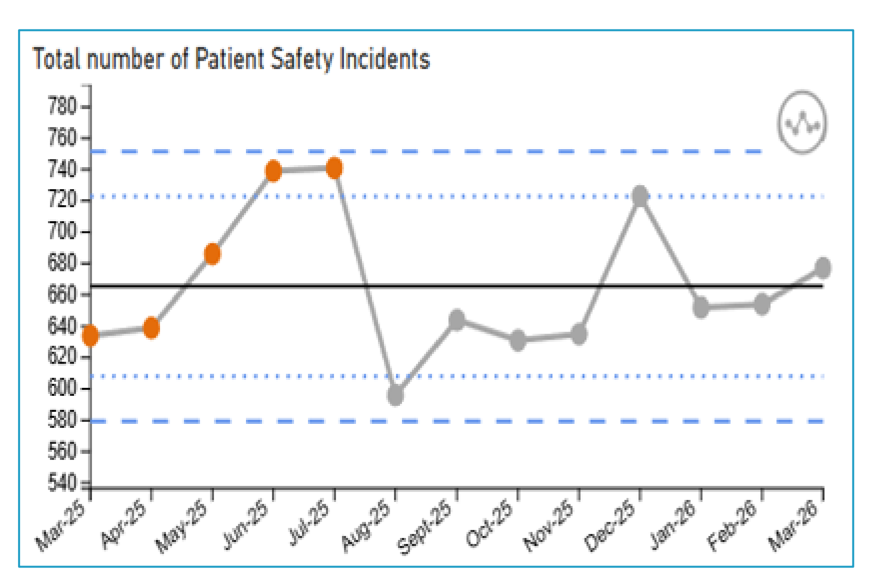


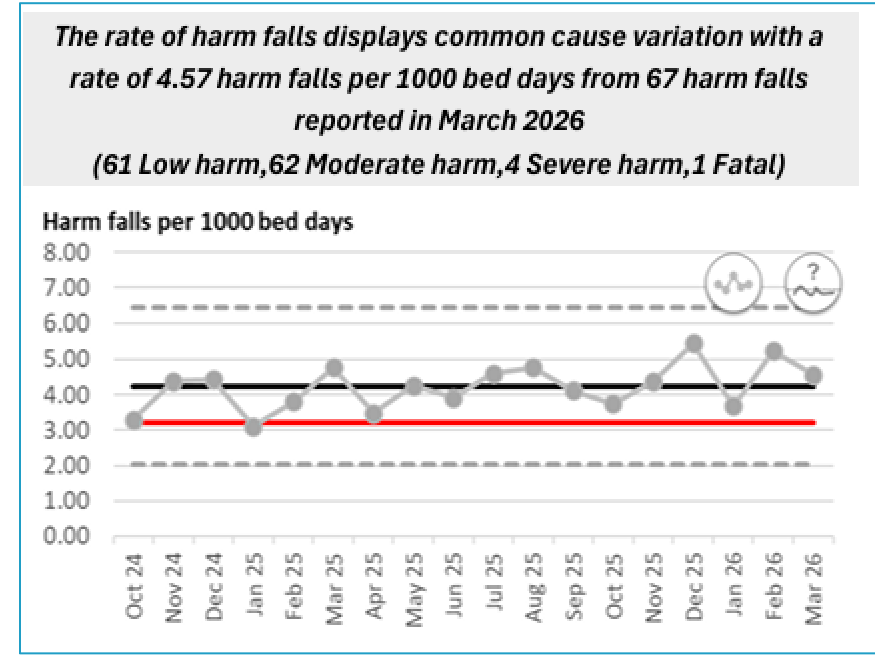


- The Trust received 111 compliments in March 2026, representing a significant increase compared to February. Feedback continues to highlight staff kindness, professionalism and compassionate care.
- Friends and Family Test (FFT) performance remains strong, with an overall Trust score of 92.1% from 1,925 responses.
  - A&E: 87.2%
  - Inpatients & Day Cases: 92.3%
  - Outpatients: 93.4%
  - Maternity: 100%
  - Community: 96.8%
  - Mental Health: 100%

- March 2026 data demonstrates sustained stability in patient experience performance, with complaint and PALS volumes remaining within expected variation and acknowledgement performance consistently strong.
- Whilst improvements in response timeliness are noted, the number of overdue complaints highlights an ongoing risk, particularly in relation to older or more complex cases.
- Strong FFT results, increased response rates and a marked rise in compliments provide assurance of compassionate care delivery. Consistent thematic trends offer clear and actionable opportunities for improvement, particularly in relation to quality of care and communication, which should continue to be addressed through established divisional and Trust governance arrangements.

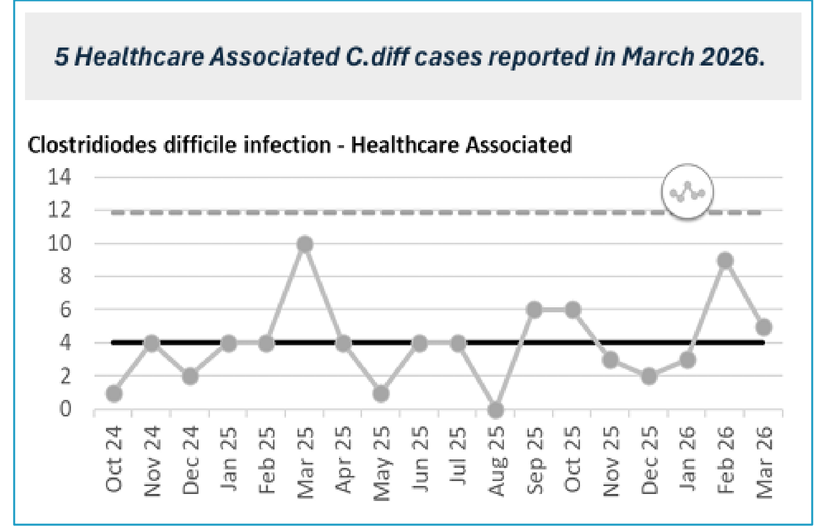
Patient safety incidents – March 26 data (reported to Quality Governance Committee)

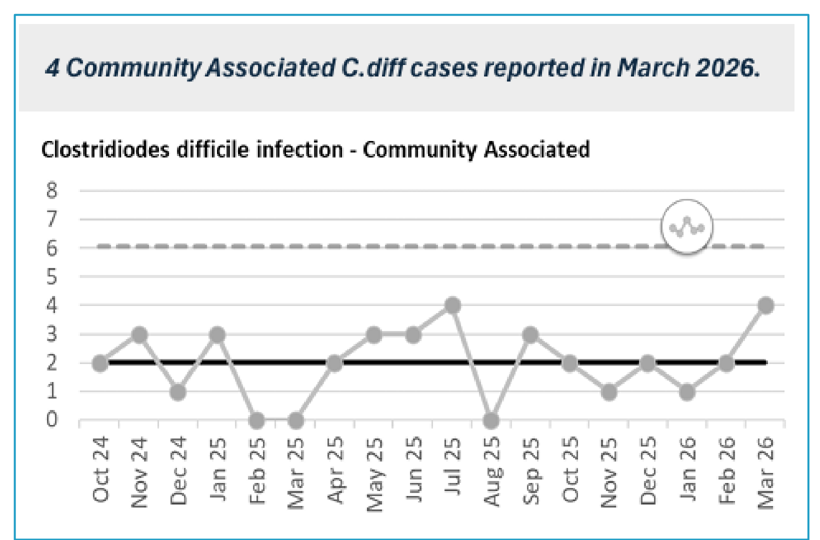


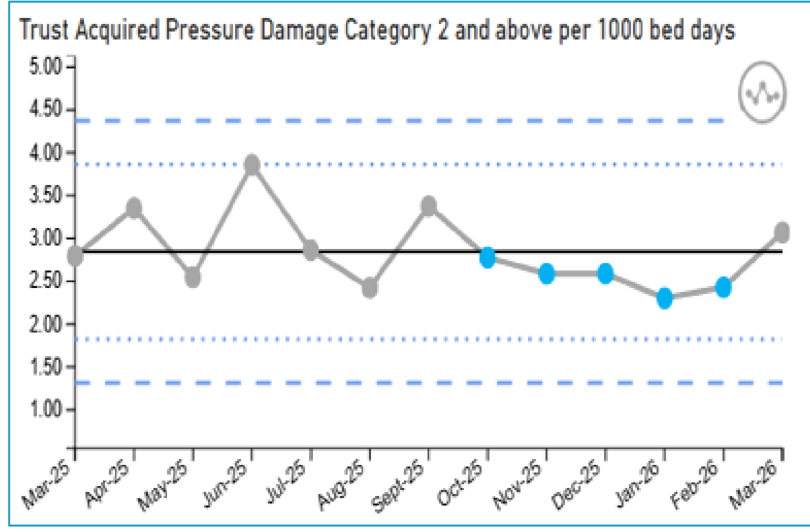


- Patient Safety Incidents continue to display common cause variation in March 2026 (i.e. no significant change in historical trends). A slight increase in the incidents reported is observed on the previous month, to 677 from 651; a decrease in the rate per 1000 bed days to 46.2 from 49.4.
- Improvement work remains in progress through the Falls Prevention Group, including further falls training planned for the end of April and the new falls section now live within the digital activities of daily living care plan.
- Alongside this, focused work continues within Elderly Care under Matron leadership, particularly on wards 24 and 25. This includes increasing meaningful activity for patients and restoring aspects of the ward environment as therapeutic space to help reduce risk and support safer mobility.

Patient safety incidents – March 26 data (reported to Quality Governance Committee)

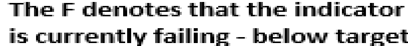


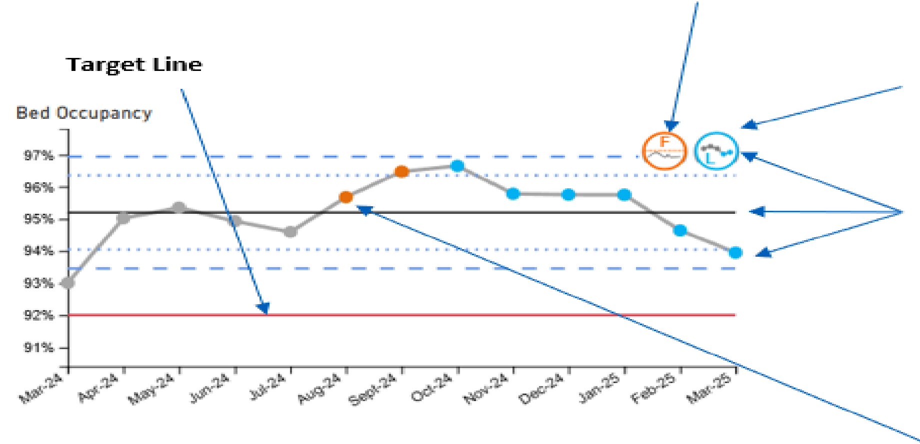




- Common cause variation continues to be observed in respect of pressure damage.
- Healthcare Associated C.Difficile infections exceeded the 2026 threshold of 36 – 47 cases were reported during 2025/26, although remained in common cause variation. An action plan is in place to support the reduction in infection rates.

Appendix 1 – Interpreting Statistical Process Control Charts





4 points of improving trend is showing positive variation

Solid line (Mean) - based on historic data. Dotted lines (upper/lower process limits) represents where 99% of the historic data points are placed.

A run of points above the Target highlights concerning special cause variation. This would warrant action to understand what may be causing it

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

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.

Appendix 2 – Metrics definitions

- **Formal complaints** to be acknowledged in 3 working days.
- **Timeframes for response** are agreed with the complainant – usually not more than 40 working days (dependent on the content, complexity and work to be involved).
- For complex cases a request can be made in writing for an extension to increase the time for response to 60 working days.
- **Informal complaints** are defined as concerns received and resolved via PALS (Patient Advice and Liaison Service).
- **Patient safety incidents** are graded for physical and psychological harm as follows: no, low, moderate, severe and fatal (physical harm only).
- Moderate physical harm includes needing additional healthcare of less than 2 weeks inpatient care and/or less than 6 months of further treatment; limiting independence for less than 6 months; or affecting the success of treatment but without reducing life expectancy or accelerating a disability.
- **Pressure ulcers** are graded 1 to 4, with 1 being the least severe.

11. Board Committee assurance updates

i) People and Organisational Development Committee - Adam Crampsie / Amanda Venner

ii) Group Audit Committee - Rob Hughes, Audit Committee Chair

Work of the People and OD Committee

Maggie Pavlou, Chair of the Committee

September 2025 – March 2026

Examples of issues considered, and assurances received

PODC have met 4 times since August 2025

- People Chapter Delivery Plan
- People & OD Future Model of Delivery
- Equality, Diversity & Inclusion inc. Anti-Racism Charter
- NHS Staff Survey and GMC Survey
- Absence Management
- Reflective Review of Lessons Learnt from ER cases
- NHS Job Evaluation and National Job Profiles – Nursing & Midwifery
- Ten Point Plan for Resident Doctors
- Guardian of Safe Working Reforms
- Review of Effectiveness and Terms of Reference

Reports

POD Steering Group Assurance Reports / ADQM / WRES and WDES / Gender Pay Gap / Guardian of Safeworking / Annual Revalidation Report / Internal Audit / Nurse Staffing Report and Establishment Review

Key Risks

The Committee are currently monitoring 3 risks on the Organisational Risk Register

NHS
Gateshead Health
NHS Foundation Trust

Risk of harm to staff (psychological and physical) due to exposure to violence and aggression from patients and visitors who exhibit challenging behaviours. This could result in injury, increased absence from work, staff morale and confidence and potentially effect recruitment and retention.

Risk that the Trust is unable to fully mature and implement its strategic workforce plan across the medium-term planning period. As a result of partial workforce modelling beyond 2026/27, reliance on assumptions linked to financial recovery and emerging transformation programmes, and further work required to translate workforce reductions and skill-mix changes into detailed implementation plans. Resulting in reduced assurance over the safe and sustainable delivery of workforce reductions, achievement of productivity and agency reduction ambitions, and effective management of workforce risks in the later years of the plan.

Risk that Colleagues have negative experiences at work and do not feel valued or respected in the workplace as highlighted by the staff survey. This is due to Poor behaviours displayed by other colleagues that are not acceptable and not line with Trust values or behavioural framework. Resulting in ongoing low engagement, increased turnover, burnout, and higher levels of sickness absence which may result in compromised quality of care for patients.

Case study - Strategic Goal 2 – Great Place to Work

Ambition 3 - We will be an employer and training provider of choice within the local Community recognising our role as an anchor institution

Areas of Discussion	Assurance & Impact	Learning & Next Steps
Staff Survey	Oversight strengthened through BU governance and SE&I Group; delivery of Trust-wide and local actions with early signs of improvement.	Strengthen accountability and visibility of impact; clearer "you said, we did" and focus on measurable outcomes.
10 Point Plan Resident Doctors	Full assurance via Resident Dr Peer Lead; strong baseline compliance and clear trajectory beyond national standards.	Increase awareness and engagement; extend learning across wider workforce.
Freedom to Speak Up	Improved insight into workforce concerns (culture, behaviours, safety); targeted interventions in hotspot areas.	Improve clarity of routes and communication; strengthen triangulation with other datasets.
Anti-Racism Charter	Structured delivery in place (dashboard, training, benchmarking) with national compliance achieved.	Embed long-term cultural change; strengthen leadership accountability and Board development.
Nurse Staffing	Day-to-day safe staffing maintained; partial assurance due to HCA workforce gaps.	Develop Band 2–3 pipeline and targeted recruitment; strengthen real-time assurance.

Is the work of People & OD Committee making a difference?

- Improving attendance and workforce resilience
- High-quality training environment – externally recognised
- Improving experience for resident doctors
- Strengthening how we deliver the People Chapter of the Corporate Strategy
- Strengthening culture, safety and speaking up
- Building the foundations for a more inclusive organisation
- Maintaining safe staffing and building the future workforce

Key Priorities for Assurance: May 2026 – October 2026

Monitoring delivery of the People Chapter of the corporate strategy in addition to monitoring organisational risk, considering in the context of the board assurance framework.

Caring for our people	Growing and developing our people					Being an employer and training provider of choice				
Guardian of Safeworking	GMC Survey	WRES & WDES	Gender Pay Gap Multi-year Plan	EDI Six Monthly Update	National Job Profiles – Nursing & Midwifery	NHS Staff & Pulse Survey	Freedom to Speak Up	Ten Point Plan for Resident Doctors	Nurse and Midwifery Staffing Reports and Establishment Revie	Sexual Safety Charter

Any questions?

Work of the Group Audit Committee

Rob Hughes, Chair of the Committee

20th May 2026

Some of the key issues considered and assurances received

External Audit

- Positive timing around the planning and start of the 25/26 fieldwork
- Timeframes for completion of the 25/26 audit presented to the Audit Committee in April
- Non-Exec review of the Annual Accounts took place at the end of April

Internal Audit

- Regular receipt of progress against 2025/26 plan, review of completed audits and monitoring the timeliness and implementation of recommendations
- Received 2026/27 plan for approval at Audit Committee meeting in April
- Positive balance between Trust and QEF audit days and reduction of QEF days

Risk and Process Management

- Regular update reports received from Executive Risk Management Group
- Reassurance over dynamic use of the Risk Register by the executive
- Revised Board Assurance Framework work ongoing with some updates around governance changes due

Counter Fraud

- Regular receipt of progress against 2025/26 plan
- Support with the Failure to Prevent Fraud Corporate Offence Self Assessment

Regulatory and Governance

- No examples of Non-Compliance with Standing Financial Instructions (SFIs)
- Proposed changes to the Corporate Governance Manual were approved for onward ratification by Trust Board

Key risks

Do Not Attempt Cardiopulmonary Resuscitation (DNA CPR) procedures following recent audit

Completion of 25/26 Internal Audit plan

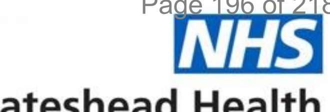
Key priorities for assurance over the next six months

DNA CPR new policy and all actions completed from the limited assurance follow up report

Continued overview of progress against agreed audit and counter-fraud workplans

Continued overview of progress against External Audit recommendations

Prepare for review of Group year-end reporting, ensuring that regulatory deadlines are met and that continuous improvement is made in the quality of reporting



Any questions?

GOVERNANCE

12. Council of Governors Attendee Role

To be presented by Jennifer Boyle, Company Secretary

Report Cover Sheet Agenda Item: 12

<table>
<tr><td>Report Title:</td><td colspan="4">Council of Governors Attendee Role Description</td></tr>
<tr><td>Name of Meeting:</td><td colspan="4">Council of Governors</td></tr>
<tr><td>Date of Meeting:</td><td colspan="4">20 May 2026</td></tr>
<tr><td>Author:</td><td colspan="4">Diane Waites, Corporate Services Assistant</td></tr>
<tr><td>Sponsor:</td><td colspan="4">Sir Paul Ennals, Chair</td></tr>
<tr><td>Report presented by:</td><td colspan="4">Jennifer Boyle, Company Secretary</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">To consider the role description for the Council of Governors attendee role</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">Membership, Governance and Development Committee – 6th April 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">• Following the reforms set out in the government’s 10 Year Health Plan for England, the Trust has taken the decision to pause Governor elections
• This has resulted in some Governors being unable to be re-elected therefore an alternative option is being proposed to provide a way in which the input of those Governors impacted by the election pause can be retained
• A non-voting attendee role has been developed to enable those Governors to continue to make an active contribution and represent the voices of our communities and patients.
• The role was considered by the Membership, Governance and Development Committee and recommends that the Council approves the role description.</td></tr>
</table>

Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Council is requested to approve the Council of Governors Attendee role description following the recommendation of the Membership, Governance and Development Committee.				
Trust strategic priorities that the report relates to:	☒	Excellent patient care			
	☒	Great place to work			
	☒	Working together for healthier communities			
	☒	Fit for the future			
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	Not directly linked to a specific strategic objective, but these positions will play a vital role in our assurance and escalation processes.				
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	None identified				
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Council of Governors Attendee Role Description

1. Executive Summary

1.1. The report outlines the proposal to develop a non-voting Governor attendee role following the decision to pause Governor elections in 2026/27.

1.2. The pause to elections will affect 7 of our Governors whose terms of office are due to end on 4th January 2027.

1.3. The attendees would be non-voting but invited to participate in public and private Council of Governors meetings and Governor committees / groups (with the exception of the Governor Remuneration Committee and Board Committee observations, which would need to be undertaken by elected / appointed Governors).

1.4. The attendee role term of office would commence following the end of the current Governor term of office and cease once any legislative changes are made. Should the legislative changes take longer than anticipated, then the arrangement would be reviewed by the Council after 12 months in post. The right to reinstate the election process is reserved, should there be a significant delay in the legislation or change in planned policy.

1.5. The proposed role description (Appendix 1) was considered by the Membership, Governance and Development Committee at its last meeting in April 2026 and it is recommended that the Council approves the attendee role description.

2. Introduction

2.1. The reforms set out in the government's 10 Year Health Plan for England confirms that Foundation Trusts will no longer be required to have Governors, with public and staff views instead being gathered through more modern and flexible engagement methods. Should the legislation be passed in accordance with currently understood timescales, it would take effect from April 2027, and all Foundation Trusts will need to comply.

2.2. Given these changes, the Trust has taken the decision to pause Governor elections.

2.3. It is felt that continuing with an election cycle for a role that is intended to be phased out would create unnecessary confusion for members, candidates and the wider public. Importantly, if we were to proceed with Governor elections in 2026 then this would also misalign with national policy

2.4. The decision to pause the elections was discussed at the February 2026 Council of Governors and Governors expressed support for the decision.

2.5. The pause to elections will affect 7 of our Governors whose terms of office are due to end on 4th January 2027 and they will cease to be a Governor from 5th January 2027

2.6. The Trust wants to assure those Governors that their contributions and commitment is valued and as such has developed a proposal to provide a way in which the input of those Governors impacted by the election pause will be retained through a non-voting attendee role. This was raised verbally at the last Council of Governors with a commitment to develop the detail behind the proposal and bring this to the next Council in May 2026 for formal approval.

3. Key issues / findings

3.1. The Council of Governors attendee role will be reserved only for those Governors impacted by the decision to pause elections and will enable them to represent the voices of our communities and patients.

3.2. The role will be non-voting but attendees will be invited to participate in public and private Council of Governors meetings and Governor committees / groups (with the exception of the Governor Remuneration Committee and Board committee observations, which would need to be undertaken by elected / appointed Governors).

3.3. The attendee role term of office would commence following the end of the current Governor term of office and cease once any legislative changes are made.

3.4. Should the changes take longer than anticipated, then the arrangement would be reviewed by the Council after 12 months in post. The right to reinstate the election process is reserved, should there be a significant delay in the legislation or change in planned policy.

3.5. The role description (Appendix 1) was considered by Membership, Governance and Development Committee at its last meeting in April 2026 and it is recommended that the Council approves the attendee role description.

4. Solutions / recommendations

4.1. The Council of Governors is requested to approve the Council of Governors Attendee role description following the recommendation of the Membership, Governance and Development Committee.

Appendix 1: Council of Governors Attendee Role Description

Eligibility and Appointment

The eligibility and appointment criteria for the Council of Governors Attendee role is reserved only for those Governors impacted by the decision to pause elections.

Duties of the Council of Governors Attendee

- This is a non-voting role, but attendees will be invited to participate in public and private Council of Governors meetings and Governor Committees / Groups (with the exception of the Governor Remuneration Committee and Board Committee observations

- To represent the voices of our communities and patients

Person specification

To be able to fulfil this role effectively the Council of Governors Attendee will:

- Have integrity in accordance with the Nolan Principles;

- Work in the best interest of patients and of the Foundation Trust in accordance with the Code of Conduct for Governors;

- Have an understanding of the Trust's Constitution;

- Be committed to the values of the Foundation Trust; and

- Be committed to representing the voices of our community, patients and colleagues.

UPDATES FROM GOVERNOR COMMITTEES AND GROUPS

13. Membership, Governance and Development Committee Assurance Report

To be presented by Steve Connolly, Lead Governor/Committee Chair

Committee Escalation and Assurance Report

Name of Governor Committee	Membership, Governance and Development Committee
Date of Governor Committee:	8 April 2026
Chair of Governor Committee:	Steve Connolly (Lead Governor)

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

- No issues of significant concern

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

- The Committee discussed the future role of Governors in light of the proposals within the NHS 10 year plan and options continue to be explored with other Alliance Trusts to develop a proposal for how the Trust might continue to ensure effective patient and community engagement. An informal private Governor meeting has been arranged to discuss this further and feedback will be provided at the next Governor workshop in June 2026.
- Similar discussion took place in relation to Trust membership, and the importance of continued engagement was recognised to gain views and intelligence.
- Updates were provided to the Committee in relation to PLACE visits and some concerns were raised following one of the visits. The importance of feedback in learning from the visits and to be assured that changes have been enacted was noted. The Committee acknowledged the importance of the visits to provide Governors with an active role, and this will be considered as part of future engagement plans.

Assure
(key assurances received and any highlights of note for the Council, including recommendations for items requiring Council approval / ratification)

- The Committee reviewed the Governor Attendee Role Description which has been developed following the decision to pause Governor elections in 2026/27. This is a non-voting role to enable those Governors impacted by the pause to continue to make an active contribution and represent the voices of our communities and patients. The Committee was in favour of the role and therefore has provided a recommendation to the Council of Governors to approve the role at its next meeting in May 2026.

• The Committee reviewed the results of the Council of Governors effectiveness survey which has demonstrated good assurance and there were no additional actions required.
Risks (any new risks / proposed changes to risk scores)

14. Governor Remuneration Committee Assurance Report

To be presented by Chris Toon, Committee Chair

Committee Escalation and Assurance Report

Name of Governor Committee	Governor Remuneration Committee
Date of Governor Committee:	15 April 2026
Chair of Governor Committee:	Chris Toon, Appointed Governor for Gateshead College

Alert ***(matters of significant concern requiring escalation to the Council for further action)***
• No issues of significant concern to alert the Council to.
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)***
• No advisory issues to note.
Assure ***(key assurances received and any highlights of note for the Council, including recommendations for items requiring Council approval / ratification)***
• The Committee reviewed and approved the appraisal process for the Chair and Non-Executive Directors (please see Appendix 1). It was highlighted that the appraisal approach continues to align to the NHS England Leadership Competency Framework. This has been adapted for local use and reflects learning from the 2024/25 cycle (including reducing duplication and the overall burden of completing feedback forms). It was noted that this also provides a streamlined, consistent approach to capture feedback on the Chair's Great North Healthcare Alliance role across Newcastle, Northumbria and Gateshead. **The Committee recommends that the process is ratified by the Council of Governors.**
Risks (any new risks / proposed changes to risk scores)

Appendix 1

Non-Executive Directors Appraisal Process

The Chair will be supported in the completion of NED appraisals by the Vice Chair prior to the recommended completion date of 30th September 2026. The proposed process is as follows (note the Vice Chair appraisal will be conducted by the Chair and follow the below process):

1. **Self assessment** (mid-May) - Non-Executive Directors will be asked to complete a self-assessment based on the appraisal preparation form.

2. **Multi-source assessment** (mid-May) – all Board Members will be asked to complete an assessment for each Non-Executive Director using the multi-source assessment feedback form.

   For Governors, the Lead Governor, supported by the Deputy Lead Governor, will host a private meeting with the Council to seek feedback on each domain area. The Lead Governor will then share themes and trends with the Vice Chair. This will be completed at the same time as Governors are asked for feedback on the Chair.

3. **Chair and Vice Chair meeting** (late May) – the Chair and Vice Chair to meet in late May to ensure that the Vice Chair can gather together any specific points of feedback / areas for discussion from the Chair and reflect these into the individual NED appraisals.

4. **Evaluation** (mid-June) – the Vice Chair will evaluate the collated assessment and self-assessments for each Board Member and prepare for the appraisals.

5. **Appraisal output** (late June to late-August) - the appraisals will take place ahead of the 30 September 2026 deadline using the NHS England appraisal summary form and assurance over the appraisal outcomes will be shared with the Governor Remuneration Committee in October 2026.

Chair Appraisal Process

The appraisal for the Chair is conducted by the Senior Independent Director (SID) prior to the national timescale for the completion and submission of Chair appraisals to NHS England Regional Directors by 30 June 2026.

As Sir Paul Ennals is the Chair of 3 FTs with separate legal contracts, as well as the Great North Healthcare Alliance, it is proposed that a Trust appraisal will take place with each Trust asking the same questions regarding the Chair's performance including in his

Alliance role. This aspect will then be reviewed by the SIDs collectively and a consistent summary of the Alliance feedback will be incorporated into each Trust appraisal.

The proposed process is therefore as follows:

1. **Self assessment** (early May) – the Chair will be asked to complete a self-assessment using the appraisal preparation form.

2. **Multi-source assessment** (early May) – all Board Members will be asked to complete an online survey which includes questions about the Chair's Alliance role and will be consistent across the 3 Trusts to enable a streamlined approach to the appraisals.

   Other key stakeholders will be approached to provide a view on the Chair's Alliance role with responses shared with the SIDs of all three Trusts to feed into the Alliance aspect of the appraisal.

   For Governors, the Lead Governor, supported by the Deputy Lead Governor, will host a private meeting with the Council to seek feedback on each domain area. The Lead Governor will then be requested to share themes and trends with the Senior Independent Director. With respect to the Alliance element of the role, Governors across all three trusts will be given the same prompts / questions to ensure parity. These are:

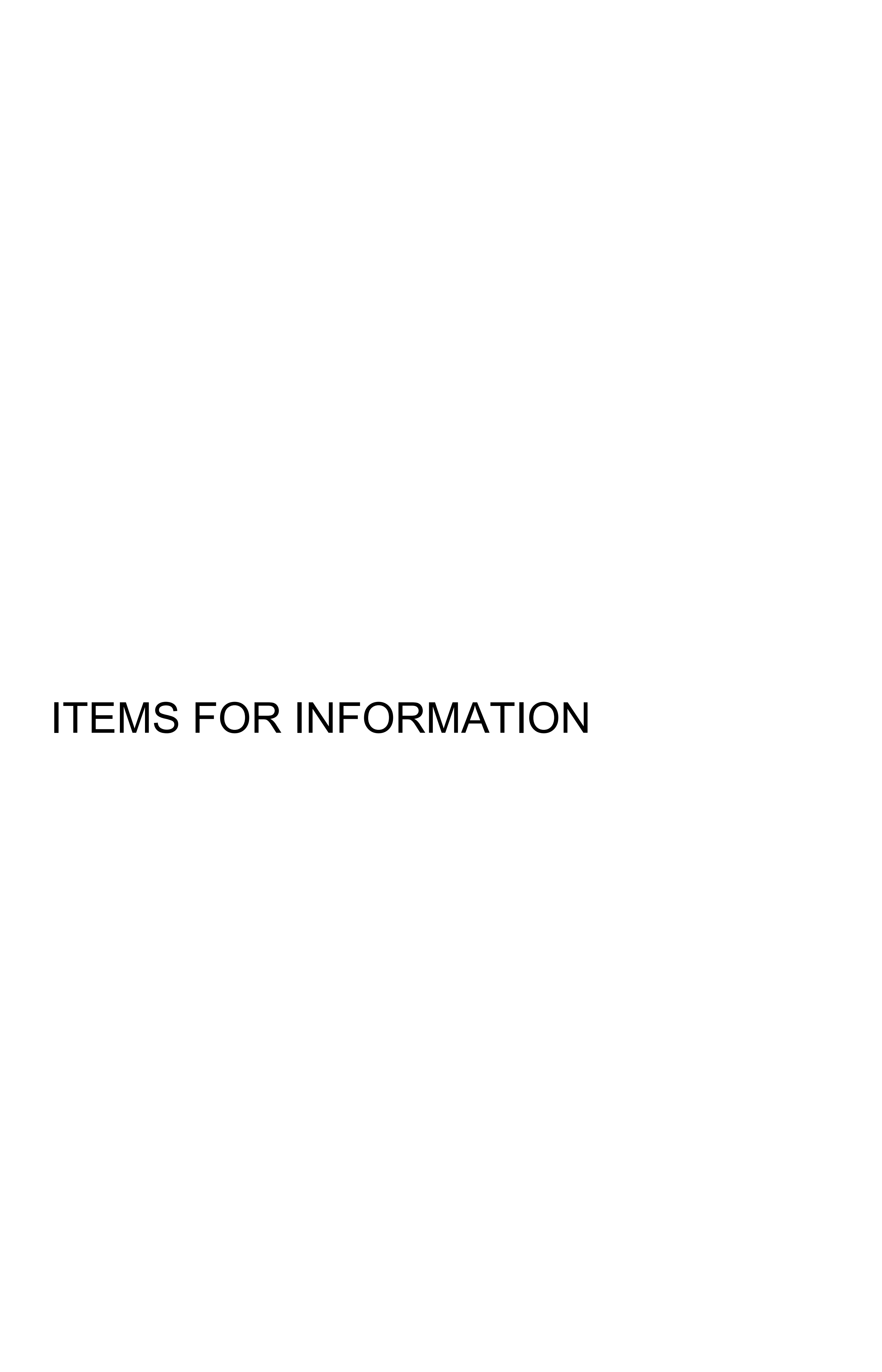
   - How does the Chair help Gateshead Health gain patient and staff benefits through the Alliance?
   - How effectively does the Chair shape the Trust's strategy while considering wider NHS and Alliance priorities?
   - How well does the Chair support collaboration and shared learning across Newcastle, Northumbria, and Gateshead?

   This aspect is completed at the same time as Governors are asked for feedback on the NEDs.

3. **Evaluation** (late May) – the SID will evaluate the collated assessment and self-assessments from each Board Member and prepare for the appraisals.

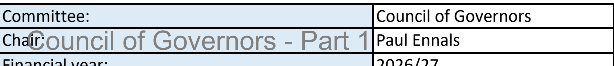
4. **SID meeting** (early June) – the three SIDs to meet to discuss the Alliance feedback from the multi-source assessment process and agree the key points to feed into each Trust appraisal from this respect.

5. **Appraisal output** (mid June) - the appraisal will take place ahead of the 30 June 2026 deadline using the NHS England appraisal summary form and assurance over the appraisal outcomes will be shared with the Governor Remuneration Committee in July 2026.



ITEMS FOR INFORMATION

15. Cycle of business 2026/27



Committee:	Council of Governors
Chair:	Paul Ennals
Financial year:	2026/27

Denotes an item for Part 2 of the meeting

	Lead	Purpose of item	May-26	Sep-26	Nov-26	Feb-27
Standing Items						
Apologies	Chair	For Information	√	√	√	√
Declaration of interests	Chair	For Information	√	√	√	√
Chair's business	Chair	For Information	√	√	√	√
Minutes	Chair	For Decision	√	√	√	√
Action log & matters arising	Chair	For Assurance	√	√	√	√
Cycle of business	Chair	For Information	√	√	√	√
Meeting review / reflections	Chair	For Discussion	√	√	√	√
Board and Committee Updates						
Chief Executive's Update* including ICS / ICB updates	Chief Executive	For Assurance	√	√	√	√
Governor Dashboard	Chief Executive	For Assurance	√	√	√	√
People and OD Committee Report	Committee Chair	For Assurance	√			√
Quality Governance Committee Report	Committee Chair	For Assurance			√	
Finance & Performance	Committee Chair	For Assurance			√	
Audit Co (including Audit Committee Annual Report and Terms of Reference)	Committee Chair	For Assurance	√			√
Digital Committee	Committee Chair	For Assurance		√		
Charitable Funds	Committee Chair	For Assurance		√		
Trust Updates Including Strategy						
Patient / staff story / service showcase	Various	For Assurance	√	None due to AGM	√	√
Speech and Language Therapy Services		For Assurance	√			
ICS / ICB update presentation	ICB	For Discussion				
QE Facilities	QEF Board Chair / QEF Managing Director	For Assurance			√	
NHS Staff Survey results	Director of People & OD / Chair of the HR Committee	For Assurance	√			
Governors response to Quality Accounts	Chief Nurse	For Decision	√			
Annual planning update	Director of Strategy and Planning	For Assurance				√
Equality, diversity and inclusion update	Group Executive Director of People and OD	For Assurance		√		
Great North Healthcare Alliance updates	Chair and CEO	For Assurance	√	√	√	√
Governance						
Review of Constitution	Company Secretary	For Decision	Deferred	√		
Non-Executive Director appointments	Chair	For Decision	Ex-ord meeting			√
Performance appraisal and assessment outcomes - Chair and Non-Executive Directors	Chair (for NEDs) Senior Independent Director (For Chair)	For Assurance		√		
Council of Governors' Register of Interests	Company Secretary	For Decision				√
Council of Governors' Annual Effectiveness Survey - Results	Company Secretary	For Discussion				√
Ratification of the terms of reference for Governor groups	Company Secretary	For Decision				√
Lead Governor & Deputy Lead Governor Appointments	Company Secretary	For Decision	not required			√
Appointments to Governor committees (every two years)	Company Secretary	For Information			√	
Annual report, accounts and auditor's report. NOTE this is addressed via the AGM	*Executive Directors (co-ordinated by Company Secretary)*	*For Information*		√		
Appointment of external auditors (2025/26)		*For Decision*				
Elections and Members						
Election update	Company Secretary	For Information		paused		
Election results / new Governor welcome	Chair	For Information				
Updates from Governor Committees and Groups						
Membership, Governance and Development Committee	Chair of the Group	For Assurance	√	√	√	√
Governor Remuneration Committee	Chair of the Group	For Assurance	√	√	√	√

16. Top 3 messages

17. Any Other Business

18. Review of the meeting

19. Date and time of the next meeting

The next meeting of the Council of Governors will be held at 10.00am on Wednesday 30 September 2026