Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 2d

Report Title:	**Board Committee Effectiveness Reviews – Finance and Performance Committee and Quality Governance Committee**
Name of Meeting:	Board of Directors
Date of Meeting:	29 July 2026
Author:	Company Secretary
Sponsors:	Group Director of Finance Chief Nurse Medical Director Committee Chairs
Report presented by:	Company Secretary
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒ **Discussion:** ☐ **Assurance:** ☒ **Information:** ☐ To provide assurance over the effectiveness of the Finance and Performance Committee and Quality Governance Committee
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☒ *No gaps in assurance* · **Partially assured** ☐ *Some gaps identified* · **Not assured** ☐ *Significant assurance gaps* · **Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Finance and Performance Committee – April 2026 Quality Governance Committee – April 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*	**Finance and Performance Committee – Appendix 1** • The review provides evidence of good compliance with the terms of reference with some ongoing actions identified to address the areas of non-compliance. • Minor amendments are proposed to the terms of reference to bring them up to date with current Committee practice. • There are no financial implications or additional risks identified from this paper. **Quality Governance Committee – Appendix 2**

<table>
<tr><td></td><td colspan="2">The review provides evidence of good compliance with the terms of reference.
Minor amendments are proposed to the terms of reference to bring them up to date with current Committee practice.
Some areas for consideration regarding the flow of assurance to the Committee are highlighted – clinical audit, surveys and learning disability patient care.
There are no financial implications or additional risks identified from this paper.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="2">It is recommended that the Board is assured by the outcome of the effectiveness reviews, noting the high level of compliance with the terms of reference in both cases.</td></tr>
<tr><td rowspan="4">Trust strategic priorities that the report relates to:</td><td>☒</td><td>Excellent patient care</td></tr>
<tr><td>☐</td><td>Great place to work</td></tr>
<tr><td>☒</td><td>Working together for healthier communities</td></tr>
<tr><td>☒</td><td>Fit for the future</td></tr>
<tr><td>Trust strategic objectives that the report relates to (2025 to 2030 strategy):</td><td colspan="2">1. We will be a clinically-led organisation focused on delivering safe, high-quality care and improving health outcomes for our patients
2. We will ensure our patients experience the best possible compassionate care and make every contact count
3. We will continually improve our services creating a restorative culture where learning, innovation and research can flourish
7. We will work in collaboration with our partners to improve the health of our population and reduce health inequalities
10. We will ensure effective and efficient use of our resources identifying opportunities to improve productivity and ensure the best use of public money
12. We will focus on productive utilisation of our estate to facilitate care in the right setting and providing our services in an environmentally sustainable way</td></tr>
</table>

Links to CQC Key Lines of Enquiry (KLOE):	Caring ☐	Responsive ☒	Well-led ☒	Effective ☒	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	None directly linked to this paper				
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐		**No** ☐		**Not applicable** ☒

APPENDIX 1 - Finance and Performance Committee Effectiveness Review

1. Executive Summary

1.1. This paper presents the 2025/26 effectiveness review of the Finance and Performance Committee and provides assurance on the Committee's operation against its terms of reference.

1.2. Overall compliance is good. The review confirms that key standing items (including strategic objectives/constitutional standards, and review of the Organisational Risk Register and Board Assurance Framework) were routinely considered and that most members/regular attendees achieved the expected 75% attendance threshold (with two exceptions, one of which was due to a period of absence).

1.3. A small number of terms of reference requirements were not met in full during the year, including: the absence of divisional finance exception reports; reporting on material contracts beyond QEF; reduced flow of Financial Planning and Performance Assurance Group (FPPAG) 3A reports; and the investment strategy not being reviewed within the last 12 months.

1.4. Minor amendments are proposed to update the terms of reference so they reflect current Committee practice and reporting lines. The Committee is asked to (i) note the outcome of the effectiveness review, (ii) approve the updated terms of reference for recommendation to the Board for ratification, and (iii) note the proposed follow-up actions, including scheduling an investment strategy review early in 2026/27 and continuing to strengthen contract governance and assurance reporting.

2. Introduction

2.1. It is good practice for formal committees and groups to review their effectiveness on an annual basis. This is also incorporated into the terms of reference.

2.2. The term of reference were last reviewed in July 2025, but this did not include a review of the effectiveness of the Committee or its compliance with the terms of reference due to anticipated changes to the Board committees at that time.

3. Attendance

3.1. As per the terms of reference there are 7 members of the Committee and 5 regular attendees. The terms of reference state that members and attendees are expected to achieve 75% attendance annually.

3.2. A review of attendance for 2025/26 demonstrates that of the current members / regular attendees most achieved the 75% attendance rate or higher. There were

only two exceptions to this (one member and one attendee, who was absent from work for a period of time and hence the rationale is understood).

4. Terms of reference

4.1. A review of compliance has been conducted to compare the terms of reference and the work undertaken by the Committee in 2025/26:

Domain	Responsibilities per the terms of reference	Assessment of compliance from the review of agendas
Strategy, Planning and Risk	• Scrutiny of the adequacy of the Trust's financial, operational, capacity and demand estimates, forecasts and planning assumptions. • Assurance over delivery of national/local strategies • Oversight of strategic objectives • Review of Board Assurance Framework (BAF) • Review of Organisational Risk Register (ORR) • Assurance over the delivery of specific major strategic projects.	• The Strategic Objectives and Constitutional Standards report has been reviewed at every meeting of the Committee. • The ORR and the BAF have been reviewed at every meeting (except in August when the new BAF was under development), with evidence that the discussions on risk influenced scoring. • The Committee played an integral role in seeking assurance around the development of the medium term plan. This included consideration of the higher risk assumptions or deviations from national / regional expectations which then enabled the Committee to make a recommendation to the Board for approval. • The Committee also played a key role in reviewing major strategic proposals and making appropriate recommendations to the Board, for example in relation to Phase 2 of the Community Diagnostic Centre (CDC).
Finance	• Review and monitor the Trust's contractual performance • Scrutiny of the monthly consolidated finance report • Review exception reports from divisions and seek assurance over recovery plans • Review a register of contracts and seek assurance over the performance of those deemed to be material	• The Committee received the monthly financial report at each meeting for assurance. • The Committee has received a number of reports on the higher risk elements of the Trust's financial position / performance, including specific reports on the cash and CRP positions. • It is noted that divisional exception reports have not been presented to the Committee, although the routine finance report does disaggregate performance against delegated budgets and CRP performance by division. *It is for the Committee to determine whether this approach*

Domain	Responsibilities per the terms of reference	Assessment of compliance from the review of agendas
		provides it with sufficient assurance over financial performance (noting that new performance meetings with divisions are being established in the governance structure). • The governance around contracts has already been identified as an area for strengthening (as reflected in recent Board discussions on the Aubrey report). It is noted that the Committee has not reviewed a register of contracts or other assurance items relating to the performance of key contracts (other than with QEF). • The Committee has been appraised of the work being undertaken on block contract deconstruction in line with the national requirements. In addition in March 2026 the Committee approved the 2026/27 Provider Selection Regime NHS Provider Direct Award Contracts and recommended them for Board ratification. • It is noted that the 3A reports from the tier 2 Financial Planning Performance and Assurance Group (FPPAG) have not flowed to the Committee as frequently as outlined in the cycle of business. This is primarily due to FFPAG meetings being stood down during the year. Under the revisions to the governance structure it has been identified that FFPAG as a group will be disbanded and financial assurance will flow via the new Sustainability Group.
Capital and Investment	• Receive quarterly reports and monitor progress against the capital plan • Review the Trust's investment strategy at least annually • Review and discuss any significant initiatives, projects and issues that impact financially • Review of business cases in accordance with delegated limits	• Progress against the capital plan has been routinely covered within the monthly finance report. • In addition to this the Committee has received specific reports on major capital projects and made subsequent recommendations to Board where required. This includes but is not limited to: the CDC, gamma camera and theatres ventilation projects. • Linked to this the Committee has reviewed a number of capital business cases and associated contract awards

Domain	Responsibilities per the terms of reference	Assessment of compliance from the review of agendas
	• Receive assurance reports from the Supplies and Procurement Group	during the year. This includes the examples referenced above plus backlog maintenance and X-ray capital schemes. • The Committee has not reviewed the investment strategy within the last 12 months. • Assurance reports from the Supplies and Procurement Group no longer flow to the Committee, but are received at the Executive Committee (and previously to Gateshead Health Leadership Group).
Performance	• Review the leading indicators and elective recovery reports • Monitor capacity, demand and delivery of national standards	• The Committee has received regular 3A reporting from the Operational Oversight Group. • As noted previously the Strategic Objectives and Constitutional Standards report has been reviewed at every meeting of the Committee. • The Committee received exception reporting to provide assurance over the actions taken to address the Picture Archiving and Communication (PACs) critical incident, as well as deep dives into Urgent and Emergency Care 4 and 12 hour standards. •
Subsidiary Governance	• Seek assurance over the Trust's subsidiary, QE Facilities, against its contract with the Trust • Monitor the impact of the Subsidiary on Group financial performance • Review and recommend the Green Plan for formal ratification and seek assurance over the delivery of the Green Plan twice a year.	• The Committee received QEF finance assurance reports in May, July, September, January and March. The report details financial performance against QEF's contract with the Trust as well as overall QEF financial performance. • It is noted that wider non-financial QEF performance is not reported to this Committee, nor is that the intention (wider assurance flows from QEF Board to Trust Board and well as through the contract monitoring meetings). The wording of the terms of reference should be revised to reflect this. • The Committee has considered a number of items linked to the Green Plan during the year including the output of the external environmental

Domain	Responsibilities per the terms of reference	Assessment of compliance from the review of agendas
		sustainability governance report and the updated Green Plan (which was subsequently approved at Board). • The Committee also considered the Premise Assurance Model (PAM) self-assessment in August. The PAM is an NHSE mandatory self-assessment which assesses estates and facilities management. It is required to be submitted to NHSE annually. The PAM had not previously been considered at the Committee or formally signed off by the Trust Board – this represented a gap in governance which was addressed in 2025/26.
Regulatory and Governance	• Receive internal audit reports • Review feedback from NHS England • Review emerging regulatory guidance/requirements	• Internal Audit reports and a recommendations monitoring report have been routinely included on the agendas throughout the year. • From a governance / regulatory perspective the Committee also considered reports on the new NHS Oversight Framework (NOF) ratings, as well as the output of the regional financial sustainability audit in June 2025.

4.2. Overall compliance is good, however the review identified a small number of exceptions to the terms of reference. In summary they are:

- the absence of divisional finance exception reports (with reliance instead on the disaggregated routine finance report). **It is for the Committee to determine whether this provides sufficient oversight of exceptions**;
- the Committee not having reviewed a contracts register or assurance on material contracts beyond QEF (already recognised as a gap with a plan to strengthen contract governance and functions);
- 3A reports from FPPAG not flowing as frequently as anticipated due to meetings being stood down (with assurance expected to transition via the new Sustainability Group);
- the investment strategy has not been reviewed within the last 12 months. **It is recommended that this is reviewed by the Committee in early 2026/27 to satisfy this requirement**;
- assurance reports from the Supplies and Procurement Group now flow to the Executive Committee rather than this Committee; and
- wider non-financial performance of QEF is not reported to the Committee, but nor should it (requiring the terms of reference wording to be updated to reflect intended assurance routes).

4.3. Based on this assessment of compliance and a full review of the terms of reference the following additional updates are proposed as shown in the amended terms of reference:

- To note that the Executive Director of People and OD is now a member of the Committee.
- To note the expected attendance of the Vice Chair when the Chair is unable to attend (although welcome to attend all meetings);
- Clarification that QEF colleagues only need to attend to present their related agenda items, rather than routinely;
- Clarification that on an exception basis the Chair can be counted for quoracy purposes if there are no alternative options (the Chair is usually an attendee rather than a member);
- Removal of references to specific supporting strategies, given that the Trust has moved away from this approach – the 5 year strategy contains relevant chapters rather than a suite of supporting strategy documents;
- Removal of reference to Supplies and Procurement Committee reporting to F&P – noting that issues of non-compliance with the Standing Financial Instructions should actually be reported to the Group Audit Committee;
- Updates to list of groups which have a reporting line into F&P Committee; and
- Minor adjustments to terminology throughout.

5. Recommendations to the Finance and Performance Committee

5.1. It is recommended that Finance and Performance Committee members and attendees are assured by the outcome of the effectiveness review, noting the good level of compliance with the terms of reference and the plans in place to strengthen the areas highlighted (such as contracting).

5.2. The Committee is asked to (i) note the outcome of the effectiveness review, (ii) approve the updated terms of reference for recommendation to the Board for ratification, and (iii) note the proposed follow-up actions, including scheduling an investment strategy review early in 2026/27 and continuing to strengthen contract governance and assurance reporting.

6. Post meeting summary

6.1. The Committee concurred with the recommendations contained within the paper and approved the updated terms of reference for ratification at Board subject to two amendments:

- Final verification of the Tier 2 groups reporting to the Committee; and
- The inclusion of an assurance role for the Committee over strategic estates related issues / projects.

6.2. Both items were incorporated into the version of the terms of reference presented for Board ratification in July 2026.

Appendix 2 - Quality Governance Committee Effectiveness Review

1. Executive Summary

1.1. The annual effectiveness review confirms the Quality Governance Committee operated effectively in 2025/26, demonstrating good compliance with its Terms of Reference and providing a high level of assurance over quality governance.

1.2. Minor updates to the Terms of Reference are proposed to align governance documentation with current Committee membership/attendance arrangements and the evolved cycle of business.

1.3. The Committee is asked to approve the updated Terms of Reference for recommendation to the Board, and to note the key assurance flow areas highlighted for further consideration (clinical audit assurance, survey learning, and learning disability patient care reporting).

2. Introduction

2.1. It is good practice for formal committees and groups to review their effectiveness on an annual basis. This is also incorporated into the terms of reference.

2.2. The term of reference were last reviewed in July 2025, but this did not include a review of the effectiveness of the Committee or its compliance with the terms of reference due to anticipated changes to the Board committees at that time.

3. Attendance

3.1. As per the terms of reference there are 5 members of the Committee and 6 regular attendees. The terms of reference state that members and attendees are expected to achieve 75% attendance annually.

3.2. A review of attendance for 2025/26 demonstrates that of the current members / regular attendees most achieved the 75% attendance rate or higher. There were only two exceptions (one member and one attendee), both reaching 57% attendance (i.e. 4 out of 7 meetings). This is not considered to be a significant deviation from expected attendance.

3.3. It is noted that the terms of reference refer to the attendance of the Associate Director of Nursing for Mental Health, Learning Disabilities, Patient Safety and Patient Experience. This post does not exist and should be removed from the terms of reference.

3.4. A review of attendance also identifies a number of other observations:

- The Associate Director Midwifery is included as an attendee in the terms of reference. In reality the Associate Director of Midwifery is only required to attend for the maternity-related agenda items and therefore this should be clearly explained in the terms of reference to appropriately distinguish this from the attendees who are expected to attend for the whole meeting;
- The Chair now attends Quality Governance Committee routinely and therefore could be included as an additional attendee (on an exception basis the Chair can be counted for quoracy purposes if there are no alternative options); and
- The Chief Executive also attends routinely and can be included as a member.

4. Terms of reference

4.1. The Quality Governance Committee terms of reference were last reviewed in February 2025 and approved by the Trust Board in March 2025. This review of compliance has been conducted against these Terms of Reference and covers the meetings from April 2025 to March 2026 (i.e. the 2025/26 financial year).

Domain	Responsibilities	Commentary
Strategy, Planning and Risk	• Assurance over assurance over the delivery of the **strategic objectives** • Assurance over the delivery of **national and local-level strategies** • Assurance over actions taken to address strategic emerging **quality-related developments / issues** • Review of Board Assurance Framework (**BAF**) • Review of Organisational Risk Registers (**ORR**) • Assurance over compliance with the Emergency Preparedness, Resilience and Response (**EPRR**) standards	• The **Strategic Objectives and Constitutional Standards report** has been reviewed at every meeting of the Committee. • The Committee has taken a lead role in seeking assurance over the development and delivery of the **Quality Account** and its associated priorities, with related agenda items being presented in May, July and February. • The **ORR and the BAF** have been reviewed at every meeting (except in August when the new BAF was under development), with evidence that the discussions on risk influenced scoring. • The **Chief Nurse and Medical Director each prepare strategic updates** which are presented early in the agenda and draw the attention of members and attendees to key items of strategic importance (which are then outlined in more detail through linked agenda items). This supports the Committee to prioritise its time on the key areas outlined in this reports. • The **ICB** also routinely provided a verbal strategic overview, which

Domain	Responsibilities	Commentary
		provides a wider external strategic update and viewpoint to inform Committee discussions. • An **EPRR assurance report** was presented to the Committee in August and February. The reports provided assurance over the process and outputs of the Core Standards compliance annual submission.

Safety	• Scrutiny of the Leading Indicators Report.
	• Assurance that the Trust has effective **systems for safety**
	• Assurance regarding compliance with **safe staffing** levels and well as the outcome from the Safer Nursing Care Tool
	• The robustness of procedures to ensure that adverse **incidents** and events are detected, openly investigated, with lessons learned being promptly applied
	• assurance that the Trust embeds **learning from deaths**
	• assurance that the Trust appropriately responds to requests and requirements from **coroners and other regulatory bodies** in respect of patient safety
	• assurance over **health and safety** compliance
	• reporting from **SafeCare Steering Group** on medicines, medical devices, infection prevention and control
	• assurance that **safeguarding** is compliant with national and local requirements
	• assurance on **maternity services** bi-monthly through the maternity oversight report.
		• The **Strategic Objectives and Constitutional Standards report** has been reviewed at every meeting of the Committee. This includes the Leading Indicators.
		• From July 2025 onwards the Committee reviewed a **Quality and Safety report** at each meeting. This outlines performance against a range of metrics, including a suite of safety metrics.
		• The Committee has received some **exception / deep dive reports** during the year to seek additional assurance over areas of concern. This has included Surgical Site Infections (SSIs) and cancer recovery.
		• **Safe Staffing** reports have been included on every agenda during the year, including updates on maternity staffing (e.g. July) and neonatal staffing (e.g. August).
		• A number of reports considered throughout the year focussed on **incident management and learnings**, including:
		  • A Patient Safety and Learning report in May and July 2025;
		  • Updates from the new Incident Learning and Oversight (iLOM) meeting and thematic incident trends included in the Quality and Safety Report; and
		  • Falls updates in July and August.
		• The Committee received **learning from deaths** and medical examiner reports throughout the year (noting that the data from Q1 and Q2 were provided together in November, rather than Q1 being presented on a more timely basis). **Coronial matters** have been included in the Quality and

Domain	Responsibilities	Commentary
	• assurance that quality and safety concerns raised via **Freedom to Speak Up** are appropriately addressed and lessons learned.	Safety report's accompanying narrative. • The Committee has received **health and safety** reports throughout the year. This has included the 3A reports from Health and Safety Group, quarterly health and safety reports and an annual health and safety report. • The 3A reports from SafeCare Steering Group have been formally presented to the Committee throughout the year. In addition, each agenda has included time for a SafeCare discussion from a division on a cyclical basis, including a dedicated item for QE Facilities. • The Committee has received the **safeguarding** annual report 2024/25 in November, with a revised version presented in February 2026 following discussion at the Clinical Safeguarding Group. Other related reports have included the Children in Care Annual Report presented in August. An overview of safeguarding concerns has also been included in the Quality and Safety Report throughout the year. • At each meeting there is a dedicated section on **maternity** performance. This has routinely included the Maternity Oversight Report, but there are also examples throughout the year of exception reporting – for example caesarean section deep dive, LMNS safety concerns and a Reg 28 homebirth update. • **Freedom to Speak Up** reports were presented to the Committee in November and December (noting that the reports were scheduled closer together than planned due to the August report being deferred).
Patient Experience	• The **Leading Indicators Report** will be used to provide an overview of aspects of patient experience metrics	• The Strategic Objectives and Constitutional Standards report has been reviewed at every meeting of the Committee. This includes the **Leading Indicators**.

Domain	Responsibilities	Commentary
	• assurance that the Trust has effective **systems for delivering a high quality experience** for all its patients and users • robust systems for learning lessons from complaints and sharing good practice identified through compliments and patient feedback. • assurance that the Trust is delivering high quality care for patients with learning disabilities via SafeCare reporting. • embedding of good practice or improvement actions resulting from patient surveys • address health inequalities	• From July 2025 onwards the Committee reviewed a **Quality and Safety report** at each meeting. This outlines performance against a range of metrics, including a suite of patient experience metrics. The accompanying narrative report includes a section on patient experience which identifies themes and trends and the overall patient experience position. • The Committee has not considered any specific reports on the delivery of care to patients with **learning disabilities**. The ToR details that assurance should flow from SafeCare Steering Group. A review of the 3A reports identifies reference to staffing and recruitment in the June report, but no further references are made during the year. • There has been a dedicated agenda item on **survey outcome** reports on most meeting agendas. At most meetings there has been nothing to report under this item, but the Cancer Inpatient Survey was presented to the August meeting. Friends and Family Test (FFT) outcomes have been reported via the Quality and Safety Report. It is noted that other reports, such as the CQC maternity survey were not presented in full as part of this agenda item (although a high level summary was provided as part of the Maternity Integrated Oversight Report). This indicates that there may be scope to utilise this agenda item to greater effect to share both good practice and learnings from surveys. • **Health inequalities** updates were received in May, August and December.
Clinical effectiveness, leadership and training	• The Leading Indicators Report will be used to provide an overview of aspects of clinical effectiveness • assurance that the Trust has effective systems for	• The Strategic Objectives and Constitutional Standards report has been reviewed at every meeting of the Committee. This includes the **Leading Indicators**. • Clinical effectiveness features in the **Quality and Safety** report, which

Domain	Responsibilities	Commentary
	monitoring clinical outcomes and clinical effectiveness • Assurance over the effective engagement of clinical leads in quality improvement initiatives • Assurance that clinical audit processes support effective clinical practice via escalations from the Safecare Steering Group	provides statistics on clinical audits and Getting It Right First Time (GIRFT) and NICE guidance and clinical guidelines. • The Committee did previously receive bespoke reports on the delivery of the clinical audit plan. These are now presented at a lower level within the governance structure. It is for the Committee to determine whether the current reporting via the Quality and Safety report and via 3A reporting from SafeCare provides sufficient assurance over this area (noting the Audit Committee receive reports on clinical audit controls and processes).
Regulatory and Governance	• compliance with core regulatory standards • seeking assurance that the Trust's annual Quality Account is compliant with regulatory requirements • the robustness of quality-assurance processes relating to research • Internal Audit Report • Reports from external reviews • Emerging regulatory guidance/requirements	• As outlined earlier, the Committee has discharged its responsibilities regarding the Quality Account. • Internal Audit reports have been routinely included on the agendas throughout the year. It is recommended that a report tracking the implementation of actions arising from the these reports is included on future agendas (similar to the tracking report presented at People and OD Committee and Finance and Performance Committee). • Reports from external visits feature as a standing agenda item.

4.2. The assessment concludes that the Committee has good overall compliance with its responsibilities (and therefore provides a high level of assurance against the Terms of Reference for 2025/26), evidenced by regular scrutiny of key reports and standing agenda items across the main domains.

4.3. Gaps in compliance (as identified in the effectiveness review) are minor and relate mainly to assurance flow, timeliness, and keeping the Terms of Reference aligned to practice:

- Patient experience – learning disabilities. Coverage via Safecare's 3A report has been limited. It is not clear that the Committee has therefore received sufficient information to be assured that the Trust is delivering high quality care for patients with learning disabilities. ***Consideration should therefore be given to whether more bespoke reporting is required to discharge this responsibility***;

- Patient experience – surveys: A standing survey outcomes agenda item often had “nothing to report”; some surveys (e.g. CQC maternity survey) were not presented in full (only summarised elsewhere), suggesting the item could be used more effectively to share learning and good practice;
- Clinical effectiveness – clinical audit assurance: the Committee no longer receives bespoke clinical audit plan reports (now handled lower in the governance structure). ***The Committee should consider whether current reporting provides sufficient assurance***.
- Safety – timeliness of learning-from-deaths reporting: Q1 and Q2 data were provided together in November, rather than Q1 being reported in a more timely way.
- Safety – FTSU scheduling: one FTSU report was deferred, resulting in reports being scheduled closer together than planned.
- Regulatory/governance – internal audit follow-up: while internal audit reports were received, it is recommended to add an action implementation tracking report to strengthen assurance that actions are completed.
- Terms of Reference accuracy: the ToR includes references that don’t match current roles/practice (e.g., a role that does not exist, and attendance expectations that differ in practice for some attendees), requiring updates to avoid governance misalignment.

4.4. Based on this assessment and a full review of the terms of reference the following updates to be terms of reference are recommended:

- Internal audit follow-up: add an Internal Audit action implementation tracking report to future agendas to provide assurance that actions are completed and overdue items are escalated appropriately.
- As the Trust provides older person’s mental health services, it is important to ensure that assurance over the delivery of these services flows to Quality Governance Committee. A new Mental Health Integrated Report is now presented to the Committee to support this – the terms of reference require updating to reference this.
- As outlined on the BAF, a gap has been identified in relation to assurance over the Equality and Quality Impact Assessment (EQIA) process flowing to the Committee. This will now be covered in the Interim Chief Nurse’s report. Reference should be made to this within the terms of reference.
- Terms of Reference alignment: update as per section 3 of the report to remove non-existent roles and clarify attendance/quoracy arrangements so that governance documentation reflects how the Committee operates in practice.

5. Recommendations

5.1. It is recommended that Quality Governance Committee members and attendees are assured by the outcome of the effectiveness review, noting the good level of compliance with the terms of reference.

5.2. Members are requested to review and approve the terms of reference (Appendix 1) noting the proposed changes highlighted on the document and to consider the areas highlighted in the paper for further consideration (coverage of learning disabilities, clinical audit and survey outputs).

6. Post meeting summary

6.1. The Committee concurred with the recommendations contained within the paper and approved the updated terms of reference for ratification at Board subject to two amendments:

- The inclusion of the Associate Medical Director for Quality and Safety as an attendee; and
- Final verification of the Tier 2 groups reporting to the Committee.

6.2. Both items were incorporated into the version of the terms of reference presented for Board ratification in July 2026.

Initial Ockenden Nottingham report & National Maternity & Neonatal review

North East and North Cumbria
Local Maternity and Neonatal System

1st July 2026
PPSLN

FINDINGS, CONCLUSIONS AND ESSENTIAL ACTIONS from the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust

Published 24 June 2026

Findings, conclusions and essential actions from the independent review of maternity services at Nottingham University Hospitals NHS Trust

1. Listening to Women & Families
IEA 1: Strengthening women-centred communication and informed choice

2. Workforce Planning & Safe Staffing
IEA 2: Support a nationally agreed perinatal workforce planning methodology as a critical enabler of perinatal improvement at pace and scale

3. Training & Multi-Professional Learning
IEA 3: National IEA for Labour Ward Coordinator Role
IEA 4: All trusts must support Training for Midwives in the use of Speculum Examination
IEA 5: Enhanced Maternal Care

4. Risk Assessment Throughout Pregnancy

IEA 6: Delivering Safe, Personalised and Equitable Maternity Care Through Early Risk Recognition, Coordinated Care and Responsive Services

IEA 7: National standard for standardisation and recording of fetal growth risk assessment

IEA 8: There must be a national standard and documentation for maternity triage and record keeping in maternity care provision

IEA 9: Support the development and implementation of a structured assessment framework for the latent phase of labour, ensuring clarity when the ‘latent phase of labour’ becomes abnormal requiring escalation

IEA 10: All Trusts must define criteria for the safe use of telephone postnatal follow-up, indicating when telephone follow-up is acceptable or when face-to-face follow-up is mandatory

IEA 11: National standard for obstetric anaesthetic record-keeping

IEA 12: Safe, accessible and comprehensive maternity anaesthetic documentation

IEA 13: DHSC/NHSE should introduce and support access to coordinated multidisciplinary debrief and psychological support

5. Incident Investigation & Family Involvement
IEA 14: Funding for implementation of Maternity Patient Safety Incident Reporting Framework (PSIRF)

6. Governance & Board Accountability
IEA 15: Strengthened multidisciplinary governance and learning

7. Culture, Teamwork & Psychological Safety
IEA 16: Foster a compassionate, psychologically safe, and learning culture
IEA 17: DHSC/NHSE should recommend and support recruitment processes and implement a consistent onboarding package for new starters

8. Mothers Who Have Died and Post Death Care
IEA 18: 1. All Trusts to ensure compliance, audited annually, with the NHS Records Management Code of Practice (2023)
Post-Death Care

National response

North East and North Cumbria
Local Maternity and Neonatal System

- Roll out of Martha's Rule to all maternity and neonatal settings in England
- Strengthening candour and cooperation in future reviews
- Human Tissue Authority (HTA) action requiring all Trusts to review mortuary records

National Maternity and Neonatal Investigation

North East and North Cumbria
Local Maternity and Neonatal System

Independent Investigation into Maternity and Neonatal Services in England
Final report and recommendations

Published 30 June 2026

WEBSITE_NMNI-Final-Report-and-Recommendations.pdf

1. The Department of Health and Social Care (DHSC) must create a statutory Maternity and Neonatal Commissioner, introducing legislation into the Health Bill at the earliest possible opportunity, and appointing a Commissioner within six months of Royal Assent.
2. DHSC, NHSE, Integrated Care Boards (ICBs) and NHS trusts must take action to listen to the voices of women, birthing people and families within 12 months.
3. DHSC, NHSE and CQC must drive improvement, within 12 months, of the quality, transparency, oversight and accountability of investigations and ensure learning is captured and acted upon when things go wrong.
4. DHSC/NHSE must design a Modern Service Framework for maternity and neonatal services within 12 months and begin rollout within 18 months.

5. DHSC, NHSE, ICBs, NHS trusts, the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) must treat racism, discrimination and inequality as a critical maternity safety issue – within 12 months, with work starting immediately.

6. DHSC/NHSE must clarify existing system governance, oversight and accountability structures and improve the effectiveness of regulatory oversight within nine months.

7. DHSC, NHSE, ICBs and NHS trusts must work with colleges, universities, post graduate educators and others to improve culture and teamworking, and strengthen leadership at all levels of the system and across professions within 12 months.

8. DHSC/NHSE must deliver estates and digital systems that are fit for modern maternity and neonatal care with 12-month, five-year and 10-year investment commitments and implementation deadlines.

National response

North East and North Cumbria
Local Maternity and Neonatal System

- NHS England leadership event – CEOs, Chief Nurses, Medical Directors
- 30th June 2026

Letter from Jim Mackey

- 10 point plan for maternity and neonatal services – set of urgent actions to support and report into the National Maternity and Neonatal Taskforce
- National Action Plan – published December 2026
- Reporting template – to be shared soon
- £10.6m in 2026/27 – recruitment of NQMs
- Creation of Maternity and Neonatal Commissioner
- £41m investment into estates

National response – Urgent Actions

North East and North Cumbria
Local Maternity and Neonatal System

1. Listening to women & families – roll out of Martha's Rule
2. Listening to women & families using real-time reported outcomes – experience & clinical audit data – Board level action
3. Dual board-level accountability between MDs & CNs – DOMs & CDs should attend Board
4. "Amos into action" staff listening exercise
5. Addressing inequalities in maternity & neonatal outcomes
6. Ensuring 24/7 safety & responsiveness
7. Trusts to review their homebirth service
8. Responding to patient safety incidents, complaints & concerns with humanity, candour & trauma-informed response
9. Deliver safe & effective triage
10. Post-death care