Board of Directors - Part 1

Schedule	Wednesday 29 July 2026, 9:30 AM — 12:00 PM BST
Venue	Room 3 / Teams
Organiser	Diane Waites

Agenda

AGENDA

NHS Gateshead Health NHS Foundation Trust

Board of Directors (Part 1 – Public)

A meeting of the Board of Directors (Part 1 – Public) will be held at 9:30am on Wednesday 29th July 2026, in Room 3, Education Centre, Queen Elizabeth Hospital / via Microsoft Teams

AGENDA

No	Start time	Item	Purpose	Lead	Paper / Verbal
1. OPENING MATTERS					
a	09:30	Welcome and apologies for absence	Information	Chair	Verbal
b	09:32	Declarations of interest	Information	Chair	Verbal
c	09:33	Minutes of the last meeting held on 27 May 2026	Decision	Chair	Paper
d	09:34	Action log and matters arising	Assurance / decision	Chair	Paper
e	09:35	Top Organisational Risks	Information	Chair	Paper
f	09:37	Patient & Staff Story	Information	Chief Nurse	Presentation
2. GOVERNANCE					
a	09:52	Chair's Report	Assurance	Chair	Paper
b	09:57	Chief Executive's Report	Assurance	Chief Executive	Paper
c	10:10	Assurance from Board Committees:			
		i) Finance and Performance – June and July 2026	Assurance	Chair of the Committee	Paper
		ii) Quality Governance Committee – June 2026	Assurance	Chair of the Committee	Paper
		iii) Group Remuneration Committee – June and July 2026	Assurance	Chair of the Committee	Paper
		iv) People and Organisational Development Committee – July 2026	Assurance	Chair of the Committee	Paper
		v) Digital Committee – July 2026	Assurance	Chair of the Committee	Paper
		vi) Group Audit Committee – June 2026	Assurance	Chair of the Committee	Paper
d	10.30	Board Committee Terms of Reference	Decision	Company Secretary	Paper
3. EXCELLENT PATIENT CARE					
a	10:35	Learning from Deaths Quarterly Report	Assurance	Group Medical Director	Paper
b	10:45	Maternity Integrated Oversight Report	Assurance	Associate Director of Midwifery/SCBU	Paper
		i) Maternity Incentive Scheme	Assurance	Associate Director of Midwifery/SCBU	Paper
		ii) Maternity Safety Champion Report	Assurance	Maternity Safety Champion	Paper
c	11:00	Nurse Staff Exception Report	Assurance	Chief Nurse	Paper

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No	Start time	Item	Purpose	Lead	Paper / Verbal
4. GREAT PLACE TO WORK					
a	11:05	Freedom to Speak Up Guardian Report	Assurance	FTSU Guardian	Paper
b	11:15	Staff Standards and Leadership and Management Framework	Assurance	Executive Director of People and Organisational Development	Paper
5. FIT FOR THE FUTURE					
a	11:25	Governance Reports			
		i) Organisational Risk Register	Assurance	Chief Nurse	Paper
b	11:30	Finance Report	Assurance	Group Director of Finance	Paper
c	11:35	Strategic Objectives and Constitutional Standards Report	Assurance	Group Director of Finance	Paper
6. ITEMS FOR INFORMATION / MEETING GOVERNANCE					
a	11:45	Cycle of Business 2026/27	Information	Company Secretary	Paper
b	11:46	Questions from Governors in Attendance	Discussion	Chair	Verbal
c	11:50	Any Other Business	Discussion	Chair	Verbal
d	11:55	Date and Time of Next Meeting – 9.30am on Tuesday 29th September 2026	Information	Chair	Verbal
Exclusion of the Press and Public To resolve to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed					

1. OPENING MATTERS

a - Welcome and Apologies for Absence
Presented by the Chair

b - Declarations of Interest

Presented by the Chair

c - Minutes of the Meeting Held on 27 May 2026

Presented by the Chair

NHS Gateshead Health NHS Foundation Trust

Board of Directors (Part 1 – Public)

Minutes of a meeting of the Board of Directors (Part 1) held at 9.30am on Wednesday 27th May 2026 in Room 3, Education Centre, Queen Elizabeth Hospital and via MS Teams.

Name	Position
Members present	
Sir Paul Ennals	Chair
Andrew Besford	Non-Executive Director
Adam Crampsie	Non-Executive Director
Gavin Evans	Managing Director for QE Facilities
Sean Fenwick	Acting Chief Executive
Joanne Halliwell	Group Chief Operating Officer
Martin Hedley	Non-Executive Director / Senior Independent Director
Carmen Howey	Group Medical Director
Kris Mackenzie	Group Director of Finance
Gerry Morrow	Vice Chair
Maggie Pavlou	Non-Executive Director
Beth Swanson	Interim Chief Nurse
Amanda Venner	Group Director of People & Organisational Development
Attendees present	
Jennifer Boyle	Company Secretary
Helen Fox	Head of Communications and Engagement
Gill Hunter	Incoming Non-Executive Director
Mary Jobson	Matron for Community Midwifery, Antenatal and Postnatal Services (Item 26/05/3a)
Vicky Kemp	Matron (Item 26/05/3a)
Diane Waites	Corporate Services Assistant
Governors and Observers	
Paul Johnson	Public Governor – Central & Eastern Gateshead
Dr Lakkur Murthy	Public Governor – Western Gateshead
	One member of the public
Apologies	
David Elliott	Chief Digital Officer
Robert Hughes	Non-Executive Director

Agenda Item No		Action Owner
Opening Matters		
26/05/1a	**Welcome and apologies for absence:** The meeting being quorate, Paul Ennals declared the meeting open at 9.30am. He welcomed those present including Gill Hunter who has been appointed as the new Non-Executive Director and will join the Board once recruitment checks have been completed. He also welcomed the Trust Governors, observers and members of the public. There were no other advance items of business to be made aware of for consideration under the *Any Other Business* agenda item.	

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	Apologies were received from David Elliott and Rob Hughes.	
26/05/1b	**Declarations of Interest:** There were no declarations of interest.	
26/05/1c	**Minutes of the Previous Meeting:** The minutes of the meeting of the Board of Directors held on Wednesday 25th March 2026 were approved as a correct record.	
26/05/1d	**Action Log and Matters Arising from the Minutes:** The Board reviewed the action tracker as below: • Action 26/03/2d – to reflect continued work around digital record integration within the Aubrey self-assessment action plan. This has been added to the action plan and therefore action agreed for closure. • Action 26/03/3e – to look at the increase in violence and aggression incidents against red flags within the nurse staffing exception report and staff survey results. Work is being undertaken around this and will be reviewed via the People and Organisational Development Committee and Quality Governance Committee. Action agreed for closure. The Board reviewed the actions closed at the last meeting which ensures actions have been closed in line with expectations and the agreements made at the previous Board meeting. There were no further comments.	
26/05/1e	**Top Organisational Risks:** The top (composite) organisational risks were confirmed by the Executive Risk Management Committee on 5 May 2026 as remaining the same. These are as follows: • Financial Sustainability – risk of inability to invest in staff and clinical services, including supporting financial collaboration with partners. • Estates – risk to sustainability of core infrastructure and to invest in clinical advances and the working environment for our staff. • Digital - risk of an inability to sustain and advance our digital offer impacting on the delivery of optimal clinical care, staff engagement and experience and our ability to deliver transformation.	

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	Paul Ennals reminded the Board to consider these during presentation of agenda items.	
26/05/1f	**Patient and Staff Story:** Beth Swanson shared a volunteer story from Aileen Wilson which was previously presented at the Trust's Patient Experience Group in January 2026 and celebrates the contribution of Trust volunteers during National Volunteers Week (1st to 7th June 2026). Beth Swanson reminded the Board that volunteers make a significant contribution to patient experience, staff support and Trust culture across services and Aileen's story demonstrates the positive impact volunteering has had on her wellbeing, confidence, purpose and community connection following retirement. She highlighted that learning from volunteer experience will continue to inform the further development and strengthening of volunteering opportunities across the Trust. Following a query from Paul Ennals on the number of volunteers within the organisation, Beth Swanson reported that there are over 100 with opportunities across different roles but further work is being considered on how this can be improved including involving younger people to provide support and experience in relation to career development and work experience. Adam Crampsie queried whether the impact of volunteers was being measured and Beth Swanson explained that this is captured within patient experience data, but consideration could be given on the development of a survey. Paul Ennals emphasised the benefits that volunteers provide and highlighted that some of the Trust Governors are currently volunteers which could be considered as part of discussions around future roles. It would also be beneficial to share effective working across the Alliance Trusts. The Board wished to formally thank the volunteers for their support and recognised the positive impact of volunteering on patients, visitors, staff and volunteers themselves.	
Governance		
26/05/2a	**Chair's Report:** Paul Ennals gave an update to the Board on some current issues, events and engagement work taking place across the organisation. He began by highlighting that this will be the last Board meeting for Jo Halliwell and Gavin Evans who will be leaving the Trust shortly and wished to formally record the Board's sincere thanks and wished them well for the future. Damon Kent will be joining the Trust on 1st June as QE Facilities Managing Director and will undertake the role in addition to	

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	his current position as Managing Director of Northumbria Healthcare Facilities Management (NHFM), a wholly owned subsidiary of Northumbria Healthcare NHS Foundation Trust. Paul Ennals highlighted that he is continuing to work closely with Governors around the proposed legislation to formally remove the statutory functions of Councils of Governors nationally but reaffirmed the Board's commitment to ensure that the valuable voices of our communities, patients, colleagues and partners continue to be heard. The development of proposals for future engagement continues with Governors as well as Alliance Trust colleagues to consider future models. After consideration, it was: **RESOLVED:** to receive the report for assurance.	
26/05/2b	**Acting Chief Executive's Report:** Sean Fenwick gave an update to the Board on current issues which have been aligned to the Trust's strategic priorities. He also wished to record his thanks to Jo Halliwell and Gavin Evans for their work and contribution to the Trust as part of the Executive Team. Sean Fenwick drew attention to the key areas in relation to national policy, context and operating models and highlighted that a new Secretary of State for Health and Social Care has recently been appointed and assurances have been provided that there will be no material changes to the current direction of travel which continues to drive the key shifts within the NHS 10 year plan. Work continues around understanding of the NHS Oversight Framework metrics and confirmation around quality measures is required. In relation to national performance headlines, it has been reported that national referral to treatment targets have been met however increases in A&E attendances reflects pressures being experienced. Sean Fenwick drew attention to the Trust's strategic priorities for Excellent Patient Care and highlighted that significant pressures continue in relation to breast services and work is being prioritised to develop and implement short term recovery plans and longer terms plans to be able to support patients and colleagues. A Care Quality Commission inspection took place in Nuclear Medicine recently with no significant issues raised. In relation to Great Place to Work, Sean Fenwick thanked those staff involved during the industrial action to ensure that our patients, services and site remained safe. A new Star Shoutout Board has been launched	

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	to recognise colleagues who have gone above and beyond and has been well utilised. In relation to Working Together for Healthier Communities, Sean Fenwick reported that the Community Diagnostic Centre (CDC) at the Metrocentre is expanding into Phase 2 which will create capacity for more than 38,000 additional diagnostic appointments and tests each year. He also highlighted that he recently attended the summit on antisemitism in London which was hosted by the Prime Minister and reiterated the Trust's commitment to be an inclusive and compassionate place for both colleagues and patients. Paul Ennals reported that at the recent Council of Governors meeting, Aron Sandler indicated that the Jewish community felt very comfortable attending the Trust and are well supported by the whole organisation which is testament to the excellent care provided by staff. Discussion took place in relation to current pressures within breast services and Jo Halliwell explained that short term additional capacity is being put in place to support recovery of waiting times and a memorandum of understanding is being developed between neighbouring trusts to provide qualitative support. Maggie Pavlou commented that County Durham and Darlington NHS Foundation Trust are engaging in proactive communications to increase public confidence and discussions are also taking place within primary care. Assurance was provided to the Board around the implications of potential harm to patients in relation to potential delays in diagnosis and Jo Halliwell explained that a proactive review process is in place which is being monitored via the Quality Governance Committee and Finance and Performance Committee. Sean Fenwick explained that a clear plan is being addressed across the North East and North Cumbria Integrated Care system but further learning opportunities are required to ensure that fragile services are proactively reviewed. Carmen Howey highlighted that this is being looked at as part of the newly established Great North Healthcare Alliance Clinical Framework Group to consider resilience of services and shared risk mitigation plans. Paul Ennals felt that assurance has been provided that the Executive Team are managing potential risks and that where patients have cancer there have been no delays in starting treatment. Jo Halliwell highlighted that positive patient feedback continues to be received around high quality services provided and recovery plans are being effectively managed. After further discussion, it was: **RESOLVED:** to receive the report for assurance.	
26/05/2c	**Assurance from Board Committees:** The Board reviewed the Committee escalation and assurance reports which identify areas of concern and ongoing monitoring of assurances.	

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	Finance and Performance Committee: Martin Hedley provided a brief verbal overview to accompany the narrative reports from the April 2026 meeting. He reported that there was one alert relating to breast services which was also discussed in detail at yesterday's meeting and has been moved to an advisory issue due to the mitigations highlighted in previous discussions. In relation to the recent meeting which took place on 26th May 2026, Martin Hedley reported that challenges were recognised in relation to revenue plans and unidentified gaps in cost reduction plans. He briefed the Board that this has been classified as an alert on the assurance report. The Committee received several reports for consideration and are recommended for approval following discussion in Part 2 of the meeting. **Quality Governance Committee:** Adam Crampsie provided a brief verbal overview to accompany the narrative report following the April 2026 meeting. He reported that there was one alert to highlight relating to the maternity System C Badgernet national alert following the identification of a coding issue affecting the automatic population of high-risk body mass index (BMI) data. This has created a risk that some women who should have been identified as requiring aspirin prophylaxis during pregnancy, may not have been automatically flagged by the system therefore manual checking processes and retrospective risk assessment reviews have taken place to identify potentially affected women and ensure appropriate treatment is provided. A cross-referral has been made to the Digital Committee regarding the issue as well as wider governance oversight relating to digital clinical support functionality. Adam Crampsie also drew attention to some advisory issues relating to health and safety overdue incidents and highlighted enhanced dashboard reporting and escalation processes are now in place. He previously reported on the Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and World Health Organisation (WHO) audits which were highlighted as alerts at the last meeting, but positive actions have been implemented, and a further update will be provided to the Committee in August 2026 where all actions are expected to be completed. Further discussion took place around the Badgernet alert and Carmen Howey confirmed that the issue had been identified by the Trust and the community midwifery team had undertaken a look back exercise and no patient harm has been identified. Andrew Besford reported that discussions have also taken place at the Digital Committee and a meeting has taken place with the Chief Executive of System C with David	QGC cycle of business

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	Elliot and David Thompson. Clinical Safety Officers are also being trained to be able to identify system issues, with two trained so far. Paul Ennals felt that assurance had been provided that mitigation plans had been put in place and that there was no evidence of patient harm. Further discussion will take place in Part 2 of the meeting. **Group Remuneration Committee:** Martin Hedley provided a brief verbal overview to accompany the narrative report following the March and April 2026 meetings. He reported that there were no alerts to highlight but drew attention to some advisory issues relating to the recruitment proposals for the substantive Chief Executive, Chief Operating Officer and QE Facilities Managing Director. **People and Organisational Development Committee:** Maggie Pavlou provided a brief verbal overview to accompany the narrative report following the May 2026 meeting. She reported that there were two alerts to highlight relating to vacancies within the non-registered healthcare assistant workforce which is contributing to gaps in establishment and an apprenticeship development programme business case is in progress to support this. This also relates to discussions taking place around the apprenticeship levy and will be picked up within the Executive Committee. The other alert relates to internal audit actions for the Senior Medical Staffing Audit and Sean Fenwick will be reviewing this with Executive colleagues. Maggie Pavlou drew attention to some advisory issues relating to Maintaining High Professional Standards processes and it was agreed that further Board oversight of cases would be useful and will be reported to the Committee via the regular employee relations activity report. Discussion also took place at the Committee around processes relating to the Board Assurance Framework and how this can be used more effectively and collectively with other Board Committees and will be discussed later in the meeting. **Digital Committee:** Andrew Besford provided a brief verbal overview to accompany the narrative report following the May 2026 meeting. He reported that that there were no alerts to highlight but drew attention to some advisory issues relating to discussions around electronic patient records and highlighted that progress is being made but challenges remain particularly in relation to funding, resources and procurement processes. Discussion also took place around the backlog of subject access requests, and Andrew Besford highlighted that this is being looked at from an Alliance perspective to develop a standardised approach and Carmen Howey explained that additional processes are	

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	being put in place to enable better understanding and ensure appropriate responses are developed. Andrew Besford also highlighted that the Information Commissioners Office has recently released some guidance to support with this due to complex information streams. Paul Ennals thanked the Committee Chairs for their reports which provides good assurance that processes are in place to address alerts and advisory issues raised. After consideration, it was: **RESOLVED**: to receive the reports for assurance	
26/05/2d	**Annual Board Declarations of Interest:** Jennifer Boyle presented the latest Board of Directors' Register of Interests which have been declared in accordance with local and national policy and is publicly accessible through the Board papers. She confirmed that unless stated on the register, declarations have been made by Board Members during May 2026 and therefore represent the latest record of interests declared. The register will continue to be updated throughout the year should any changes be made. After consideration, it was: **RESOLVED**: to formally approve the annual register of interests for the Board of Directors.	
26/05/2e	**Strategic Communications Report:** Helen Fox provided an overview of communications activity during quarter four (January to March 2026), including support for organisational priorities, leadership communication, stakeholder engagement and management of reputational risk during a period of operational pressure and national policy change. She reported that this was the first report to the Board therefore requested any feedback to be provided. Maggie Pavlou felt that it was important to focus on staff communications following review of the staff survey results and Amanda Venner highlighted that this is being looked at by the Executive Team as part of wider learning with Alliance partners. Gerry Morrow suggested that it would be useful to have mechanisms in place to allow staff to provide feedback and share information and Amanda Venner reported that face to face feedback is important and the walkabouts have proved useful therefore there are opportunities to use this more robustly. It was felt that it would be useful to share more positive stories, but Helen Fox explained that this had been challenging due to capacity within the team therefore further consideration was required.	

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	Following a query from Adam Crampsie in relation to internal reach activity and how this was being measured and benchmarked, Helen Fox explained that there is an awareness of what is being cascaded digitally but there are challenges in measuring what is being communicated between staff and line managers. Paul Ennals welcomed the report and highlighted the importance of staff communications. He felt that it would be beneficial to provide some statistical process control (SPC) charts, and it was noted that the report will continue to be developed. Following consideration, it was: **RESOLVED**: to receive the communications activity report for Quarter 4 (January to March 2026) for assurance.	
Excellent Patient Care		
26/05/3a	**Maternity Integrated Oversight Report:** Mary Jobson and Vicky Kemp presented an overview of maternity and neonatal metrics for April 2026 which also includes the North East and North Cumbria Local Maternity and Neonatal System Provider Trust Reporting for Quarter 4. Mary Jobson reported that there was one alert to highlight relating to a maternal death which has been referred to the Maternity and Newborn Safety Investigations (MNSI) team. She reported that learning has been shared through joint anaesthetic/obstetric Safecare arrangements which highlighted antenatal clinic capacity as a factor requiring consideration within the wider review however no causative link has been established at this stage. Beth Swanson highlighted that further discussion would take place in Part 2 of the meeting and Gerry Morrow commended the team for their candour and approach during these difficult circumstances. Mary Jobson drew attention to some advisory issues relating to the establishment of a multidisciplinary task and finish group to create a “bloodless surgery” pathway and provided assurance that several guidelines have been updated and approved. She highlighted that the Early Pregnancy Assessment Unit (EPAU) has been relocated which has been welcomed and provides greater benefits for patient pathways. Discussion took place around the maternity System C Badgernet national alert which was discussed earlier in the meeting, and Mary Jobson reported that a robust manual review had taken place of patient records which has identified a low number of affected women and appropriate treatment is being provided. Vicky Kemp highlighted that confidence remains in the system by the team, and the benefits are recognised in providing robust records.	

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	Maternity Safety Champion Report: Gerry Morrow presented his report which provides additional assurance to support the Maternity Integrated Oversight Report based on regular discussion with our people, patients and maternal and neonatal voices partnership (MNVP) service users. Gerry Morrow drew attention to some of the key issues and highlighted that some progress has been achieved in relation to providing additional capacity within the Women's Health Clinic. He also highlighted that he recently attended the Tyneview Children's Centre for a day of the midwife celebration and meeting and an issue was raised in relation to the limited numbers of transcutaneous bilirubin meters available and the team have been encouraged to request for additional meters via charitable funds. Paul Ennals commented that this was a helpful report which provides positive assurance to the Board. Carmen Howey felt that it may be beneficial to share the report with the divisional teams and this will be followed up outside of the meeting with Beth Swanson. After consideration, it was: **RESOLVED:** to receive the reports for assurance. Mary Jobson and Vicky kemp left the meeting.	CH / BS
26/05/3b	**Nurse Staffing Exception Report:** Beth Swanson presented the report for February and March 2026 which provides assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis to provide adequate staffing levels. She highlighted that the report covers two months and demonstrates continued staffing pressures due to sustained higher patient acuity and dependency, vacancies within the non-registered workforce, and the operation of multiple escalation areas. Beth Swanson reported that improvements have been made to the Optima Allocate system to provide real time visibility of red flag reporting to support operational management and provide reporting metrics for escalation and assurance and will be monitored via the workforce assurance meetings. Adam Crampsie felt that it would be beneficial to provide a thematic overview to the People and Organisational Development Committee and there may be some additional metrics to factor in following the recent NHS England visit. Gerry Morrow reported that discussion took place at the Finance and Performance Committee around C Difficile rates and mitigation plans and a report is due to be presented to the Quality Governance Committee to provide more detail. He felt that it would be beneficial to triangulate this	BS

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	into this report going forward particularly in relation to escalation wards and beds per unit and Beth Swanson will look at this. Following discussion, it was: **RESOLVED:** to receive the report for information and assurance.	BS
Fit for the Future		
26/05/4a	**Governance Reports:** **Organisational Risk Register (ORR):** Beth Swanson presented the updated ORR to the Board which shows the risk profile of the ORR, details of risk movements over the previous 12-month period, review compliance, and top composite organisational risks. This report covers the period 17th March to 17th May 2026. She reported that there are currently 17 risks on the ORR. Following the Executive Risk Management Group meetings in April and May 2026, there have been 4 risks added to the ORR relating to the delivery of cancer performance standards and quality of care delivery within the breast service, contracting functions, GP shared care arrangements and potential failure to comply with the requirements of the new Failure to Prevent Fraud offence. There have been no escalations or reductions and 3 closed risks relating to achievement of the 2025/26 financial plan, extended lengths of stay within the Emergency Department, and organisational capacity over the 2025/26 winter period. There has been an improvement in compliance with reviews and associated actions, and these continue to be reviewed. Carmen Howey highlighted that the risk relating to GP shared care arrangements is due to be closed as discussions have progressed. Adam Crampsie raised some concerns around the number of risks with no movement and if there had been any progress on discussions around whether these should be categorised as ALARP (as low as reasonably practicable). He drew attention to the risk relating to the non-compliance with statutory fire safety legislation due to recent national investigations and whether this should be considered a top organisational risk. Sean Fenwick explained that further debate needs to take place at the Executive Risk Management Group around the composite organisational risks and level of detail of underpinning specific risks. Jennifer Boyle highlighted that there are plans to review risk appetite within the Board Development programme and may be beneficial to bring this forward. In relation to the risk around the non-compliance with statutory fire safety legislation, Gavin Evans reported that a review of fire regulations across the site has taken place to better understand the risk and some mediation works has been taking place in areas of concern and further work will be included in capital plans for this year. This will be reported via the Health	

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	and Safety Report which is presented to the Quality Governance Committee. Andrew Besford felt that there may be further actions required around the digital composite risk to ensure that mitigations are in place to work towards reducing the risk and Sean Fenwick reported that this will be considered by the Executive Risk Management Group. Paul Ennals commented that further work around risk appetite and strategy was required to provide the Board with further assurances and this will be discussed at the Board Development session which will be brought forward. Following discussion, it was: **RESOLVED:** to receive the report for assurance. **Board Assurance Framework (BAF):** Jennifer Boyle presented the current Board Assurance Framework (BAF) which has been updated through the Board committees and the top 3 composite risks added to the 'linkages to key risks' section on each BAF extract where relevant. She reported that no summary risks have yet reached their target scores (due to be achieved by March 2027) or reduced in score and some concerns were raised following discussion at the People and Organisational Development Committee and Quality Governance Committee regarding the lack of movement in summary risk scores. It was agreed that the Executive Directors would take an action to review the BAF and its strategic delivery out-with the meeting. As such the Committees have commissioned the Executive Directors and Company Secretary to undertake a full and reflective review of the BAF to enable the Committees to exact maximum strategic benefit and assurance from this important document. Feedback will be provided to the Board and its Committees and any resulting changes to the way in which the BAF operates to support the control environment and reduce strategic risk. Paul Ennals felt that it was important for the Board to review this as a whole and will be discussed further as part of the Board Development session. After consideration, it was: **RESOLVED:** to receive the BAF for completeness, accuracy and triangulation against the assurances and risks discussed as part of the Board meeting, being assured that work continues to populate the controls, assurances and associated gaps.	JB

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Agenda Item No		Action Owner
26/05/4b	**Finance Report:** Kris Mackenzie provided the Board with assurance against delivery of the approved 2026/27 revenue and capital plan as at 30th April 2026 (Month 1). She reported that the Trust has reported an actual deficit of £0.570m which is an adverse variance from plan of £0.571m which is mainly due to the under achievement against the Cost Reduction Programme and an increase in bank and agency use due to current vacancies. The variance in cost reduction plans comprises of £0.807m relating to unidentified schemes and £0.751m slippage against identified schemes. Further discussion will take place with the Board in Part 2 of the meeting in relation to discussions with NHS England and potential financial controls following Executive Committee discussions. After consideration, it was: **RESOLVED:** to receive the Month 1 financial position and note partial assurance for the achievement of the 2026/27 planned financial targets.	
26/05/4c	**Strategic Objectives and Constitutional Standards Report:** Jo Halliwell presented the report which provides the Board with oversight and assurance of the key performance metrics which underpin the delivery of the Trust strategy for Month 1 2026/27. She drew attention to some of the main headlines and highlighted that urgent and emergency care performance has improved but remains below plan which is mainly due to unexpected emergency department consultant vacancies, but plans are in place to address this. Beth Swanson is leading on work around bed occupancy with a strong focus on patient flow and discharge. Elective care performance is positive and the Trust is achieving its overall referral to treatment standards. Beth Swanson highlighted the increased C.Difficile rates and provided assurance that a detailed report will be presented at the Quality Governance Committee. The Board acknowledged the challenges around current performance targets but was assured that plans are in place to address these. Following consideration, it was: **RESOLVED:** to receive the report for assurance and note the key areas of improvement and challenge.	

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Agenda Item No		Action Owner
Items for Information / Meeting Governance		
26/05/5a	**Cycle of Business 2026/27:** Jennifer Boyle presented the cycle of business for 2026/27 which outlines forthcoming items for consideration by the Board. It provides advanced notice and greater visibility in relation to forward planning and Board members are asked to provide any feedback to ensure this is reflective of the required Board business. After consideration, it was: **RESOLVED:** to review the cycle of business for 2026/27.	
26/05/5b	**Questions from Governors in Attendance:** Paul Johnson raised a query around communication channels and suggested that volunteers and Governors could support in spreading and gathering information and Paul Ennals felt that this could be explored further. He raised a further query in relation to the apprenticeship levy and queried whether external partners were involved. Amanda Venner reported that the Trust works closely with local schools and colleges and there are also discussions taking place with other providers to develop further plans.	
26/05/5c	**Any Other Business:** There was no other business raised.	
26/05/5d	**Date and Time of Next Meeting:** The next meeting of the Board of Directors will be held at 9.30am on Wednesday 29th July 2026.	
Exclusion of the Press and Public: Resolved to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed.		

d - Action Log and Matters Arising
Presented by the Chair

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PUBLIC BOARD ACTION TRACKER

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

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
26/05/3a	27/05/2026	Maternity Safety Champion Report	To consider sharing the report with divisional teams	29/07/2026	CH / BS	Agreed with Maternity Safety Champion that this will be shared as suggested. **Action recommended for closure.**	
26/05/3b	27/05/2026	Nurse Staffing Exception Report	To provide a thematic overview to the People and Organisational Development Committee in relation to red flag reporting and consider additional metrics following the recent NHS England visit.	29/07/2026	BS	Aim to have this as an appendix to next report to POD Committee.	
			To triangulate C.difficile rates into the report in relation to escalation wards and beds per unit	29/07/2026	BS	To be included in the triangulation section of staffing report moving forward.	
26/05/4a	27/05/2026	Organisational Risk Register and Board Assurance Framework	To bring forward discussions on risk appetite and BAF functions within the Board Development plan	29/07/2026	JB	July 26 – approach to be agreed with CEO and Chair. Action to remain open.	

Closed Actions from last meeting

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

e - Top Organisational Risks

Gateshead Health NHS Foundation Trust

Top Organisational Risks – July 2026

The top (composite) risks were considered by the ERMG on 6 July 2026 and were agreed as follows

The top organisational risks are as follows:

1. **Sustainability Risk –** the CEO to draft a new broader sustainability risk for agreement that incorporates financial sustainability and operational delivery.

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

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

f - Patient and Staff Story

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 1f

Report Title:	**Patient Story**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29 July 2026			
Author:	Presentation developed by Jane Conroy, Head of Quality and Patient Experience, following the West Locality Team within Community's reflective story			
Executive Sponsor:	Beth Swanson, Chief Nurse			
Report presented by:	Jane Conroy, Head of Quality and Patient Experience			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☒
	*To share a patient story that demonstrates how compassionate, person-centred community nursing, supported by effective multidisciplinary working, enabled a patient with highly complex palliative care needs to remain and die in their preferred place of care while highlighting the impact on staff and the importance of supporting workforce wellbeing.*er 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*	The information within this presentation has been previously reviewed by Community and was presented at Safecare SG on 21 July 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*	This paper story, kindly shared with permission from the family and the staff involved: • Demonstrates the delivery of high-quality, person-centred care based on understanding what mattered most to the patient and family. • Highlights the complexity of caring for a patient with progressive illness, advanced communication needs and non-invasive ventilation within a community setting.			

Gateshead Health NHS Foundation Trust

• *Equality, diversity and inclusion*	• Showcases effective multidisciplinary collaboration between Community Nursing, the Home Ventilation Team, Specialist Palliative Care and Macmillan services to deliver coordinated care at home. • Illustrates the professional judgement, flexibility and teamwork required to respond to changing patient needs while maintaining safe care for the wider caseload. • Reinforces the importance of honest, compassionate communication and strong therapeutic relationships in supporting patients and families through difficult decisions. • Demonstrates the value of structured staff debriefing and psychological support following emotionally demanding care recognising workforce wellbeing as integral to delivering safe, compassionate care. • Provides assurance that the patient's preferred place of death was achieved through coordinated, high-quality community-based care.	
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	Members are asked to: • Receive and note the patient story. • Recognise the contribution of Community Nursing and multidisciplinary partners in delivering compassionate, person-centred end-of-life care. • Note the importance of investing in workforce development, multidisciplinary collaboration and staff wellbeing to sustain the delivery of high-quality community services. • Consider the learning from this patient story in supporting the Trust's commitment to person-centred care, quality improvement and compassionate leadership.	
Trust strategic priorities that the report relates to:	☒	Excellent patient care
	☒	Great place to work
	☐	Working together for healthier communities

Gateshead Health NHS Foundation Trust

	☐	Fit for the future			
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	List strategic objective here				
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):					
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

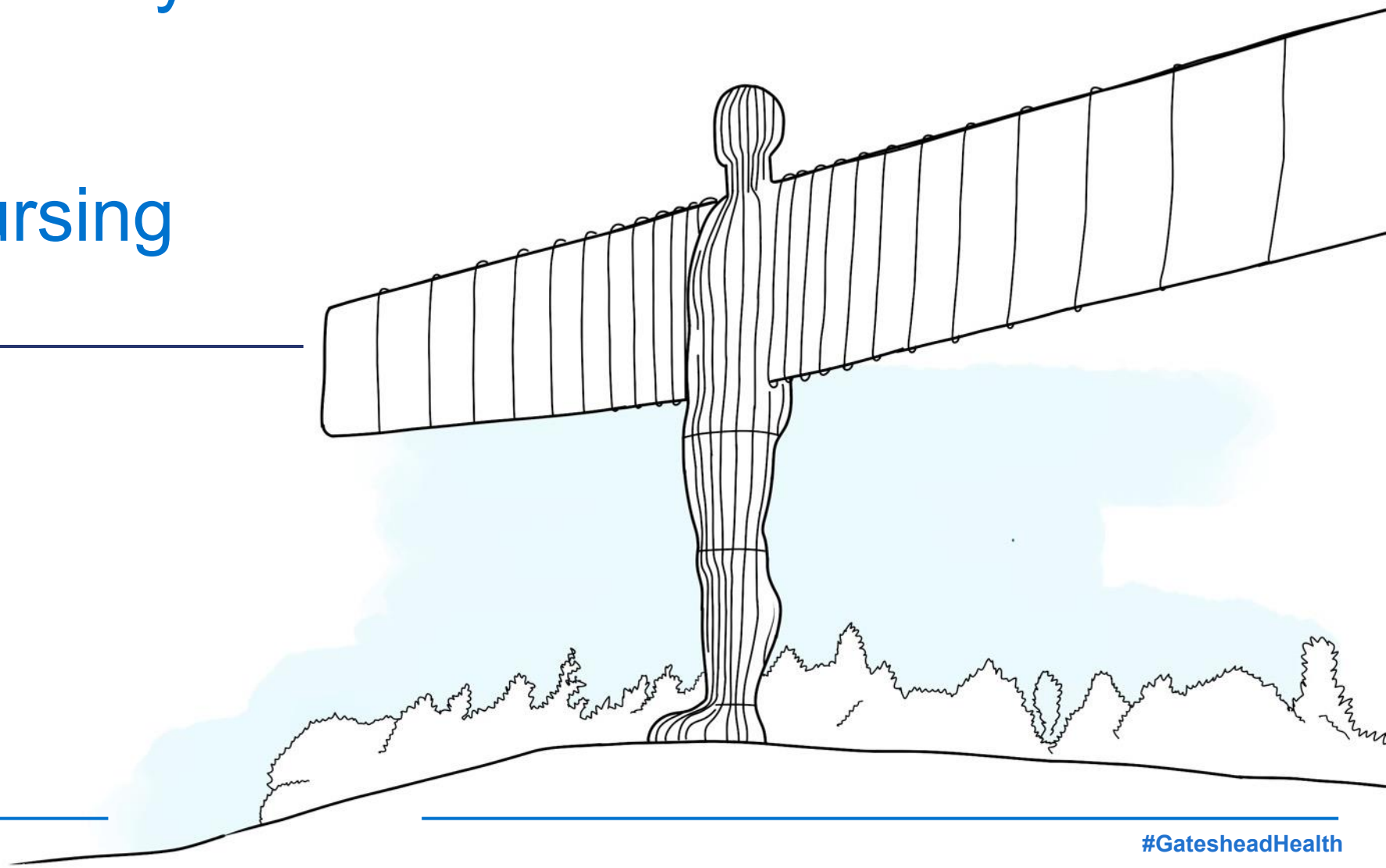
Gateshead Health
NHS Foundation Trust

Home was where they wanted to be

A Community Nursing Patient story

Board of Directors

July 2026



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Supporting patients to remain at home

“Care began with one clear priority – understand what mattered most to the patient”

The West Locality Community Nursing team recently cared for a patient living with a progressive and incurable condition. The patient had complex physical, psychological, emotional and social needs and was supported by the team for almost a year.

Initially the patient joined the Community Nursing caseload for palliative support. However, as their condition deteriorated, their needs increased significantly, eventually requiring multiple visits each day.

Throughout the patient’s journey, the team remained focussed on delivering compassionate, individualised care and supporting the patient to remain at home.

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Building trust through communication

“The patient and their family knew the team, trusted them and felt safe in their care”

The patient had complex communication needs, requiring the Nursing team to use advanced communication and assessment skills. Visits were often lengthy, allowing staff the time needed to understand the patient’s wishes and accurately assess their symptoms.

Over time, the team developed a strong therapeutic relationship with both the patient and their family.

There were occasions when staff needed to have frank and difficult conversations about the patient’s changing condition. These conversations were approached with honesty, sensitivity and compassion, enabling the team to maintain the trust of the patient and family throughout.

Gateshead Health NHS Foundation Trust

Caring through unfamiliar complexity

“Non-invasive ventilation was new to team members”

The patient used non-invasive ventilation, which was unfamiliar to some members of the Community Nursing Team.

To provide safe and appropriate care, staff worked closely with the Home Ventilation Team, Macmillan colleagues and Palliative Care Consultants. The multidisciplinary team support helped the Nurses to develop their knowledge and confidence while ensuring that the patient received coordinated care in their home.

As the patient’s condition progressed, staff also supported the patient and family through difficult and honest conversations about the possible withdrawal of ventilation.

This was new and emotionally challenging territory for the team, but they continued to place the patient’s wishes, comfort and dignity at the centre of every decision.

Gateshead Health NHS Foundation Trust

A team caring together

“When one Nurse needed to stay, the rest of the team quietly stepped in”

Caring for the patient and family was challenging, particularly during evenings and weekends when immediate access to specialist advice could be more limited.

During periods of crisis, visiting Nurses sometimes needed to remain with the patient for longer than expected. Other members of the team supported and took responsibility for remaining visits, allowing colleagues to stay with the patient without compromising the care of others.

The team regularly checked in with one another and recognised the emotional impact the experience was having on colleagues.

Their response demonstrated compassionate care depends not only on individual commitment, but on a team culture in which people support one another.

Gateshead Health NHS Foundation Trust

Achieving what mattered most

“Through courage, compassion and commitment, the team enabled the patient to die in their preferred place”

Following the patient’s death, the Nursing team received overwhelming thanks from the family for the care and support they had provided.

The patient’s preferred place of death was home. Through the commitment of the Community Nursing team, supported by specialist colleagues, this wish was achieved.

The outcome represented far more than the successful delivery of clinical care. It reflected the strength of the relationships built with the patient and family, the flexibility of the service and the willingness of staff to go above and beyond during and exceptionally difficult period.

Gateshead Health NHS Foundation Trust

Supporting staff after complex care

“Caring does not end when the patient dies – the team also need space to reflect, learn and recover”

Following the patient’s death, the Nursing team attended two structured debriefing sessions.

One session was led by the Palliative Care Consultant and focussed on the clinical and emotional experience of caring for a dying patient who remained on non-invasive ventilation. A further session was facilitated by a Clinical Psychologist, providing staff with an opportunity to process the emotional impact of the care they had delivered.

These sessions recognised that staff wellbeing is an essential part of maintaining compassionate and sustainable care.

Gateshead Health NHS Foundation Trust

The impact of Community Nursing

“Behind every visit is clinical expertise, professional courage and a commitment to be there when patients and families need us most”

This story illustrates the complexity of care delivered by the Community Nursing team every day.

It demonstrates the advanced communication, clinical judgement, partnership working and emotional resilience required to care for patients with complex and changing needs in their own homes.

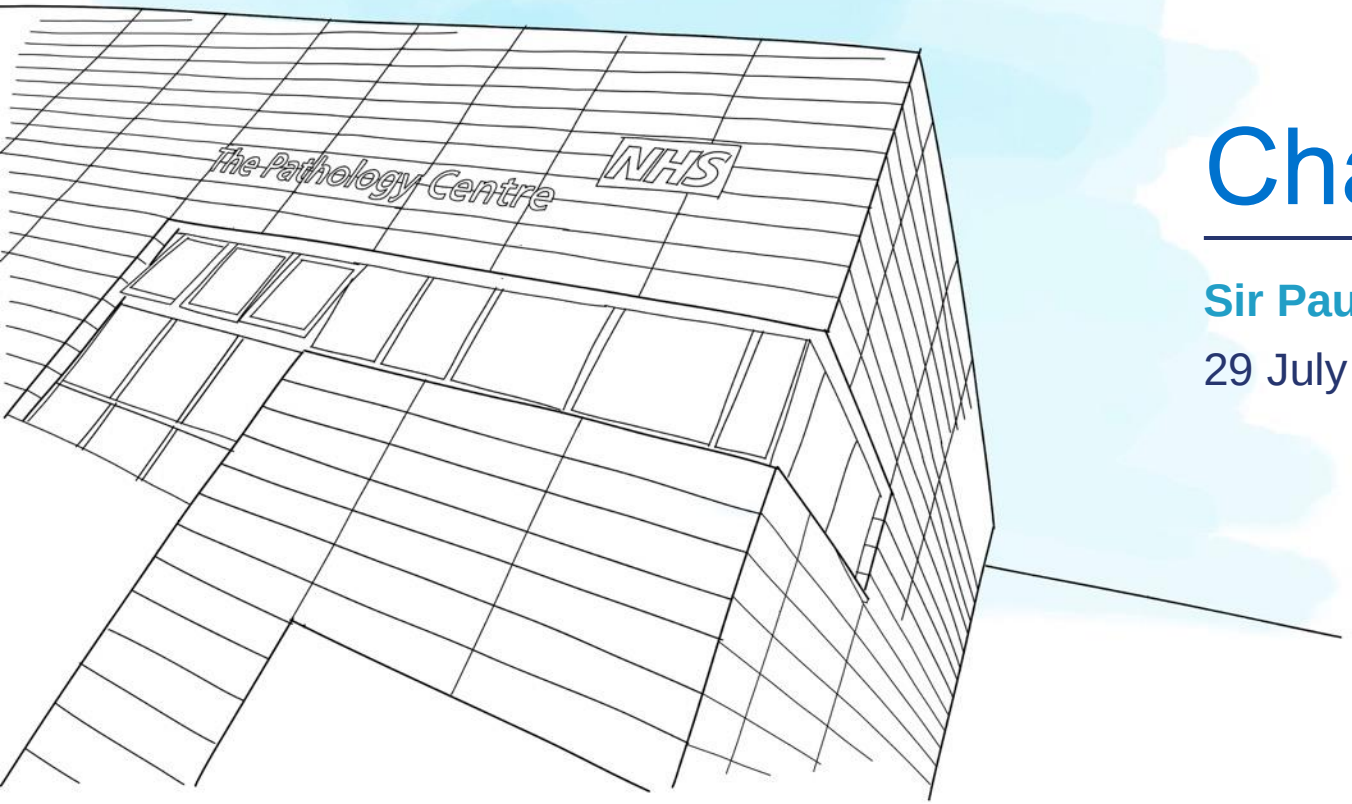
Most importantly, it shows the difference Community Nurses make to patients and families – enabling people to feel safe, supporting them through uncertainty and helping them remain in the place that matters most to them.

2. GOVERNANCE

a - Chair's Report

Presented by the Chair

Gateshead Health NHS Foundation Trust



Chair's Report

Sir Paul Ennals, Chair of the Board of Directors

29 July 2026

Gateshead Health NHS Foundation Trust

Board Updates

Non-Executive Directors

- I am delighted to formally welcome Gill Hunter to her first Board meeting. Gill has extensive legal experience as well as a strong focus on culture and inclusion.
- In June the Board formally appointed Maggie Pavlou as the Senior Independent Director, effective from 1 July 2026 to 30 September 2027. The process included consultation with the Council of Governors via the Lead Governor.
- In June Martin Hedley resigned from the Board of Directors in order to relocate back to the USA. He will remain on the Board until September. On behalf of the Board I would like to express my sincere thanks to Martin for his contribution and commitment to both the Non-Executive Director and Senior Independent Director roles.
- In light of Martin's resignation our Council of Governors approved a proposal to commence recruitment for a Non-Executive Director with finance qualifications, skills and experience. The recruitment will commence shortly.
- Finally, given the current and forthcoming changes to our Non-Executive Director team I have reflected on our Board committee composition and chairing arrangements. Regular rotation of committee membership supports good governance by encouraging fresh thinking, enhancing cross-organisational insight, and ensuring experience and knowledge are shared more widely across the Board. A number of changes will take place in late July / August.

Gateshead Health NHS Foundation Trust

Board Updates

Executive Directors

- Following an external recruitment process I am very pleased to confirm the appointment of Dr Sean Fenwick as our substantive Chief Executive. Sean has served as Acting Chief Executive since August 2025 and has already made a significant contribution, providing clear leadership and building strong relationships across the Trust and with partners.
- Additionally Beth Swanson has been appointed as Chief Nurse following an external recruitment process. Beth is also a familiar face, having served as Interim Chief Nurse since October 2025. Beth has shown strong clinical dedication and compassionate leadership – we are delighted to welcome her to the substantive role.
- At today's public Board meeting we are joined for the first time by Damon Kent, who has joined QE Facilities as Managing Director. Damon is undertaking the role alongside his position as Managing Director of Northumbria Healthcare Facilities Management (NHFM), a wholly owned subsidiary of Northumbria Healthcare NHS Foundation Trust. This is an excellent example of Great North Healthcare Alliance collaboration.
- Finally, we look forward to welcoming Sheena Fish to the role of Chief Operating Officer in the coming months following an external recruitment process. Sheena brings a proven track record of operational leadership within the North East healthcare landscape. Sheena will join the Board in autumn 2026.

Governor Updates

Gateshead Health NHS Foundation Trust

- Since the last Board meeting the Vice Chair and I have had several opportunities to engage with members of our Council of Governors, including monthly meetings with the Lead and Deputy Lead Governors.
- We held a further workshop with Governors to explore the concept of future engagement should the Health Bill be passed. This included a first review of a set of draft principles for engagement. The session provoked some interesting discussions and suggestions - we are committed to ensuring that our decision-making is informed by the voices of our communities, patients and colleagues.
- Work is taking place across the Alliance to develop the proposed models for engagement, recognising that whilst each trust may develop different models aligned to local needs, it would be helpful to ensure consistency in underlying principles. A summary paper on progress made to-date across the Alliance was considered at the Alliance Steering Group meeting in July 2026. Company Secretaries will continue to work close together on this concept alongside key colleagues from each trust.
- As outlined in the earlier slide, Governors have met to approve the proposed recruitment of a finance Non-Executive Director. The Governor Remuneration Committee will take a lead role in the recruitment over the next couple of months.

Gateshead Health NHS Foundation Trust

Governance – fit and proper persons

- Assurance is provided that the annual fit and proper persons return was been completed and submitted to the NHS England Regional Director by the deadline of 30 June 2026.
- The return covers the period 1 July 2025 to 26 June 2026.
- I have completed the return which provides assurance that all Board Members have been confirmed as ‘fit and proper’ in line with the NHS England Fit and Proper Person Framework. It also confirmed that Board Member references have been completed for all leavers.
- I can confirm to the Board that all Board Members have been tested and concluded as being fit and proper in line with the Framework. There are no issues arising from the fit and proper persons test being managed for any Board Member.
- Martin Hedley, as Senior Independent Director for the period under review, also completed the return in respect of my own fit and proper test outcome.
- In line with a recommendation from AuditOne, a 25% sample check of the files and conclusions was undertaken by the Executive Director of People and Organisational Development prior to submission. No issues were identified in relation to the fit and proper person status of those Board Members tested.

b - Chief Executive's Report

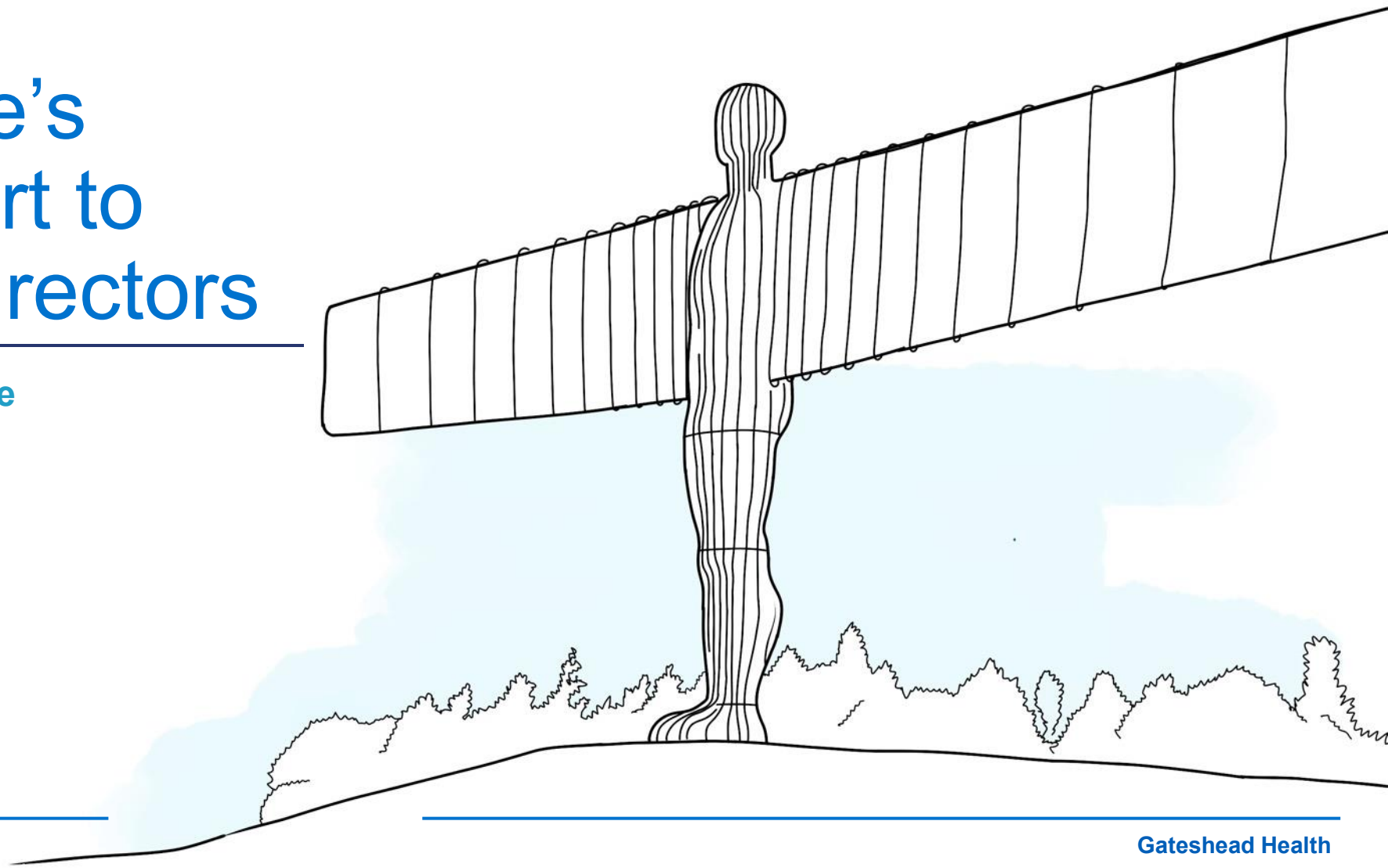
Presented by the Chief Executive

Gateshead Health
NHS Foundation Trust

Chief Executive's Strategic Report to the Board of Directors

Dr Sean Fenwick, Chief Executive

29th July 2026



Gateshead Health NHS Foundation Trust

National statistics and context

National policy, context and operating models

NHS England published the minimum standards for planned patient care. They have been co-designed with patients, carers, clinicians and the NHS. Boards are expected to set out a statement setting out their approach to compliance and how they will improve where a standard is not met

The new NHS College of Leadership and Management launched the NHS Leadership and Management Framework. This marks the publication of new NHS staff standards including the first national standard on line management.

The Amos investigation into maternity and neonatal services and the Ockenden review into maternity services at Nottingham have both been published. NHS England has sent out a 10-point plan of urgent improvement actions, bring together the critical actions from both reviews.

Resident doctors voted to accept an offer from the government, bringing an end to industrial action. Pay will be 35.2% higher on average than 4 years ago, with complementary pay structure reform. Up to 4,500 additional training places will be created. Consultant doctors have voted in favour of a mandate to take strike action.

The Lord Mann review of antisemitism and other forms of racism in the NHS has been published. All 35 recommendations have been accepted by the government and the Department of Health and Social Care. The Trust is working through the series of immediate actions outlined in the review.

NHS England published the 2026/27 Oversight Framework in June. This has been updated to align with the new NHS operating model and bring fairness, proportionality, consistency, transparency and predictability to the oversight of providers and ICBs.

Gateshead Health NHS Foundation Trust

National performance headlines

National performance – May and June 2026

National: A&E continued high demand (June):
75% of patients seen in 4 hours (target: 82%)
June was the second busiest month on record.

National cancer performance (May):
79% against the target of 80% for the faster diagnosis standard (28 days)
69.6% against the 62 day target of 85%

National diagnostics (May):
24.0% of patients have been on an NHS waiting list for diagnostic tests for 6 weeks

Gateshead context (June):
77.7% of patients seen in 4 hours

Gateshead context (May):

44.9% against the faster diagnostic standard
68.3% against the 62 day target

Gateshead context (May):

7.7% of patients have been on waiting list for diagnostic tests for more than 6 weeks

Excellent patient care

Gateshead Health NHS Foundation Trust

- Our **pathology labs** have been spotlighted by NICE (National Institute of Health and Care Excellence) as a leading example of early adoption of the faecal immunochemical test (FIT). The simple at-home test helps clinicians identify high-risk individuals quickly whilst preventing unnecessary procedures for patients.
- Our teams have promoted **learning disability** awareness week using the theme of *'do you see me?'*, focussing on people with learning disabilities being seen, heard and valued. Promotion of this is vitally important to ensure that we are responsive, compassionate and respectful to our patients.
- In June colleagues held an **Infection, Prevention and Control** champion day. This provided valuable opportunities for learning and development, including sharing best practice, as part of our ongoing commitment to delivering safe high-quality care.
- We have launched an innovative **virtual reality breast screening experience** designed to promote early intervention screening. This seeks to use technology to transform patient care by removing the anxiety which can be associated with medical appointments.

Great place to work

- We launched our **apprenticeship programme for Healthcare Assistants**. We are aiming to recruit 35 apprentices to join a paid route into healthcare, with training and support to help them build their skills and progress into a higher-level healthcare support worker role. This is part of our work to support the local community by opening up NHS career opportunities for people who may not have considered healthcare before, or who were unsure where to start. We have received many strong applications. We look forward to welcoming these new colleagues to Gateshead to commence their careers with us.

- As part of our drive to improve performance, productivity and sustainability we have to make careful decisions about how we best utilise our time, skills, equipment and resources. As part of this work we have launched a **Mutually Agreed Resignation Scheme** (MARS) for colleagues to consider. The scheme is entirely voluntary and will close on 29 July 2026.
- This month we have been celebrating **South Asian Heritage Month**, sharing the stories of our colleagues and learning from each other. Last month we celebrated our diverse community of LGBTQ+ patients and colleagues as part of **Pride Month**. The Pride celebrations have included a Great North Healthcare Alliance Newcastle Pride breakfast event for colleagues, friends and family.

- Janet Thompson, Corporate Matron, and Yvonne Tamburro, Lead Nurse for Practice Education, have been recognised with **national Chief Nursing Officer Silver Awards** for their outstanding contribution to nursing, patient care and education.

Working together for healthier communities

Gateshead Health NHS Foundation Trust

- **Dr Ruth Sharrock**, Consultant Respiratory Physician, was awarded Honorary Membership to the Faculty of Public Health in June. Honorary membership acknowledges those professionals who have made a significant contribution to Public Health. Ruth has been instrumental in shaping and advancing our local approach to addressing health inequalities, providing clinical leadership and championing a system-wide approach to changing the way we work.
- Following changes at Integrated Care Board level, our **Gateshead Interface** meetings are being re-established as a key forum for working together with primary care colleagues, with a focus on ensuring patients can access care closer to home wherever possible.
- As part of **CDC Phase 2** we have an opportunity to design the new space around what our local population needs. We are seeking the valuable input of colleagues to help inform the hospital services and patient pathways that could move into a community setting, or benefit from new ways of working within the CDC.

Fit for the future

Gateshead Health NHS Foundation Trust

- Our ranking in the acute sector **NHS Oversight Framework (NOF)** league table for Quarter 4 2025/26 dropped from 65th to 96th place out of a total of 134 trusts. We remain in Segment 3 of 4. The key drivers behind the changed position relate to operational pressures against the plan we submitted to NHS England, including four hour performance in A&E and our cancer position. The cancer position is largely reflective on the pressures on breast services which is in part impacted by demand changes across the region. We have a credible plan to recover our position and expect to see improvements in future quarters.
- In response to our delivery against the **financial plan** in the first quarter of the year we know we need to take additional steps to accelerate work to reduce waste, improve efficiency and use our resources more efficiently. Work is being undertaken to strengthen our financial position, deliver our Cost Reduction Programme (CRP) and improve efficiency whilst protecting patient care.
- We are progressing a number of key **estates projects** including work on theatre ventilation, maternity, fire safety improvements and planning for the next phase of the Community Diagnostic Centre (CDC). We recently opened the new early pregnancy unit on Ward 26. These investments play a critical part in improving the environment for patients and colleagues and supporting future service developments.
- On 17 June we celebrated the hard work of our **estates and facilities colleagues** at QE Facilities. The teams play a vital role in supporting clinical teams and services across the Trust, helping us to deliver outstanding care to our patients every day.
- Our **annual report and audited accounts** were submitted to NHS England ahead of the national deadline. They have now been laid before Parliament and published on our website. They will be formally presented at our Annual General Meeting on 30 September.

c - Assurance from Board Committees

i) Finance and Performance Committee - June and July 2026 - presented by the Chair of the Committee

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

iii) Group Remuneration Committee - June and July 2026 - presented by the Chair of the Committee

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

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

vi) Group Audit Committee - June 2026 - presented by the Audit Committee Chair

Gateshead Health NHS Foundation Trust

3A Escalation and Assurance Report

Name of Committee / Group:	*Finance and Performance Committee*
Date of Committee / Group:	*30 June 2026*
Chair of Committee / Group:	*Martin Hedley*

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

- There were no alert items.

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

The following advisory item was identified:

- **Financial Performance** – There are a number of factors impacting on financial performance including CRP delivery, the underlying deficit and workforce pressures. A recovery plan has been presented to the Committee.
- **Deteriorating Performance** – Reporting of a deteriorating performance across a number of areas including cancer and workforce.
- **Operational Oversight Group Triple A Report** – there are gaps in the report and it does not appear to reflect the level of challenge in some areas of the organisation or to set out clear actions to be taken forward.
- **Staff Engagement** – there is a concern about the impact of the recovery plan on staff engagement and work is needed with the Comms Team in relation to this.
- **Pay Award** – this will have an adverse impact on the Trusts financial position and an increase to the CRP target is needed to mitigate this. There is an emerging risk that this could impact on the forecast outturn.

Assure
(key assurances received and any highlights of note)

The Committee received the following assurances:

- **Board Assurance Statement** – The Committee approved the Board Assurance Statement from the CEO and Chair to be provided to NHS England.

Gateshead Health NHS Foundation Trust

• **Recovery Plan** – the Committee considered and accepted the recovery plan. • **Environmental Sustainability Biannual Report** – considered by the Committee and progress recognised. • **Internal Audit Report – Patient Monies –** reported to the Committee for information.
Risks (any new risks / proposed changes to risk scores)
• No new risks were identified.
Cross-referrals to other Committees / Groups / Executive Director Leads
• There were no cross referrals.

Gateshead Health NHS Foundation Trust

3A Escalation and Assurance Report

Name of Committee / Group:	*Finance and Performance Committee*
Date of Committee / Group:	*27 July 2026*
Chair of Committee / Group:	*Adam Crampsie*

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

- **Cancer performance:** The committee remains concerned about 28-day Faster Diagnosis and 62-day treatment performance, particularly in Breast and Urology. There is insufficient assurance on the recovery trajectories, capacity required and timing of improvement. A detailed update will return to the next committee.
- **Internal audit actions:** The committee could not take assurance on the overdue patient monies actions, including two high-priority actions. Further assurance is required on the interim controls, named owners, milestones and revised completion dates. Links to alerts raised by other committees on the delivery of internal audit actions.
- **Financial performance:** Cost Reduction Programme delivery remains significantly below plan and the underlying exit deficit is forecast at £40.98m against a £34.91m target. The committee could not take assurance that the gap will be closed. A division-by-division plan will return, setting out immediate measures, recurrent schemes, named owners, delivery dates and a risk-adjusted assessment of delivery.

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

The following advisory item was identified:

- **QEF financial performance:** The committee received partial assurance on QEF's financial position and the actions being taken to address the remaining Business Efficiency Programme gap.
- **Premises Assurance Model:** The committee did not endorse the return because the supporting 88 actions were not provided for assurance. The action plan will return with the highest risks, owners, timescales and evidence of completion before approval to submit.
- **Community Diagnostic Centre Phase 2:** There remains uncertainty around the funding, affordability and operational model. Further information will flow through the Executive Committee before additional assurance is provided.
- **NHS financial risk stratification:** The committee received notification of the Trust's position under the new NHS financial risk stratification arrangements.

Gateshead Health NHS Foundation Trust

Further detail is required on the confirmed category, the implications for the Trust and the specific measures and oversight arrangements that will follow.

- **Operational flow:** There are early signs of improvement, but performance remains well below the required standards. Further assurance on the overall flow action plan, trajectories and sustainability of improvement will return to the next committee.
- **Capital programme:** Further assurance is required on the sensitivities and interdependencies within the capital programme, including the effect of funding decisions and prioritisation on scheme delivery, safety and operational performance.

Assure
(key assurances received and any highlights of note)

The Committee received the following assurances:

- **Estates Returns Information Collection:** The committee received assurance on completion of the annual return, subject to the identified data and backlog maintenance issues being followed up.
- **Winter planning:** Planning for winter 2026/27 has commenced, with governance and the timetable for completion and stress testing being established. To return through formal governance processes in August.
- **Elective performance:** The Trust was ranked third nationally for 18-week referral-to-treatment performance in the most recent nationally benchmarked data. The number of patients waiting more than 52 weeks has also reduced to two.
- **31-day cancer performance:** The Trust was ranked first nationally for the 31-day cancer treatment standard in the most recent nationally benchmarked data.

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

- No new risks were identified.

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

- **Cross-referral to Quality Governance Committee:** Seek assurance on the quality and safety impact of cancer delays, particularly within Breast and Urology, including any actual or potential patient harm, the approach to harm reviews, patient tracking and the controls in place while recovery plans are delivered.

NHS Gateshead Health NHS Foundation Trust

Committee Escalation and Assurance Report

Name of Board Committee	Quality Governance Committee
Date of Board Committee:	17 June 2026
Chair of Board Committee:	Adam Crampsie

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

Healthcare-associated infection (HCAI) Performance

- The Trust has exceeded trajectory in several infection indicators, including CDI and bloodstream infections.
- The Committee is not comfortable with the current position but recognise that mitigations are in place and this is being monitored via Safecare.
- This issue is currently identified as an alert, but it is expected to come down to advise on the basis of the action being put in place.

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)

Martha's Rule

- Progress has been slower than expected but infrastructure is now in place and progress is expected over the next six months. There will be regular updates to Safecare and a progress report to be provided to the next meeting of the Committee.

Clinical Effectiveness

- A wider discussion is needed outside of the meeting to consider how assurance could be provided to the Committee on clinical effectiveness, possibly through an annual paper providing triangulation around clinical audit, GIRFT and NICE compliance.

Maternity Incentive Scheme Year 8 Gap Analysis

- This has been delayed due to capacity issues but is due to be reported to the next meeting in August. There are no major concerns and the approach has been simplified in comparison to previous years.

Badgernet

- Issues have been escalated to System C and a follow up meeting is being arranged. The review of cases is almost complete with some patients picked up but no harm identified.

Oversight of use of digital systems for clinical decision making

- In the light of the Badgernet issues the Committee highlighted the need for professional responsibility for clinical decisions and raised a concern in relation to assurance of oversight and the potential for this to become a greater issue as the use of AI develops.

Work on Flow and Discharges

- Flow and discharge pressures continue to impact operational performance and patient experience.
- An update on the work on flow led by the Interim Chief Nurse to be reported to the next meeting.

Patient Safety Investigations and Complaints Backlog

- The Committee noted the current position in relation to Patient Safety Investigations and Complaints backlogs and the need to see improvements and this may require changes to policies and training.

Health and Safety

- Violence and aggression had been highlighted as an alert item on the Health and Safety Group triple A report and although it is recognised that a lot of action has taken place a measurable reduction in violence and aggression has not yet been delivered.
- Trust Board Oversight of Health and Safety.

ICB Changes

- Quality oversight is being reinstated under the new structure with a quarterly Quality Management Group
- The Committee was advised about LSB reporting changes.

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

Positive assurances were agreed in relation to:

- Maternity IOR
- Business Cases for HCA Development and Nursing Apprenticeships approved, and recruitment campaigns are underway
- Positive results from the CQC patient survey
- EQIA Process reviewed
- Health Inequalities – progress made on all workstreams

Gateshead Health NHS Foundation Trust

• Research and Innovation – 11 commercial studies this year compared to 2 in previous year. • Mortality Council backlog – positive progress made • Falls – improved performance reported • Cragside CQC visit • Premises Assurance Model (PAM)
Risks (any new risks / proposed changes to risk scores)
• There were no new risks identified.
Cross-referrals (by exception only)
• There were no cross referrals

Gateshead Health NHS Foundation Trust

3A Escalation and Assurance Report

Name of Committee / Group:	Group Remuneration Committee
Date of Committee / Group:	2 June 2026 and 1 July 2026
Chair of Committee / Group:	Martin Hedley

Alert ***(matters of significant concern requiring escalation for further action)***
• There were no matters to alert the Board to.
Advise ***(areas subject to ongoing monitoring where some assurance has been noted / further assurance sought or emerging developments that the Committee / Group is seeking assurance over)***
• No advisory items were identified.
Assure ***(key assurances received and any highlights of note)***
• At its meeting in June the Committee formally approved the appointment of Dr Sean Fenwick to the substantive Chief Executive position in line with the parameters agreed at the previous meeting. • In June the Committee also approved the outline plans for the recruitment to the Chief Nurse and Chief Operating Officer positions, including proposed timescales and salary ranges. • In July the Committee met to approve the appointment of Beth Swanson as Chief Nurse and Sheena Fish as Chief Operating Officer in accordance with the parameters set at the June meeting.
Risks (any new risks / proposed changes to risk scores)
• No new risks identified.
Cross-referrals to other Committees / Groups / Executive Director Leads
• None

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3A Escalation and Assurance Report

Name of Committee / Group:	People & OD Committee
Date of Committee / Group:	8 July 2026
Chair of Committee / Group:	Maggie Pavlou

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

1. **Violence & Aggression –** remains an area of concern, with increasing discussion across governance forums indicating a potential escalation in organisational risk. There has been no meaningful improvement in the overall violence and aggression score and a number of actions remain overdue. Work is underway to strengthen oversight, action tracking and triangulation of information across committees, with a commitment to report an updated position in September.

2. **EDI Six-Month Update –** the Committee is not yet assured that the current EDI programme is delivering sufficient impact on the experience and outcomes of our people. Whilst a range of activity is underway, there is a need to strengthen the link between actions, measurable outcomes and organisational priorities. A data-led review, informed and validated through staff network engagement and lived experience, is being undertaken to identify a small number of Board-endorsed priorities where focused effort and resource can have the greatest impact. Recommendations will be presented in September.

3. **Healthcare Support Worker (HCA) vacancies –** levels remain a workforce risk within a number of services. Whilst vacancy levels continue to be monitored closely, the current recruitment pipeline and apprenticeship opportunities are expected to improve the position by September. Work is also underway to establish the Trust's tolerable level of risk through triangulation with other quality and safety indicators, including falls and incident data, recognising the benefits associated with a more stable and substantive workforce.

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

4. **Staff Standards and NHS Leadership Management Standards –** launched nationally on 6 July 2026. As accountability for implementation sits with Trust Boards, consideration is required around how these standards will be embedded locally in a meaningful and measurable way. Further work is underway to assess

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the implication for the Trust, including alignment with existing workforce priorities, leadership expectations and staff experience improvement activity. A more detailed report will be presented to the Board meeting in July.

5. **Nurse Staffing Report –** the Committee noted concerns regarding nurse staffing indicators within the Special Care Baby Unit (SCBU) and requested additional assurance regarding the ongoing safety and sustainability of staffing arrangements to be reported through to the Quality Committee to ensure appropriate oversight. More broadly, there remains an opportunity to strengthen triangulation between workforce metrics, quality indicators and patient outcomes to provide a more comprehensive assessment impact. Work requested to enhance trend analysis to identify any areas of significant variances and articulation of assurance via accompanying narrative.

6. **Resident Doctors Offer –** the potential implications of the national Resident Doctors training offer and associated impact on education supervision, placement capacity and training infrastructure was discussed. There is a potential risk that organisational capacity may not be sufficient to support additional placements. A further paper will be presented to Committee to assess capacity requirements, risk and mitigating actions.

7. **People & OD Steering Group –** the Committee noted the decision to stand down May's POD Steering Group due to operational pressures, school holidays and multiple apologies. The Group provides an important mechanism for reviewing and escalating workforce-related risk, issues and assurances to Committee and were concerned that around the level of assurances that were being provided where the usual route of scrutiny has not taken place as well as maintaining visibility of any matters requiring escalation.

8. **Core Skills Compliance –** Core skills have declined in-month by 5%, previously 87% but currently 82%. Below the 85% target and ask via People & OD Steering Group in June 2026 to ensure compliance in teams Trust wide.

9. **NHSE Workforce Deep Dive –** The NHS England team attended to carry out a Workforce Deep Dive on 6 July 2025 and are scheduled to return in 10 days' time to further review.

Assure
(key assurances received and any highlights of note)

10. **Local Staff Survey Actions –** received assurance that feedback from local staff survey discussions has provided additional insight into workforce experience and priorities. Themes and nuances identified through local engagement activity have infirmed and strengthened the wider staff survey response and will contribute to further discussions at Executive level regarding organisational priorities and actions.

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11. **Medium Term Plan –** received assurance regarding the range of compliance and control measures introduced by way of a 'reset' to strengthen oversight and accountability. Whilst recognising the importance of the controls in restoring operational grip and control, the Committee also acknowledges the need to balance compliance requirements with local empowerment and leadership autonomy as the organisation moves towards longer term sustainability.

12. **Lord Mann Report –** received assurance that the findings of the Lord Mann Review did not identify any significant gaps in existing arrangements. It is recognised that this cannot sit as a standalone piece but needs to align with the broader strategic work underway within the Trust. Further consideration and focus to be given to ensuring that implementation is meaningful for the Trust's workforce and local population.

13. **Nursing and Midwifery Job Profiles –** received assurances regarding progress. Regional collaboration continues, however Trust's including Gateshead Health NHS Foundation Trust are starting to break pace, with a detailed local project plan due to be presented to the Executive sign off. Robust governance arrangement in place. A pilot within Outpatients is planned for September 2026, with ongoing consideration being given to organisational capacity to deliver the Band 5 review programme.

14. **Employee Relation Q1 Report –** received assurance from the report with no significant hotspots being identified during the reporting period. The Committee requested continued monitoring and trend analysis to identify emerging themes or areas of concern.

15. **Sexual Safety Charter –** received assurance regarding progress against the Sexual Safety Charter, include evidence of appropriate action being taken where concerns have been substantiated. Whilst recognising that sexual safety remains an area which is historically under-reported, the Committee noted increasing confidence amongst staff to speak up and raise concerns through formal channels. Further work needed to explore intersectionality, power dynamics and the relationship between reported cases and staff experience data to strengthen organisational understanding and response.

16. **Freedom to Speak Up –** received assurance regarding the arrangements to support staff to speak up continue to strengthen, including strengthened governance, improved triangulation and the introduction of the Staff Experience and Inclusion Oversight Group. Assurance also received that concerns are being appropriately reviewed, escalated and addressed through this established governance process.

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17.	**Ten-Point Plan –** received assurance regarding progress against plan, including completion of the Board Assurance Framework which will be presented separately for consideration. National recognition received for work on the Sanctuary Room. A temporary gap in peer support provision has been identified pending the arrival of the next cohort of doctors starting in August, with plans in place to restore this capacity.
18.	**Internal Audit Paper –** received full assurance that all open and overdue People and OD related audit actions are complete.
Risks (any new risks / proposed changes to risk scores)	
19.	No new risks to add.
20.	Proposal to reduce BAF risk that the Trust's culture does not reflect the organisational values from a 16 to a 12. The proposed reduction reflects the breath of improvement activity in place, evidence of improving workforce indicators, strengthened workforce intelligence and triangulation arrangements, positive network engagement and continued success in attracting high-quality candidates to senior leadership and clinical appointments. The Committee considered that these factors demonstrate positive progress and support a reduced risk rating, while still recognising the continued focus is required to sustain improvement.
Cross-referrals to other Committees / Groups / Executive Director Leads	
N/A	

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3A Escalation and Assurance Report

Name of Committee	Digital Committee
Date of Committee	8 July 2026
Chair of Committee	Andrew Besford

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

- **Cyber KPIs** – concern over whether the risks are visible enough. The CAF/DSPT standards are met but this is a basic standard. There is a need to focus on EPRR plans. Residual risk will always be there.

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

- **Digital Strategy** – Indicative roadmap has been developed but this is not yet costed. There is a need for clinicians to be involved in the design. Partial assurance provided.
- **Non-elective EPR** – The full Business Case will be considered alongside competing priorities. Progress continuing on the business case. Key risks identified.
- **Data and Business Intelligence** - The direction of travel is being developed and will flow through the Executive Committee.
- **Communication Systems** – A verbal update has been provided, and a report will flow through to the Executive Committee before coming back to the Digital Committee.
- **Systems Outside of the Digital Team** - to consider how we assure ourselves over current systems and developing a 'rules of the road' for new systems to go through the Executive Committee.
- **Pathology** – This area has the most IT outside of the Digital Team and also has systems linked regionally. The future operating model to be considered by the Executive Committee with a paper to Digital Committee next time.
- **Critical Incidents** – 3 incidents experienced:
  - Vantage licence/middleware issue – incident managed well and action will be taken up with the supplier.
  - Extended Maestria microbiology downtime – assured by business continuity.
  - Critical Phone Line Incident – a review will take place with recommended actions. Business continuity plans worked well.
- **KPIs** – Alliance Reporting Pack not yet available but due to be provided after the summer.
- **SIRO** – to re-establish annual reporting. This will be strengthened through the Executive Committee and will come back to the Committee in September.

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- **DDAT Steering Group** – Triple A Report – in future this will be reported via Executive Committee so that actions can be developed and reported through to the Committee. A number of positive items included in the report.
- **Organisational Risk Register** – Thematic risks will be accepted on to the ORR.
- **NHS cyber assurance self assessment** - boards and executives to assure themselves that cyber security risks are being managed effectively, with clear, sustained programmes for improvement.
- **Unlawful Access to Patient Records** – there is a national campaign and there will be local comms aimed at understanding responsibilities.

Assure
(key assurances received and any highlights of note)

- **Clinical Safety:**
  - **Badgernet –** Assurance provided on the handling of the Badgernet issues.
  - **CMM Prescribing and administration incidents** – anomaly fixed and clear route for escalation
  - **CSO Training** – 16 individuals now trained and plans for more.
- **Digital and Data Programme Overview** – this is in a good form with clarity in relation to the escalation of risks – although there is nothing currently to escalate.
- **Internal Audit** – a good plan has been agreed. DSPT was discussed.
- **BAF** – the risk scores to stay the same

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

- There were no new risks identified.

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

- There were no cross referrals.

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Committee Escalation and Assurance Report

Name of Board Committee	Group Audit Committee
Date of Board Committee:	22 June 2026
Chair of Board Committee:	Rob Hughes

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

- Value for Money Arrangements – The External Auditors identified a significant weakness in relation to financial sustainability criteria. This was first reported in 2024-25. A management response has been provided setting out the actions being taken. The Audit Committee are assured on the work that is underway and acknowledge that the underlying deficit has reduced significantly over the last year. There remains, however, a risk in relation to longer term financial sustainability for which there is not yet full assurance over the mitigations and actions.

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)

- **Internal Audit: Patient Monies and Property Follow Up Audit –** Limited Assurance rating received with two high and seven medium agreed management actions. A working group has been established to address the recommendations.

- **Head of Internal Audit Opinion -** The overall opinion assurance level is 'good' which is consistent with the previous year. However, this was marginal/borderline based on the balance of ratings of individual audit reports and the responsiveness of management to audit actions. This presents an opportunity for learning and improvement in 2026/27.

- **Executive Risk Management Group (ERMG) Update** – A reduction in action compliance was noted but assurance provided that this is being addressed via ERMG with an expected improvement by the next Audit Committee meeting.

- **Freedom to Speak Up Processes and Control** – Good assurance was provided around the control environment and policy compliance, but further assurance was requested by the Committee that staff feel safe to speak up without fear of detriment. This would be included in future reports.

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- **Do Not Attempt Cardio Pulmonary Resuscitation (DNA CPR) Audit Update** – The Committee received a comprehensive report which provided reflections on why previous actions had not been fully completed, as well as assurance over the actions taken since the re-audit. The actions are due to be closed by August and this will be reported through to the Executive Committee, Quality Governance Committee and then Audit Committee in September. It was agreed that contingency days will be used for a follow up in Q4.

- **Losses and Special Payments** – it was identified that further work was required improve the control environment on salary overpayments and white goods repayments for leavers in order to limit exposure to losses. The Audit Committee requested a thematic review and an analysis of the amounts recovered compared to the amounts recommended for write-off. Assurance was provided that Counter Fraud are also focussing on this area.

- **Conflicts of Interest –** Improved compliance in relation to absolute numbers of returns given the increased numbers of staff covered by the policy (percentage compliance remained broadly similar at 71%) – the inclusion of declarations of interest as part of medical appraisals and the planned work by Counter Fraud will help with further improvements going forward. Colleagues will continue to be encouraged to make timely returns to ensure that any potential instances of non-compliance with the policy can be addressed promptly rather than retrospectively.

- **Overdue actions –** The Committee identified a concern in relation to the number of overdue actions on the action log and overdue audit actions. A paper on the audit follow-up process will be reported to the next meeting in September and this will set out greater Executive oversight of audit action follow up.

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

- **External Audit Completion Report and Annual Report –** The Committee noted the proposed unqualified opinion (subject to final audit procedures being completed, which were not expected to impact upon the proposed opinion). No significant deficiencies in internal control were identified and unadjusted misstatement were not considered to be material. An error in relation to the revaluation reserve would be corrected in 2026/27. Positive feedback was provided regarding the audit process and engagement of management.

- **Items recommended for approval to the Trust Board:**
  - Group Financial Statements 2025-26
  - Annual Report including Annual Governance Statement (including going concern and Audit Committee annual report sections)

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• **Internal Audit Charter 2026-27 –** The Committee approved the Internal Audit Charter 2026-27. The principles remain the same with a minor change to include the CEO in the escalation protocol. • **Counter Fraud –** the Committee received and noted the Counter Fraud Progress Report and agreed the 2026-27 Counter Fraud Work Plan.
Risks (any new risks / proposed changes to risk scores)
There were no new risks.
Cross-referrals to Tier 1 Board Committees
There were no cross referrals

d - Board Committee Terms of Reference Presented by the Company Secretary

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Report Cover Sheet Agenda Item: 2d

Report Title:	**Board Committee Terms of Reference**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29 July 2026			
Author:	Jennifer Boyle, Company Secretary			
Sponsor:	Chairs and Executive Leads for the Board Committees			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To ratify the terms of reference for the Finance and Performance Committee and the 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 – May 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*	Both committees reviewed and approved their terms of reference as part of their annual effectiveness reviews. Copies of the reviews of effectiveness are available in the supplementary information pack accompanied the Board papers. Copies of the proposed terms of reference are appended to this paper: Appendix 1 - Finance and Performance Committee; and Appendix 2 – Quality Governance Committee. Key updates to terms of reference include: • Adjustments to membership and attendees – note these have been further revised to reflect additional changes following the Chair's review of Non-Executive Director committee membership; • Updates to the groups reporting to the committees;			

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	• Updates to terminology and function to reflect changes to the governance (e.g. removal of reference to supporting strategies and inclusion of estates within the remit of Finance and Performance Committee; and the addition of new integrated mental health reporting and impact analysis reporting to Quality Governance Committee).				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Finance and Performance Committee and the Quality Governance Committee recommend their respective terms of reference to the Board for ratification.				
Trust strategic priorities that the report relates to:	☒	Excellent patient care			
	☐	Great place to work			
	☒	Working together for healthier communities			
	☒	Fit for the future			
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	Collectively the Board Committees (Tier 1) support the Board in ensuring that there is effective assurance, accountability, risk management and decision-making in place. Well-governed Board committees ultimately support the achievement of the strategic objectives.				
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	-				
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

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Appendix 1

Board Committee (Tier 1) Terms of Reference

Gateshead Health NHS Foundation Trust

Finance and Performance Committee

Constitution and Purpose – The Finance and Performance Committee is a formal committee of the Board with delegated responsibility to monitor, review and make recommendations to the Trust Board with regard to the detailed financial and operational performance of the Trust.

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

Date Adopted / Reviewed	Finance and Performance Committee – May 2026 Board of Directors – July 2026 (TBC)
Review Frequency	Annual
Review and approval	Finance and Performance Committee
Adoption and ratification	Board of Directors

Membership	The Committee shall be appointed by the Trust Board and shall consist of: • Four Non-Executive Directors • Chief Executive • Group Director of Finance • Chief Operating Officer • Medical Director **or** Chief Nurse • Executive Director of People and Organisational Development

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	The Committee shall be chaired by a Non-Executive Director with relevant skills and experience. A Non-Executive Director shall be nominated as Vice Chair for the Committee (on a dynamic basis – i.e. as required).
Attendance	• Deputy Director of Planning and Performance • Director of Strategy and Partnerships • Deputy Director of Finance • Trust Chair • Audit Committee Chair A QE Facilities representative (the Director of Finance or Deputy) is required to attend to present QEF-related items when they form part of the agenda, but is not required to attend the full meeting. Executive Directors and senior managers should ensure that a deputy attends in their absence. All Non-Executive Directors have an open invitation to attend the meetings. Other Executive Directors and Senior Managers may be invited to attend meetings depending upon the issues under discussion.
Meeting frequency and quorum	Meetings shall be held **monthly** and as required by the national planning timetable. Meetings shall be held prior to the Trust Board to support the timely flow of assurance and items for escalation. To be quorate there should be at **least 2 Non-Executive Directors** and **1 Executive Director** present. The Committee reserves the right to pragmatically invite other Non-Executive Directors to attend for a single meeting in order to achieve quoracy if the lack of quoracy is short term / short notice. Note that the Chair can be elevated to the status of 'member' on a short term single-meeting basis in order to pragmatically support quoracy where no alternative options exist. Members and regular attendees are expected to achieve **75% attendance** annually.

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Meeting organisation	The Committee shall be supported administratively by the Corporate Governance Manager. In accordance with the Trust's Standing Orders, **papers will be circulated to members and attendees six days before the meeting** wherever possible, and no later than three clear days before the meeting, save in emergency. Minutes of the Committee's meetings are held by the Corporate Governance Manager and are circulated (alongside the agenda for the following meeting), to members and attendees.

Committee duties and responsibilities	
Strategy, planning and risk	To undertake **detailed scrutiny** of the adequacy of the Trust's **financial, operational, capacity and demand estimates, forecasts and planning assumptions** (in line with the latest regulatory requirements), making a recommendation to the Trust Board with respect to their approval. To **seek assurance over the delivery of the strategic objectives** mapped to the Committee for monitoring at the commencement of the financial year via the Strategic Objectives and Constitutional Standards report. To seek assurance over the **delivery of national and local-level strategies** relating to finance and operations. To **review the sections of the Board Assurance Framework (BAF)** mapped to the Committee for oversight and assurance, triangulating the control and assurance assertions on the BAF with the assurances and risks identified during each meeting. To **review the Finance and Operations-related risks from the Organisational Risk Register**, seeking assurance over the effective management of these risks towards the achievement of their target scores. The Committee will triangulate the risk registers against the assurances and risks emerging from the meeting for completeness. To seek **assurance over the delivery of specific major strategic projects** (with a significant likely finance or performance impact)

	which have been delegated to Finance and Performance Committee by the Board of Directors.
Finance	To **review and monitor the Trust's contractual performance** and associated income, considering the implications of longer-term financial strategy for the Trust, taking into consideration the outcomes reported to the Committee from contract review meetings. To undertake detailed scrutiny of the **monthly consolidated finance report** and financial regulatory returns. This includes seeking assurance over the following areas: • achievement of the financial and use of resources metrics identified in regulatory frameworks and planning guidance. • Achievement of cost reduction programme (CRP) plans • Budget versus actual performance, including forecasting where appropriate To review **exception reports from divisions** and seek assurance over recovery plans, in line with the accountability framework requirements. To review a **register of contracts** and seek assurance over the performance of those deemed to be material – financially or reputationally.
Capital, investment and estates	To monitor progress against the **capital plan** and make any recommendations to the Trust Board as required. To **review the Trust's Investment Strategy** at least annually, making recommendations for amendments to the Trust Board. To **review and discuss any significant initiatives, projects and issues that impact financially** on the Trust and that the Committee deem appropriate, and make recommendations to the Board as necessary. This should be in accordance with the Trust's Scheme of Delegation. **Review of business cases** in accordance with the delegated limits outlined within the Trust's Scheme of Delegation.

	To seek assurance in relation to **strategic matters relating to the Trust estate** – for example the Estates Returns Information Collection (ERIC), significant estates investments, projects and risks.
Performance	**Review the Strategic Objectives and Constitutional Standards reports** with a particular focus on performance measures, seeking assurance over the plans in place to deliver against targets and the actions in place to address those areas reported as exceptions (including any major standalone performance recovery plans). To monitor capacity, demand and delivery of national standards against planned levels (including with reference to the medium term plan) and make recommendations to the Trust Board where required.
Subsidiary governance	To seek assurance over the financial **performance of the Trust's subsidiary**, QE Facilities, against its contract with the Trust. To monitor the impact of the subsidiary on **group financial performance**. To **review and recommend the Green Plan for formal ratification** at the Board of Directors in line with its lifespan. To **seek assurance over the delivery of the Green Plan** twice a year and report this to the Board via the 3A (alert, advise, assure) report.
Regulatory and governance	To receive for information and assurance **Internal Audit reports** pertaining to the remit of the Committee. To review **feedback from NHS England** relating to financial, operational and planning matters. This includes any implications arising from the NHS Oversight Framework (NOF) ratings and assessment. To review any material **emerging regulatory guidance / requirements** in relation to finance and operational matters on behalf of the Board.

Reporting and monitoring	
Sub-groups	The following sub-groups report into the Committee: • Operations Oversight Group The minutes and summary of assurances and escalations document are received by the Committee as part of the flow of assurance through the Trust's governance structure.
Board reporting	A 3A assurance report (alert, advise, assure) from the Committee will be presented by the Chair to the next meeting of the Board of Directors.
Monitoring	Compliance with the terms of reference will be reviewed via an annual self-assessment. This will inform any proposed revisions to the terms of reference and the cycle of business. The outcome of the effectiveness and terms of reference review is presented to the Board of Directors following considered by the Committee.

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Appendix 2

Tier 1 Board Committee Terms of Reference

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Quality Governance Committee

Constitution and Purpose – The Quality Governance Committee is a formal Tier 1 committee of the Board with delegated responsibility to monitor, review and make recommendations to the Trust Board with regard to all aspects of quality of clinical care; quality and clinical governance systems; clinical risk issues, research & development; and regulatory standards of quality and safety.

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

Date Adopted / Reviewed	April 2026
Review Frequency	Annually
Review and approval	Quality Governance Committee – April 2026
Adoption and ratification	Trust Board – July 2026 (TBC)

Membership	The Committee shall be appointed by the Trust Board and shall consist of: • 3 Non-Executive Directors – one with clinical / medical expertise and knowledge to act as Committee Chair • Group Medical Director • Group Chief Nurse • Group Chief Operating Officer • Chief Executive

	A Non-Executive Director shall be nominated as Vice Chair for the Committee.
Attendance	The following will be expected to attend the Committee on a routine basis: • Deputy Chief Nurse • Chair • Head of Quality and Patient Experience • Head of Risk and Patient Safety / Chief Nursing Information Officer • Associate Medical Director for Quality and Safety • Senior Representation from the ICB to observe Note that the Associate Director of Midwifery is required to attend for maternity-related items only, rather than the full meeting. Executive Directors and senior managers should ensure that a deputy attends in their absence. Other Executive Directors and Senior Managers may be invited to attend meetings depending upon the issues under discussion. Two nominated Governors will be in attendance at the Committee as observers.
Meeting frequency and quorum	Meetings shall be held **bi-monthly.** Additional extraordinary meetings of the Committee can be called by the Chair in accordance with business need. To be quorate there should be at **least 1 Non-Executive Director** and 2 **Executive Directors** present. The Committee reserves the right to pragmatically invite other Non-Executive Directors to attend for a single meeting in order to achieve quoracy if the lack of quoracy is short term / short notice Members and regular attendees are expected to achieve **75% attendance** annually.

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Meeting organisation	The Committee shall be supported administratively by the Corporate Governance Manager. In accordance with the Trust's Standing Orders, **papers will be circulated to members and attendees six days before the meeting** wherever possible, and no later than three clear days before the meeting, save in emergency. Minutes of the Committee's meetings are held by the Corporate Governance Manager and are circulated (alongside the agenda for the following meeting), to members and attendees.

Committee duties and responsibilities	
Strategy, planning and risk	To **seek assurance over the delivery of the strategic objectives** mapped to the Committee for monitoring at the commencement of the financial year. This will be conducted via review of the Leading Indicators / Integrated Oversight Report. To approve and seek assurance over the **delivery of national and local-level strategies** relating to the remit of the Committee. To seek assurance over actions taken to address **strategic emerging quality-related developments / issues** through the routine overview reports provided by the Chief Nurse, Medical Director and ICB. To **review the sections of the Board Assurance Framework (BAF)** mapped to the Committee for oversight and assurance, triangulating the control and assurance assertions on the BAF with the assurances and risks identified during each meeting. To **review the quality / medical–related risks on the Organisational Risk Register**, seeking assurance over the effective management of these risks towards the achievement of their target scores. The Committee will triangulate the risk registers against the assurances and risks emerging from the meeting for completeness. To seek assurance over compliance with the **Emergency Preparedness, Resilience and Response (EPRR) standards** to order

	to ensure that potential risks to patient safety are effectively mitigated.
Safety	The **Leading Indicators Report** will be used to provide an overview of aspects of safety performance and enable spotlight reporting on areas of greatest risk. This report includes maternity and neonatal quality and safety indicators and is also reviewed by the Board (resulting in monthly review of maternity metrics). Seek assurance that the Trust has **effective systems for safety**, with particular focus on quality, patient safety, staff safety and wider health & safety requirements. This should also include routine assurance regarding compliance with **safe staffing levels** and well as the outcome from the **Safer Nursing Care Tool** reporting. Seek assurance over the Equality and Quality Impact Assessment process and outcomes, as reported to the Committee through the Chief Nurse's report. Seek assurance over the delivery of safe, high quality mental health services via the Mental Health Integrated Report. Seek assurance over the **robustness of procedures to ensure that adverse incidents and events are detected, openly investigated, with lessons learned being promptly applied** and appropriately disseminated in the best interests of patients, of staff and of the Trust. To seek assurance that the Trust embeds **learning from deaths** and had a robust process in place which complies with mandatory requirements. The Committee will receive assurance reports relating to learning from deaths (including the annual report), mortality data and reports from the Medical Examiner. To seek assurance that the Trust appropriately **responds to requests and requirements from coroners and other regulatory bodies** in respect of patient safety. To seek assurance over **health and safety** compliance through quarterly updates and the health and safety annual report. Through the reporting from **SafeCare Steering Group** the Committee will seek to gain assurance that:

Gateshead Health NHS Foundation Trust

	• the Trust has in place such systems of work and controls that **ensure medicines are effectively managed** and complaint with legislative requirements. • the Trust has in place such systems of work and controls that **ensure medical devices are effectively managed** and complaint with legislative requirements. • the Trust has in place systems of work and controls that ensure **infection prevention and control** is effectively managed and compliant with legislative requirements. To gain assurance that **safeguarding** is compliant with national and local requirements such that patients are safe in the Trust's care. On behalf of the Board the Committee will seek assurance on **maternity services** bi-monthly through the maternity oversight report. To seek assurance that quality and safety concerns raised via **Freedom to Speak Up** are appropriately addressed and lessons learned.
Patient experience	The **Leading Indicators Report** will be used to provide an overview of aspects of patient experience metrics and enable spotlight reporting on areas of greatest risk. Seek assurance that the Trust has **effective systems for delivering a high quality experience** for all its patients and users, with particular focus on **involvement and engagement** for the purposes of learning and making improvement. To provide assurance to Trust Board that there are robust systems for **learning lessons from complaints**, and action is being taken to minimise the risk of occurrence of adverse events. This should include the **sharing of aspects of good practice identified through compliments** and patient feedback. To seek assurance that the Trust is **delivering high quality care for patients with learning disabilities** in accordance with nationally and locally prescribed standards via the reporting from SafeCare Steering Group.

	The Committee will seek assurance over embedding of good practice or improvement actions resulting from **patient surveys**. To seek assurance that work is being undertaken to address **health inequalities** and improve patient outcomes and experience in this regard.
Clinical effectiveness, leadership and training	The **Leading Indicators Report** will be used to provide an overview of aspects of clinical effectiveness and outcomes (in accordance with the metrics defined in NHS England's Single Oversight Report) and enable spotlight reporting on areas of greatest risk. Seek assurance that the Trust has **effective systems for monitoring clinical outcomes and clinical effectiveness,** with particular focus on ensuring patients receive the best possible outcomes of care across the full range of Trust activities. To seek assurance over the **effective engagement of clinical leads** in the development and delivery of quality improvement initiatives. To seek assurance that clinical audit processes support effective clinical practice via the assurance and escalations from SafeCare Steering Group.
Regulatory and governance	To monitor, scrutinise and provide assurance to the Trust Board on the Trust's **compliance with core regulatory standards**, including the Care Quality Commission's Fundamental Standards, quality-related elements of NHS England metrics and NICE guidance. This will be conducted via assurances and escalations from the SafeCare Steering Group. On behalf of the Board, take a lead role in **seeking assurance that the Trust's annual Quality Account is compliant with regulatory requirements**, reflective of the main achievements and challenges during the year and has been appropriately consulted upon. The Committee will receive six-monthly updates on progress against the Quality Account priorities. To triangulate through assurance the **robustness of quality-assurance processes relating to all research undertaken** in the name of the Trust and / or by its staff, in terms of compliance with

	standards and ethics, and clinical and patient safety improvement processes. To receive for information and assurance **Internal Audit reports** pertaining to the remit of the Committee. To seek assurance over the implementation of key Internal Audit recommendations. To receive for information and assurance any **reports from external reviews** pertaining to the remit of the Committee, for example Regulation 28 reports. To review any material **emerging regulatory guidance / requirements** in relation to quality and clinical matters on behalf of the Board.

Reporting and monitoring	
Sub-groups	The following sub-groups report into the Committee: • SafeCare Steering Group (with additional reports from divisional SafeCare meetings on a rotational basis). • Group Health and Safety Group The minutes and summary of assurances and escalations documents are received by the Committee as part of the flow of assurance through the Trust's governance structure.
Board reporting	An assurance report from the Committee will be presented by the Chair to the next meeting of the Board of Directors.
Monitoring	Compliance with the terms of reference will be reviewed via an annual self-assessment. This will inform any proposed revisions to the terms of reference and the cycle of business. The outcome of the effectiveness and terms of reference review is presented to the Board of Directors following consideration by the Committee.

Gateshead Health
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3. EXCELLENT PATIENT CARE

a - Learning from Deaths Quarterly Report presented by the Group Medical Director

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 3a

Report Title:	**Learning from Deaths – Quarter 4 25/26**			
Name of Meeting:	Trust Board			
Date of Meeting:	29th July 2026			
Author:	Wendy McFadden – Clinical Effectiveness Lead Andrew Ward Senior Information Analyst – Quality & Patient Safety			
Executive Sponsor:	Dr Carmen Howey – Group Medical Director			
Report presented by:	Dr Carmen Howey – Group Medical Director			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To provide assurance that GHNT is learning from deaths according to national guidance.			
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:	Mortality & Morbidity Steering Group SafeCare Steering Group Quality Governance Committee			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	The paper outlines the process for the review of deaths within the organisation and the way in which those review processes enable learning from good practice and learning where there is evidence that care could be improved. Three extraordinary meetings took place throughout January to March to address the backlog of cases awaiting review. The number awaiting review has reduced to 50. Considerable progress has been made in the review of the deaths of patients with a Learning Disability, four cases remain outstanding for review by the Mortality Council (these have all been reviewed by the Learning Disability Nurses). The number of deaths of patients with a serious mental illness has reduced to 16. The report sets out new ways of working to improve consistency, efficiency and impact of mortality reviews, whilst ensuring best use of available clinical and organisational resources.			

	The report describes how other sources of data are triangulated with the information from the mortality review processes to ensure a joined-up understanding of any issues related to patient deaths which would cause us concern. The paper provides partial assurance regarding our internal processes as 50 cases still await review.				
Recommended actions for this meeting:	The Board is asked to receive this paper for assurance and note the changes to the review timescales set out in Section 6.				
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):	**Excellent patient care** 1. We will be a clinically-led organisation focused on delivering safe, high-quality care and improving health outcomes for our patients 2. We will ensure our patients experience the best possible compassionate care and make every contact count 3. We will continually improve our services creating a restorative culture where learning, innovation and research can flourish				
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☐	Responsive ☒	Well-led ☐	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	4873- *score of 15:* *Risk of inability to safely manage critically ill children under the age of 5 due to a combination of delays to inter-hospital transfer and a skills deficit for the MDT in managing children under 5.* *4704* score *15:* *Risk of failure to review appropriate clinical information due to multiple systems and lack of interoperability of data stored across a variety of digital systems and in paper format, this could result in patient harm or sub optimal care*"				
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☒	**Not applicable** ☒		

Learning from Deaths Report – Quarter 4 2025-26

1 Introduction:

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

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

2 Mortality data summary

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

2.1 Deaths in Emergency Care and In-patients

There were 15 deaths in the Emergency Care department compared to 20 deaths in the equivalent quarter for the previous year, a decrease of 5. The measure remains within common cause variation. (see Figure 1)

276 inpatient deaths observed in quarter three compared to 309 observed in the equivalent quarter for the previous year, a decrease of 33 and remaining within common cause variation on the SPC chart. (see Figure 2)

The SHMI (Summary Hospital-level Mortality Indicator) has shown signs of stabilising in recent months and has fallen slightly, remaining within the expected range (see Figure 3).

The gap between observed and expected mortality in the SHMI has narrowed slightly hence the recent fall in the SHMI. The number of expected deaths has stabilised as SDEC activity has been fully removed from the SHMI for the last three periods.

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

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. Trusts continue to await further guidance.

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

5.6 compared to a national figure of 6.7 codes per spell. Non-Elective spells: 6.6 compared to 6.2 codes per spell. (see Figure 5). The coding team locally advise that our coding is accurate and only includes the coding relevant to the last hospital spell, as it should.

The % of spells with palliative care coding recorded has stabilised at 3.0% of spells, compared to 2.1% for England (see Figure 6)

There are two SHMI Mortality Alerts from Healthcare Evaluation Data (HED) for specific diagnosis groups.

Peripheral and visceral atherosclerosis. 16 deaths observed against 6.9 expected calculated by the SHMI. All deaths occurred in hospital and have been scrutinised by the Medical Examiner's Office and were deemed to be 'Definitely not preventable and 'Good Practice'

Acute and unspecified renal failure. 46 deaths observed versus 29.3 expected calculated by the SHMI. 31 deaths occurred in hospital. A random sample of the cases that occurred in hospital have internal scrutiny. No concerns regarding the management of renal failure were found. A coding issue regarding acute kidney injury was identified and learning identified is going to be shared with the coding and clinical teams. In addition, the SafeCare leads will provide teaching sessions for the coding teams on this diagnosis.

The unadjusted mortality rate provided by the North-East Quality Observatory (NEQOS) shows that rate varies between trusts and quarters across the period October 2022 to September 2025 (Figure 4), with the current period ranging from 2.3% at South Tees to 4.7% at North Cumbria. The SHMI and the unadjusted rate include all deaths in hospital plus deaths within 30 days of discharge. For Gateshead the crude rate in Q2 2025-26 is below the rate observed in Q2 204-25 (most recent available data from NEQOS).

2.2 Rolling 12-month scrutiny data:

Considering deaths in the Trust in the 12 months preceding the end of quarter four. There were 1,134 deaths, of which 1,103 (97.3%) were scrutinised by the Medical Examiner.

Medical Examiner scrutiny deemed 1,071 cases (94.4%) to be 'Definitely not preventable' and 'Good Practice' identified in 1,037 cases (91.4%). 16 cases (1.4%) identified potentially 'Some evidence of preventability' and 'Room for improvement' identified in 46 cases (4.1%). 16 cases (1.4%) were unable to be scored for preventability, and referred to the Mortality Council, 31 cases (2.7%) were not scored. (see Table 2)

Considering all deaths and mortality review during the period 12-month period ending Q4 2025-26 (ME Scrutiny, Ward Level Reviews, Mortality Council Reviews) provides the following scores.1,056 cases (93.1%) 'Definitely not preventable' and 1,020 cases (89.9%) Good Practice.

No deaths were judged to be more likely than not to have been due to problems in the care provided to the patient, Hogan 4 or above.

31 cases (excluding complaints, the total including complaints is 26) (2.7%) from the period awaiting Mortality Council review, and 18 cases (1.6%) awaiting a ward review following referral by the Medical Examiner at the time of writing. (see Table 8).

3 Learning from Ward Level Reviews:

44 ward level reviews took place during quarter 4, 42 were 'Definitely not preventable', 1 'Slight evidence of preventability' and 1 'Possibly preventable (less than 50:50)'.

From the quality of care review perspective, 27 deaths were deemed to be 'Good Practice', 9 'Room to improve in clinical care', 3 'Room to improve in organisational care' and 4 'Room to improvement in both clinical and organisational care' and a score was not recorded for 1 case. Where learning or the opportunity to share good practice is identified in a ward review, this will be actioned and shared within Division and across Divisions where this is appropriate.

Ward level reviews are only required to be undertaken following a referral from the Medical Examiner; however, wards can review any of the deaths that have occurred on their wards should they wish.

3.1 Themes of good practice identified through Ward Reviews:

- Best interest decision making demonstrated throughout with appropriate input from learning disability teams
- Discussions with family members
- MDT discussions
- Recognition of legal power of attorney
- Informed decision making regarding ceiling of care and palliation
- Good clinical care
- Good support from mental health team and psychology

3.2 Learning identified and actions arising from Ward Reviews

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

- **Documentation and Information Systems**
  - Incomplete or inaccessible documentation (particularly fluid balance charts) limited real-time clinical oversight and retrospective review.
  - Use of multiple parallel systems (paper notes, Careflow, Nervecentre, specialist records) increased risk of missed tasks and unclear plans.
  - Lack of integrated electronic records contributed to loss of handover information and review delays.

  Learning: Improved integration and electronic documentation would enhance patient safety, continuity of care, and governance review quality.

  Multiple systems is recorded as an organisational risk - "*4704 Risk of failure to review appropriate clinical information due to multiple systems and lack of interoperability of data stored across a variety of digital systems and in paper format, this could result in patient harm or sub optimal care*"

- **Fluid, Electrolyte, and Nutritional Management**

  - Inconsistent fluid balance recording reduced ability to recognise and respond promptly to electrolyte abnormalities.

- Weekend delays in review of fluids and blood results were a recurring vulnerability.
- Inaccurate MUST scoring delayed dietetic input in some cases.
- Long-term nutritional requirements (e.g. post-bariatric surgery supplementation) were not always identified or prescribed on admission.

Learning: Clear ownership and reliable documentation of fluids, electrolytes, and nutrition are essential, particularly in frail and high-risk patients.

Task & Finish Group is in the process of being reinvigorated to take forward the improvement work required for managing fluid balance.

- **Weekend and Out-of-Hours Pressures**
  - Reduced MDT availability limited shared decision-making for complex medical, mental health, and social issues.
  - No consistent weekend mechanism for shared-risk discharge discussions.
  - Handover plans were not always completed, particularly across weekends.

  Learning: Weekend systems represent a recognised risk point for complex patients and require strengthened handover and escalation processes.

- **Transfers and Handover Between Clinical Areas**
  - Transfers between ED, EAU, wards, and specialty teams sometimes lacked documented senior review or clear handover of risk.
  - Patients transferred with elevated early warning scores were not always reviewed promptly on arrival.

  Learning: Structured handover and early senior review at points of transfer are critical to maintaining continuity and safety.

- **Frailty Recognition and Advance Care Planning**
  - DNACPR decisions were generally appropriate but broader EHCP discussions were sometimes delayed despite repeated admissions.
  - Frequent ward moves and care under multiple specialties reduced continuity and delayed holistic recognition of end-of-life trajectories.

  Learning: Earlier frailty identification and advance care planning may support more coordinated and patient-centred care.

- **Communication and Family Experience**
  - Communication with families was generally good; however, documentation of key discussions (e.g. discharge rationale, ceilings of care) was occasionally incomplete.
  - Practical care issues (mouth care, dentures, access to belongings, response times to PRN medication) significantly influenced family experience.

  Learning: Attention to fundamental care and clear documentation strongly affects perceived quality of care.

4 Learning from Mortality Council

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

For the period 1st January to 31st March 2026, six Mortality Council meetings took place. three planned and three additional meetings, resulting in 46 deaths being reviewed within the quarter.

4.1 Thematic Learning from Mortality Council Review

Good Practice Identified:

- Excellent documentation from the Acute Oncology Nurse explained diagnosis uncertainty, risk of deterioration, expected trajectory
- good communication with family regarding ceilings of care, decisions were aligned to patient's wishes and timely escalation to ITU

Clinical and Organisational Learning Identified and actions taken:

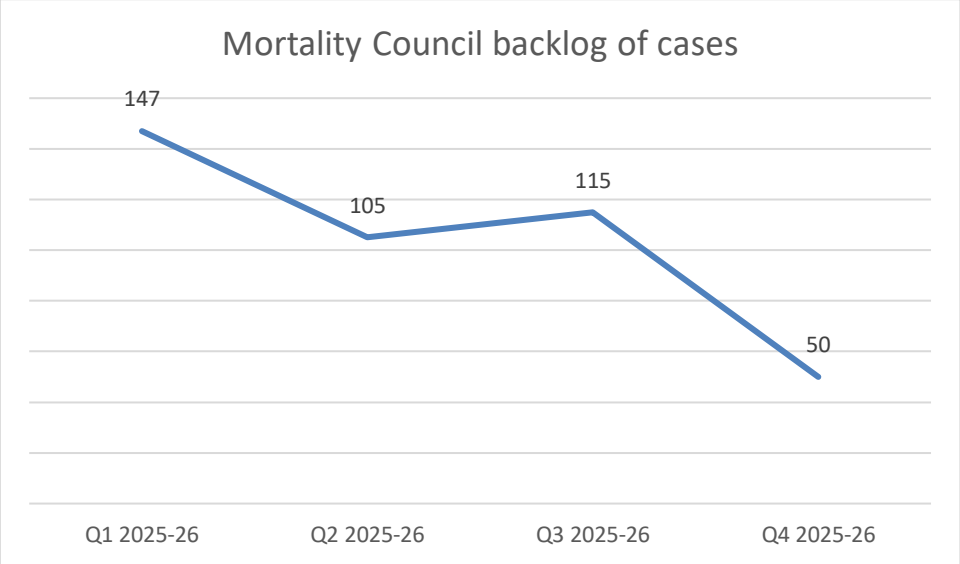
Learning	Who's responsible	Outcomes
System Capacity & Escalation Failures Paediatric review highlighted regional capacity constraints (PICU/HDU bed shortages, NECTAR delays, withdrawn bed acceptance). These were systemic, with no clear regional escalation mechanism when capacity was exhausted. This directly affected timeliness of transfer.	Escalated through Surgical Division and is now on risk register: *"4873* score *15: Risk of inability to safely manage critically ill children under the age of 5 due to a combination of delays to inter-hospital transfer and a skills deficit for the MDT in managing children under 5.*	Progress monitoring through Executive Risk Management Group
Documentation Gaps & Fragmented Records Recurring theme was critical information not being visible, incomplete, or poorly documented: • Birth history missing from infant records • Outsourced endoscopy records not integrated • Emergency events in CDC not documented	Multiple systems is recorded as an organisational risk - "*4704* score *15: Risk of failure to review appropriate clinical information due to multiple systems and lack of interoperability of data stored across a variety of digital systems and in paper format, this could result in patient harm or sub optimal care*"	Progress monitoring through Executive Risk Management Group and Digital Committee

• Inconsistent documentation of CPR decisions • Lack of clarity around declined treatments (e.g., surgery, nutrition)		
Recognition of Deterioration & Escalation of Care Several cases showed delays or missed opportunities in recognising deterioration: • Malnutrition not escalated • Delayed investigations (e.g., C.diff sample) • Unclear escalation when patients repeatedly declined essential care • Uncertainty around CPR initiation in the absence of DNACPR	Fed into Nutrition Steering Group Fed back to divisional teams Raised with Medical Staffing	Via Nutrition Steering Group AAA report to Safecare steering group Divisional safety huddles will monitor for further incidents. Process has been changed to ensure all locums have the relevant CPR training prior to commencing in the Trust
Communication Challenges Communication issues contributed to misunderstanding and complaints from families	Associate directors of nursing Surgical Safecare team	To be discussed in the Nursing and midwifery professional forum. Learning regarding consent and capacity fed back to surgical division to action and plan and disseminate local learning
Emergency Preparedness in Non-Acute Settings CDC and other non-acute environments lacked: • Internal emergency call systems • On-site crash team • Clear emergency pathways • Consistent documentation of emergency event	After Action Review completed by CSS SBAR now developed and will be sent with patients from CDC in future. Guidelines also updated.	Presented to Clinical Support & Screening SafeCare
Discharge Planning & Vulnerability Assessment There were repeated concerns about unsafe or	Missed safeguarding concern raised with CNTW to investigate	CNTW patient safety lead attended mortality council and raised a n incident for CNTW to investigate due to

poorly supported discharges, especially for: • Patients with learning disabilities • Frail or socially vulnerable individuals • Patients with complex home circumstances	Learning fed back to the divisional safecare teams to disseminate learning to local teams OPMH safecare team	incorrect safeguarding process. Divisional safety huddles to monitor for themes of inappropriate discharge in InPhase reporting. OPMH team fed back to TEWV Any themes emerging can then be monitored by iLOM.
PACS issues identified following major incident period	To be investigated by CSS safecare team	Will be monitored by the iLOM meeting and outcomes of reports resented at ELSOP.

5 Addressing Mortality Council Backlog

At the beginning of 2025/26, the backlog stood at 147. The chart below demonstrates the reduction over the preceding 12 months:



Three extraordinary Mortality Council meetings, as well as three prescheduled meetings took place in quarter 4 resulting in 46 cases being reviewed.

By the end of Q4 the backlog stands at 50 outstanding cases:

2024 - 5
2025 – 26
2026 – 19

Learning Disabilities deaths – update on backlog of cases for review

Four learning disability deaths still require a mortality council review (three of these are listed for April 2026); however, they have been reviewed by the learning disability lead nurse and any immediate learning actioned.

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

Progress has been made with the backlog of serious mental illness deaths. A breakdown of the16 remaining cases is below:

Under 65s	5 in total 2025 – 4 2026 - 1	Listed for April
Over 65s	11 in total 2024 – 4 2025 – 7	2 listed for April 4 listed for April

6 Proposed new ways of working – Q1 2026/27

To improve the consistency, efficiency, and impact of mortality reviews while ensuring best use of available clinical and governance resources, it is proposed to make changes to the way in which mortality reviews are carried out, which if approved will result in a change to the Learning from Deaths policy.

The following defines clear criteria when cases require:

- Ward-level review only
- Escalation to Mortality Council
- Specialist input (e.g., Learning Disability or Mental Health)

Key Changes:
Introduction of Structured Judgement Reviews (SJR) - a standardised template will be implemented at ward level to ensure consistent, high-quality reviews of all applicable deaths. (Appendix 3)

Enhanced Ward-Level Ownership - reviews will be conducted locally wherever appropriate, with outcomes recorded on the Mortality Database and escalated where necessary.

Targeted Use of Mortality Council - the Mortality Council will focus on cases meeting defined criteria, ensuring timely and proportionate oversight. All escalated cases will be reviewed within 12 weeks.

The table below details the proposed methods of review for each criteria:

Criteria	**Proposed method of review**
Bereaved families and carers, or staff, have raised a significant concern about the quality of care provision;	Any patient death where a formal complaint is raised will be scrutinised in mortality council. Mortality Council within 12 weeks of receipt of the complaint with complaint response and ward level review. Staff concerns escalated through ward level review to Mortality Council
Learning Disability and Autism deaths over 18 years of age	Mortality Council and Learning Disability specialist review within 12 weeks of death
Serious Mental Illness	No input from mental health services ME review identifies no issues= no further review required Input from mental health service – Mortality Council with Mental Health specialist review within 12 weeks of death Deaths under Mental Health section – Mortality Council with ward level and specialist mental health review within 12 weeks of death
Deaths in a service specialty, particular diagnosis or treatment group where an 'alarm' has been raised with the provider through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator);	'Alarm' to be reviewed within Mortality & Morbidity Steering Group initially, who may commission an extraordinary Mortality Council to review cases within the 'alarm' criteria
Deaths in areas where people are not expected to die, for example in relevant elective procedures;	Mortality Council with ward level review within 12 weeks of death
Child deaths*	Mortality Council with ward level review within 12 weeks of death with subsequent review following post-mortem
Maternal deaths	Mortality Council with ward level review within 12 weeks of death with subsequent review following post-mortem
A further sample of other deaths that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall. This does not have to be a random sample and could use practical sampling strategies such as taking a selection of deaths from each weekday.	ME referrals – Mortality Council with ward level review within 12 weeks of death Referrals from ward level review – Mortality Council Deaths classified as Hogan 2 or more ME or ward level review – Mortality Council

* does not include neonatal deaths, they are subject to separate process defined within the Perinatal Mortality Review Tool

Governance and oversight:
While ward teams will undertake initial reviews and escalate concerns as appropriate, the Mortality Council will retain responsibility for central oversight and the detailed review of relevant cases. The Mortality & Morbidity Steering Group will continue to monitor trends and escalate system-level risks to ensure organisational learning and improvement.

Conclusion:
The introduction of these changes is expected to see greater consistency and quality of reviews, more efficient use of specialist resources, improved timeliness of case review (within 12 weeks), stronger organisational learning and quality improvement and continued compliance with national guidance. Going forwards we will report the volume of deaths reviewed each quarter against each of the different categories and the backlog against the timescale agreed.

7 Triangulation of Mortality Data

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

Inphase

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

Patient Safety Team

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

Legal Services

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

Mortality Council

- For deaths reviewed by the Mortality Council, information is collated in advance of the meeting in relation to complaints/PALs, patient safety, legal and safeguarding, to ensure that the full picture is available for the discussion.

- Formal Complaints received from relatives/carers of the deceased are shared by the complaints team for discussion at the Mortality Council.
- Outcomes and learning from Inquests for individual patients are presented to the Mortality Council.
- A quarterly learning summary from the Mortality Council is developed and shared throughout the organisation.
- Learning from Mortality Council is also shared via Divisional SafeCare Meetings and the Safety Brief which is replacing the learning aspect of the Learning Panel.
- Deaths with significant learning/harm can also be discussed in the Incident Learning Oversight Meeting.

7 Summary

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

Although three extraordinary Mortality Councils were held in quarter 4, it continues to be challenging to work through the existing backlog of cases to be reviewed and opportunities to identify learning and escalate any relevant cases into other governance processes e.g. patient safety and patient experience. The plans laid out in section 6 have been designed to improve on this position from quarter 1 2026/27 onwards.

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

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

8 Recommendation

The Board is asked to receive this paper for assurance and note the changes to the review timescales set out in Section 6, previously approved within Mortality & Morbidity Steering Group, SafeCare Steering Group and Quality Governance Committee.

Appendix 1:

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

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

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

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

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

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

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

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

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

Appendix 2: Mortality charts

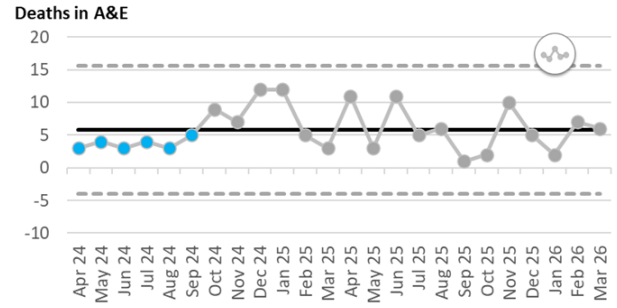


Figure 1: Deaths in A&E

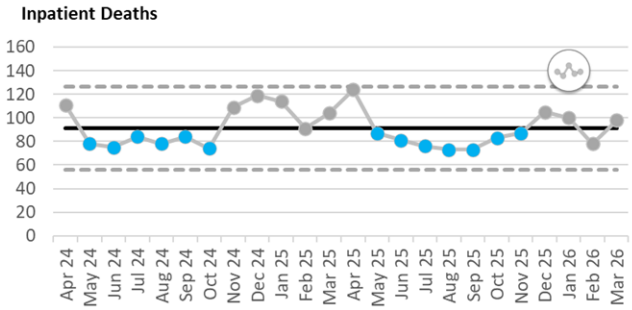


Figure 2: Inpatient Deaths

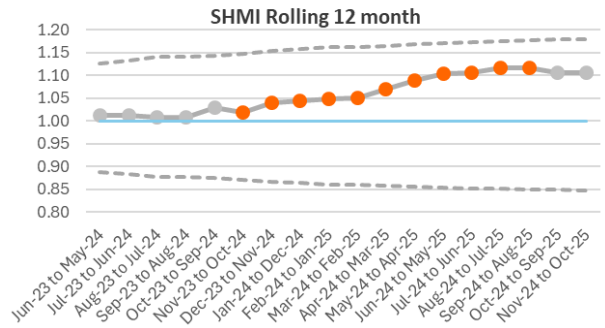


Figure 3: SHMI Rolling 12 months

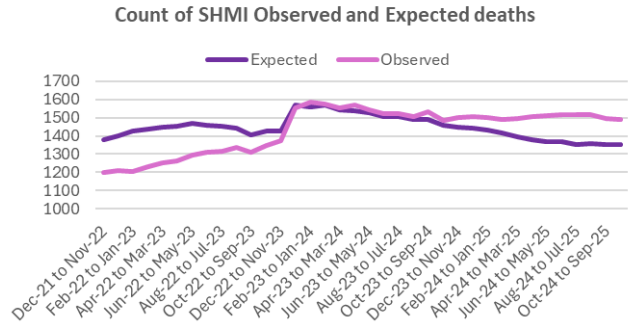


Figure 4: Observed and Expected Deaths

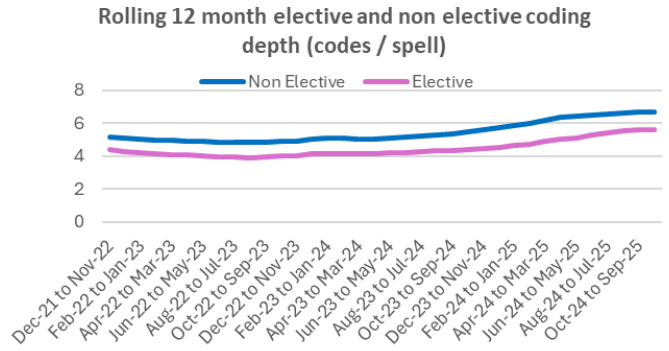


Figure 5: Elective and Non-Elective Coding Depth Rolling 12 months

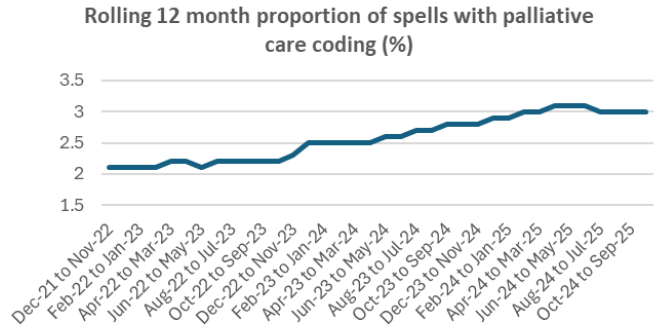


Figure 6: Proportion of spells with palliative care coding Rolling 12 months

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

	Alert	CCS Diagnostic Group	Period	Observed Deaths	Expected Deaths	Obs -Exp	SHMI	% of cases with scrutiny (where death within Trust Hospital)	% Definitely not preventable	% NCEPOD Good Practice
	SHMI	Peripheral and visceral atherosclerosis	Jan-25 to Dec-25	16 (16 in hospital)	6.9	9.1	233	100% 16 of 16	100%	100%
	SHMI	Acute and unspecified renal failure	Jan-25 to Dec-25	46 (31 in hospital)	29.3	16.7	157	67.4% 31 of 46	100%	96.8%

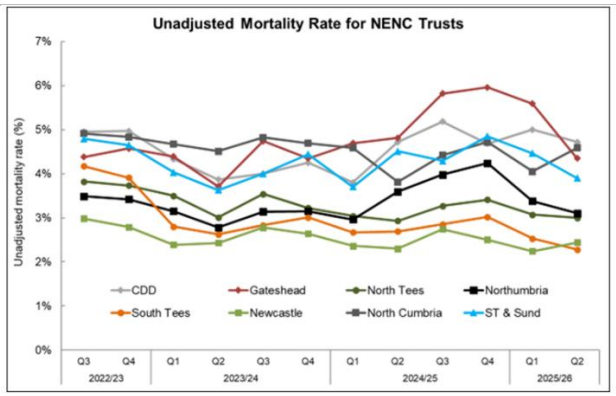


Figure 7 Unadjusted Mortality Rate NENC

Medical Examiner Scrutiny	
Deaths in period	1134
Deaths Scrutinised by Medical Examiner	1103
% of Deaths scrutinised by the Medical Examiner	97.3%

Hogan Scores		
Definitely not preventable	1071	94.4%
Some evidence of preventability	16	1.4%
Unable to score - Refer to Mortality Council	16	1.4%
Not scored by the Medical Examiner*	31	2.7%

NCEPOD Scores		
Good practice	1037	91.4%
Room for Improvement	46	4.1%
Unable to score - Refer to Mortality Council	20	1.8%
Not scored by the Medical Examiner*	31	2.7%

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

Table 2: Medical Examiner Scrutiny 12 months ending Q4 2025-26 Hogan and NCEPOD Scoring

Hogan Scoring		
1 Definitely Not Preventable	42	95.5%
2 Slight evidence of preventability	1	2.3%
3 Possibly Preventable (Less than 50:50)	1	2.3%
4 Probably preventable (more than 50:50)	0	0.0%
5 Strong Evidence Preventable	0	0.0%
6 Definitely Preventable	0	0.0%
Initial review but not yet scored	0	0.0%
Total	44	100%

NCEPOD Scoring		
1 Good practice	27	62.8%
2 Room for improvement - Clinical Care	9	20.9%
3 Room for Improvement - Organisational Care	3	7.0%
4 Room for improvement - Clinical and Organisational care	4	9.3%
5 Less Than Satisfactory	0	0.0%
6 Insufficient data	0	0.0%
Initial review but not yet scored	0	0.0%
Total	43	100.0%

Table 3: Ward team reviews in the quarter outcomes.

Hogan Scoring		
1 Definitely Not Preventable	20	90.9%
2 Slight evidence of preventability	1	4.5%
3 Possibly Preventable (Less than 50:50)	1	4.5%
4 Probably preventable (more than 50:50)	0	0.0%
5 Strong Evidence Preventable	0	0.0%
6 Definitely Preventable	0	0.0%
Initial review but not yet scored	0	0.0%
Total	22	100%

NCEPOD Scoring		
1 Good practice	8	36.4%
2 Room for improvement - Clinical Care	7	31.8%
3 Room for Improvement - Organisational Care	3	13.6%
4 Room for improvement - Clinical and Organisational care	4	18.2%
5 Less Than Satisfactory	0	0.0%
6 Insufficient data	0	0.0%
Initial review but not yet scored	0	0.0%
Total	22	100.0%

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

Hogan Scoring		
1 Definitely Not Preventable	38	82.6%
2 Slight evidence of preventability	5	10.9%
3 Possibly Preventable (Less than 50:50)	1	2.2%
4 Probably preventable (more than 50:50)	0	0.0%
5 Strong Evidence Preventable	0	0.0%
6 Definitely Preventable	0	0.0%
Initial review but not yet scored	2	4.3%
Total	46	100%

NCEPOD Scoring		
1 Good Practice	21	45.7%
2 Room for improvement - Clinical Care	3	6.5%
3 Room for Improvement - Organisational Care	10	21.7%
4 Room for improvement - Clinical and Organisational care	10	21.7%
5 Less Than Satisfactory	0	0.0%
6 Insuficient data	0	0.0%
Initial review but not yet scored	2	4.3%
Total	46	100.0%

Table 5: Mortality Council reviews in the quarter

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

NCEPOD Scoring		
1 Good Practice	1	33.3%
2 Room for improvement - Clinical Care	0	0.0%
3 Room for Improvement - Organisational Care	2	66.7%
4 Room for improvement - Clinical and Organisational care	0	0.0%
5 Less Than Satisfactory	0	0.0%
6 Insuficient data	0	0.0%
Initial review but not yet scored	0	0.0%
Total	3	100.0%

Table 6: Learning Disability Deaths reviewed in the quarter

Hogan Scoring		
1 Definitely Not Preventable	12	92.3%
2 Slight evidence of preventability	1	7.7%
3 Possibly Preventable (Less than 50:50)	0	0.0%
4 Probably preventable (more than 50:50)	0	0.0%
5 Strong Evidence Preventable	0	0.0%
6 Definitely Preventable	0	0.0%
Initial review but not yet scored	0	0.0%
Total	13	100%

NCEPOD Scoring		
1 Good Practice	12	92.3%
2 Room for improvement - Clinical Care	1	7.7%
3 Room for Improvement - Organisational Care	0	0.0%
4 Room for improvement - Clinical and Organisational care	0	0.0%
5 Less Than Satisfactory	0	0.0%
6 Insuficient data	0	0.0%
Initial review but not yet scored	0	0.0%
Total	13	100.0%

Table 7: Severe Mental Illness Deaths reviewed in the quarter

Hogan Scoring		
1 Definitely Not Preventable	1056	93.1%
2 Slight Evidence of Preventabiliy	4	0.4%
3 Possibly Preventable (Less than 50:50)	2	0.2%
4 Probably preventable (more than 50:50)	0	0.0%
5 Strong Evidence Preventable	0	0.0%
6 Definitely Preventable	0	0.0%
Awaiting Mortality Council Review	31	2.7%
Awaiting Ward Team Review	18	1.6%
Not reviewed / scored	23	2.0%
Total	1134	100%

NCEPOD Scoring		
1 Good Practice	1020	89.9%
2 Room for improvement - Clinical Care	6	0.5%
3 Room for Improvement - Organisational Care	17	1.5%
4 Room for Improvement Clinical and Organisational Care	18	1.6%
5 Less Than Satisfactory	0	0.0%
6 Insuficient data	0	0.0%
Awaiting Mortality Council review	29	2.6%
Awaiting Ward Team Review	18	1.6%
ME identified room for improvement but not referred	1	0.1%
Not reviewed / scored	25	2.2%
Total	1134	100.0%

Table 8: Scoring outcomes from all mortality review for deaths in the 12-month period ending Q4 2025-26.

Appendix 3: Structured Judgment review form

Gateshead Health NHS Foundation Trust

Mortality Structured Judgement Review (SJR) Proforma (V1.0)

Please complete the patient's details below using your clinical judgement within the context of a local safecare review.

Case-notes reviewed			
Patient Name:	Hosp No: Age / DoB:		
Date of admission: Admission diagnosis: Date of Death:	Please print your name: Job title: Contact number: Date of review:		
Expectation of death			
Was this patient expected to die at admission? Was this patient expected to die subsequently?		Yes ☐ Yes ☐	No ☐ No ☐
Brief Case Summary/Synopsis			
MCCD 1a Cause of death: Coroners Case : Yes ☐ / No ☐			
Elective Admission ☐	Emergency Admission ☐		
Admitted from:			
Own Home ☐	Residential/Nursing/Care Home☐	Other ☐	
Warden/Sheltered Accommodation ☐	Other Hospital ☐	Unable to tell ☐	

Phase of Care 1: On Admission (first 24hrs) – *Brief description*				
Care during this phase was	Very Poor-1	Poor-2	Adequate-3	Good-4 Excellent-5

During the first 24hrs of Admission, was -			
Was the patient seen by consultant within 14 hrs of admission	Yes ☐	No ☐	Unable to tell ☐
Was patient death anticipated within 24hrs of admission	Yes ☐	No ☐	Unable to tell ☐

Phase of Care 2: On-going care – *Brief description*				
Care during this phase was	Very Poor-1	Poor-2	Adequate-3	Good-4 Excellent-5

During Admission, did any of the following occur? *(tick all that apply)*			
Sepsis	Yes ☐	No ☐	Unable to tell ☐
AKI	Yes ☐	No ☐	Unable to tell ☐
Hospital Acquired Infection (Pneumonia, Covid, C-Diff, etc)	Yes ☐	No ☐	Unable to tell ☐
In-patient Fall	Yes ☐	No ☐	Unable to tell ☐
Inappropriate ward transfers	Yes ☐	No ☐	Unable to tell ☐
Unexpected return to Theatre	Yes ☐	No ☐	Unable to tell ☐
Signs of deterioration that were not acted upon	Yes ☐	No ☐	Unable to tell ☐

Phase of Care 3: Care during a procedure – *Brief description or tick here if No procedure was undertaken* ☐
Care during this phase was Very Poor-1 Poor-2 Adequate-3 Good-4 Excellent-5

Phase of Care 4: Peri-Operative Care – *Brief description or tick here if No procedure was undertaken* ☐
Care during this phase was Very Poor-1 Poor-2 Adequate-3 Good-4 Excellent-5

Phase of Care 5: End of Life Care – *Brief description*
Care during this phase was Very Poor-1 Poor-2 Adequate-3 Good-4 Excellent-5

During End of Life, was there - *(tick all that apply)*			
Regular Consultant Review	Yes ☐	No ☐	Unable to tell ☐
A Personalised Care Plan to support the patient's death	Yes ☐	No ☐	Unable to tell ☐
RESPECT form completed	Yes ☐	No ☐	Unable to tell ☐
Discussions with family/carers regarding deterioration	Yes ☐	No ☐	Unable to tell ☐
Evidence that Patient's End of Life wishes were followed	Yes ☐	No ☐	Unable to tell ☐

Assessment of Problems in Care		
Were there any problems with the care of the patient?	Yes ☐	Please continue below : **Problem types** *then OAoC*
	No ☐	Please continue directly to *Overall Assessment of Care*

Problem type(s) *(tick/select an answer **only** for those that occurred)*	**If this problem occurred did it lead to harm?**		
1. Assessment, investigation or diagnosis [incl risk of pressure ulcer, falls, VTE]	Yes ☐	No ☐	Probably ☐
2. Medication / IV fluids / electrolytes / oxygen	Yes ☐	No ☐	Probably ☐
3. Treatment and management plan [incl prevention of pressure ulcer, falls, VTE]	Yes ☐	No ☐	Probably ☐
4. Infection control management	Yes ☐	No ☐	Probably ☐
5. Operation / invasive procedure	Yes ☐	No ☐	Probably ☐
6. Clinical monitoring [incl failure to recognise / respond to changes]	Yes ☐	No ☐	Probably ☐
7. Resuscitation following a cardiac or respiratory arrest	Yes ☐	No ☐	Probably ☐
8. Other problem not fitting in the categories above	Yes ☐	No ☐	Probably ☐

Overall Assessment of Care *[in accordance with good practice] – Brief description*					
Care overall was	Very Poor-1	Poor-2	Adequate-3	Good-4	Excellent-5

Documentation					
Standard of Documentation was	Very Poor-1	Poor-2	Adequate-3	Good-4	Excellent-5
Order of the Case-notes were	Very Poor-1	Poor-2	Adequate-3	Good-4	Excellent-5

Hogan Score:		
1. Definitely not preventable	Yes ☐	No ☐
2. Slight evidence of preventability	Yes ☐	No ☐
3. Possibly preventable but not very likely less than <50% but close call	Yes ☐	No ☐
	Yes ☐	No ☐
4. Probably preventable > 50% but close call	Yes ☐	No ☐
5. Strong evidence for preventability	Yes ☐	No ☐
6. Definitely preventable		

Please list learning points / changes in practice / good practice for sharing / any other actions eg resulting from M&M discussion:
1
2
3
Above includes learning relevant to other specialties: Y / N

Outcome from Structured Judgement Review	
1. **No further action required** (overall score is 3 or above and no problems in care identified which probably or did lead to harm)	☐
2. **Case to be discussed/presented** at Speciality M&M for Shared Learning	☐
Please record date and outcome of M&M Discussion below:	
3. **Escalation to Higher Level Review** (overall score is less than 3 or problems in care identified which probably or did lead to harm)	☐

Higher Level Review ***(To be completed by Trust Mortality Lead or nominated Clinician)***	
Outcome from Higher Level Review	
1. No further action required	☐
2. Case to be discussed/presented at Trust Mortality Group for shared Learning	☐
3. Escalation to Incident/Investigation	☐
4. Other outcome (as specified above)	☐
Higher Level Review Completed by:	**Date of Review:**

RCP guidance for Reviewers:
NMCRR-guide-for-reviewers-NEW.pdf

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

NHS Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 3b

Report Title:	**Maternity Integrated Oversight Report July 2026**			
Name of Meeting:	Trust Board – Part 1			
Date of Meeting:	29 July 2026			
Author:	Mrs Karen Parker Associate Director of Midwifery/SCBU			
Executive Sponsor:	Beth Swanson, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Karen Parker			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	This report presents an overview of maternity and neonatal metrics for July 2026			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Obstetrics & Gynaecology Safecare 9/7/2026 Division of Surgery, Women's Health and Children Operational Board 29/7/2026 Safety Champions 17/7/2026 Safecare Steering Group 21/7/2026			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	**Alert** • No new alerts **Advise** • Ockenden Nottingham Maternity Report & National Maternity & Neonatal Review (Amos) both published • Interim assurance visit for Safety Action D Maternity Incentive Scheme – August 2026 **Assure** • Guidelines approved – Unauthorised Access & Abduction Policy, Neonatal Pulse Oximetry, SCBU Ward SOP & daily acuity monitoring • Regional heatmap – reduction in score following resolved stakeholder concerns			

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Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	Accept as monthly perinatal report				
Trust strategic priorities that the report relates to:	☒	Excellent patient care			
	☐	Great place to work			
	☒	Working together for healthier communities			
	☐	Fit for the future			
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	Centre of excellence for Women's Health				
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	4852 – Maternity Theatres 2275 – SCBU workforce				
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Gateshead Health NHS Foundation Trust

Maternity
Integrated Oversight Report

Maternity data from June 2026

Executive Summary

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

- No alerts

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

- Ockenden Nottingham Maternity Report & National Maternity & Neonatal Review (Amos) both published – exception report slides included
- Interim assurance visit for Safety Action D Maternity Incentive Scheme – August 2026

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

- Guidelines ratified - Unauthorised Access & Abduction Policy, Neonatal Pulse Oximetry, SCBU Ward SOP & daily acuity monitoring
- Regional heatmap – reduction in score following resolved stakeholder concerns

Slide No.!	Metric *data reporting is for preceding month - January 2026 report is December 2025 data	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Notes
Monthly reports														
	Minimum board measures data set	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	Monthly Maternity dashboard activity data	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	Maternity Incentive Scheme compliance	✓	✓					✓						GAP analysis of Year 8
	Maternity Outcomes Signal (MOSS)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	Regional Heatmap	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	MDT workforce	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Exception reports (as required)														
	SPC exception reports	✓	✓	0	0	0	0	0						
	PSII/MNSI/perinatal mortality – new & completed cases	0	✓	0	✓	0	✓	0						
	Risk register – new emerging risks & updates	✓	✓	✓	✓	✓	✓	✓						
Quarterly reports		Q2 2025/ 26	Q3 2025/26			Q4 2025/26			Q1 2026/27			Q2 2026/27		
	Perinatal Mortality Review Tool (PMRT)	✓				✓					✓			
	Transitional Care & ATAIN (avoiding term admissions to neonatal units)				✓			✓		✓			✓	
	SBLCB (Saving Babies Lives Care Bundle)		✓						✓			✓		
	Complaints, Compliments & Incidents	✓			✓			✓			✓			Q1 complaints also reported this month
	Maternity Inequalities Dashboard			✓			✓			✓			✓	Deferred to next month due to capacity
Bi-annual reports		Q1 & Q2 2025/ 26	Q3 & Q4 2025/26						Q1 & Q2 2026/27					
	Legal NHSR Scorecard/DofC compliance	✓						✓				✓		Awaiting new scorecard publication
	Culture survey action plan	✓						✓					✓	Deferred to next month due to perinatal leadership team required

2026/27		April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Number of perinatal losses		<5	<5	<5									
Number of MNSI cases		<5	0	0									
Number of incidents logged as moderate harm or above		0	0	0									
Minimum obstetric safe staffing on labour ward		100%	100%	100%									
Service user feedback	FFT “Overall how was your experience of our service” – total score for very good and good responses	100%	100%										
	Complaints	<5	<5	0									
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust		0	0	0									
Coroner Reg 28 made directly to Trust		0	0	0									
MOSS Safety Signals		0	0	0									
Regional Heatmap Score		23	23	17									

Exception report – Nottingham Review (Ockenden) & National Maternity & Neonatal Review (Amos)

Gateshead Health NHS Foundation Trust

- Two major national reviews published during June 2026
- 10-point plan for Maternity & Neonatal Services (Jim Mackey)
- High level summary link below:

10 Point Plan for maternity and neonatal services

Action required	Progress	Action	Responsible (role)	By when
1. Listening to women and their families by rolling out Martha's Rule	NENC Martha's Rule implementation project group already underway supported by HiNENC – report included in March 2026 IOR	Link to Gateshead wider Trust implementation of "Call for Concern"		
2. Listen to women and their families using real time and transparently reported outcomes and experience and clinical audit data that are acted upon at board level	CQC Patient Survey – 2025 action plan & 2026 survey underway	Exploring ED pilot of real-time service user experience		
3. Dual board-level accountability between medical directors and chief nursing officers for maternity and neonatal care		Review governance process & ensure ADoM & CL present to both Part 1 & 2 of Board		
4. 'Amos into action' staff listening exercise				
5. Addressing inequalities in maternity and neonatal outcomes	Use of health inequality dashboard to inform service development NENC Cultural Curiosity session included in mandatory training	Identify core MDT to lead Perinatal Equity & Anti-Discrimination Programme work (NHSE) – intro meeting 27/7/26		

10 Point Plan for maternity and neonatal services

Action required	Progress	Action	Respon sible (role)	By when
6. Ensuring 24/7 safety and responsiveness of maternity and neonatal services	Await national guidance – currently have 24/7 Consultant on call & compliant with current RCOG & ASA recommendations			
7.Trusts to review their homebirth services	Audit already underway Skills drills, NLS, appropriate training in place Initial self-assessment completed Dec 2025	Report in August IOR	KP	
8. Responding to patient safety incidents, complaints and concerns with humanity, candour and a trauma-informed approach	Compliant with Trust complaints processes, Duty of Candour	Review previous TRiM training		
9. Deliver safe and effective triage in maternity services (already committed by Government)	BSOTS implemented March 2026	Continue review & development of this service using QI methodology National Triage guidance published July 2026 - benchmark		
10. Post death care (already committed by Government)	Fuller report Board assurance underway		KR	

Gateshead Health NHS Foundation Trust

Maternity Incentive Scheme – Year 8

- 6 safety actions in Year 8 of the MIS
- Initial gap analysis performed:
  - 1 action identified which may present a risk to full compliance
  - F4 – Perinatal Culture Improvement Plan
- Mid-year assurance visit to GHNFT:
  - 27 August 2026
  - Safety Action D – Service-user voice & equity

Safety Action	Not started	Compliance risk	In progress & on track	Meets compliance	Fully embedded	Total sub-actions
A	2	0	4	0	1	7
B	0	0	5	0	0	5
C	1	0	5	0	0	5
D	2	0	0	0	0	0
E	0	0	3	0	0	3
F	1	1	1	1	0	3
Local work	0	0	0	0	0	0
National	0	0	0	0	0	0
Total	6	1	18	1	1	

NENC Regional heatmap June 2026

Gateshead Health NHS Foundation Trust

Regional Maternity Heatmap

Data refreshed: 02/07/2026 09:40:53

Scoring

Region: North East and Yorkshire

NHS England

Heatmap month: June 2026

Provider	Overall score	CQC Mat overall rating	Stake holder concerns	CQC S29a	CQC s31	Ext. ind. review	Coroner reg 28	Mat Oversight	MIS	CNST repay ment	Eth. DQ	CQC Mat Survey	SBL	Midw ives vac.	MSW vac.	Obs vac.	Unfilled roles	Snr L'ship not in post	Safety champs	Birthrate + (last 3 yrs)	Neonatal death rate	Perinatal death rate	Stillbirth rate
[redacted]	63.0	5.0	6	5	0	5	0	5	4	1	0	2	3	2	2		0	5	0	0	5	5	3
	37.0	5.0	3	0	0	0	0	3	3	0	0	3	5	1	4		1	0	0	0	3	3	3
	29.0	3.0	4	0	0	0	0	3	0	0	0	2	0	0	2		1	0	0	0	5	5	3
	29.0	3.0	3	0	0	0	0	0	0	0	3	2	4	0	5		1	0	0	1	1	3	3
	27.3	2.3	2	0	0	0	0	0	2	0	0	3	4	1	3		1	0	0	0	3	3	3
	27.0	3.0	3	0	0	0	0	0	0	0	0	2	3	0	5		3	0	0	1	1	3	3
	27.0	2.0	3	0	0	0	0	2	0	0	0	0	0	1	5		1	0	0	0	5	5	3
	25.0	5.0	3	0	0	0	0	2	0	0	0	2	3	2	1		3	0	0	0	0	1	3
	25.0	1.0	2	0	0	0	0	0	0	0	0	2	0	1	2		1	5	0	0	5	3	3
	23.0	3.0	2	0	0	0	0	0	0	0	0	2	1	0	5		1	0	0	0	3	3	3
	23.0	1.0	0	0	0	0	0	0	0	0	3	2	1	0	5		0	0	0	0	5	3	3
	22.0	3.0	1	0	0	0	0	2	0	0	0	3	0	1	1		1	0	0	1	3	3	3
	20.0	1.0	2	0	0	0	0	0	2	0	0	3	3	0	1		1	0	0	0	1	3	3
	20.0	3.0	3	0	0	0	0	0	0	0	0	1	0	0	2		0	0	0	0	5	3	3
	20.0	1.0	3	0	0	0	0	0	0	0	0	0	0	0	4		1	0	0	0	5	3	3
	19.0	3.0	4	0	0	0	0	0	0	0	0	2	0	2	0		1	0	0	0	1	3	3
	19.0	1.0	2	0	0	0	0	0	0	0	0	3	2	0	2		0	0	0	0	3	3	3
	19.0	3.0	1	0	0	0	0	3	2	0	0	2	0	0	0		1	0	0	0	1	3	3
	18.0	1.0	2	0	0	0	0	0	0	0	0	2	2	0	3		1	0	0	0	1	3	3
GATESHEAD HEALTH NHS FOUNDATION TRUST	17.0	1.0	1	0	0	0	0	0	0	0	0	0	0	0	0		1	5	0	0	3	3	3
[redacted]	17.0	1.0	1	0	0	0	0	0	0	0	0	3	0	1	2		1	0	0	1	1	3	3

*lower score is better

NENC Regional heatmap June 2026

Gateshead Health NHS Foundation Trust

Regional Maternity Heatmap

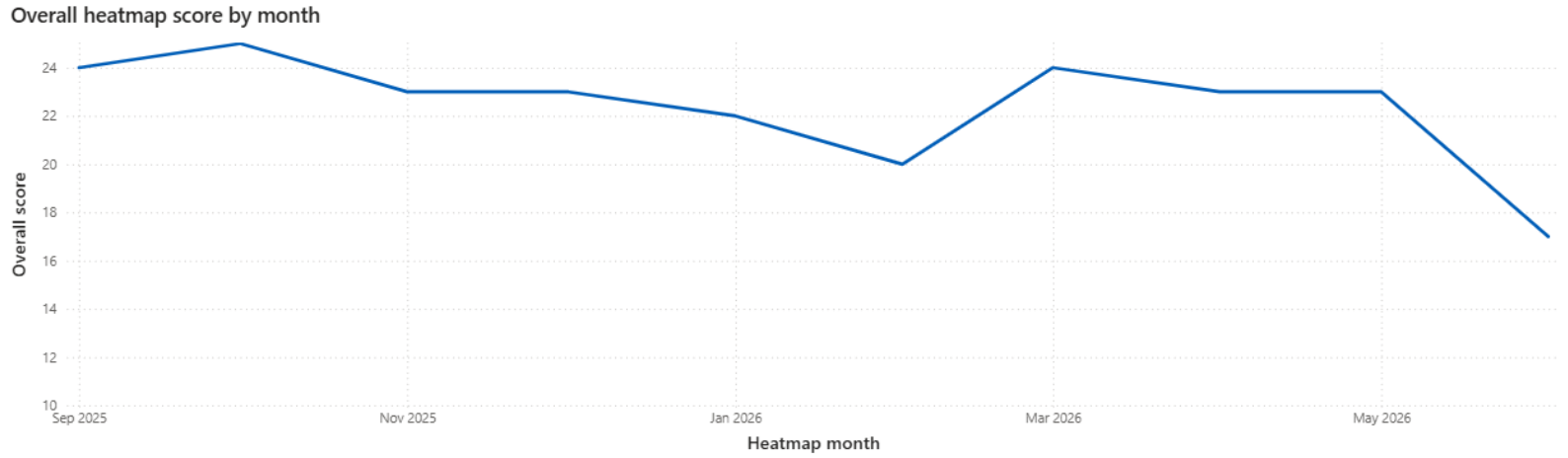
Data refreshed: 02/07/2026 09:40:53

Provider Scoring Summary

Region: North East and Yorkshire

NHS England

Select a trust: GATESHEAD HEALTH NHS FOUNDATION TRUST



Heatmap month	Overall score	CQC Mat overall rating	Stake holder concerns	CQC S29a	CQC s31	Ext. ind. review	Corone r reg 28	Mat Oversight	MIS	CNST repay ment	Eth. DQ	CQC Mat Survey	SBL	Midw ives vac.	MSW vac.	Obs vac.	Unfilled roles	Snr L'ship not in post	Safety champs	Birthrate + (last 3 yrs)	Neonatal death rate	Perinatal death rate	Stillbirth rate	MOSS
June 2026	17.0	1.0	1	0	0	0	0	0	0	0	0	0	0	0	0		1	5	0	0	3	3	3	0
May 2026	23.0	1.0	3	0	0	0	0	0	0	0	0	0	0	1	3		1	5	0	0	3	3	3	0
April 2026	23.0	1.0	3	0	0	0	0	0	0	0	0	0	0	1	3		1	5	0	0	3	3	3	0
March 2026	24.0	1.0	4	0	0	0	0	0	0	0	0	0	0	1	3		1	5	0	0	3	3	3	0
February 2026	20.0	1.0	1	0	0	0	0	0	0	0	0	0	0	1	0		1	5	0	0	5	3	3	0
January 2026	22.0	1.0	1	0	0	0	0	0	0	0	0	0	3	0	0		1	5	0	0	5	3	3	0
December 2025	23.0	1.0	1	0	0	0	0	0	0	0	0	0	3	1	0		1	5	0	0	5	3	3	0
November 2025	23.0	1.0	0	0	0	0	0	0	0	0	0	0	3	2	0		1	5	0	0	5	3	3	0
October 2025	25.0	1.0	0	0	0	0	0	0	0	0	0	0	5	2	0		1	5	0	0	5	3	3	0
September 2025	24.0	1.0	0	0	0	0	0	0	0	0	0	0	5	1	0		1	5	0	0	5	3	3	0

*lower score is better

NENC Regional heatmap
June 2026 – stakeholder concerns

Gateshead Health NHS Foundation Trust

SQAS;

- *Stakeholder concern closed*

ODN (covering Yorkshire);

- *Existing concern not yet closed*: Medical staffing levels and ongoing safety concerns highlighted via LMNS assurance visit Feb 2026. Specialised Commissioning are working with the Trust to ensure an action plan is in place and timescales for actions are met.

ICB;

- *Stakeholder concern closed*

MDT workforce update May/June 2026

Gateshead Health NHS Foundation Trust

Staff group	Workforce gaps			Bank usage	Minimum staffing requirements	Risks & escalations (Risk register ID where applicable)
	Vacancy rate	Sickness rate	Maternity leave rate			
	Target <2.5%	Target <4.9%				
Midwifery	-6%	5.6%	5.6%	1.84wte		Maternity theatre staffing #4859 business case approved – phased implementation being arranged
Midwife Support workers & Healthcare Assistants	-11.3%	5.7%	5.1%	2.17wte		Women's Health Clinic HCA staffing #4729 business case to GHLF & EMT for decision – declined therefore review within division & nurse staffing team to explore options to support
Obstetric Consultants **Resident doctors**					Minimum Consultant staffing on labour ward **100%**	Antenatal Clinic Capacity #4712
Neonatal Nurses	8.1%	14.2%	14.3%	0.96wte	BAPM compliance **Q4 2025/26 82.2%** QIS compliance **100%**	SCBU/ANNP workforce #2275 business case approved – movement of budget & recruitment in progress
Paediatric Consultants **Resident doctors** **ANNP**					BAPM compliance: **Currently holding a 0.5 gap on the 1:7 Consultant rota, covered with locum – Consultant recruitment active** **Current ANNP gap of -1.54wte (but 1wte ANNP trainee in post)**	SCBU/ANNP workforce #2275 business case approved – movement of budget & recruitment in progress
Obstetric Anaesthetists					Obstetric anaesthetist immediately available for the obstetric unit 24 hours a day with clear lines of communication to anaesthetic Consultant **100%**	

MDT workforce update June 2026

Gateshead Health NHS Foundation Trust

Red Flags		No	Factors		No	Actions		No
LWC supernumerary	=	7	Unexpected midwife sickness/absence	↑	31	Delay to commence IOL/planned procedure	=	11
1-1 care in labour	=	0	Midwife redeployed to other area	↑	9	Delay in transfer to theatre	↑	1
Delay in IOL	↑	8	Midwife on transfer duties	↑	4	2nd theatre in use	↑	2
Delay in meeting LSCS timing	=	0	Support staff less than rostered numbers	↑	26	Delay in ongoing IOL	↑	19
Missed or delayed care	=	0	Midwife scrubbed in theatre	↑	27	Unable to perform ward round due to acuity	↓	0
Delay in triage	=	0	2 or more Band 5 midwives on duty	↑	51	Redeploy staff internally	↓	28
			Unable to provide 2nd midwife for emergency theatre	↓	3	Staff unable to take breaks/working late	↑	5
			Unable to fill vacant shift	↓		Specialist midwife/manager working clinically	=	2
						Escalate to manager on call	↑	1
Total	↑	15		↑	153		↑	69

Gateshead Health NHS Foundation Trust

Delays to triage red flag data

- Birthrate+ acuity tool is completed on labour ward & therefore triage delay data is not included
- Separate monitoring of triage times via BSOTS project in place – commenced June 2026
  - June 2026 – 18 breaches >30 minute triage
- For formal post-implementation reporting in August – following first completed quarter of implementation (Q1 2026/27)
- Initial learning:
  - Under-reporting of breaches – new process, message reminders to all staff, expect to see gradual increase in reported breaches
  - Regional reporting process embedded – Gateshead last Trust to roll-out – anecdotally, breaches not out-with other neighbouring units
  - Challenges remain with accurate telephone data reports to report all required triage metrics into regional process – support from HiNENC & Badger digital midwives to understand

Risk register – new emerging risks & updates

Risk ID	Division	Description	Initial Grade	Current Grade	Target Grade	Comments
Top Service Risks						
2984	Surg2	There is a risk to our ability to continue to run maternity services from the designated building due to a catastrophic failure of the steam supply, resulting in enactment of a business continuity plan	20	20	8	No change
4852	Surg2	There is a risk of missed deterioration to mothers or babies in maternity theatre and/or on labour ward due to an outdated and inadequate workforce model that does not meet national guidance for safe obstetric theatre staffing. This could result in avoidable patient harm which could result in delay to meet emergency delivery timing standards, delays to elective caesarean section lists, avoidable admissions to SCBU, perinatal death, severe harm or never events.	20	15	5	No change
3107	Surg2	There is a risk of delayed treatment due to maternity estate being in a separate building resulting in the potential for severe harm to mothers & babies	20	15	5	No change
4712	Surg2	Risk that we do not have sufficient antenatal clinic capacity within Consultant job pans, resulting in reduced service provision	15	12	6	No change

Risk register – new emerging risks & updates

Risk ID	Division	Description	Initial Grade	Current Grade	Target Grade	Comments
Risk review						
4882	Surg2	There is a risk of delayed or missed reviews of babies in the maternity and neonatal service. Due to the current medical workforce model that is not compliant with national safe standards for SCU Level 1 neonatal settings. This could result in missed opportunities to prevent deterioration, delays to urgent assessment and intervention, and harm to babies in the neonatal and maternity service.	15	9	6	Risk reduced following recruitment of neonatal nurses and approval of business case for ANNP
4897	Surg2	There is a risk of missed or delayed clinical risk identification, clinical decision making and care delivery in maternity and neonatal services. This is caused by recurrent BadgerNet system instability, unreliability, functional and clinical safety defects and supplier-identified safety issues (including system crashes, data loss, and delayed or ineffective resolution of known issues by the supplier.) Resulting in compromised patient safety, potential harm to mothers and babies, increased scrutiny from regulators, loss of clinical confidence in digital systems, and reputational and assurance impacts at Board, Audit Committee and regional level.	20	10	5	Risks remain unchanged, but will be able to reduce following completion of harm reviews &m meeting with SystemC CEO
4909	Surg2	There is a risk that there may be historical cases of poor perinatal outcomes as a result of incorrect risk assessment population on the Badgernet maternity system. Resulting in potential harm to mothers and babies.	10	5	5	

Reducing Length of Separation (Mum and Baby) QI Project

North East and North Cumbria
Local Maternity and Neonatal System
NHS Foundation Trust

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

North East and North Cumbria
Local Maternity and Neonatal System
NHS Foundation Trust

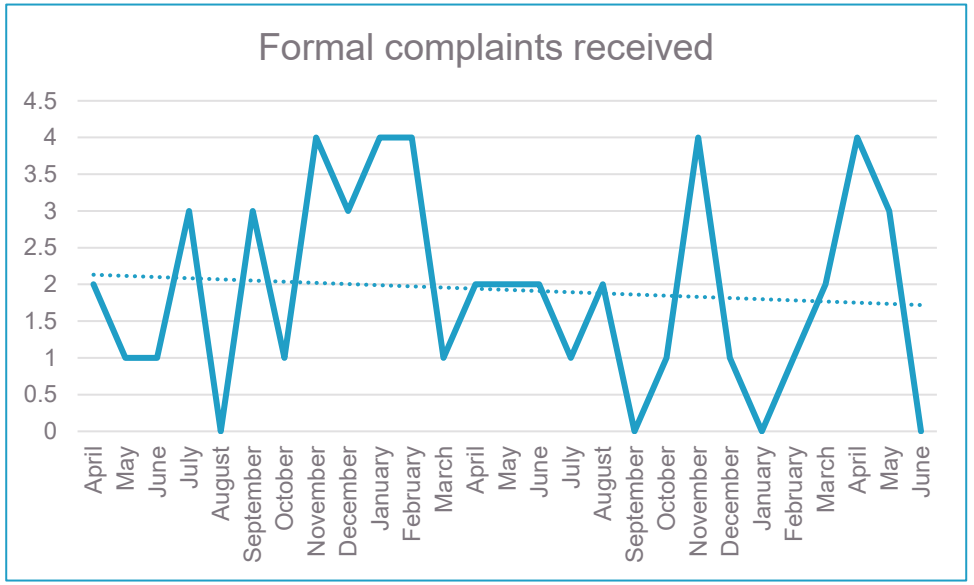
Neonatal Learning completed in Q4 (Please see notes on what to include here)

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

Q4 2025/26 & Q1 2026/27 Complaints Summary

Gateshead Health NHS Foundation Trust

- <5 formal complaints received in Q4
- 7 formal complaints received in Q1



- Overall downward trend in complaints continues
- There is an increase in complaints in Q1
- 1 complaint was resolved by telephone call, 8 received formal written responses, 1 complaint received a follow-up complaint as dissatisfied with response, 1 complaint had a F2F meeting with Consultant/midwife

Q4 & Q1 Complaints Summary

Gateshead Health NHS Foundation Trust

Themes:

- Ongoing communication – consent given prior to procedures (eg. for episiotomy, fetal pillow) or management of emergency scenarios (eg. PPH), but need to ensure ongoing communication to ensure patient aware of what is happening in real time to provide reassurance/remove shock/trauma from unexpected events

- Expectations – lots of evidence of good discussions, information giving, shared-decision making in antenatal periods – lived experience sometimes feels like pressure, not all information understood, expectations around what to expect (eg. in IOL, enhanced recovery, ward-based postnatal care vs 1-1 intrapartum care)

- Communication – individual, between teams/other provider Trusts

i) Maternity Incentive Scheme
presented by the Associate Director of Midwifery/SCBU

NHS Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 3bi

Report Title:	**Maternity Incentive Scheme Year 8 July 2026**			
Name of Meeting:	Trust Board			
Date of Meeting:	29 July 2026			
Author:	Mrs Karen Parker Associate Director of Midwifery/SCBU			
Executive Sponsor:	Beth Swanson, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Karen Parker			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	This report presents an initial gap analysis of compliance with Year 8 of the Maternity Incentive Scheme			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Obstetrics & Gynaecology Safecare 9/7/2026 Division of Surgery, Women's Health and Children Operational Board 29/7/2026 Safety Champions 17/7/2026 Safecare Steering Group 21/7/2026			
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*	Year 8 of the Maternity Incentive Scheme was published in March 2026 with six Safety Actions. Full compliance is required with each part of the six actions for eligibility of the rebate CNST payment scheme. The service has previously reported full compliance for successive years of the scheme. There is only one action that the service feels may present a potential risk to compliance; Safety Action F; F4; the service is identifying leads and a plan to meet this action. GHNFT has been selected for a mid-year supportive assurance visit for Safety Action D on 27th August 2026.			

Gateshead Health NHS Foundation Trust

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

Maternity Incentive Scheme (MIS) Assurance Framework

Gateshead Health NHS Foundation Trust

July 2026 – initial gap analysis report for Year 8

Karen Parker – Associate Director of Midwifery & SCBU

Executive Summary

This report presents an initial gap analysis of Gateshead Maternity and Neonatal Service against the six safety actions outlined in the NHS Resolution Maternity Incentive Scheme (MIS) Year 8 core standards, launched in March 2026.

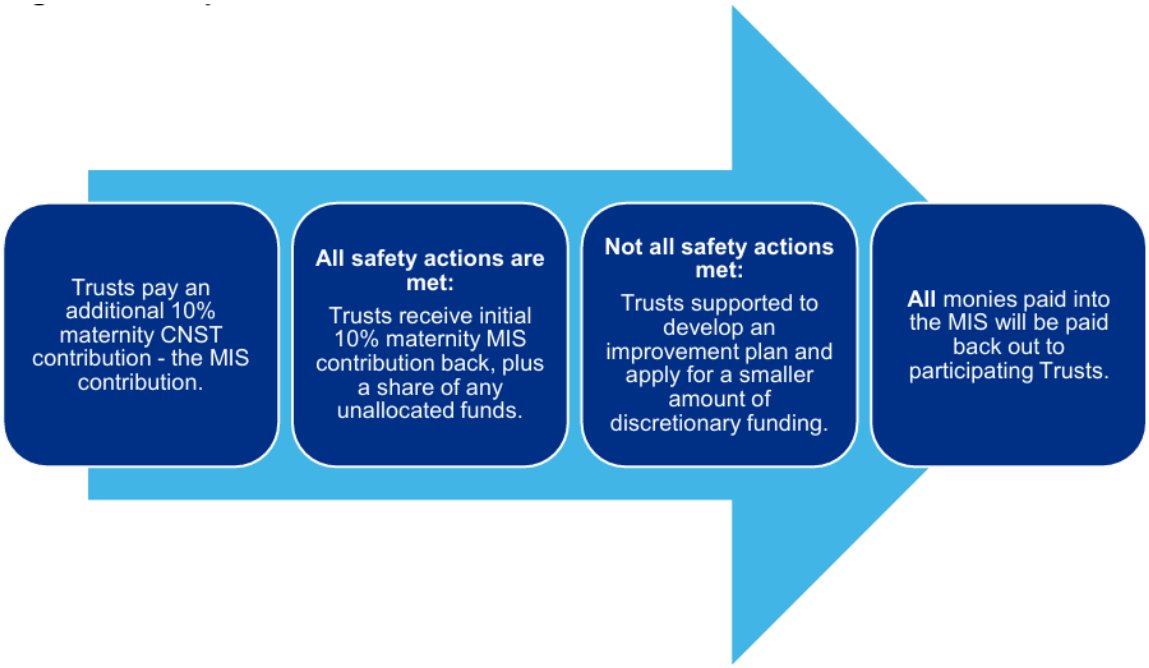
The document outlines the requirements associated with each of the six safety actions and provides a summary of the key activities required to achieve full compliance. These actions represent the national framework for improving safety and outcomes across maternity services.

The NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme continues to play a central role in supporting the delivery of safer maternity care. Now in its eighth year, the scheme applies to all acute Trusts providing maternity services and participating in CNST. Year 8 has been described as a transition year, with safety actions refreshed and strengthened in response to national inquiries, evidence, and system-wide feedback.

The revised framework introduces a streamlined set of **six core safety actions**, enabling Trusts to focus on the interventions most likely to improve outcomes for women and babies.

Trusts that demonstrate full compliance with all six safety actions are eligible to recover the maternity element of their CNST contribution and receive a share of any unallocated funds.

Any monies recovered by achieving full compliance must be ring-fenced for use in the maternity service and this has been agreed by the Trust board in accordance with CNST and Ockenden requirements.



Background

The six safety recommendations are aligned to what a safe and responsive maternity service should be able to demonstrate, enabling Trusts to focus on the areas that will have the greatest impact for their population.

NHSR provides an audit tool to support Trusts with evidence gathering and Trust board assurance. Monthly evidence assessments will be completed using the audit tool and all evidence to support the declaration of compliance is held in a shared repository by the service to enable review and assurance. Trusts must achieve all six safety actions.

Year 8 of the scheme runs from 1 April 2026 – 30 November 2026, with compliance reported at the end of this time period. A mid-year checkpoint has been introduced (July/August), this is advisory only intended to help Trusts remain on track to meet requirements.

Trusts will need to report compliance with MIS by **12:00 on 2 March 2027** using the Board declaration form. The declaration form is submitted to the Trust Board with an accompanying joint presentation detailing position and progress with perinatal safety actions by the Perinatal Leadership Team, including the Maternity and Neonatal Voices Partnership (MNVP) Lead.

Initial gap analysis

The service has completed a high level gap analysis to identify significant changes to the standards, clinical and or midwifery leads for each Safety Action and commenced an action and monitoring plan.

There are six Safety Actions, with a total of 27 sub-actions. Work is already in progress and on track in 18 or the 27 sub-actions, 2 sub-actions are completed/fully embedded. There are 6 sub-actions still to start work on.

There is only one action that the service feels may present a potential risk to compliance; Safety Action F; F4;

Perinatal Culture Improvement Plan
Trusts must demonstrate that they have an agile perinatal culture improvement plan in place which triangulates data and engagement from multiple sources, uses recognised improvement methodology to evidence progress and impact, and is reviewed by the Trust Board at least six monthly.

This action requires *Trusts to have a perinatal culture improvement plan that triangulates data from multiple sources, uses recognised improvement methodology, and is reviewed by the Board at least six-monthly.*

The perinatal leadership team completed the NHS England Perinatal Leadership programme and developed a departmental culture plan in 2025 as part of Year 7 of the Maternity Incentive Scheme Safety Actions.

Year 8 presents an opportunity to embed a robust multi-disciplinary perinatal leadership team to progress future departmental, regional and national culture and leadership actions. This will start with the newly launched **Perinatal Equity and Anti-Discrimination Programme (PEADP)**; the first meetings and core attendees from the Gateshead service are in development.

Overview of progress on MIS Year 8 safety action requirements

Safety Action	Not started	Compliance risk	In progress & on track	Meets compliance	Fully embedded	Total sub-actions
A	2	0	4	0	1	7
B	0	0	5	0	0	5
C	1	0	5	0	0	5
D	2	0	0	0	0	0
E	0	0	3	0	0	3
F	1	1	1	1	0	3
Local work	0	0	0	0	0	0
National	0	0	0	0	0	0
Total	6	1	18	1	1	

Mid-year assurance visit

Part of the new MIS Year 8 process is the inclusion of a mid-year assurance review visit. This visit does not form part of the end of year assessment of final compliance, but is intended as a supportive discussion to provide additional support to teams. Trusts are randomly selected for review of a randomly selected Safety Action.

Gateshead Health NHS Foundation Trust CEO was notified on 2nd July 2026 that the organisation had been selected to take part in this process.

An assurance visit date was mutually agreed to take place on 27th August 2026, to review Safety Action D.

An assurance evidence rubric was shared in advance of the planned review and all members of the Safety Champions, Senior Divisional Leadership team, and Maternity and Neonatal teams were made aware of this date with specific individual invitations relevant to the Safety Action D requirements.

D1. Communication equity, language support and accessible information

Published requirement: Trusts should demonstrate continued progress towards ensuring that women and families, including those who may require translation, interpreting support, or reasonable adjustments, are supported to understand their care, options and decisions at key points in the perinatal journey. Trusts should recognise that where information is not understood, consent may not be informed, valid or lawful, and reliance on family members, friends or informal interpretation must be treated as a patient safety, safeguarding and human rights risk. The supplementary guidance highlights clear local processes for timely access to professional interpreters, accessible information in formats suited to individual needs, routine checking of understanding, reasonable adjustments where required, service user input to improve communication materials, governance oversight of communication risks and interpreter use, and evidence for Board assurance that communication equity processes are being applied consistently.

1: No clear evidence that the Trust has a structured approach to communication equity, language support or accessible information.	**2:** Some arrangements are in place, but they are inconsistently applied, poorly evidenced, or there is limited assurance that women and families are supported to understand their care.	**3:** Local arrangements are broadly in place and some monitoring is evident, but documentation, reasonable adjustments, or governance oversight is inconsistent.	**4:** Strong evidence of clear communication equity processes, timely interpreter access, accessible information, and governance oversight of risks, themes and improvements.	**5:** A well-embedded and consistently applied approach, with strong assurance that women and families are supported to understand their care, clear evidence of improvement informed by service user feedback, and active Board understanding of communication-related risks and inequities.

Finding:

Reviewer prompts:

- How does the Trust ensure women and families can understand their care, options and decisions at key points in the journey?
- Are professional interpreters and accessible formats routinely available in practice, or does this depend on local workarounds?
- How is understanding checked and documented, particularly where there are communication barriers or reasonable adjustment needs?
- Can the Trust show how service user feedback or community insight has informed improvements to communication materials or approaches?
- Is there governance oversight of communication risks, interpreter use, informed consent themes, and action taken where gaps are identified?

What reviewers might expect to see:

- interpreter access process and evidence of use in practice
- accessible information in relevant formats
- documentation that understanding and consent support are checked and recorded
- reasonable adjustments where needed
- service user input into communication improvements
- governance reporting on communication risks, themes and mitigation

Evidence observed:

D2. Service-user voice driving safety and quality improvement

Published requirement: Trusts must demonstrate that insights from women, families and carers using maternity and neonatal services are captured and used to inform service improvement plans. Trusts must use demographic data to understand their local population and demonstrate that the voices of women and families from different demographic groups are actively captured and used to shape priorities within the service. Progress with this work should be monitored through established governance routes quarterly to ensure that actions lead to measurable improvements in safety, quality or experience. The supplementary guidance highlights multiple accessible routes for gathering feedback, active efforts to hear from under-represented groups, a service improvement plan clearly shaped by service user insight, routine use of demographic data to identify disparities, governance monitoring of progress and escalation of gaps, examples of service user themes influencing practice, use of recognised improvement methodology, and Board-level assurance that service user and equity issues are informing decision-making.

1: No clear evidence that service user insight is systematically captured or used to inform safety and quality improvement.	**2:** Some service user feedback is gathered, but it is limited, poorly connected to improvement activity, or there is little evidence that under-represented groups are being heard.	**3:** Service user insight is being captured and some improvement activity is linked to it, but the use of demographic data, governance oversight, or evidence of measurable impact is inconsistent.	**4:** Strong evidence that service user voice is actively captured through multiple routes, used to shape improvement priorities, and monitored through governance with attention to equity and demographic differences.	**5:** A mature and well-embedded approach in which diverse service user voices clearly shape priorities, actions and pathway changes, demographic data is routinely used to identify and address inequities, and Board-level assurance shows that service user insight informs decision-making at every level.

Finding:

Reviewer prompts:

- How does the Trust gather service user insight from women, families and carers across maternity and neonatal services?
- Are there multiple and accessible ways for people to contribute, and is there evidence that under-represented groups are being actively included?
- How is demographic data used to understand who is being heard, where disparities exist, and what needs to change?
- Can the Trust show clear examples of where service user themes or feedback have shaped priorities, pathway changes, training or communication?
- Is progress monitored through governance routes quarterly, with Board visibility of key service user and equity issues and the actions taken in response?

What reviewers might expect to see:	Evidence observed:
• multiple routes for gathering service user feedback • evidence of outreach to different demographic groups • service improvement plan informed by service user insight • demographic data used to identify disparities and actions • governance monitoring of progress and escalation of gaps • examples of service user themes influencing practice or priorities • Board-level reporting on service user voice, equity issues and action taken	

Notes:

Overall:

Overall reviewer comments:

Recommendation

The Board are asked to review and accept this report as assurance of an initial gap analysis of compliance with Year 8 of the MIS. Minutes of the governance route for this paper will be held as evidence of assurance of compliance at the end of the MIS year 8 reporting timeframe.

Monitoring and Compliance

Progress against the six Maternity Safety actions is monitored via service level and divisional meetings. This is documented in our Maternity Service operational risk management strategy and reported monthly to the Trust Board or Quality Governance Committee as the approved appropriate sub-committee for the Board.

A detailed action plan can be viewed alongside the evidence held in a shared repository by the maternity service.

The Maternity team have undertaken an assurance review by AuditOne of the evidence submitted for Year 4 during this year of the scheme. A repeat assurance review will be planned in line with the Trust audit schedule.

Trust submissions are validated against a number of external sources including MBRRACE-UK, NHS Digital Maternity Services Data Set submissions, MNSI and NHS Resolution. They are also sense-checked against any external concerns from regional assurance processes, CQC or similar bodie

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

NHS Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 3bii

Report Title:	**Maternity Safety Champion Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29 July 2026			
Author:	Dr Gerry Morrow, Maternity Safety Champion and Non-Executive Director			
Sponsor:	Dr Gerry Morrow, Maternity Safety Champion and Non-Executive Director			
Report presented by:	Dr Gerry Morrow, Maternity Safety Champion and Non-Executive Director			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To provide additional assurance to support the Maternity Integrated Oversight Report based on regular discussion with our people, patients and maternal and neonatal voices partnership (MNVP) service users			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	-			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• This report seeks to support the triangulation of information and intelligence from a variety of sources, providing a voice for our people and patients at Board through the Maternity Safety Champion. • Key issues will be presented and progress on these issues will be described in each report, which will be provided six times a year.			
Recommended actions for this meeting:	Board Members are requested to review the content of this report for assurance in conjunction with the Maternity			

Gateshead Health NHS Foundation Trust

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

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

Risks / implications from this report (positive or negative):	
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	3107 - Risk that MDT are delayed to a maternity emergency/delayed CCU transfers for maternity patients due to separate buildings (15) 2984 – Risk of delayed treatment due to maternity estate being in a separate building (15) 2341 - There is a risk to ongoing business continuity of service provision due to ageing trust estate (16) 4694 - Non achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m (15) 4713 - The 2025-26 cost reduction programme is not achieved both in year and on a recurring basis (16)

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

Gateshead Health NHS Foundation Trust

Maternity Non-Executive Director Safety Champion Report July 2026

1. Executive Summary

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

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

- Regulatory burden;
- Two national maternity reports have been published since last report
- Interim Maternity Incentive Scheme (MIS) safety action D visit planned for 27th August 2026
- Business case submission

2. Introduction

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

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

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

3. Progress on issues

3.1. Regulatory burden:

Despite assurances from NHS England that the burden would be reduced by a streamlined reporting process, this has not transpired. Current action plans for submission are:

1. MNVP plan
2. CQC survey plan
3. Equity and equality plan
4. Saving babies lives q1

5. Maternity care bundle
6. MIS baseline audit
7. Perinatal equity and discrimination
8. LMNS assurance visit plan
9. Antenatal newborn screening action plan

3.2. Two national maternity reports:

Ockenden Report 2026
Findings, conclusions and essential actions from the independent review of maternity services at Nottingham University Hospitals NHS Trust

Baroness Amos Report 2026
Final Reports - National Maternity and Neonatal Investigation

Ongoing work to establish the detail of what this means for us at Gateshead and more widely in the region. Will be presented at subsequent maternity safety meetings and board.

3.3. MIS Safety Action D visit:

This will focus predominantly on communication; accessibility, interpretation services, and service user voice. Our MNVP colleagues will be available, and we have involved Jane Conroy in the meeting and information gathering prior to the meeting.

3.4. Business Case Submission

Two business cases were submitted recently. One for ANNP staffing has been supported and we are out to advert for these members of staff.

The second relates to the theatre staff and this is currently under discussion regarding budget.

4. Summary

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

c - Nurse Staffing Exception Report
Presented by the Chief Nurse

NHS Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 3c

Report Title:	**Nursing Staffing Exception Report- April and May 2026**			
Name of Meeting:	Trust Board			
Date of Meeting:	29th July 2026			
Author:	Helen Larkin, Clinical Lead for E-Rostering			
Executive Sponsor:	Beth Swanson, Interim Chief Nurse			
Report presented by:	Drew Rayner, Deputy Chief Nurse			
Purpose of Report	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☒
	This report is to provide assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis to provide adequate staffing levels.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by:				
Key issues:	**Alert** April and May 2026 continued to present sustained workforce pressures across inpatient areas, most notably within the Healthcare Support Worker (HCSW) workforce. While Registered Nurse vacancy rates remain low (1.6–1.7%), HCSW vacancies remain high at around 14%, impacting the Trust's ability to consistently achieve planned staffing levels. There were repeated breaches of the 80% safe staffing threshold across a number of wards for both Registered and unregistered staff, with some areas demonstrating ongoing challenges across both months. Operational pressures have been further impacted by high patient acuity and dependency levels, ongoing staff unavailabilities, demand associated with escalation beds, and difficulties filling HCSW bank shifts and reliance on agency usage. Although red flag reporting reduced from March and remained stable across April and May (78 to 77), compliance with review and closure processes requires			

	continued strengthening. Staffing-related incidents increased slightly in May (6 to 8), though harm remained low. **Advise** A range of actions are in place and progressing to address workforce risks and improve resilience: • Establishment review and implementation now completed and in place from April, strengthening night staffing, skill mix review and Ward Manager supervisory capacity. • Targeted HCSW recruitment continues, including localised recruitment approaches, bank recruitment campaigns (including student pipelines) • Partnership with Derwentside College, with new starters expected into the Trust in August. • Band 2 to Band 3 apprenticeship pathway approved and progressing to support sustainable pipeline development. • Continued use of real-time staffing management systems and staffing escalation protocols to dynamically deploy workforce aligned to acuity and demand. • Strengthening of red flag governance and visibility, with system improvements implemented and KPIs for review/closure being embedded. **Assure** Despite ongoing workforce challenges, there is evidence that robust systems and processes are in place and operating effectively to maintain patient safety through: • Daily senior nurse oversight (Matron and site team**)** ensures proactive management of staffing risks through redeployment, and professional judgement. • Risk assessment processes are embedded, supported by real-time acuity data and SafeCare systems informing decision-making. • No significant harm trends identified, with staffing-related incidents predominantly low harm across both months. • Services reporting low fill rates (e.g. SCBU, Ward 28) provide contextual assurance relating to occupancy, acuity and model of care. Overall, the organisation remains partially assured, with clear mitigating actions in place; however, HCSW workforce gaps and associated reliance on temporary staffing continue to present a material risk requiring sustained focus.
Recommended actions for this meeting:	The Board is asked to: • receive the report for partial assurance

<table>
<tr><td></td><td colspan="5">• note the work being undertaken to address the shortfalls in staffing and support ongoing actions to mitigate risk.</td></tr>
<tr><td rowspan="4">Trust strategic priorities that the report relates to:</td><td>☒</td><td colspan="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:</td><td colspan="5"></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">There were six nurse-staffing incidents raised via InPhase during the month of April. Areas who reported are Peapod, SCBU, PIU, Ward 9, community and Ward 24. These are highlighted within this report.
Risk 4854- Risk to safe delivery of patient care due to the significant vacancy position of Healthcare Support Workers within the Trust.</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>

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

1. Executive Summary

This report provides an exception overview of nursing and midwifery staffing for April 2026. While average fill rates remain broadly stable, a number of wards fell below the 80% staffing threshold and are reported by exception, largely due to Healthcare Support Worker (HCSW) vacancies, sickness absence and maternity leave. The Trust continues to mitigate daily operational pressures through Matron-led professional judgement; redeployment based on patient acuity and demand, and targeted recruitment activity. Total Trust Registered vacancy rates remain low at 1.7%, showing an improvement from March 2.4%, however the unregistered vacancy rate remains significantly higher at 14.2%, however this is still a reduction from March at 18.8%. Despite improvement this continues to present a workforce challenge and is recorded on the risk register within the Medicine and Community division and Corporate services. Recruitment to the bank has been undertaken, with another round planned in May 2026, and a Band 2 to Band 3 development pathway is being progressed. Additional to this the Clinical Lead for e-roster has met with Derwentside college in March to discuss potential Band 3s about to complete Health care qualifications in June. An advert has now been circulated to Derwentside, Newcastle and Gateshead students to apply. Improvements to red flag reporting and resolution are underway, alongside a wider programme to review ward establishments and strengthen night staffing and Ward Manager supervisory time. The Board is asked to note the current position and support the actions being taken to strengthen workforce resilience and staffing governance.

2. Introduction

This report details the staffing exceptions for Gateshead Health NHS Foundation Trust during the month of April 2026. The staffing establishments are set utilising the Safer Nursing Care staffing tool (SNCT) within a triangulated approach of professional judgement and clinical outcomes. SNCT is a recognised, nationally used evidence-based tool that matches the acuity of patients with the staffing requirements for acute medical and surgical wards. Varying tools for the Emergency Department and Paediatrics are utilised. Mental health Services use the Mental Health Optimal Staffing Tool (MHOST), and Maternity use the Birth Rate Plus tool. Bi-annual reviews are reported to Quality Governance Committee and the Trust Board.

2. Staffing

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

NHS Table 1: Whole Trust wards staffing April 2026

Day	Day	Night	Night
Average fill rate - registered nurses/midwives (%)	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
⇧ **91.9%**	⇧ **82.8%**	⇩ **95.2%**	⇩ **103.4%**

The Trust is required to present information on funded establishments (planned) against actual nurses on duty. The above figures are average fill rates and thus do not reflect daily challenges and operational pressures to maintain adequate staffing levels.

Exceptions:

The guidance on safe staffing requires that the Board will be advised of those wards where staffing capacity and capability frequently falls short of what is planned, the reasons why, any impact on quality and the actions taken to address gaps in staffing. In terms of exception reporting, Gateshead Health NHS Foundation Trust reports to the Board if the planned staffing in any area drops below 80%.

Safer Nursing Care Tool (SNCT) data collection is completed bi-annually in January and July each year. Patient acuity and dependency data is triangulated with key performance indicators and professional judgement templates in line with the Developing Workforce Safeguards and Safe Staffing Recommendations (NHSi 2018). A revised SNCT tool has been introduced, which incorporates 1-1 enhanced care requirements along with considerations for single side room environments to support establishment reviews. Data collection is completed on a six-monthly basis, with the most recent collection commenced in January 2026.
There has been a programme of work undertaken within the organisation to review Ward establishments in response to rostering practice efficiencies. This is in response to a recognised need to strengthen nurse staffing levels at night, and support designated supervisory time for Ward Managers to drive safety and quality patient care. This work is now completed and became effective from April rotas. Recognition of these changes within the financial ledger is planned to be completed by June.

Ward Managers and Matrons continue to work hard to staff their areas safely using the resources available. As a result, there are occasions where staff are allocated to support overall staffing levels rather than within the planned skill-mix proportions.

The exceptions to report April are as below:

April 2026	
Registered Nurse Days	**%**
Cragside Court	78.5%
Critical Care	72.8%
SCBU	69.9%
Ward 14 Medicine	74.7%
Ward 28 Orthopaedic Elective Ward	68.9%
Registered Nurse Nights	**%**
JASRU	68.3%
Sunniside Unit	68.3%
Ward 9 Respiratory	70.5%

Ward 10	69.6%
HCSW Days	**%**
Critical Care Dept	61.7%
JASRU	77.0%
SCBU	61.0%
Ward 8 Cardiology	59.0%
Ward 21 Trauma & Ortho	70.1%
Ward 28 – Orthopaedic Elective Ward	40.9%
Ward 26 Gynae	68.9%
Ward 27 Treat/Centre	69.4%
HCSW Nights	**%**
Critical Care Dept	45.1%
SCBU	63.5%
Ward 28	49.6%

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

- Redeployments of RN and HCSW on a daily and at times hourly basis between wards according to patient acuity and demand.
- Concentrated support from the Matrons and the People and Organisational Development team to address the sickness absence levels within the divisions and to recruit to vacant posts.

4. Vacancies

The Trust wide Registered Nursing vacancy rate is 1.7%, equating to 21.5 WTE. This is an improvement of 12.3 WTE compared to March. Most vacancies are within the Band 5 and Band 6 workforce. Recruitment remains ongoing aligned with student graduation cycles.

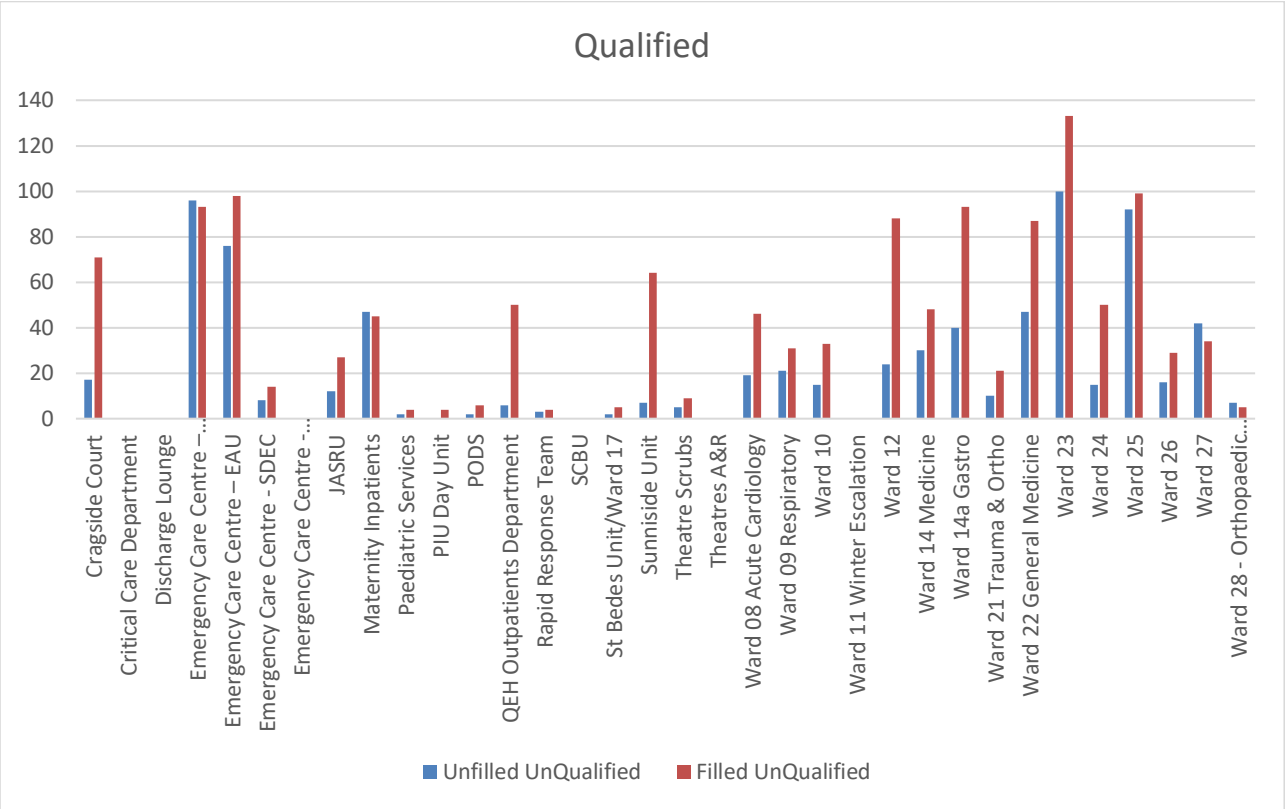
The HCSW vacancy position for the Trust is 14.1% with 74.3 WTE vacant positions. This is a significant improvement from February, reflective of the adjustments to Nursing establishments following the Enhanced Rostering Programme and skill mix review. The current position with HCSW vacancies remains on the risk register within the Medicine and Community division as well as being identified as a Corporate risk. This is an area of particular concern as the HCSW internal bank is also depleted.

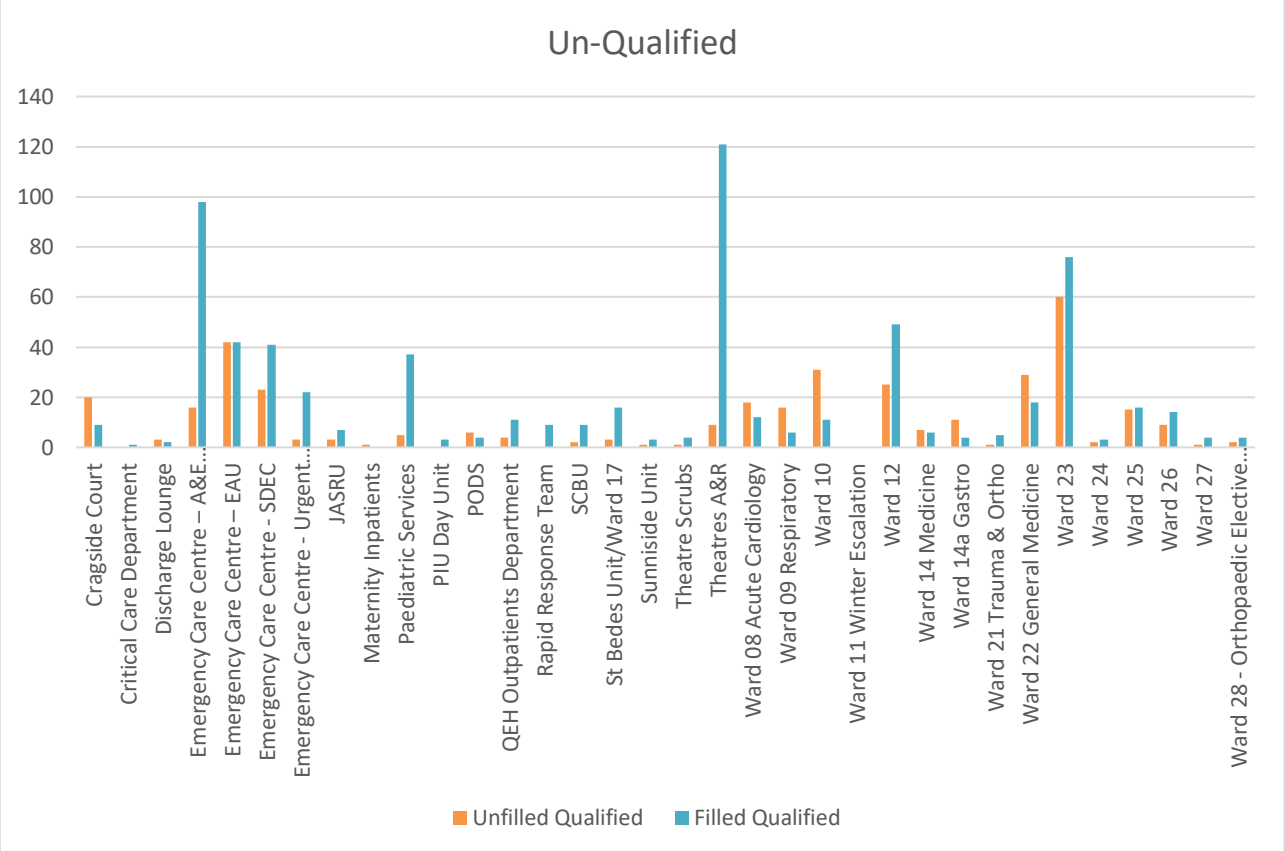
Following a Trustwide recruitment campaign, only 5.6 WTE Band 3 HCSW posts were appointed from the central advertisement. Recruitment is also being actioned at service line level within Divisions, with a targeted approach anticipated will be more effective. This position is also being felt regionally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

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

5. Temporary Staffing

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





Some HCSW bank shifts have been challenging to fill, specifically due to the volume of shifts available. Recent recruitment activity for bank only HCSW positions has taken place, specifically to offer positions to our home student nurses. This process is important to ensure we continue to replenish the turnover of bank only workers. This process was successful in offering 38 bank positions. A further advert is currently active for students and internal candidates to apply for as bank workers to ensure we have sufficient staff to meet current demand.

6. Care Hours Per Patient Day (CHPPD)

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

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

Ward level CHPPD is outlined in Appendix 1. For the month of April, the Trust total CHPPD was 7.6. This compares lower when benchmarked with other peer-reviewed hospitals (7.9 peer average) and is likely impacted by our HCSW vacancy position and patient dependency levels.

7. Monitoring Nurse Staffing via Incident Reporting system

The Trust has an escalation process in place for addressing staffing shortages with identified actions to be taken. Further discussion is to take place to scope the potential for identifying thresholds that trigger when a staffing related incident should be submitted via inphase to provide reporting consistency. In addition to this the ongoing work to triangulate fill rates and care hours against reported staffing and patient safety incidents, has highlighted that the subcategories available to the reporter within the incident reporting system requires review to streamline and enable an increased understanding of the causes of the shortages. For example, short notice sickness, staff redeployment or inability to fill the rota. Six staffing incidents were raised during April, including the levels of physical and psychological harm (Appendix 2). Nurse staffing was directly referenced in one inphase in relation to harm, this was marked as low physical harm.

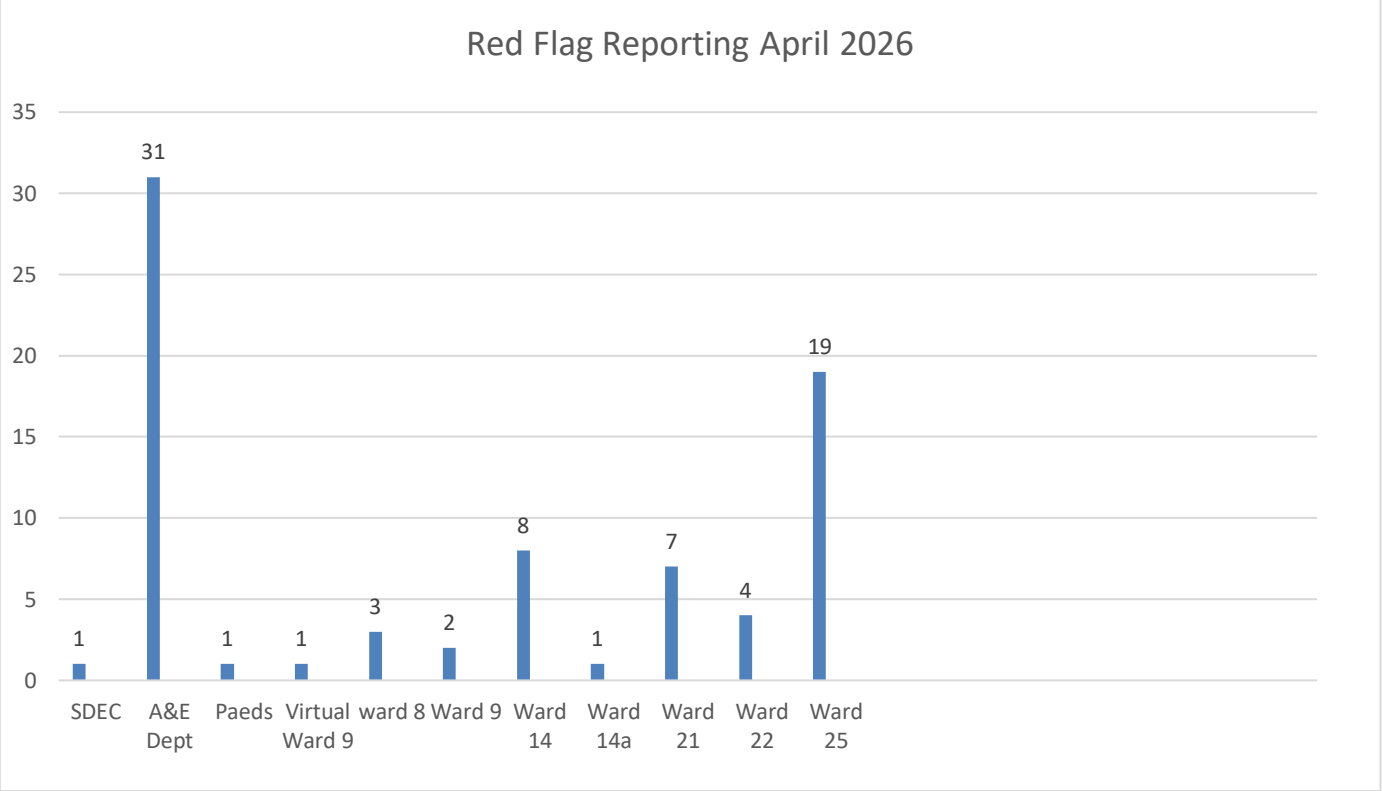
8. Nursing Red Flags

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

During April 78 nursing red flags were reported, A significant reduction from the 127 raised in March. Red flags must be escalated promptly to the Matron or senior nurse for action

and mitigation. In April two of these red flags raised were recorded as reviewed within the Safecare live system. It should be noted that the reporting system that notifies Matrons of Red Flags did fail during April. This has been resolved now. The two highest reporting areas were Ward 25 with 19 red flags and A&E with 31. Ward 25 report this in response to the HCSW vacancy challenges, A&E report similar challenges alongside high acuity.

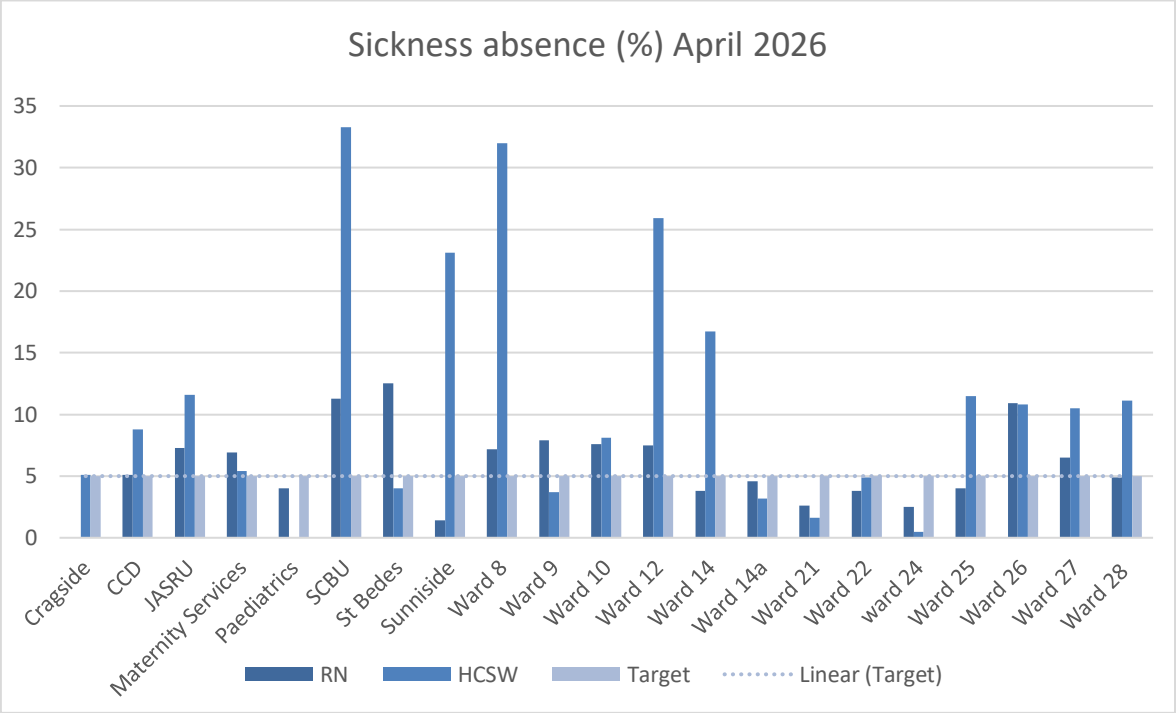
Mid - February saw us move to a position where it can provide clear assurance that red flags are being raised appropriately, acted on in a timely way, and closed with clear evidence. Work with Optima Allocate was set up on the 18th of February to improve real time visibility of red flag reporting to support operational management of safe staffing and provide reporting metrics for escalation and assurance. Now in place, compliance with review, response and closure will be monitored as a key performance indicator with Divisions.



9. Absence levels

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

Data extracted from Health Roster.



10. Governance

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

11. Triangulation and actions taken

Critical Care Department demonstrated fill rates below 80% for Registered Nurse Days (72.8%) and Unregistered Nurse Days (61.7%). The Band 5 workforce has been impacted by Maternity leave, long term sickness absence, short term sickness absence and 11 episodes of redeployment to support other areas across the Trust.
There are additional shortfalls within the Band 6 workforce. However a Band 7 was present for 7 day cover and able to support with patient care where required as well as and clinical leadership. Patient acuity and dependency reported lower during periods of the month.

SCBU demonstrated a daytime RN fill rate of 69.9%, down from 74.1% in March. HCSW fill rates were below 61% for both days and 63.5% on nights. Our Head of Midwifery assures the unit was safely staffed and the HCSW role is not required 24/7 resulting in reduced fill rates. A meeting was held between the Head of Midwifery and Health roster to review the establishments and rostering patterns aligned to support accurate reporting.

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

Cragside Court report 78.5% fill rates for Registered staff days, an improvement from March. Sunniside have been able to staff one Registrant per night, fill rates are 68.3% however, there has been no cross-covering support available.

Eleven areas demonstrate below 80% fill rates for HCSW due to the high number of vacancies. As of April, there was 74.3 trust wide vacancies (14.1%). Active monitoring, and redeployments are currently being used to mitigate understaffed areas based on real time risk assessments and patient acuity and dependency. Due to planned and unplanned shortages, it is increasingly challenging to meet the demand with bank staff, therefore there continues to be a reliance on agency staff also to mitigate risk to patient safety.

12. Recommendations

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

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

Decrease from previous month Increase form previous month

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative patient count over the month	Registered midwives / nurses	Care Staff	Overall
Cragside Court	78.5%	82.0%	133.9%	160.4%	272	6.4	8.3	14.8
Critical Care Dept	72.8%	61.7%	90.2%	45.1%	228	32.4	2.7	35.0
Emergency Care Centre - EAU	81.9%	81.9%	97.9%	95.1%	1305	5.7	3.9	9.6
JASRU	103.0%	77.0%	68.3%	131.1%	590	3.3	3.9	7.3
Maternity Unit	89.4%	108.1%	110.6%	122.7%	608	14.4	4.6	19.0
Special Care Baby Unit	69.9%	61.0%	120.2%	63.5%	119	15.6	2.5	18.1
St. Bedes	87.0%	94.3%	104.8%	99.8%	290	5.2	3.7	8.9
Sunniside Unit	91.8%	128.7%	68.3%	94.1%	120	12.4	10.3	22.7
Ward 08	101.9%	59.0%	104.9%	98.7%	622	4.5	2.2	6.7
Ward 09	122.7%	89.3%	70.5%	111.5%	862	2.6	2.1	4.7
Ward 10	123.6%	81.9%	69.6%	103.8%	765	2.9	2.2	5.1

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Ward 12	112.3%	92.3%	87.5%	116.5%	797	2.8	2.3	5.2
Ward 14 Medicine	74.7%	86.2%	91.7%	99.1%	762	3.1	2.2	5.3
Ward 14a Gastro	114.4%	159.2%	98.7%	102.8%	766	3.1	3.2	6.3
Ward 21 T&O	111.8%	70.1%	103.5%	111.4%	863	3.3	2.7	6.0
Ward 22	89.4%	92.0%	87.7%	101.7%	923	2.3	2.7	5.0
Ward 24	117.9%	87.5%	97.3%	98.9%	914	2.9	2.6	5.5
Ward 25	104.4%	85.8%	98.6%	93.0%	955	2.6	2.4	5.0
Ward 26	102.6%	68.9%	90.2%	114.3%	679	3.6	2.7	6.3
Ward 27	110.4%	69.4%	104.5%	100.6%	879	3.1	2.0	5.1
Ward 28	68.9%	40.9%	101.2%	49.6%	213	7.0	3.4	10.5
QUEEN ELIZABETH HOSPITAL - RR7EN	**91.9%**	**82.8%**	**95.2%**	**103.4%**	**13532**	4.7	3.0	7.6

Appendix 2 INPHASES submitted in relation to nurse staffing.

Incident Date.	Investigating Department	Category(s)	Subcategory	Level of Physical Harm	Level of Psychological Harm
4/4/26	PeaPod	Staffing/resource issue	Insufficient Nurses (due to staff shortages/unfiled shifts)	Low physical harm	No psychological harm
7/4/26	Special Care Baby Unit	Staffing/resource issue	Staffing-insufficient nurses (other reason)	No physical harm	No psychological harm
16/426	PIU Day Unit	Staffing/resource issue	Insufficient Nurses (due to Staff Movements)	No physical harm	No psychological harm
17/4/26	Respiratory Medicine	Staffing/resource issue	Insufficient Nurses (due to staff shortages/unfiled shifts)	No physical harm	No psychological harm
25/4/26	West Locality Community	Staffing/resource issue	Staffing-insufficient nurses (other reason)	No physical harm	No psychological harm
28/4/26	Ward 24	Staffing/resource issue	Staffing-insufficient staff (other)	No physical harm	No psychological harm

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

13. Executive Summary

This report provides an exception overview of nursing and midwifery staffing for May 2026. While average fill rates remain broadly stable, a number of wards fell below the 80% staffing threshold and are reported by exception, largely due to Healthcare Support Worker vacancies, sickness absence and maternity leave. The Trust continues to mitigate daily operational pressures through Matron-led professional judgement; redeployment based on patient acuity and demand, and targeted recruitment activity. Total Trust Registered vacancy rates remain low at 1.6%, showing an improvement from April 0.1%, however the unregistered vacancy rate remains significantly higher at 14.1%. Despite improvement this continues to present a workforce challenge and is recorded on the risk register within the Medicine and community division and Corporate services. Recruitment to the bank has been undertaken, in May and June 2026, and approval to progress the Band 2 to Band 3 development pathway has been received. Additional recruitment with Derwentside college has provided seven successful applicants and are expected to commence employment in August. The Board is asked to note the current position for May and support the actions being taken to strengthen workforce resilience and staffing governance.

14. Introduction

This report details the staffing exceptions for Gateshead Health NHS Foundation Trust during the month of May 2026. The staffing establishments are set utilising the Safer Nursing Care staffing tool (SNCT) within a triangulated approach of professional judgement and clinical outcomes. SNCT is a recognised, nationally used evidence-based tool that matches the acuity of patients with the staffing requirements for acute medical and surgical wards. Varying tools for the Emergency Department and Paediatrics are utilised. Mental health Services use the Mental Health Optimal Staffing Tool (MHOST), and Maternity use the Birth Rate Plus tool. Bi-annual reviews are reported to Quality Governance Committee and the Trust Board.

2. Staffing

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

NHS Table 1: Whole Trust wards staffing May 2026

Day	Day	Night	Night
Average fill rate - registered nurses/midwives (%)	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
91.4%	**84.9%**	**96.7%**	**107.3%**

The Trust is required to present information on funded establishments (planned) against actual nurses on duty. The above figures are average fill rates and thus do not reflect daily challenges and operational pressures to maintain adequate staffing levels.

Exceptions:

The guidance on safe staffing requires that the Board will be advised of those wards where staffing capacity and capability frequently falls short of what is planned, the reasons why, any impact on quality and the actions taken to address gaps in staffing. In terms of exception reporting, Gateshead Health NHS Foundation Trust reports to the Board if the planned staffing in any area drops below 80%.

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

Ward Managers and Matrons continue to work hard to staff their areas safely using the resources available. As a result, there are occasions where staff are allocated to support overall staffing levels rather than within the planned skill-mix proportions.

The exceptions to report May are as below:

May 2026	
Registered Nurse Days	**%**
Cragside Court	77.8%
Critical Care	68.4%
SCBU	65.7%
Ward 14 Medicine	75.4%
Ward 28 Orthopaedic Elective Ward	68.4%
Registered Nurse Nights	**%**
JASRU	72.0%
Sunniside Unit	66.1%
Ward 9 Respiratory	79.9%
Ward 10	71.3%
HCSW Days	**%**
Critical Care Dept	65.4%
SCBU	32.5%
Ward 8 Cardiology	76.2%
Ward 10	78.5%
Ward 21 Trauma & Ortho	63.1%
Ward 28 – Orthopaedic Elective Ward	33.6%

Ward 24	76.2%
Ward 26 Gynae	69.3%
Ward 27 Treat/Centre	74.2%
HCSW Nights	**%**
Ward 28	43.9%

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

- Redeployments of RN and HCSW on a daily and at times hourly basis between wards according to patient acuity and demand.
- Concentrated support from the Matrons and the People and Organisational Development team to address the sickness absence levels within the divisions and to recruit to vacant posts.

16. Vacancies

The Trust wide Registered Nursing vacancy rate is 1.6%, equating to 21.5 WTE. Most vacancies are within the Band 5 and Band 6 workforce. Recruitment remains ongoing aligned with student graduation cycles.

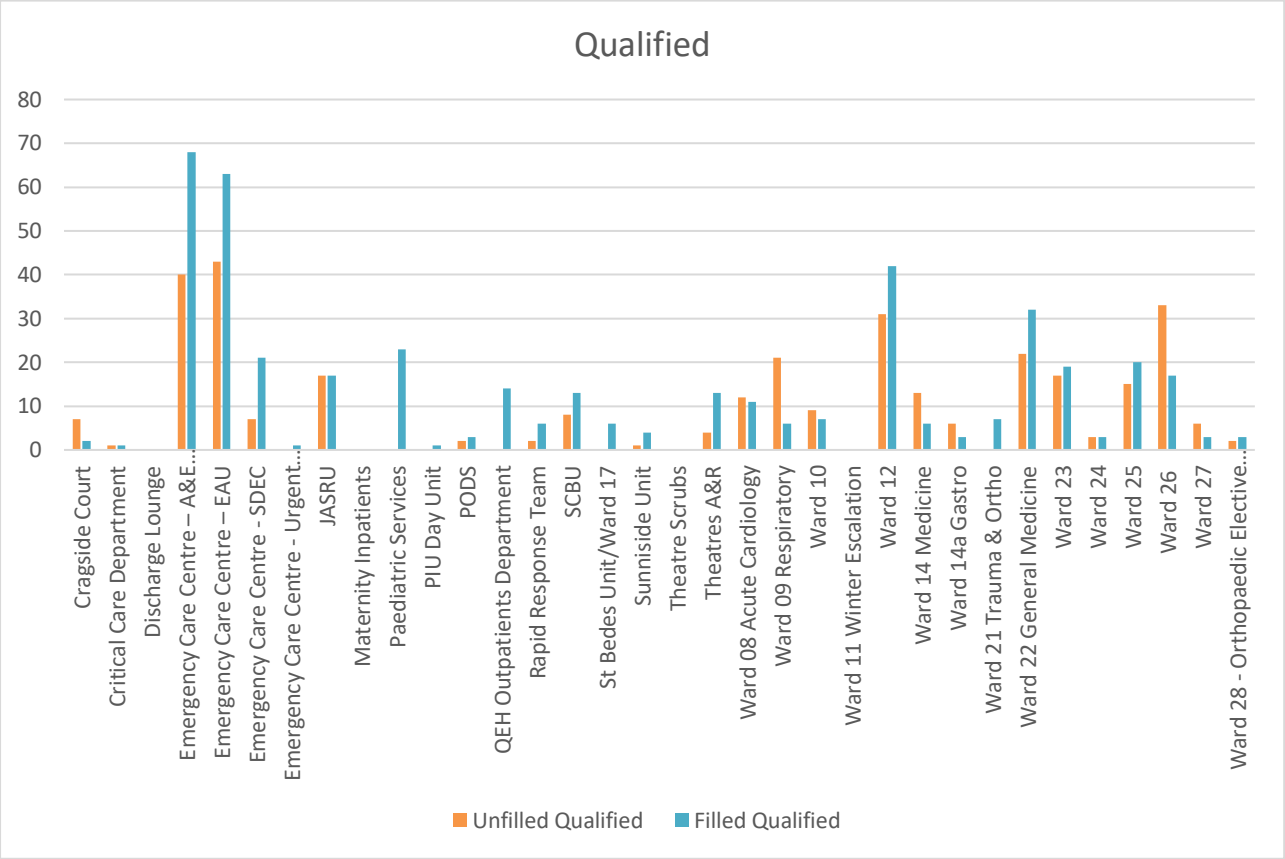
The HCSW vacancy position for the Trust is 14.1% with 74.3 WTE vacant position, which is a stable position from April. The current position with HCSW vacancies remains on the risk register within the Medicine and Community division as well as being identified as a Corporate risk. This is an area of particular concern as the HCSW internal bank is also depleted.

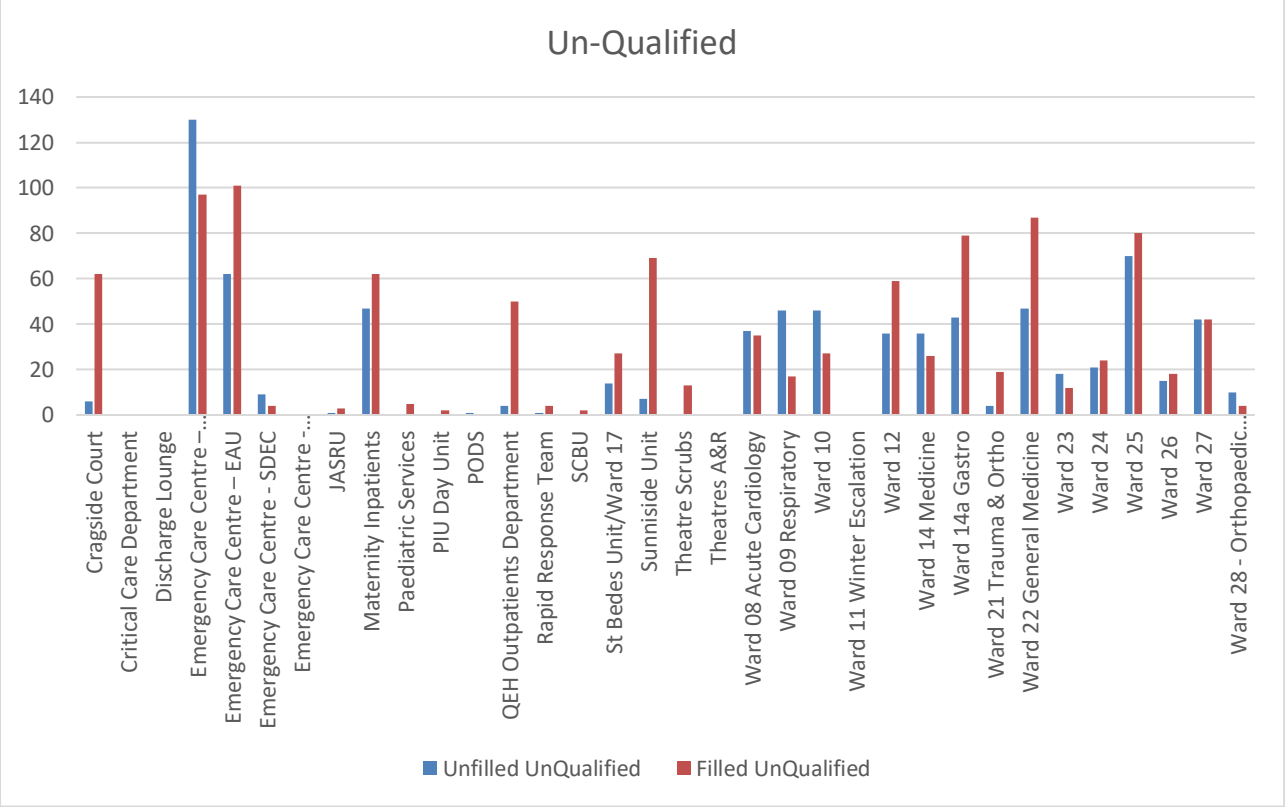
Recruitment is now be progressed at service line level within Divisions, as a more targeted approach is expected to be more effective than previous Trustwide recruitment. This position is also being felt regionally with challenges in recruiting staff directly into a band 3 post following the national re-banding work.

In parallel, a Band 2 to Band 3 Apprenticeship programme has now been approved in response to the challenges experienced in recruiting candidates with the required academic level and experience for Band 3 HCSW roles. We are working closely with Derwentside College who are supporting the recruitment and delivery of the apprenticeship pathway. This exciting new earn while you learn opportunity is in the advertising phase with the advert planned to close on June 21st 2026, and a recruitment day planned for early July.

17. Temporary Staffing

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





HCSW bank shifts continue to be challenging to fill, notably due to the volume of shifts available. Active recruitment as identified earlier is ongoing to ensure a readily available bank pool.

18. Care Hours Per Patient Day (CHPPD)

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

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

Ward level CHPPD is outlined in Appendix 1. For the month of May, the Trust total CHPPD was 7.8. This compares slightly lower when benchmarked with other peer-reviewed hospitals (7.9 peer average) however is a slightly improved position to April.

19. Monitoring Nurse Staffing via Incident Reporting system

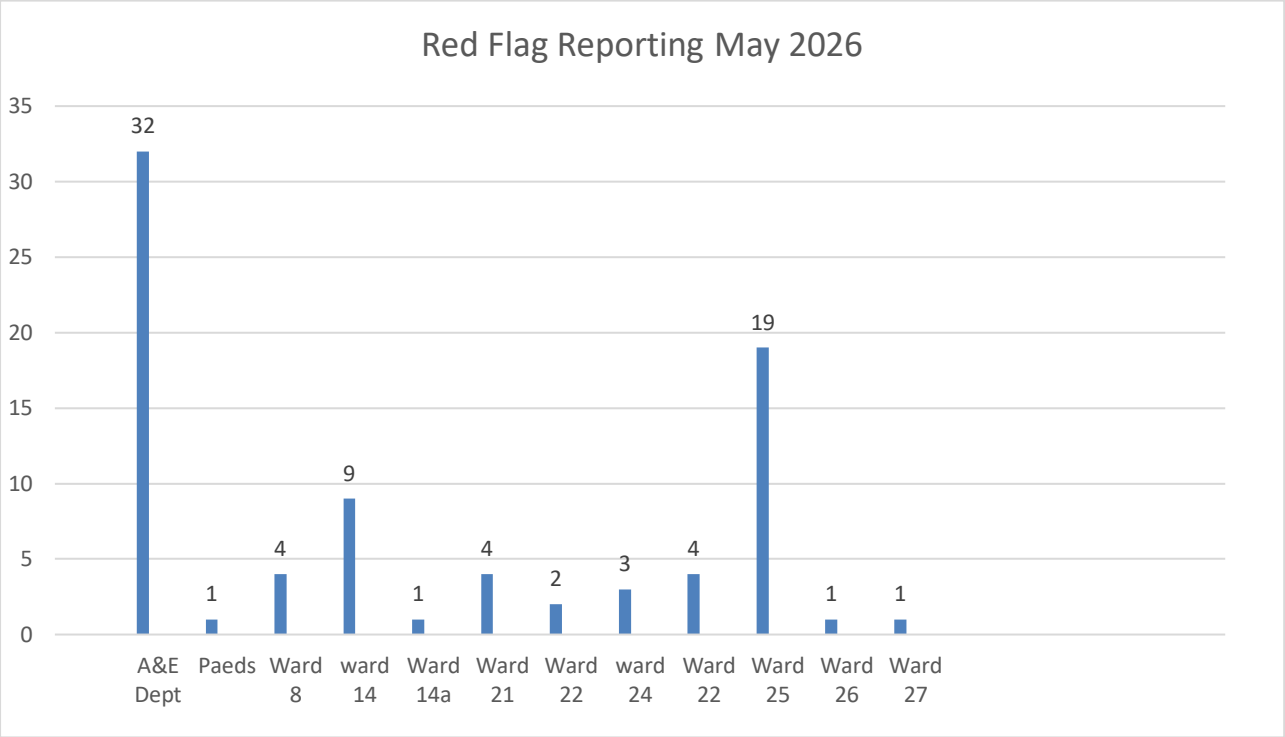
The Trust has an escalation process in place for addressing staffing shortages with identified actions to be taken. Further discussion is to take place to scope the potential for identifying thresholds that trigger when a staffing related incident should be submitted via inphase to provide reporting consistency. In addition to this the ongoing work to triangulate fill rates and care hours against reported staffing and patient safety incidents, has highlighted that the subcategories available to the reporter within the incident reporting system requires review to streamline and enable an increased understanding of the causes of the shortages. For example, short notice sickness, staff redeployment or inability to fill the rota. Eight staffing incidents were raised during May, including the levels of physical and psychological harm (Appendix 2). Nurse staffing was directly referenced in four inphase in relation to harm, this was marked as low physical harm and low psychological harm.

20. Nursing Red Flags

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

During May, 77 nursing red flags were reported. Red flags must be escalated promptly to the Matron or senior nurse for action and mitigation. In May, nine of these red flags raised were recorded as reviewed and one was resolved within the Safecare live system. The two highest reporting areas were Ward 25 with 19 red flags and A&E with 32. Ward 25 report this continues to relate to HCSW vacancy challenges, A&E report similar challenges alongside high acuity and demand.

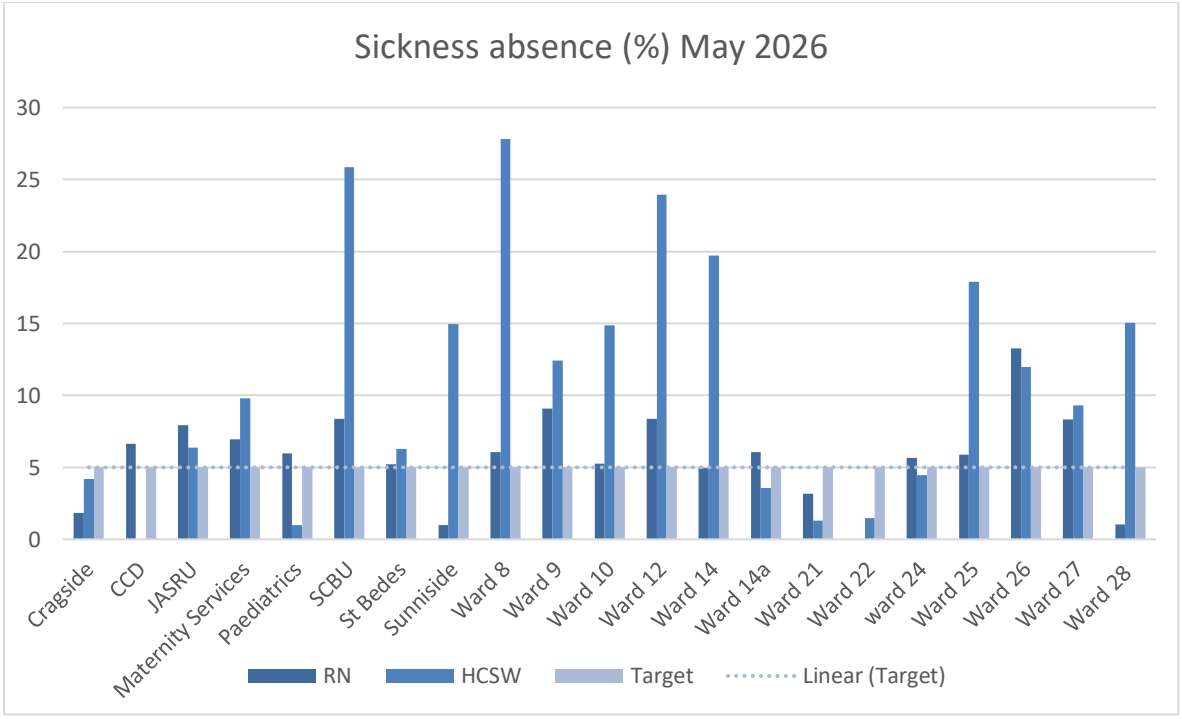
The Nursing Workforce team are working closely with the matron teams to ensure Red flags are mitigated and actioned within the system.



21. Absence levels

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

Data extracted from Health Roster.



22. Governance

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

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

23. Triangulation and actions taken

Critical Care Department demonstrated fill rates below 80% for Registered Nurse Days (68.4%) and Unregistered Nurse Days (65.4%). No red flags or inphases have been raised during May in relation to staffing. Average occupancy for the department during May was 51%.

SCBU demonstrated a daytime RN fill rate of 65.7%. HCSW fil rates were 32.5% for days. The occupancy for the department was 42%, and the Head of Midwifery assures the department was safe during the month.

Ward 28 continues to report a reduction in RN days and HCSW for both days and nights. The ward manager assures, staffing levels are safe for the bed occupancy (46%) and acuity/dependency of the ward. There were no incidents or red flags reported.

Cragside Court report 77.8% fill rates for Registered staff days. Sunniside have been able to staff one Registrant per night, fill rates are 66.1% as a result of this however, there has been no cross-covering support available.

Ten areas demonstrate below 80% fill rates for HCSW due to the high number of vacancies. This position appears to be gradually improving, potentially as a result of bank and agency usage. Active monitoring, redeployment are currently being used to mitigate understaffed areas based on real time risk assessments and patient acuity and dependency to ensure safety.

24. Recommendations

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

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

Decrease from previous month Increase form previous month

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative patient count over the month	Registered midwives / nurses	Care Staff	Overall
Cragside Court	77.8%	87.8%	125.3%	151.8%	168	10.4	14.2	24.6
Critical Care Dept	68.4%	65.4%	87.7%	80.5%	190	38.3	4.1	42.3
Emergency Care Centre - EAU	83.0%	86.8%	97.4%	102.2%	1393	5.5	4.0	9.6
JASRU	117.9%	83.8%	72.0%	128.4%	612	3.7	4.1	7.8
Maternity Unit	88.7%	107.1%	110.3%	108.2%	642	14.0	4.3	18.3
Special Care Baby Unit	65.7%	32.5%	106.0%	87.9%	199	8.8	1.7	10.5
St. Bedes	85.7%	108.2%	113.7%	156.2%	297	5.4	4.8	10.2
Sunniside Unit	81.8%	148.8%	66.1%	99.9%	223	6.3	6.4	12.6
Ward 08	99.0%	76.2%	105.7%	106.7%	638	4.5	2.6	7.1
Ward 09	131.4%	86.2%	79.9%	121.9%	886	2.8	2.1	4.9
Ward 10	127.4%	78.5%	71.3%	114.9%	790	3.0	2.2	5.2

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Ward 12	121.2%	92.7%	90.1%	137.2%	825	3.0	2.5	5.5
Ward 14 Medicine	75.4%	87.0%	93.9%	113.3%	788	3.1	2.3	5.5
Ward 14a Gastro	107.6%	159.7%	100.2%	104.5%	787	3.0	3.2	6.2
Ward 21 T&O	75.4%	87.0%	93.9%	113.3%	788	3.1	2.3	5.5
Ward 22	86.8%	92.2%	95.8%	93.0%	954	2.4	2.6	4.9
Ward 24	124.4%	76.2%	104.5%	98.1%	936	3.1	2.4	5.5
Ward 25	103.8%	97.9%	107.6%	99.0%	922	2.8	2.8	5.7
Ward 26	91.1%	69.3%	98.0%	104.3%	680	3.5	2.7	6.3
Ward 27	108.6%	74.2%	105.3%	107.5%	914	3.0	2.1	5.2
Ward 28	68.4%	33.6%	104.8%	43.9%	208	7.5	3.0	10.6
QUEEN ELIZABETH HOSPITAL - RR7EN	**91.4%**	**84.9%**	**96.7%**	**107.3%**	**13915**	4.7	3.1	7.8

Appendix 2 INPHASES submitted in relation to nurse staffing.

Incident Date.	Investigating Department	Category(s)	Subcategory	Level of Physical Harm	Level of Psychological Harm
6/5/26	Ward 14	Staffing/resource issue	Insufficient Nurses (due to staff movements)	No physical harm	No psychological harm
5/5/26	Ward 9 Respiratory	Staffing/resource issue	Staffing – delay / difficulty obtaining clinical assistance	No physical harm	No psychological harm
7/5/26	Ward 12	Staffing/resource issue	Staffing Insufficient Nurses (other reasons)	No physical harm	No psychological harm
8/5/26	Specialist Palliative Care Team	Staffing/resource issue	Insufficient Nurses (due to sickness)	No physical harm	Low psychological harm
14/5/26	Ward 25	Staffing/resource issue	Insufficient nurses (due to staff shortages/ unfilled shifts)	No physical harm	Low psychological harm
14/5/26	Ward 25	Staffing/resource issue	Staffing-insufficient staff (other)	No physical harm	No psychological harm
30/5/26	Ward 25	Staffing/resource issue	Staffing-insufficient staff (other)	Low physical harm	No psychological harm
30/5/26	PeaPod	Staffing/resource issue	Staffing – delay / difficulty obtaining clinical assistance	No physical harm	No psychological harm

4. GREAT PLACE TO WORK

a - Freedom to Speak Up Guardian Report

Presented by the FTSU Guardian

Gateshead Health NHS Foundation Trust

Board of Directors Agenda Item: 4a

Report Title:	**Freedom to Speak Up Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	Wednesday 29th July			
Author:	Tracy Healy Freedom to Speak Up Guardian			
Executive Sponsor:	Beth Swanson, Interim Chief Nurse and Professional Lead for Midwifery and AHP Amanda Venner, Group Director of People and OD			
Report presented by:	Tracy Healy Freedom to Speak Up Guardian			
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** ☒	**Partially assured** ☐	**Not assured** ☐	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	POD Committee 8th July 2026			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	**Alert:** Inappropriate behaviour remains a recurrent theme highlighted by teams across the organisation, and lack of actions being taken to manage bad behaviours. **Advise:** Changes to National FTSU Services and in line with DASH Report. **Assure:** The introduction of the Staff Experience and Inclusion Oversight Group and POD Culture. Insight and Triangulation meetings support sharing of data for triangulation and will also support future improvement programmes, with plan of patient safety team representation to be co-opted into the meetings broadening the representation and triangulation of data sets.			

Gateshead Health NHS Foundation Trust

Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	• Note this report as evidence of the ongoing work of the Freedom to Speak Up Guardian in supporting our staff in making speaking up business as usual. • Recognise the work to date that commits our organisation to embed the 'Speak Up, Listen Up and Follow Up' principles and practices • Continue the Trusts commitment to ensuring every voice is heard.	
Trust strategic priorities that the report relates to:	☒	Excellent patient care
	☒	Great place to work
	☐	Working together for healthier communities
	☐	Fit for the future
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	1.1 We will be a clinically led organisation focused on delivering safe, high-quality care and improving health outcomes for our patients. 1.2 We will ensure our patients experience the best possible compassionate care and make every contact count. 2.1 We will care for our people, creating a fair, inclusive and respectful environment where everyone can thrive in their role.	

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

Risks / implications from this report (positive or negative):	
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	4797 - There is a risk that colleagues have negative experiences at work and do not feel valued or respected in the workplace as highlighted by the staff survey. This is a result of poor behaviours displayed by other colleagues that are not acceptable and not line with Trust values or behavioural framework. This results in ongoing low engagement, increased turnover, burnout, and higher levels of sickness absence which may result in compromised quality of care for patients.

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

Gateshead Health NHS Foundation Trust

Freedom To Speak Up Report

Introduction

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

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

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

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

5. This report provides the Board with a summary of FTSU activity for 2025 – Current Q1 2026.

Gateshead Health NHS Foundation Trust

Freedom to Speak Up (FTSU) Report Executive Summary: January 2026 – June 2026

Executive Summary

This report summarises Freedom to Speak Up (FTSU) activity between January - June 2026.
Following a temporary reduction in activity during 2025 due to the absence of the substantive FTSU Guardian, reporting levels have continued to increase following the Guardian's return and the establishment of interim arrangements. Focus during this period has remained on strengthening the service, improving staff experience, and embedding a positive speaking-up culture.

Key Themes and Organisational Learning

Analysis continues to identify concerns relating predominantly to behaviours, culture, and civility across the organisation. Areas generating higher levels of concerns include Outpatient Pharmacy, Medicine 2 and 3, Pathology, and Dietetics. Concerns within Dietetics have shown a consistent pattern over the last two years, particularly relating to bullying, harassment, and inappropriate behaviours.
These themes align with findings from staff survey results and wider workforce intelligence and continue to be escalated through established governance and triangulation arrangements, (see dashboard above for data information).

Equality, Diversity and Inclusion

National and local data demonstrate that colleagues from protected characteristic groups remain less likely to raise concerns. During this reporting period, 47% of cases were raised by staff with a protected characteristic, with one-third relating directly to that characteristic. (see data for protected characteristics on dashboard above)
In response, the Trust has strengthened triangulation arrangements and introduced the Staff Experience and Inclusion Oversight Group to improve intelligence sharing, identify emerging themes, and support targeted improvement activity.

Service Development and Improvement

Significant progress has been made in strengthening the FTSU service, including:

- Completion of the FTSU Standard Operating Procedure (SOP), pending governance approval. (Appendix 3)
- Development of a Manager and Leader Guide to support consistent management responses to concerns. (Appendix 4)
- Publication of a Freedom to Speak Up Route Map to improve accessibility and staff awareness.
- Ongoing review of People Policies to ensure appropriate support for staff who raise concerns.

These developments aim to improve consistency, timeliness, psychological safety, and staff confidence in speaking up.

Gateshead Health NHS Foundation Trust

National and Regional Developments

National reporting requirements continue to be met. Changes to national oversight arrangements mean FTSU governance is now jointly managed through NHS England and compliance monitoring through the Care Quality Commission (CQC) Well-led key line of enquiry.
The Trust continues to work collaboratively through regional and alliance networks, including the Northern FTSU Alliance and Great North Healthcare Alliance FTSU networks, to support consistency and future service improvements.
Please see Appendix 2 for summary of changes to the national FTSU services in line with Dash Report and recommendations for all NHS providers for local delivery of FTSU Services. The Board is asked to support maintaining the current Local FTSU service model, notwithstanding the recent National changes to FTSU Service following the Dash Report (July 2025).

Key Issues and Findings

Reporting Activity

Reporting activity has increased since Quarter 4 of 2025 following the return of the substantive FTSU Guardian and continued promotion of speaking up across the Trust.

Primary Themes Identified (see dashboard Appendix 1 for data sets)

- Staff behaviours, culture, bullying and harassment: 68.4%
- Worker safety concerns: 21.1%
- Patient safety/quality concerns: 5.3%
- Detriment following speaking up: 2.6%
- Fraud concerns: 2.6% (escalation was followed as per Trust Policy PP36 and appropriate action taken).

All concerns are addressed as per FTSU Policy PP35 with escalation made to Service leads and all issues discussed with Executive Leads for FTSU.

Organisational Themes

The principal themes requiring continued organisational focus are:
Incivility and disrespectful behaviours.
Inconsistent demonstration of Trust ICORE values.
Lack of compassionate and inclusive team cultures.
Psychological safety concerns, including intimidation and fear.
Inconsistent management intervention when poor behaviours are identified.
Failure to address conduct and performance concerns through established processes.
These findings remain consistent with staff survey results and triangulated workforce data.

Local Update: Actions Taken and Future Developments

Actions Completed

Establishment of the Staff Experience and Inclusion Oversight Group and enhanced triangulation meetings.

Gateshead Health NHS Foundation Trust

Impact

These initiatives have strengthened organisational learning, improved intelligence sharing, enhanced staff support, and increased visibility and accessibility of the FTSU service.

Planned Priorities

Service Development

Implement the approved FTSU SOP and Manager/Leader Guide.
Further strengthen the FTSU Champion Network.

Culture and Staff Experience

Embed the Staff Experience and Inclusion Oversight Group with introduction of Patient Safety leads to further enhance data and quality improvement plans.
Enhance triangulation of workforce and culture data.
Increase engagement with staff from protected characteristic groups.
Support the introduction of EDI App in InPhase.
Support organisational programmes focused on civility, leadership, culture, and psychological safety.

National Requirements

Prepare for revised NHS England and CQC reporting and governance arrangements.

Solutions and Recommendations

The Board of Directors is asked to:
Note the contents of this report.
Recognise progress made in embedding Speak Up, Listen Up and Follow Up principles.
Support ongoing initiatives to improve culture, psychological safety, and staff experience.
Receive assurance that concerns are appropriately reviewed, escalated, and addressed through established governance arrangements.
Support the current continuation of current FTSU Service Model.

Next Steps

Scoping of SOP and managers guide to be used across the great North Health Alliance.
Development of FTSU Policy in line with new National Policy.
Introduction of new National reporting system for FTSU and system for benchmarking nationally.

NHS Gateshead Health NHS Foundation Trust

Appendix 1

NHS Gateshead Health NHS Foundation Trust

13/07/2025, 12:47 FTSU Dashboard Data

Freedom to Speak Up Dashboard Data

NHS Gateshead Health NHS Foundation Trust

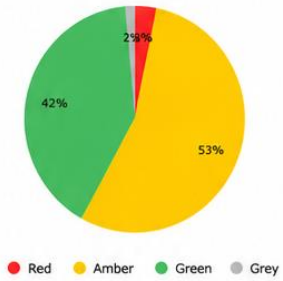
Total Cases

93

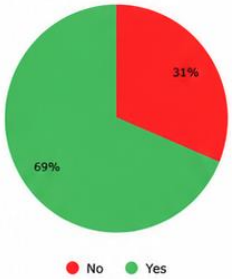
Open Cases

17

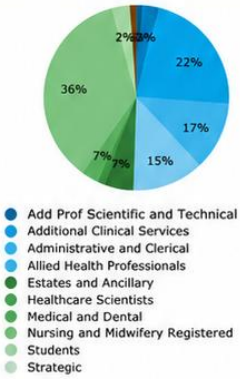
RAG Rating



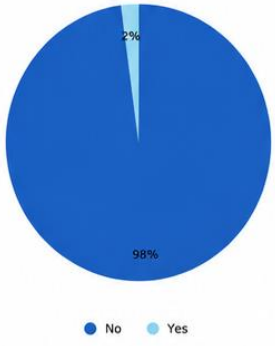
Related to Protected Characteristics



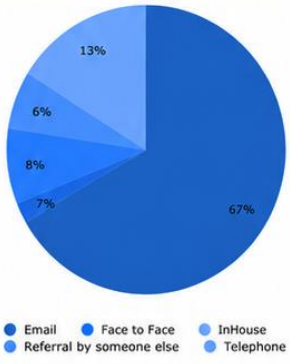
Cases by Staff Group



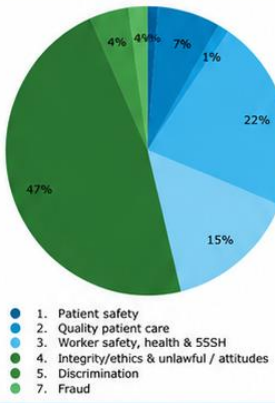
Cases raised anonymously



Method of Contact



Nature of Concern



Nature of Concern Sub-Category

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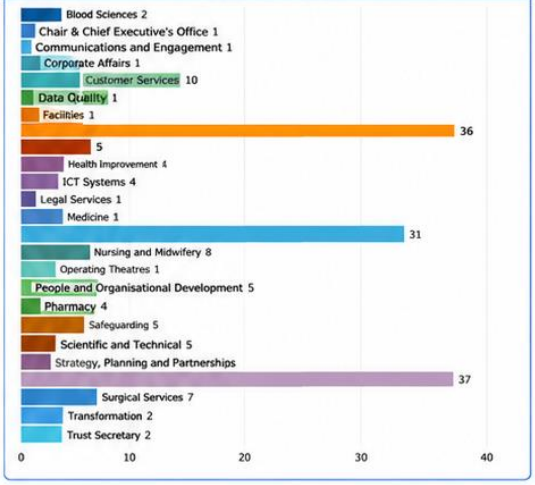
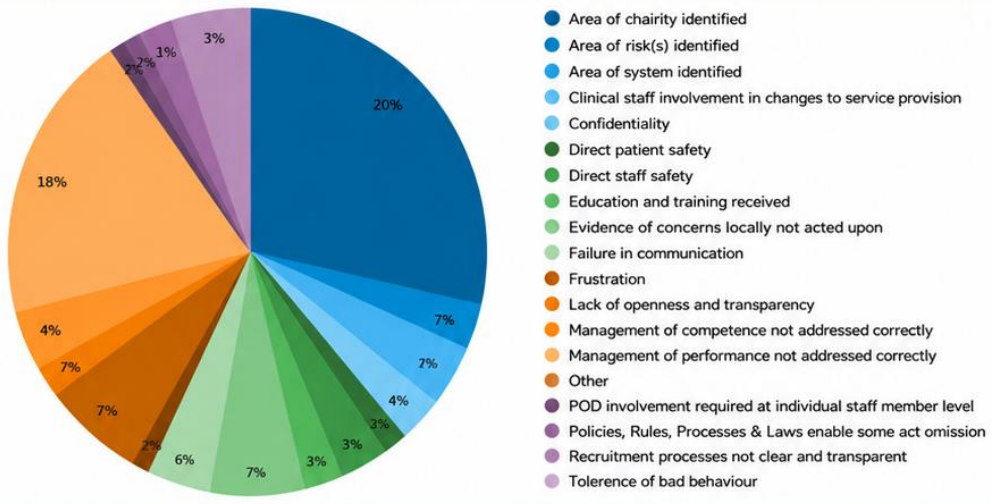
FTSU Dashboard Data

Cases by Business Unit

Cases by Service



Concern Learning



Outcomes / Recommendations

The Board is asked to support maintaining the current Local FTSU service model, notwithstanding the recent nature changes to FTSU Services.
Introduction of Standard Operating Procedure (SOP) for the FTSU Service.
Introduction of a Managers' Guide for Speaking Up.

General Comments

Processes now in place for escalation of concerns/ data from the Triangulation meeting agreed.
Changes to the disciplinary policy to reflect support for staff raising concerns.
Investigation of concerns are taking excessive timescales to complete and lack of actions being taken.
When actions are identified following investigations they are not consistently implemented or followed up.

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Appendix 2:

Executive Summary: Future of Freedom to Speak Up (FTSU) – Key Changes from 1 July 2026

Following the closure of the National Guardian's Office (NGO) on **30 June 2026**, responsibility for many FTSU functions transfers to **NHS England**, while providers, commissioners and ICBs assume greater local accountability.

What this means for Gateshead Health and other NHS Trusts

1. Greater Local Responsibility

Trusts now have sole responsibility for:

- Maintaining accurate and accessible information about how to contact their FTSU Guardian(s).
- Publishing guardian contact arrangements on the Trust website.
- Ensuring all newly appointed Guardians complete mandatory foundation training before commencing the role.
- Supporting Guardians' ongoing professional development.
- Providing access to independent psychological support once the national CQC-funded Employee Assistance Programme ends on **31 December 2026**.
- Submitting FTSU data through NHS England's national collection process.

2. National Guardian's Office Closure

The NGO will cease operating on **30 June 2026**.

As a result:

- The national public register of Guardians will close.
- NGO-led Speak Up Reviews will stop.
- NGO responsibility for policy development, training oversight and data collection ends.
- Legacy NGO resources will be archived and accessible via NHS England signposting.

NHS England's New Responsibilities

NHS England will now:

Support Guardians

- Manage general enquiries via the national contact centre.

- Provide specialist one-to-one support through the national FTSU team.
- Continue support of national and regional Guardian networks.

Training

- Host Guardian Foundation Training on the e-Learning for Health platform.
- Provide access to mentoring for new Guardians.

Data and Learning

- Collect national quantitative FTSU data from:
  - NHS Trusts
  - NHS Foundation Trusts
  - ICBs
- Analyse data and share thematic learning across the system.
- Integrate FTSU insights into wider workforce and patient safety work.

Policy and Guidance

- Maintain and update national FTSU guidance.
- Review primary care FTSU arrangements during 2026/27.
- Review wider policy and guidance for all sectors during 2027/28.

Data Collection Changes

From July 2026

Trusts and ICBs must submit:

- Quarterly anonymised FTSU data.
- Through NHS England's national collection process.
- Organisational accountability replaces Guardian accountability for submissions.

Important

- Primary care and independent providers are excluded from national data collection during 2026/27 while arrangements are reviewed.
- Local collection and analysis should continue.

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CQC Implications

The CQC will increasingly assess FTSU arrangements through the **Well-led framework**.

Inspections will consider:

- Whether effective FTSU arrangements are in place.
- Guardian accessibility and visibility.
- Training and support for Guardians.
- Leadership commitment to speaking up culture.

Key Implications for You as FTSU Guardian

Immediate Actions

✅ Confirm Trust website information is accurate, accessible and regularly reviewed.

✅ Ensure arrangements are in place for mandatory training of any new Guardians.

✅ Prepare for NHS England data submission requirements and guidance.

✅ Consider future provision of independent psychological support before December 2026.

✅ Continue engagement with regional and national Guardian networks.

Strategic Opportunities

✅ Greater integration of FTSU intelligence with workforce and patient safety improvement work.

✅ Stronger local ownership and accountability for speaking up culture.

✅ Potential to use NHS England thematic learning and Model Health System benchmarking to support Board assurance.

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Key Dates

Date	Milestone
May 2026	NHS England training platform available
30 June 2026	National Guardian's Office closes
1 July 2026	New FTSU arrangements commence
July 2026	Website publication requirements and NHS England data submissions begin
31 December 2026	National Guardian Employee Assistance Programme ends
2026/27	Primary care and independent sector review
2027/28	Wider policy and guidance review

Overall Message

The changes do **not reduce the importance of Freedom to Speak Up**. Instead, they shift responsibility from a nationally led NGO model to a **locally accountable model**, with NHS England providing support, oversight, training, system learning and data management, while Trusts take greater ownership of Guardian effectiveness and speaking up culture.

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Appendix 3:

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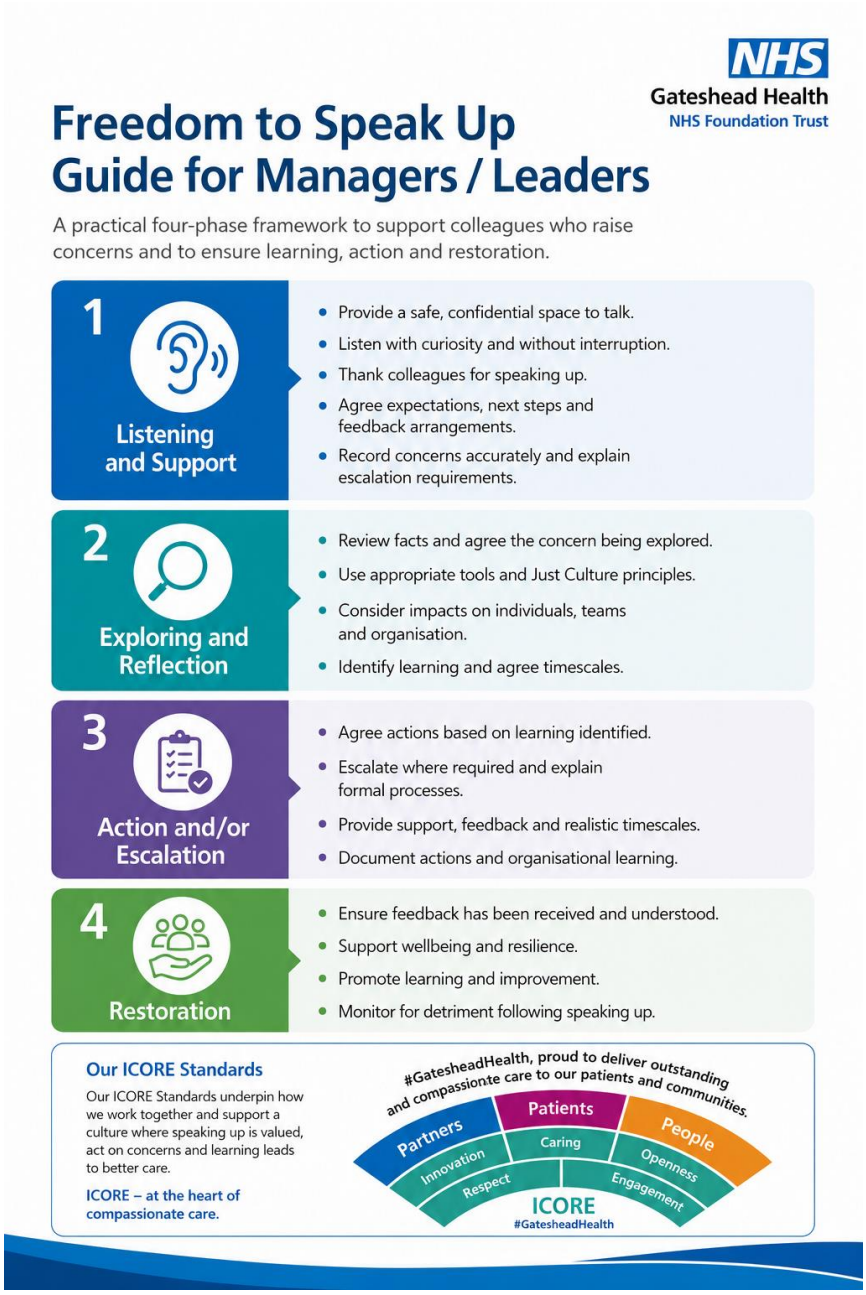
Appendix 4:



b - Staff Standards and Leadership & Management Framework

Presented by the Executive Director of People and Organisational Development

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 4b

Report Title:	**Staff Standards and Leadership and Management Framework**			
Name of Meeting:	Trust Board			
Date of Meeting:	29th July 2026			
Author:	Amanda Venner, Executive Director of People and OD			
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:** ☒
	To receive the report for information and assurance that work has been undertaken to identify any gaps and plan implementation as appropriate.			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	N/A			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	This paper is to inform the Board of the introduction of the NHS Staff Standards and the NHS Leadership & Management Framework and to outline the implications for Gateshead Health. Given the significant overlap between the two initiatives, this paper provides a single integrated update focused on organisational culture, staff experience, leadership capability and Board assurance. The paper seeks endorsement of an implementation approach that aligns and strengthens existing programmes of work and focusing on the initial gaps of training relating to digital skills, research and innovation and embedding consistent and wider ranging approaches to flexible working. Initial risks are identified as;			

Gateshead Health NHS Foundation Trust

	• Not undertaking meaningful implementation and adoption of the standards, not using these as an opportunity to truly improve staff experience. • Our future NOF rating will include staff survey scores relevant to the staff standards, and our provider capability assessment will include staff experience and engagement measures – currently these scores need improvement and could deteriorate our position.				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	Receive this paper by way of an update.				
Trust strategic priorities that the report relates to:	☐	Excellent patient care			
	☒	Great place to work			
	☐	Working together for healthier communities			
	☐	Fit for the future			
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	List strategic objective here				
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	4797 - 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)				
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Gateshead Health NHS Foundation Trust

Staff Standards and Leadership and Management Standards

1. Executive Summary

NHS England has recently introduced two closely linked national workforce initiatives:

- The NHS Staff Standards.
- The NHS Leadership & Management Framework.

Together, they represent a significant national shift in how NHS organisations are expected to support staff, develop leaders and provide assurance regarding workforce culture and experience.

Whilst presented as separate initiatives, both originate in the NHS 10 Year Health Plan and the recommendations of the Messenger Review. Both aim to improve staff experience, strengthen leadership and management capability, reduce unwarranted variation and create more consistent organisational cultures across the NHS.

The Leadership & Management Framework provides the expectations, behaviours and competencies required of NHS leaders and managers.

The Staff Standards define the experience that staff should receive as NHS employees, including effective line management, health and wellbeing support, flexible working, safety and inclusion.

For Gateshead Health, these initiatives should not be viewed as entirely new programmes of work. Many of the requirements align with existing Trust priorities and activity including leadership development, staff engagement, flexible working, health and wellbeing, violence reduction, equality, diversity and inclusion, staff survey improvement and organisational culture programmes.

The key challenge is therefore not implementation from a ‘standing start’, but ensuring existing arrangements are aligned to the national frameworks, gaps are identified, and the Board is able to demonstrate robust oversight and assurance.

The staff standards will form part of the National Oversight Framework (NOF) rating, measured through staff survey indicators as well as forming part of the Provider Capability Assessment.

2. Introduction

Nationally, NHS England has highlighted the direct relationship between leadership quality, staff experience, retention, organisational culture, patient outcomes and productivity. The new frameworks seek to establish a more consistent national approach to both leadership and staff experience across the NHS. This provides us with an opportunity to elevate staff experience and ensure that at Board level we are aware of the impact of our actions on staff experience. There is substantial evidence that improved staff experience leads to improved patient outcomes.

These initiatives are intended to strengthen and bring together existing activity rather than create parallel programmes. Trusts are expected to embed the requirements

Gateshead Health NHS Foundation Trust

within existing people, leadership, recruitment, appraisal and governance arrangements. Implementation is expected to take place during 2026/27 and into 2027 where necessary.

3. Key issues / findings

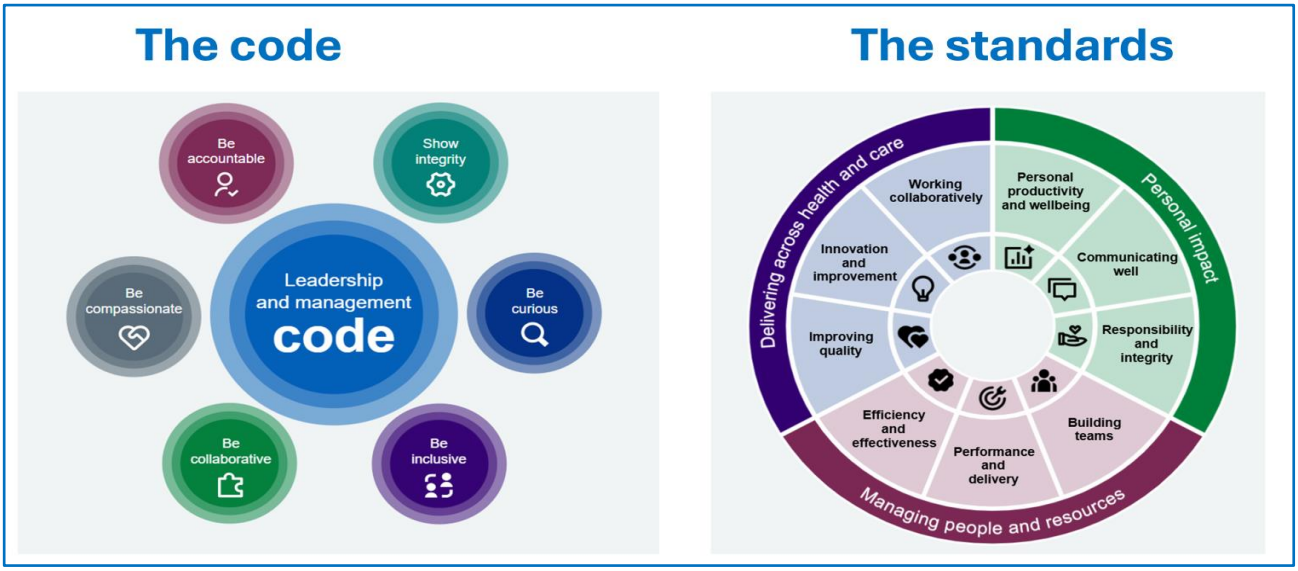
Although launched separately, the two initiatives are fundamentally interconnected.

The **NHS Staff Standards** set out what staff should experience in relation to:

- Line management.
- Health and wellbeing.
- Violence prevention and reduction.
- Sexual safety.
- Tackling racism and discrimination.
- Flexible working

The **Leadership & Management Framework** sets out:

1. A national Leadership and Management Code.
2. Leadership and management standards and competencies.
3. Self-assessment and development expectations for managers and leaders at all levels.



In practice, staff experience is heavily influenced by the capability and behaviour of leaders and managers. The quality of line management, inclusive & compassionate leadership and organisational culture is at the centre of both initiatives. The Framework can be viewed as the mechanism through which a number of the Staff Standards are delivered.

4. Current Position at Gateshead Health

An immediate gap analysis has taken place against all the combined expectations, and this has confirmed that Gateshead Health is in a strong position to respond to these national requirements because many of the core components are already established.

Current activity includes:

Leadership and Management

- Leadership and management development programmes.
- Coaching and mentoring support.
- Leadership and Management Hub.
- Behavioural frameworks and leadership development pathways.
- Succession planning and talent development activity.

Staff Experience and Culture

- Staff Survey improvement programmes.
- Health and wellbeing support offers.
- Flexible working arrangements.
- Freedom to Speak Up arrangements.
- Staff network development.
- EDI and anti-racism programmes.
- Violence reduction initiatives.
- Partnership working with Trade Unions and staff representatives.

Current Gaps - There are a small number of areas that have been identified via the gap analysis where there is clearly scope for improvement and these are:

Leadership and Management – training offers related to digital skills, research and innovation

Staff Experience and Culture – work to embed consistent and wider ranging approaches flexible working

The gap analysis shows we are largely compliant already; the challenge is behavioural adoption and consistency and ensuring that we are not simply ‘ticking the box’ and not making meaningful improvements to staff experience.

5. Risks

There are two initial risks associated with these publications;

Firstly, there is a risk that we don’t undertake meaningful implementation and adoption of the standards, and we don’t use these as an opportunity to truly improve staff

Gateshead Health NHS Foundation Trust

experience. This risks the implementation being seen as tokenistic and will limit impact and engagement.

Secondly our future NOF rating will include staff survey scores relevant to the staff standards, and our provider capability assessment will include staff experience and engagement measures. Detail is below;

NOF – The new score will contribute to our segmentation in both the People & Workforce domain and for the overall segmentation.

- Introduced from Q1 2026/27 – initially based upon the 2025 NHS Staff Survey (NSS) data (Q1-3)
- Q4 will introduce the data from the upcoming 2026 NSS – ensuring opportunity for each organisation's score to be impacted in the first year of the new standards

When the existing **Provider Capability Assessment** framework is updated in 2026, it will include updates to look at how organisations are working to improve staff engagement.

NHSE assessment

- Triangulate staff experience assurance received from the trust with any other information – e.g. what is its score, are there material staff concerns, do CQC well-led reviews highlight cultural issues? Concerns reflected in organisation's RAG rating

Organisation self-assessment

- Updated guidance in the People & Culture section to request evidence of organisations' use of staff experience information
- NHS Staff Standards will be referenced in the indicative lines of inquiry

These measures will provide us with risks given the decline in our staff survey scores this year and the potential impact this may have on our NOF rating (Calculation of weighting of staff standards metrics is still tbc).

6. Summary

The NHS Staff Standards and NHS Leadership & Management Framework should be viewed as complementary components of a single national ambition: creating consistently positive staff experiences through strong, compassionate, inclusive and effective leadership.

The majority of the required foundations are already established. Our focus will now be on alignment, assurance and demonstrating impact rather than creating additional programmes. This presents an opportunity to consolidate existing work, strengthen organisational culture and provide greater visibility of the Trust's commitment to being both a great place to work and a great place to receive care.

The immediate gap analysis provides assurance that Gateshead Health is starting from a strong position with most of the expectations within both national frameworks are already underway within existing People and OD programmes.

The initial identified gaps relate to; specific training offers related to digital skills, research and innovation and embedding consistent and wider ranging approaches to flexible working.

7. Recommendations

The Board is asked to:

a) Note the introduction of the NHS Staff Standards and NHS Leadership & Management Framework.

b) Recognise the significant interdependency between both initiatives and the role of leadership in delivering positive staff experience.

c) Acknowledge that Gateshead Health has already established many of the core components required to support implementation.

d) Endorse the next steps focused on alignment of existing programmes, addressing the gaps identified

e) Acknowledge the initial risks highlighted

f) Receive future assurance through People and OD Committee.

5. FIT FOR THE FUTURE

a - Governance Reports

i) Organisational Risk Register

Presented by the Chief Nurse

Gateshead Health NHS Foundation Trust

Board of Directors Agenda Item: 5ai

Report Title:	**Organisational Risk Register (ORR)**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29th July 2026			
Author:	Marie Malone, Corporate and Clinical Risk Lead.			
Executive Sponsor:	Elizabeth Swanson, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals			
Report presented by:	Elizabeth Swanson, Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To ensure the Board and Committees are clearly sighted on those risks that have an organisational -wide impact, the organisational risk register is compiled by the Executive Risk Management Group (ERMG) of those risks that impact on the delivery of strategic aims and objectives. This includes risks included within the Board Assurance Framework (BAF) as well as risks identified by the Group for inclusion as having an organisational impact and impact on delivery of strategic aims and objectives. The supporting report shows the risk profile of the ORR, and provides details of review compliance, and risk movements.			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	The full ORR is received into the Executive Risk Management Group meeting every month, as well Risks relevant to Tier 1 and 2 Committee Business.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.*	Risks on the ORR were reviewed at previous ERMG meetings in June and July 2026. The following updates and movements were undertaken:			

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• *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• In the period of 17th May- 17th July 2026, there were 8 risks added to the ORR, 0 escalations, 0 reductions, and 6 closures. • 18 risks in total on the Organisational risk register • Summary of movements over 12-month period is shown within the attached report. • Compliance with reviews in period remains consistent with the previous 2-month data set at 94% for risks and 91% for associated actions.
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board are asked to: • Review the risks on the report and discuss and seek further information as appropriate. • Acknowledge movements over 12-month period listed in the attached report. • Note compliance with risk and action reviews remains consistently positive in line with the previous reporting period. • Be sighted on July's top composite risks • Take assurance over the ongoing management of organisational and Strategic risk.
Trust strategic priorities that the report relates to:	☒ Excellent patient care ☒ Great place to work ☒ Working together for healthier communities ☒ Fit for the future
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	1. We will be a clinically-led organisation focused on delivering safe, high-quality care and improving health outcomes for our patients 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

Gateshead Health NHS Foundation Trust

	4. We will care for our people, creating a fair, inclusive and respectful environment where everyone can thrive in their role 5. We will grow and develop our people with a focus on celebrating achievements and creating a culture of high performance and innovation 6. We will be an employer and training provider of choice within the local Community recognising our role as an anchor institution 7. We will work in collaboration with our partners to improve the health of our population and reduce health inequalities 8. We will develop our neighbourhoods in line with the NHS 10-year plan 9. We will collaborate with system partners with an emphasis on maximising efficient use of collective resources across health and care services 10. We will ensure effective and efficient use of our resources identifying opportunities to improve productivity and ensure best use of public money 11. We will be a data informed, digitally enabled organisation using technology to transform the way we plan and deliver care 12. We will focus on productive utilisation of our estate to facilitate care in the right setting and providing our services in an environmentally sustainable way				
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	Included in report				
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Gateshead Health NHS Foundation Trust

Organisational Risk Register

1. Executive Summary

To ensure the Board and Committees are clearly sighted on those risks that have an organisational -wide impact, the Organisational Risk Register (ORR) is compiled by the Executive Risk Management Group (ERMG) of those risks that impact on the delivery of strategic aims and objectives.

This includes risks included within the Board Assurance Framework (BAF), Top composite risks, as well as risks identified by the Group for inclusion as having an organisational impact and impact on delivery of strategic aims and objectives.

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

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

This report covers the period 17th May-17th July 2026.

2. Organisational Risk Register

Movements in period

Following ERMG meetings in June and July 2026, 8 risks has been added to the ORR.
There have been 0 escalations or reductions, and 6 closures.
There are currently 18 risks on the ORR, agreed by the Executive Risk Management Group as per enclosed report.

Risks added to the Organisational risk register.

Following formal approval at ERMG and Digital committee to adopt a thematic risk approach, 2 Digital risks have been added to the ORR in period:

- **4913 (Digital)** Risk that clinical decision-making is delayed or incomplete, and that the Trust falls short of DCB0160 expectations for digital clinical safety. Due to multiple unintegrated clinical systems plus residual paper workflows, and incomplete clinical safety artefacts limit a real-time, single patient view. This could cause potential patient harm, impaired escalation of deterioration, bottlenecks in ED/SDEC and inpatient flow, and assurance gaps against national clinical safety standards. (16)

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  - Addition of Thematic risk as part of the digital deep dive review.
  - Recognised as a significant clinical risk compounded by lack of integrated patient record.

- **4907 (Digital)** Risk the Trust fails to comply with UK data protection and transparency obligations (DPA, SAR/FOI timelines) and loses control of information quality and access. Due to mixed paper/digital records landscape, uneven adoption of local records management protocols, incomplete lifecycle controls (catalogue, retention, destruction), and constrained capacity for statutory requests (SAR/FOI). This could result in Regulatory intervention (ICO), financial penalties, and reputational harm, alongside operational friction retrieving records, potential privacy breaches, and poorer staff and patient experience. (12)
  - Addition of Thematic risk as part of the digital deep dive review.
  - Recognised as a regulatory compliance risk requiring development of robust records management strategy.

The Board are asked to acknowledge the addition of 6 new financial risks in period, articulating the separation between in-year delivery versus the sustainability position.

- **4920 (Finance)**There is a risk that the trust is unable to deliver its cost reduction programme to the required quantum, quality and timescales without adverse impact on quality, safety or workforce. (16)
  - Supersedes previous CRP risk 4713
  - New contextual risk emphasising quality and workforce impact if the risk is realised

- **4923 (Finance)** Risk that the trust is unable to maintain sufficient cash liquidity, resulting in a requirement to borrow or seek external financial support in excess of that included in the plan. (16)

- **4922 (Finance)** Risk that the trust does not deliver a sustained improvement in its underlying financial position, limiting its ability to achieve long term financial balance and resilience. (16)

- **4921 (Finance)** Risk that the trust is unable to deliver the approved in year financial plan, resulting in a material variance from plan and adverse regulatory, reputational and operational consequences. (16)

- **4925 (Finance)** Risk that the trust is currently over funded relative to activity delivered, resulting in a phased reduction in funding over future periods, which may not be fully mitigated through productivity and efficiency improvements (16)

- **4924 (Finance)** Risk that the scale, timing or cost of capital investment, including backlog and major schemes, generates unaffordable revenue consequences, undermining the trusts financial sustainability and flexibility (12)

De-escalated from the ORR
1 risk has been removed from the ORR:

- **4886 (Finance)** There is a risk that the Trust may fail to comply with the requirements of the new Failure to Prevent Fraud offence. This could result in legal exposure, regulatory sanctions, reputational damage, financial penalties, and reduced assurance that fraud risks linked to staff, agents, subsidiaries or associated persons are being effectively mitigated (9)
    - Assurance provided to audit committee that plans are in place with no significant gaps in controls or assurances

Risks closed
6 Risks have been closed in period:

- **4891 (Medical Director)** Risk that patients who are registered at the 9 GP Practices in Gateshead which have not agreed to the Medicines LES will have their Shared Care Agreements returned to the Trust. Due to a lack of agreement between GP's and ICB leading to GP practices to revert to their standard contract regarding SCAs. Resulting in reduced concordance with medication regimes with worsening health outcomes, deterioration in our financial position, have negative impacts on our activity and ultimately lead to a deterioration in plan.
    - CBC are taking on the work arising from the 9 GP practices; therefore, the risk has not come to fruition.

- **4855 (Medical Director)** Risk of significant and cumulative impact to services due to a further national mandate for industrial action by Resident Doctors being in place. When enacted this may have an adverse impact on patient safety, cost pressures, clinical leadership and management capacity as well as wider staff morale and well-being.
    - Industrial action formally concluded in June 2026.

- **4713 (Finance)** There is a risk of not delivering our sustainable future Cost Reduction Programme on a recurrent basis. If this is not achieved, we will not return to our financial balance.
    - Replaced by new CRP financial risk (4920)

3 risks have been closed as part of the thematic risk approach for Digital division:

- **4402 (Digital)** The current mixed economy of health records - paper held offsite, active paper records managed on site, digital copies within the electronic document management system, live records within clinical system - may impact the trusts ability to comply with records management best practice and legislative requirements. This could lead to regulatory and reputational harm.
    - Superseded by thematic risk 4907

- **4405 (Digital)** Risk of data mismanagement, leading to inappropriate access, misuse or inappropriate disclosures. Due to failure to incorporate best practices in the management of information across the organisation. Resulting in patient harm and/or failure to comply with UK law, national standards and contractual requirements.
    - Superseded by thematic risk 4907

- **4704 (Digital)** Risk of failure to review appropriate clinical information due to multiple systems and lack of interoperability of data stored across a variety of digital systems and in paper format. This could result in patient harm or sub optimal care.
    - Superseded by thematic risk 4913

3. Top Composite Organisational Risks:

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

These are:

1. **Financial Sustainability** - Risk of inability to invest in staff and clinical services, including supporting financial collaboration with partners.
2. **Estates** - Risk to sustainability of core infrastructure and to invest in clinical advances and the working environment for our staff

3. **Digital** - Risk of an inability to sustain and advance our digital offer impacting on our staff and ability to deliver transformation

4. Compliance with Risk reviews

Compliance with reviews in period remains consistent with the previous 2-month data set at 94% for risks and 91% for associated actions.
Support and training continue to be offered by Corporate and Clinical Risk Lead.

5. Recommendations

The Board of Directors are asked to:

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

Organisational Risk Report- July 2026.

Total Risks (Current/Managed)

18

People 3

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

Quality 5

Risk Sub Type	Division	Risk ID	Risk Title	Current Rating
Safety	Surgical Services	2984	Inability to run service from current building due to the age and condition of the maternity estate and infrastructure.	20
Safety	Surgical Services	3107	There is a risk of delayed treatment due to maternity estate being a separate building	15
Safety	Digital	4913	Interoperability & Single Patient View (Trust-wide)	16
Safety	Nursing, Midwifery and Quality	4854	Trustwide Healthcare Assistant vacancy position	12
Experience	Surgical Services	4752	Delays to breast pathways due to reduced service capacity	16

Finance 8

Risk Sub Type	Division	Risk ID	Risk Title	Current Rating
Business Continuity	QE Facilities	2341	There is a risk to ongoing business continuity of service provision due to ageing trust estate	16
Contracts	Finance	4885	Inability to deliver contracting services	16
Finance	Finance	4920	Risk that the trust is unable to deliver its cost reduction programme to the required quantum, quality and timescale without adverse impact on quality, safety and workforce	16
Finance	Finance	4921	Risk that the trust is unable to deliver the approved in year financial plan	16
Finance	Finance	4922	The trust does not deliver improved underlying sustainability	16
Finance	Finance	4923	Unable to maintain sufficient cash liquidity	16
Finance	Finance	4925	Risk that the trust is overfunded relative to activity delivered, resulting in phased reduction in funding over future periods	16
Finance	Finance	4924	Risk that the scale, timing or cost of capital investment, including backlog and major schemes, generates unaffordable revenue consequences	12

Regulation 2

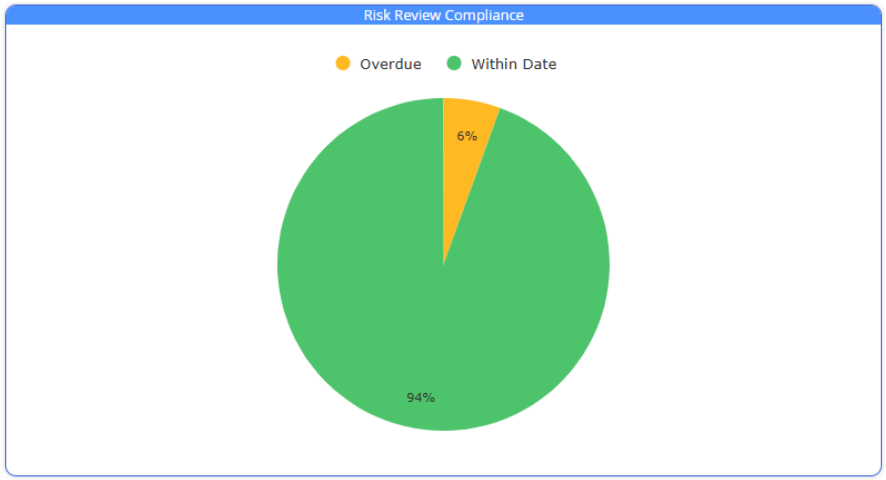
Risk Sub Type	Division	Risk ID	Risk Title	Current Rating
Compliance	QE Facilities	4839	Risk of Non-Compliance with Statutory Fire Safety Legislation	20
Compliance	Digital	4907	Information Governance & Records Lifecycle Compliance	12

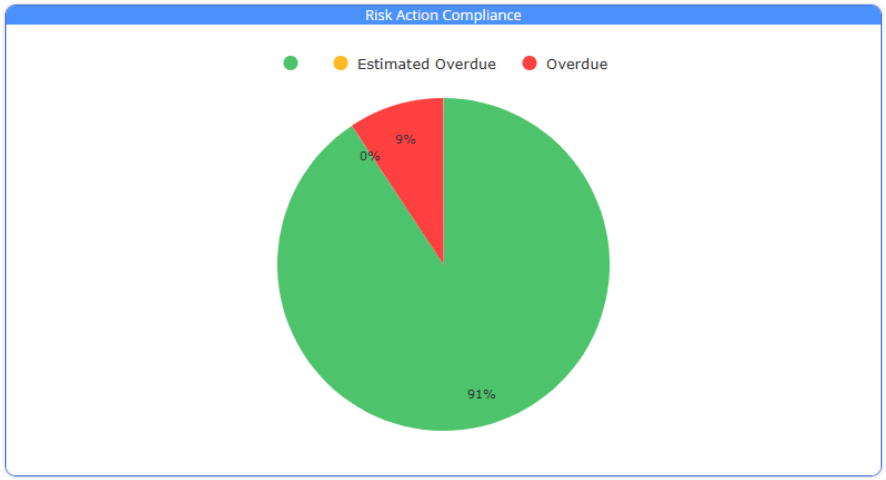
All Organisational Risks- Movements in Scores over 12 Months. August 2025- July 2026

Changes to Current Score over 12 Months

Risk ID	Risk Stage	Risk Title	Owner	Division	Service	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Apr 2026	May 2026	Jun 2026	Jul 2026
2984	Current Risk	Inability to run service from current building due to the age and condition of the maternity estate and infrastructure.	Katherine Miles	Surgical Services	Obstetrics	16	16	20	20	20	20	20	20	20	20	20	20
4839	Current Risk	Risk of Non-Compliance with Statutory Fire Safety Legislation	Genna Bulley	QE Facilities	Health & Safety					20	20	20	20	20	20	20	20
2341	Current Risk	There is a risk to ongoing business continuity of service provision due to ageing trust estate	Anthony Pratt	QE Facilities	Estates	16	16	16	16	16	16	16	16	16	16	16	16
4923	Current Risk	Unable to maintain sufficient cash liquidity	Kris Mackenzie	Finance	Finance											16	16
4922	Current Risk	The trust does not deliver improved underlying sustainability	Kris Mackenzie	Finance	Finance											16	16
4921	Current Risk	Risk that the trust is unable to deliver the approved in year financial plan	Kris Mackenzie	Finance	Finance											16	16
4920	Current Risk	Risk that the trust is unable to deliver its cost reduction programme to the required quantum, quality and timescale without adverse impact on quality,	Kris Mackenzie	Finance	Finance											16	16
4913	Current Risk	Interoperability & Single Patient View (Trust-wide)	David Thompson	Digital	IT											16	16
4885	Current Risk	Inability to deliver contracting services	Kris Mackenzie	Finance	Finance									16	16	16	16
4925	Current Risk	Risk that the trust is overfunded relative to activity delivered, resulting in phased reduction in funding over future periods	Kris Mackenzie	Finance	Finance											16	16
4752	Current Risk	Delays to breast pathways due to reduced service capacity	David Tate	Surgical Services	Surgery Administration	12	12	12	12	16	16	16	16	16	16	16	16
3107	Current Risk	There is a risk of delayed treatment due to maternity estate being a separate building	Katherine Miles	Surgical Services	Obstetrics	15	15	15	15	15	15	15	15	15	15	15	15
4907	Current Risk	Information Governance & Records Lifecycle Compliance	David Thompson	Digital	Digital Transformation and Assurance										12	12	12
4797	Current Risk	Incivility and behaviours in the workplace	Amanda Venner	People & OD	People Services			12	9	9	9	9	12	12	12	12	12
3132	Current Risk	Exposure to incidents of violence and aggression	Kate Clark	People & OD	People Services	16	16	16	16	16	12	12	12	12	12	12	12
4924	Current Risk	Risk that the scale, timing or cost of capital investment, including backlog and major schemes, generates unaffordable revenue consequences	Kris Mackenzie	Finance	Finance											12	12
4854	Current Risk	Trustwide Healthcare Assistant vacancy position	Laura Edgar	Nursing, Midwifery and Quality	Corporate Nursing							12	12	12	12	12	12
4525	Current Risk	Risk of lack of a strategic workforce planning	Claire Vesey	People & OD	Organisational Development	9	9	9	9	9	9	9	9	9	9	9	9

Risk review and action review compliance- July 2026





Top Composite Organisational Risks- July 2026

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

b - Finance Report

Presented by the Group Director of Finance

NHS Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 5b

Report Title:	**Consolidated Finance Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29th July 2026			
Author:	Ms Jane Fay, Deputy Director of Finance			
Executive Sponsor:	Ms Kris Mackenzie, Group Director of Finance			
Report presented by:	Ms Kris Mackenzie, Group Director of Finance			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	The purpose of this paper is to provide assurance against financial corporate objectives and address financial risks			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	N/A			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	The Trust has an approved 2026-27 planned deficit of **£3.338m** before adjustments for donated asset depreciation, and deficit support funding. As of June 2026, the Trust has reported an actual deficit of **£2.557m** after adjustments for donated asset depreciation. This is an adverse variance of **£1.819m** for reasons detailed in the body of this report. The position does not include Deficit Support Funding due to year-to-date performance being behind plan. The 2026-27 capital plan totals **£31.486m** including £20.074m PDC funded schemes and £11.412m internally funded schemes. Spend up to the end of June 2026 is **£0.949m**, and an under-spend of **£7.013m** for the year-to-date. Cash balances as at 30th June 2026 total **£24.310m** and **£20.984m** above planned values for the reasons detailed in the body of this report.			

Gateshead Health NHS Foundation Trust

Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The recommendation to the Trust Board is to receive the report, and record partial assurance for the achievement of 2026-27 planned financial targets.				
Trust strategic priorities that the report relates to:	☐	Excellent patient care			
	☐	Great place to work			
	☐	Working together for healthier communities			
	☒	Fit for the future			
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	We will ensure efficient and effective use of our resources, identifying opportunities to improve productivity and ensure best use of public money.				
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):					
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Gateshead Health NHS Foundation Trust

1.0 Introduction

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

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

2.0 Key Financial Performance Indicators

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

Finance KPIs	Month 03 - Jun-26 Budget £ '000	Actual £ '000	Variance £ '000	RAG	YTD Budget £ '000	Actual £ '000	Variance £ '000	RAG
I&E (Surplus) / Deficit (adjusted perf.)	247	1,156	910		739	2,557	1,819	
Operating Income	-36,967	-36,510	457		-111,578	-109,838	1,739	
Pay Expenditure	24,637	24,777	140		74,387	74,138	(248)	
Non Pay Expenditure	11,740	12,428	688		36,145	36,812	667	
Non Operating Income	-8	-90	(82)		-41	-309	(268)	
Non Operating Expenditure	629	584	(45)		1,922	1,852	(70)	
Remove capital donations / grant I&E Impact	-32	-33	(1)		-95	-98	(3)	
Balancing adj to NHSE Plan	0	0	0		0	0	0	
Bank Expenditure	634	841	208		1,879	2,614	735	
Agency Expenditure	64	142	80		187	547	361	
CRP Delivery	2,136	866	(1,270)		6,408	2,265	(4,143)	
Capital Expenditure	2,626	372	(2,254)		7,962	949	(7,013)	
Cash position	-126	-3,809	(3,683)		3,326	24,310	20,984	
Liquidity (days)	21	11	(9.7)		21	11	(9.7)	
Better Payment Practice Code (BPPC)								
NHS	95.0%	17.4%	-77.6%		95.0%	36.7%	-58.3%	
Non NHS	95.0%	99.2%	4.2%		95.0%	98.6%	3.6%	
Aged Debt								
Receivables over 90 days NHS	10.0%	30.8%	20.8%		10.0%	30.8%	20.8%	
Receivables over 90 days non NHS	10.0%	37.5%	27.5%		10.0%	37.5%	27.5%	

Table 1: Finance KPIs

2.2 The Trust reported a deficit of **£1.156m** for June, which is an adverse variance of **£0.910m** against the planned position. Year to date, the Trust has reported a deficit of **£2.557m**, which is **£1.819m** adverse variance from plan, excluding deficit support funding. This is predominantly driven by under-achievement against CRP.

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

3.0 Cost Reduction Programme

3.1 Performance against the year to date target is £2.265m against a target of £6.408m resulting in a year to date under achievement of £4.142m.

Gateshead Health NHS Foundation Trust

Division	Target as at June 26 £000	Achieved as at June 26 £000	(Under)/ Over as at June 26 £000	26-27 Annual Target £000	26-27 Forecast £000	26-27 (Under)/ Over Forecast £000
Chief Executive	38	0	(38)	166	214	48
Chief Operating Officer	61	12	(49)	265	196	(69)
Clinical Support & Screening Services	2,022	99	(1,923)	8,729	4,412	(4,317)
Community Diagnostic Centre	67	0	(67)	290	0	(290)
Digital	267	5	(262)	1,152	1,031	(121)
Estates & Facilities	63	0	(63)	274	0	(274)
Finance	27	45	18	116	181	65
Information & Performance	44	21	(23)	189	190	1
Medical Director	28	39	11	121	237	116
Medicine & Community	1,770	414	(1,356)	7,641	2,143	(5,498)
Nursing & Midwifery	54	12	(42)	233	82	(151)
POD	56	27	(29)	244	248	4
Surgery	1,662	185	(1,477)	7,178	2,120	(5,058)
Central Unallocated Target	249	1,407	1,158	1,075	5,231	4,156
Total	**6,408**	**2,265**	**(4,142)**	**27,672**	**16,284**	**(11,388)**

Table 2 Cost Reduction Performance

3.2 The annual achievement is forecast at an under-achievement of £11.388m and this risk has been escalated to the Executive Management Group to inform possible mitigations.

3.3 In response further schemes are being proposed to mitigate the shortfall and are progressing via the Trust CRP governance process, which if approved will be incorporated into future months CRP forecast.

4.0 Underlying Trust Financial Position

4.1 The Trust medium term financial plan set a target underlying 2026-27 exit deficit of £34.910m, on the assumption £15.923m of the 2026-27 cost improvement target is achieved on a recurring basis and no new recurring pressures arise in the year.

4.2 To date the Trust is forecasting delivery of £11.084m recurring cost reduction schemes and £0.846m new recurring pressure arising from the AfC and medical and dental pay award, forecasting an underlying deficit of £40.979m.

5.0 Capital

5.1 The 2026-27 approved capita plan is summarised in Table 15 at a total value of £31.486m.

5.2 The Trust has reported capital expenditure totalling £0.959m against a year-to-date plan of £7.962m. Expenditure is mainly against the Maternity Scheme totalling £0.369m, Theatre Ventilation totalling £0.323m and £0.091m against the Gamma Camera scheme.

Gateshead Health NHS Foundation Trust

Capital Scheme	2026/2027 Annual Plan £000's	2026/2027 In-Year Approvals £000's	2026/2027 Updated Annual Plan £000's	2026/2027 YTD Plan £000's	2026/2027 YTD Actual £000's	2026/2027 YTD Variance £000's	2026/2027 Forecast £000's
Gamma Camera	2,358		2,358	885	91	(794)	2,358
Theatre Ventilation	529		529	264	323	59	529
Agile Lift	24		24	24	45	21	24
Bensham Boiler	0		0	0	14	14	0
IPS/UPS SCBU	257		257	129	0	(129)	257
Estates - Fire Safety	1,000		1,000	249	18	(231)	1,000
Estates - Primary Electrical Infrastructure	2,500		2,500	624	0	(624)	2,500
Estates - General M&E	1,300		1,300	324	18	(306)	1,300
Estates - General	250		250	60	0	(60)	221
Medical Equipment Replacement	520		520	0	0	0	520
Business Critical Equipment Replacement	60		60	60	0	(60)	60
Digital	100		100	0	3	3	100
IFRS16 Lease Renewal	1,311		1,311	327	16	(311)	1,311
Clinical EPR	1,203		1,203	0	0	0	1,203
25-26 Carry Forward Scheme	0		0	0	29	29	29
Sub-total Internally Funded	**11,412**	**0**	**11,412**	**2,946**	**556**	**(2,390)**	**11,412**
2026-27 Maternity	12,000		12,000	3,000	369	(2,631)	12,000
2026-27 Estates Safety Fund	1,074		1,074	267	0	(267)	1,074
2026-26 Community Diagnostic Centre Phase 2	2,500		2,500	624	23	(601)	2,500
2026-26 Community Diagnostic Centre Phase 2	4,500		4,500	1,125	0	(1,125)	4,500
Sub-total PDC Funded	**20,074**	**0**	**20,074**	**5,016**	**392**	**(4,624)**	**20,074**
Total Capital 2026-27	**31,486**	**0**	**31,486**	**7,962**	**949**	**(7,013)**	**31,486**
Funded By:							
CDEL Depreciation	11,412	0	11,412	2,946	556	(2,390)	11,412
Public Dividend Capital	20,074	0	20,074	5,016	392	(4,624)	20,074
Charitable Funds	0	0	0	0	0	0	0
Total Funding	**31,486**	**0**	**31,486**	**7,962**	**949**	**(7,013)**	**31,486**

Table 4: Capital Programme Spend

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

6.0 Cash Balances

6.1 Group cash at the 30th June 2026 totalled £24.310m, £20.984m more than planned. The key drivers behind this favourable variance are due to trade and other payables being £16.986m higher than planned, £2.417m slippage against internally funded capital plan and trade and other receivables also being £1.581m higher than plan.

6.2 The cash balance is the equivalent to an estimated 21.47 days operating costs (May: 25.06 days).

6.3 Performance against the Better Payment Practice Code has improved in month in terms of value, with 95.4% of invoices paid within 30 days against the target 95% (May 2026: 93.9%); alongside an increase in total numbers of invoices paid at 93.6% (May 2026: 92.7%); (target 95%).

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

Gateshead Health NHS Foundation Trust

7.0 Conclusion

7.1 The Trust has reported an adjusted in month deficit of **£1.156m** an adverse variance to plan of **£0.910m**.

7.2 For the year-to-date, the Trust reported an adjusted deficit of **£2.557m** against a plan of **£0.739m** resulting in an adverse variance of £1.819m.

7.3 The Trust has reported total capital spend of **£0.949m** against a plan of **£7.962m** resulting in an underspend of **£7.013m**. Main areas of expenditure so far relate to the Theatre Ventilation Scheme, Maternity and the replacement of the Gamma Camera.

7.4 The Trust has reported achievement of **£2.265m** against the 2026-27 cost reduction plan, with **£16.284m** forecast against annual target of **£27.667m**; resulting in an early indicative shortfall of **£11.388m** that will need to be bridged to achieve the target deficit.

7.5 Group cash at 30th June 2026 totalled **£24.310m**, **£20.984m** more than planned, mainly driven by trade and other payables, which are higher than planned by **£11.306m** and **£7.013m** slippage against the capital programme.

Kris Mackenzie
Group Director of Finance
July 2026

NHS
Gateshead Health
NHS Foundation Trust

Appendix A – Statement of Comprehensive Income (SOCI)

Statement of Comprehensive Income	Month 03 - Jun-26			YTD		
	Budget £ '000	Actual £ '000	Variance £ '000	Budget £ '000	Actual £ '000	Variance £ '000
Operating Income from Patient Care activities						
Income From NHS Care Contracts	-35,256	-34,667	589	-101,381	-102,427	(1,046)
Income From Local Authority Care Contracts	-12	-44	(32)	-104	-105	(1)
Private Patient Revenue	-66	-32	34	-198	-148	49
Injury Cost Recovery	-42	-73	(32)	-125	-166	(42)
Other non-NHS clinical revenue	-18	23	41	-43	-24	19
Total Operating Income From Patient Care activities	-35,394	-34,793	**601**	-101,850	-102,870	**(1,020)**
Other Operating Income						
Education and Training Income	-1,119	-674	445	-3,289	-2,951	338
R&D Income	-178	-99	79	-328	-291	37
Funding outside of System Envelope	0	0	0	0	0	0
Other Income	-2,064	-944	1,120	-6,110	-3,726	2,384
Donations & Grants Received	0	0	0	0	0	0
Cost Improvement Programme - Income	0	0	0	0	0	0
Total Other Operating Income	-3,361	-1,717	**1,645**	-9,727	-6,968	**2,759**
Total Operating Income	-38,755	-36,510	**2,245**	-111,578	-109,838	**1,739**
Operating Expenses						
Employee Expenses - Substantive	24,993	23,683	(1,310)	72,014	70,659	(1,355)
Employee Expenses - Bank	634	841	208	1,879	2,614	735
Employee Expenses - Agency	62	142	80	187	547	361
Employee Expenses - Other	104	110	6	307	318	11
Cost Improvement Programme - Pay	0	0	0	0	0	0
Total Employee Expenses	**25,793**	**24,777**	**(1,016)**	**74,387**	**74,138**	**(248)**
Purchase of Healthcare - NHS bodies	802	1,072	271	2,350	2,960	610
Purchase of Healthcare - Non NHS bodies	163	181	18	490	526	37
Purchase of Social Care	0	0	0	0	0	0
NED's	28	13	(15)	85	39	(46)
Supplies & Services - Clinical	4,132	3,777	(354)	10,813	11,417	604
Supplies & Services - General	233	268	35	700	730	31
Drugs	2,072	2,128	57	6,215	6,270	55
Research & Development expenses	-0	1	2	1	-0	(1)
Education & Training expenses	140	80	(60)	416	361	(55)
Consultancy costs	-7	17	24	-21	20	41
Establishment expenses	293	370	77	881	1,197	317
Premises	1,496	1,633	137	4,489	4,921	432
Transport	165	145	(20)	485	412	(73)
Clinical Negligence	670	690	20	2,011	1,820	(191)
Operating Leases	212	95	(117)	637	329	(308)
Other Operating expenses	946	649	(297)	2,732	1,854	(878)
Movement in credit loss allowance	-50	2	52	-150	2	152
Cost Improvement Programme - Non Pay	0	0	0	0	0	0
Reserves	0	0	0	0	0	0
Operating Expenses included in EBITDA	**11,295**	**11,123**	**(172)**	**32,133**	**32,858**	**724**
Depreciation & Amortisation - Purchased / Constructed	1,032	1,039	7	3,096	3,118	21
Depreciation & Amortisation - Donated / Granted	32	33	1	95	98	3
Depreciation & Amortisation - Finance Leases	273	234	(39)	820	739	(81)
Impairment & Revaluation	0	0	0	0	0	0
Operating Expenses excluded from EBITDA	**1,337**	**1,305**	**(32)**	**4,012**	**3,954**	**(57)**
Total Operating Expenses	**38,425**	**37,205**	**(1,220)**	**110,532**	**110,951**	**419**
(Profit)/Loss from Operations	**(330)**	**695**	**1,026**	**(1,046)**	**1,112**	**2,158**
Non-Operating Income						
Finance Income	-14	-90	(77)	-41	-309	(268)
Gains on Disposal of Assets	0	0	0	0	0	0
Total Non-Operating Income	-14	-90	-77	-41	-309	**(268)**
Non-Operating Expenses						
Finance Expense	31	85	55	147	249	102
Gains / (Losses) on Disposal of Assets	0	0	0	0	0	0
PDC dividend expense	467	467	0	1,400	1,400	0
Total Finance Costs (for non-financial activities)	**497**	**552**	**55**	**1,547**	**1,649**	**102**
Other Non-Operating Expenses						
Misc. Other Non-Operating expenses	0	0	0	0	0	0
Total Non-Operating Expenses	**497**	**552**	**55**	**1,547**	**1,649**	**102**
(Surplus) / Deficit Before Tax	**153**	**1,157**	**1,004**	**460**	**2,451**	**1,991**
Corporation Tax	125	32	(93)	375	204	(171)
(Surplus) / Deficit After Tax	**278**	**1,189**	**911**	**835**	**2,655**	**1,820**
Balancing Adjustment to NHSE Plan			0	(1)		1
(Surplus) / Deficit After Tax from Continuing Operations	**278**	**1,189**	**911**	**834**	**2,655**	**1,821**
Remove impact of impairments	0	0	0	0	0	0
Remove capital donations / grants I&E impact	-32	-33	(1)	-95	-98	(3)
Adjusted Financial Performance (Surplus) / Deficit	**247**	**1,156**	**910**	**739**	**2,557**	**1,819**

Gateshead Health NHS Foundation Trust

Appendix B Statement of Financial Position

Statement of Position - June 2026

	2026/27 June 2026 Group Plan £000	2026/27 June 2026 Group Actual £000	Movement from plan £000
Assets			
Non-Current Assets			
Investment Property	80	80	-
Property, Plant and Equipment, Net	189,089	171,596	(17,493)
Right of Use Assets	13,205	12,090	(1,115)
Trade and Other Receivables, Net	1,567	952	(615)
Finance Lease - Intragroup	-	-	-
Trade and Other Receivables - Intragroup Loan	-	-	-
Total Non Current Assets	**203,941**	**184,718**	**(19,223)**
Current Assets			
Inventories	4,403	4,363	(40)
Trade and Other Receivables - NHS	4,785	9,852	5,067
Trade and Other Receivables - Non NHS	16,890	13,404	(3,486)
Trade and Other Receivables - Intragroup	-	-	-
Trade and Other Receivables - Other	-	-	-
Cash and Cash Equivalents	3,326	24,310	20,984
Total Current Assets	**29,404**	**51,929**	**22,525**
Liabilities			
Current Liabilities			
Deferred Income	3,376	2,017	(1,359)
Provisions	930	2,104	1,174
Trade and Other Payables	42,892	54,029	11,137
Lease Liabilities	2,613	2,761	148
Trade and Other Payables - Capital	913	1,082	169
Other Financial Liabilities - Borrowings FTFF	999	999	(0)
Other Financial Liabilities - Borrowings Other (Non-DHSC)	12	12	-
Total Current Liabilities	**51,735**	**63,004**	**11,269**
NET CURRENT ASSETS (LIABILITIES)	**(22,331)**	**(11,075)**	**11,256**
Non-Current Liabilities			
Deferred Income	1,647	1,646	(1)
Provisions	1,812	1,765	(47)
Trade and Other Payables - Other	-	-	-
Lease Liabilities	10,479	9,897	(582)
Other Financial Liabilities - Accruals	-	-	-
Other Financial Liabilities - Intragroup Borrowings	-	-	-
Other Financial Liabilities - Borrowings FTFF	9,014	9,016	2
Other Financial Liabilities - Borrowings Other (Non-DHSC)	84	84	-
Finance Lease - Intragroup	-	-	-
Total Non-Current Liabilities	**23,036**	**22,407**	**(628)**
TOTAL ASSETS EMPLOYED	**158,574**	**151,236**	**(7,338)**
Tax Payers' and Others' Equity			
PDC	183,172	183,838	666
Taxpayers Equity			
Share Capital	-	-	-
Retained Earnings (Accumulated Losses)	(37,368)	(44,244)	(6,876)
Other Reserves			
Revaluation Reserve	12,671	11,544	(1,127)
Misc Reserve	99	98	(1)
TOTAL TAXPAYERS EQUITY	**158,574**	**151,236**	**(7,338)**
TOTAL ASSETS EMPLOYED	**158,574**	**151,236**	**(7,338)**

c - Strategic Objectives and Constitutional Standards Report

Presented by the Group Director of Finance

NHS Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 5c

Report Title:	Strategic Objectives & Constitutional Standards			
Name of Meeting:	Trust Board			
Date of Meeting:	Wednesday 29th July 2026			
Author:	Deborah Renwick: Associate Director of Planning & Performance			
Executive Sponsor:	Kris Mackenzie: Group Director of Finance			
Report presented by:	Kris Mackenzie: Group Director of Finance			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Executive Committee Finance and Performance Committee			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity, and inclusion*	**Overall position** The June 2026 position presents a mixed but cautiously improving operational picture, with evidence that flow and recovery interventions are beginning to generate measurable improvements across urgent care, elective recovery and length of stay. However, these gains are not yet consistently reflected in constitutional performance, cancer standards or financial delivery. Patient flow indicators have improved for a second consecutive month, emergency care performance has recovered from previous levels, and long elective waits continue to reduce. These improvements are offset by continuing workforce fragility, sustained underperformance against cancer standards and a rapidly deteriorating financial position driven by significant CRP under-delivery.			

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	The Trust therefore remains in a high-risk position, although the risk profile is evolving. Operational risks remain significant but there are early signs of improvement, whereas financial sustainability is emerging as the most immediate and material organisational risk. **Key risks and areas requiring Board attention** 1. Financial sustainability – accelerating deterioration Financial performance represents the most significant area of deterioration during June. • Year-to-date position deteriorated to a £2.557m adverse variance against a planned breakeven position (including Deficit Support Funding). • CRP delivery remains significantly behind plan, with delivery of £2.265m against a planned £6.408m, creating a cumulative adverse variance of £4.143m. • Cash remains above the minimum requirement at £24.3m, however the report highlights forecast cash pressures later in the year should savings not become cash releasing. The underlying issue is no longer month-to-month volatility but the emergence of a structural gap between planned and delivered savings. Board implication Financial recovery and CRP to continue to be viewed as a priority strategic risk, with increasing implications for medium-term sustainability. **2. Cancer performance – persistent constitutional risk** Cancer performance remains one of the most significant constitutional and reputational concerns. • Faster Diagnosis Standard improved slightly to 47.1%, but remains substantially below the required 80% standard. • The 62-day standard remains at 65.2%*, significantly below the 80% target (* May data). • The 31-day standard remains strong at 100%. • Diagnostic performance has improved marginally but remains below target at 92.7%* against the 95% standard (* May data).

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	While deterioration appears to have slowed, there is not yet evidence of sustained recovery. Board implication Cancer performance to remain a material constitutional risk requiring continued oversight and system support. **3. Workforce – continued structural fragility** Workforce metrics continue to present a persistent delivery risk. • Vacancy rate increased from 6.9% to 7.3%. • Sickness absence remains elevated at 5.48%, above the 4.9% standard. • Anxiety, stress and depression continue to account for approximately 37% of sickness absence, with an estimated annual cost of £3.9m. • Staff engagement remains below target at 6.5. • Turnover improved marginally from 12.4% to 12.1%, although remains above target. Board implication Workforce capacity continues to constrain operational recovery and remains a key enabler risk across urgent care, cancer and financial delivery. **4. Patient flow and urgent care – emerging improvement** For the first time in several months there is evidence of sustained operational improvement. Patient Flow • Average non-elective length of stay improved from 7.61 days to 7.24 days. • Performance against RTA to bed within one hour improved from 6.5% to 11.2%, but remains significantly below the 60% target. • Patients without criteria to reside remain high at 45 and significantly above the <10 target. Urgent Care • A&E 4-hour performance improved from 74.3% to 77.7%.

- ED attendances greater than 12 hours reduced significantly from 5.1% to 1.9%.
- Ambulance handover delays improved across both 30–60 minute and >45 minute measures.

Despite these improvements, performance remains below trajectory and continues to be affected by occupancy and discharge pressures.

Board implication

Operational improvement activity is beginning to gain traction; however, the Trust remains materially below required standards and recovery remains fragile.

5. Quality, safety and estates – mixed but stable position

The overall quality profile remains broadly stable. Positive developments include:

- QIP compliance improved to 88%.
- Mental Health Act training improved to 91%, meeting standard.
- Combined estates risk score reduced further from 206 to 197.

Areas of concern remain:

- Six patient safety incidents linked to estates were reported.
- C.Diff rates remain significantly above target at 30.2 per 100,000 occupied bed days.
- Harm falls remain above target at 4.56 per 1,000 bed days.

Board implication

Quality indicators remain broadly stable, with improving estates assurance offset by continuing IPC and falls challenges.

Areas of sustained strength and assurance

The Trust continues to demonstrate strong performance in several important areas:

- Ockenden recommendations remain at 100% compliance.

Gateshead Health NHS Foundation Trust

	• Maternity Incentive Scheme remains at 100% compliance. • VTE assessment performance remains consistently above target at 98.9%. • Temporary staffing spend remains low at 0.6% of pay bill, well below threshold. • 52-week elective waits have reduced to 2 patients. **Executive conclusion** June presents the first evidence of meaningful operational improvement since the start of 2026/27, with recovery evident in patient flow, urgent and emergency care performance, elective waiting times and estates risk. These improvements suggest that a number of operational interventions are beginning to gain traction and provide cautious assurance that some of the underlying drivers of performance are moving in the right direction. However, these gains are not yet translating into sustained improvement against key constitutional standards, particularly within cancer pathways, and continue to be constrained by workforce challenges. Most significantly, the Trust's financial position has deteriorated further, driven by substantial CRP under-delivery and widening variance from plan. Overall, the Trust remains in a high-risk position, but the nature of that risk is beginning to shift. While operational resilience remains a key concern, emerging evidence of recovery means the most pressing Board challenge is increasingly how to convert operational improvement into sustainable constitutional performance and financial recovery. Sustained Board focus is therefore required on CRP delivery, financial sustainability, cancer recovery, workforce stabilisation and maintaining momentum in flow and urgent care improvement.
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	Board is asked to: • Note the improving operational position whilst recognising recovery remains fragile • Ensure that Board receives an escalation that financial recovery and CRP delivery are a principal organisational risk • Maintain focused oversight of cancer recovery

Gateshead Health NHS Foundation Trust

	• Seek assurance that operational improvements are translating into sustainable performance					
Trust strategic priorities that the report relates to:	☒	Excellent patient care				
	☒	Great place to work				
	☒	Working together for healthier communities				
	☒	Fit for the future				
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	All strategic objectives					
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒	
Risks / implications from this report (positive or negative):						
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	4752 - Risk of inability to meet cancer standards and quality of care delivery within the breast service due an evidenced capacity and demand imbalance contributed to by the service demand restrictions in place at CDDFT, and reliance upon additional sessions to provide capacity. 4920 - There is a risk that the trust is unable to deliver its cost reduction programme to the required quantum, quality and timescales without adverse impact on quality, safety or workforce. 4921 - Risk that the trust is unable to deliver the approved in year financial plan, resulting in a material variance from plan and adverse regulatory, reputational and operational consequences					
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒			

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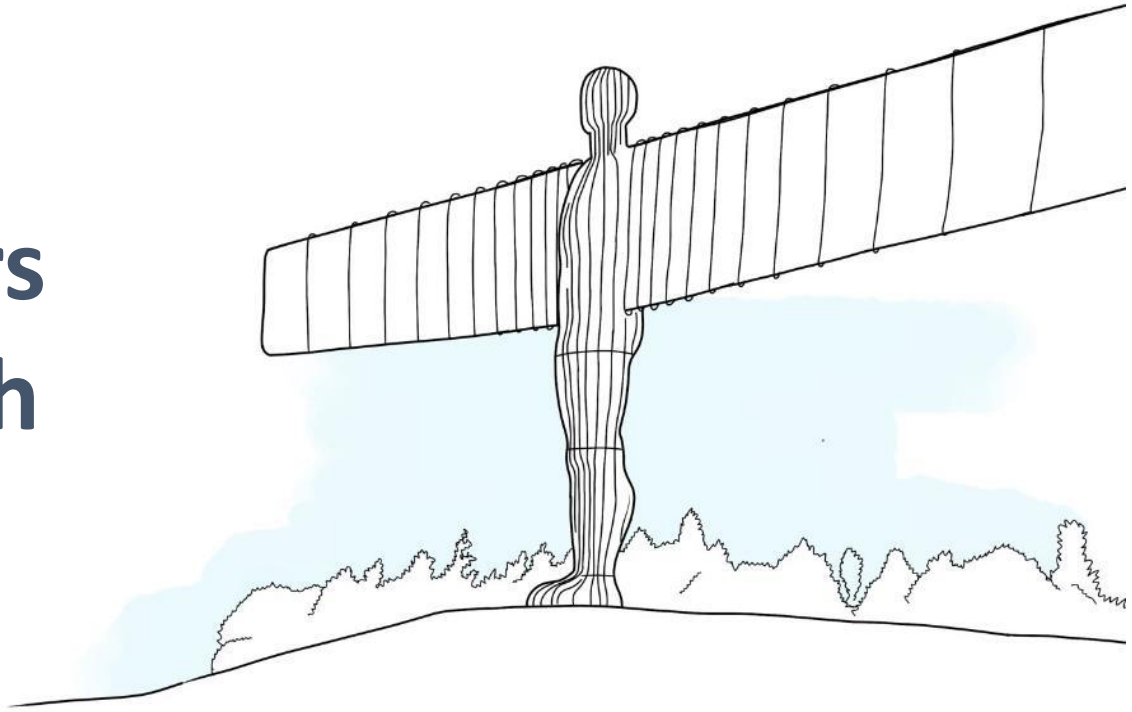
Strategic Objectives 2026/27

Leading Indicators and Breakthrough Objectives



Including Constitutional standards monitoring metrics

Reporting Period: June 2026

Strategic Objectives 2026/27	What are we aiming for

NHS Gateshead Health NHS Foundation Trust

Our patients Our people Our partners

Our vision captures what matters to us – delivering outstanding compassionate care.

Our five values can easily be remembered by the simple acronym ICORE

Innovation
We look for new ways to improve what we do and recognise that we all have a role to play in our continuous improvement.

Care
We care for our patients, communities, each other and ourselves with kindness and compassion.

Openness
We always act with integrity and transparency and are open and honest with ourselves and each other.

Respect
We treat everyone with respect and dignity, creating a sense of belonging and inclusion.

Engagement
We are inclusive and collaborative in our approach, working as a team and with our partners to deliver the best care possible.

Our Strategic aims:

1. We will continuously improve the quality and safety of our services for our patients.
2. We will be a great organisation with a highly engaged workforce.
3. We will enhance our productivity and efficiency to make the best use of our resources.
4. We will be an effective partner and be ambitious in our commitment to improving health outcomes.
5. We will develop and expand our services within and beyond Gateshead.

Our strategic intent:

- Northern Centre of Excellence for Women's Health
- Diagnostic centre of choice
- Outstanding District General Hospital

Strategic Objectives 2026/27	Executive Summary

NHS Gateshead Health NHS Foundation Trust

Improved	No Change	Needs further attention
We will continuously improve the quality and safety of our services for our patients		
Reduction in patient safety incidents linked to estate issues	Scoring in domains in areas of PLACE inspection not available	Quality Improvement Plans
	Ockenden recommendations	C.Difficile rate
	Maternity Incentive Schemes	Harm rate from falls
	Strategic approach to development of EPR	Mental Health Act Training for all registered staff
	Venous thromboembolism (VTE) risk assessment	Compliance with Level 1 training plans for learning Disability & Autism
		Severity of risk scores linked to estates
We will be a great organisation with a highly engaged workforce		
	Reduction in temporary staffing spend 0.5% of pay bill	Achievement of the internal turnover standard
		Improve the staff engagement score
		Internal sickness absence standard
		Maintain the vacancy rate at <=2.5%
We will enhance our productivity and efficiency to make the best use of our resources		
	Review and revise Green Plans	Average non-elective length of Stay < 4 Days
		Reduce the number of patients with no Criteria to Reside
		Achievement of 4-hr A&E target
		Reduce New & Follow up non value added activity to 67%
		Achievement of the trajectory to achieve 60% RTA to Bed within 1 hour
		Achievement of Zero 52 weeks.
		Reduce >12 hour total time in Emergency Department
		Risk in achievement of financial plans including CRP
We will be an effective partner and be ambitious in our commitment to improving health outcomes		
	Evidence a reduction in the number of 'fragile' and 'vulnerable' services as a direct outcome of Alliance working	Reduction in the wait for gynaecology outpatients to no more than 26 weeks
	Evidence in an improvement in health inequalities in the key focus areas linked to the determinants of Health for Gateshead	Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients
	Number of digital devices repurposed to the local community	Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 weeks
We will develop and expand our services within and beyond Gateshead		
		Increase in QEF externally generated turnover

Strategic Objectives 2026/27

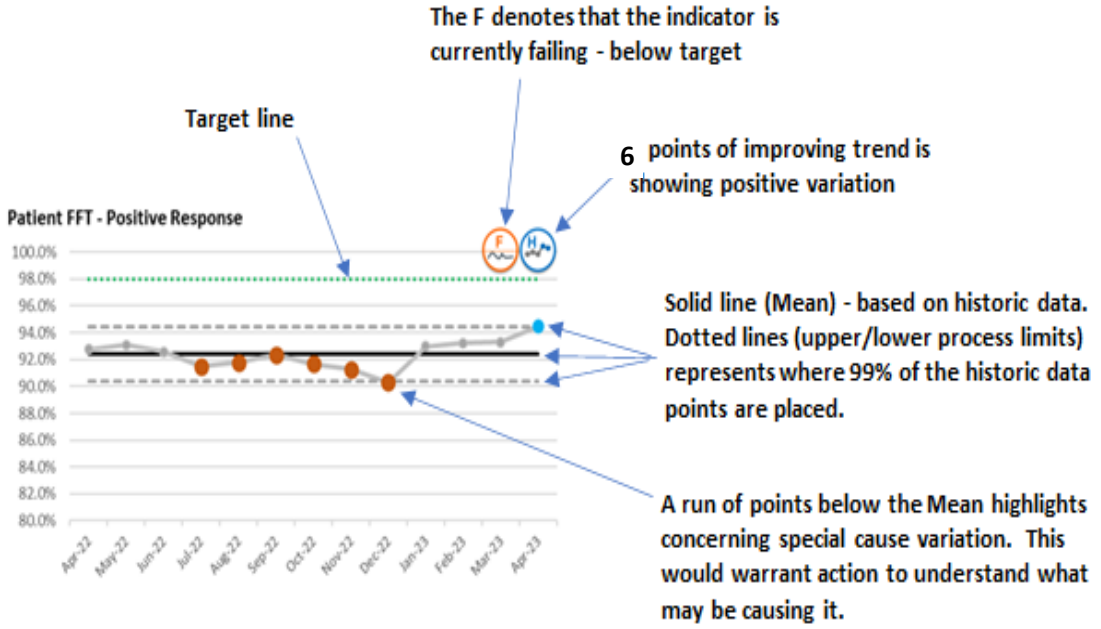
How to interpret the SPC icons and charts

NHS Gateshead Health NHS Foundation Trust

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

What are Statistical Process Control (SPC) charts

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



SPC Rules

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

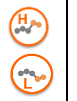
Icon Colours Explained

Variation icons: Orange indicates concerning special cause variation requiring action. Blue indicates where improvement appears to lie, and Grey indicates no significant change (common cause variation).

Assurance icons: Blue indicates that you would consistently expect to achieve a target. Orange indicators that you would consistently expect to miss the target. A Grey icon tells you that sometimes the target will be met and sometimes missed due to random variation - in a RAG report this indicator would flip between red and green.

Strategic Objectives 2026/27	Leading Indicator and Breakthrough Objectives Assurance Heatmap

NHS Gateshead Health NHS Foundation Trust

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

Strategic Objectives 2026/27

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

NHS Gateshead Health NHS Foundation Trust

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

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

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

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

Metric	Target	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Ass/Var	Trend
LEADING INDICATORS																	
Ockenden Recommendations % compliance with Total Recommendations	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Maternity Incentive Schemes % compliance with Total Recommendations	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Reduction in patient safety incidents linked to estate issues	<=4	5	6	2	2	6	8	6	5	7	5	4	6	3	6		
Compliance with the quality improvement plan indicated by the % of actions on track	100%	80%	80%	76%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	88%		
BREAKTHROUGH OBJECTIVES																	
Reduction in severity of risk score linked to estates	TBA	260	276	266	234	246	240	256	244	263	267	205	206	206	197		
Harm falls rate per 1000 bed days (5% reduction)	3.2	4.27	3.93	4.61	4.78	4.12	3.75	4.31	5.31	3.49	4.94	4.50	3.17	4.72	4.56		
C.Diff Healthcare associated rate per 100,000 occupied bed days	<=3.20	7.1	28.3	28.9	0.0	46.1	42.8	22.2	14.0	20.4	70.4	34.9	50.4	28.8	30.2		
90% of staff to complete Mental Health Act training.	90%	88.0%	86.0%	88.0%	86.0%	91.0%	89.0%	87.0%	82.0%	86.0%	87.0%	91.0%	94.4%	88.0%	91.0%		
Venous thromboembolism (VTE) risk assessment	95%	99.5%	98.9%	99.1%	99.0%	99.3%	98.9%	99.0%	99.2%	99.3%	99.0%	99.2%	99.0%	99.5%	98.9%		
85% of staff to complete Learning disability and autism training	85%	75.74%	76.83%	79.39%	80.86%	81.76%	83.00%	83.72%	84.48%	86.17%	86.95%	87.24%	82.46%	80.51%	82.30%		

Strategic Objectives 2026/27

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

NHS Gateshead Health NHS Foundation Trust

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

Measures requiring focus this month

	Measure	Summary
1	Ockenden recommendations % compliance with total recommendations	Compliance 100%, Ongoing work to maintain full compliance including updates to website & personalised care plans in collaboration with our own Maternity & Neonatal Voices Partnership (MNVP) & the Local Maternity & Neonatal System (LMNS). Required audits embedded into ongoing audit plan. No further updates required by LMNS to evidence full compliance with this report.
	Maternity incentive schemes % compliance with total recommendations	The Trust is reporting compliance at 100%. Reported & confirmed by NHS Resolution that Gateshead Maternity Service satisfied the standards for full compliance.
2	Compliance with the quality improvement plan indicated by the % of actions on track.	Latest reported data relates to June 2026 with 88% of the Improvement Plan actions delivered, this is below planned levels. Action Plans are in place with the relevant action owners for actions that are reporting risk of non achievement. Non compliant areas: Trustwide appraisal rates, Staff retention, local induction checklist compliance. Actions not yet completed: Quality Strategy : >75% staff to receive the flu vaccination - This action was not achieved. Develop a Quality Oversight Report for Allied Health Professionals in line with Trust strategic aims and ambitions, the Trust AHP 3yr strategy, the national AHP strategy and the NHS long-term workforce plan. Due to organisation change process this work has not yet been enacted. Work to bring all AHP staff together is still ongoing and until this is complete we wont have access to the right data to develop this report. This Action will be reviewed as part of the 2025/26 QIP planning work. Future actions/developments: Reduction in harm caused by falls. The trusts Falls prevention group now meets monthly, Work ongoing work to reduce falls across the organisation, as well as nationally and across the region. A national Enhanced Care program has now been established to support with how we engage with patients to reduce falls. The documentation audit is currently paused while the quality team and clinical effectiveness team do some scoping work reviewing the current questions and linking with the CQC KHLOEs.
	85% of staff to complete GHFT Level 1 learning disability and autism training from April 2024. Develop plans for Level 1 Face to face interactive training as part of mandatory training offer.	Compliance with learning disability is 2.7% below the compliance level. Learning disabilities training has been replaced with The Oliver McGowan Mandatory Taining on Learning Disability and Autism Part 1 Elearning as of the 1st January 2026. Compliance from the learning disability has been transferred over to the new e-learning. New Tier's for Oliver McGowan training are currently being rolled out on a phased basis
	Improve Mental Health Act Policy Training Compliance to 90% for all *registered* staff via training and audit.	The number of mental health staff trained is currently at 91% which is an increase from 88% in May. Compliance for qualified staff has dropped slightly and is currently is at 90%. Compliance for HCAs & support workers has increased slightly and is currently at 90%. Cragside are 94% compliant with training, Sunniside are 70% compliant. The CPN team, Younger Persons Memory Service, Memory Hub remain at 100% compliance with training. The Mental Health Liaison team remains at 89% compliance. The OT's are at 93% compliance, Which is comparable to 92% in April. Bespoke training for OT staff is arranged for all new staff members rotating into the team. Bespoke training around the consent to treatment provisions of the MHA, has been provided for pharmacy staff working on MH wards to support practice. Bespoke training on Supervised Community Treatment orders was provided for the CPN team in October 2025. This training is available to any other staff on request. MHA awareness training has been provided for 50 acute staff. Training was cancelled in May due to no attendees booking on the course. Updates on training compliance are emailed out to all MH ward/ team managers on a monthly basis. Training dates have been arranged for 2026 and are available to book via ESR. Team managers have been informed. Additional training sessions for the MH wards have been delivered to support with increasing compliance levels. An additional training session was arranged for Cragside in June to support with increasing compliance levels.
	Improve our IPC C.Difficile infection rates per 100 000 occupied bed days.	Rates per 100 000 bed days have increased to 30.2, four cases were reported in June 2026, a total of fifteen to date in 26/27. A 10 point c-diff reduction plan is in place, with a drive to 'back to basics' for clinical areas particularly around hand hygiene, AMP and learning. A review into antimicrobial prescribing is ongoing. Community prevalence continues to be higher then normal levels, reflecting national and local elevated levels of C.Diff.
	Venous thromboembolism (VTE) risk assessment	Healthcare associated venous thromboembolism (VTE), commonly known as blood clots, is a significant international patient safety issue. The first step in preventing death and disability from VTE is to identify those at risk so that preventative treatments (prophylaxis) can be given. This data collection quantifies the numbers of hospital admissions (aged 16 and over at the time of admission) who are being risk assessed for VTE to identify those who should be given appropriate prophylaxis based on guidance from the National Institute for Health and Care Excellence (NICE). The Trust continuously performs well against the standard of 95% with June performance reported at 98.9%.
	Harm related falls will reduce by 5%.	63 harm falls were reported in May 2026, 56 of these were low harm, two were moderate harm and five severe harm. The falls steering group continue to meet and progress the current action plan. There was a discussion around the way the data is collated, which may be out of line with national reporting. A paper with a suggested change is being produced by the group to highlight the proposed changes, and will assist in determining new targets for falls prevention.
3	Reduction in risks and severity of scores linked to estate issues	June position, 17 Risks with combined critical infrastructure risk score of 197. No new risks in period, 1 closure in period (ref- 3015) .
	Reduction in patient safety incidents linked to estate issues	Six patient safety incidents related to estates issues in June 2026. No common themes were identified. Figures exclude incidents related to pressure damage and incidents reported as Harm not related to Gateshead on Inphase.
	Scoring in domains in areas of PLACE inspection composite score > 95%	During the June 2026 PLACE Lite inspections across Ward 2, Ward 12, the Chemotherapy Day Unit and the Ultrasound Department, several themes emerged relating to patient safety, environmental standards and governance. Key concerns included inappropriate staff behaviours, potential breaches of patient confidentiality, emergency alarm system limitations, inadequate dementia-friendly features, maintenance issues, poor storage practices, infection prevention concerns, and environmental deficiencies such as damaged furniture, poor lighting and untidy equipment areas. Safety risks identified included unsecured sharp objects, missing bathroom safety features and limited staff presence on the ward at certain times. Despite these issues, all areas demonstrated several examples of good practice, including clean and welcoming environments, positive patient feedback regarding the standard of care, clear display of cleaning standards and patient information, friendly and professional staff, and evidence of patient-centred improvements through feedback initiatives. Dementia-friendly environments and effective communication boards were also noted in several areas. Overall, the inspections highlighted a generally positive patient experience while identifying a number of environmental, safety and governance improvements required to enhance the quality of care and patient experience across the services.
	Reduction in value of backlog maintenance score as reported via the ERIC return	A clinically prioritised plan to review and deliver the backlog maintenance programme. The challenges are limitations on capital available to support the plan & CDEL allocation. Rationalisation of our existing aging estate is required. The capital programme has been confirmed and an update will be available when capital projects are completed.

Strategic Objectives 2026/27

We will be a great organisation with a highly engaged workforce

NHS Gateshead Health NHS Foundation Trust

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

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

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

Metric	Target	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Ass/Var	Trend
LEADING INDICATORS																	
Maintain the vacancy rate	<=2.5%	5.8%	5.9%	6.6%	6.3%	5.6%	6.7%	7.2%	7.3%	7.5%	7.5%	7.2%	6.8%	6.9%	7.3%		
Improve the staff engagement score	>=7.3			5.63						5.88			5.97				
BREAKTHROUGH OBJECTIVES																	
Achievement of the internal turnover standard	<=12%	11.9%	11.9%	12.0%	11.7%	12.1%	12.6%	12.4%	12.1%	12.0%	12.0%	12.2%	12.1%	12.4%	12.1%		
Achievement of the internal sickness absence standard	4.90%	5.64%	5.61%	5.58%	5.58%	5.57%	5.52%	5.50%	5.45%	5.41%	5.43%	5.46%	5.48%	5.50%	5.48%		
Reduction in temporary staffing spend of pay bill evidenced month on month	<=2.3%	0.2%	0.5%	0.5%	0.5%	0.3%	0.5%	0.4%	0.4%	0.7%	0.5%	0.6%	0.8%	0.9%	0.6%		

Measures requiring focus this month

Measure	Summary
Maintain the vacancy rate at <=2.5%	The group has 370 wte vacant compared to budget with a vacancy rate of 7.3%, up from 6.9% in May 26. Most notable is the gap of 68.1 wte compared to budget in Support to Nursing Staff with a vacancy rate of 13%. Clinical Support and Screening Services divison has a 6.3% vacancy rate at June-26, a gap of 77.6 wte and QEF have a vacancy rate of 15.8% at June-26, a gap of 120.9 WTE
Improve the staff engagement score to 7.3	The annual staff survey results had a 42% completion rate, and an overall engagement score of 6.5, but a decline of 0.53 in the April People Pulse. There are various factors leading to this decline but areas with the largest in year change are career development and learning, advocacy and organisational confidence, and feeling valued. The results have been cascaded throughout in January/February, and the Board and senior leaders have agreed two key areas of focus; working harder to show that patient care is our top priority and prioritising engagement. Divisions reported on local progress via People and OD Steering Group in June 2026, outlining clear action plans to improve staff experience locally.
Achievement of the internal turnover standard of 9.7%	Turnover decreased in June to 12.1% from 12.4% in May 2026. QEF TUPE-related outlier caused a temporary increase in our turnover rate in March 26, as turnover is reported on a rolling 12-month basis, the impact of these transfers will remain within the metric for 12 months before dropping out of the calculation Excluding QEF reduces group turnover from 12.1% to 10.4%.
Achievement of the internal sickness absence standard of 4.9%	Sickness absence has reduced slightly to 5.48% in June 26, same as May 26. In-month sickness absence was 5.0% in June 2026, 0.1% lower than June 2025. Anxiety, stress & depression continues to be the most prevalent reason for absence accounting for 37% of all sickness absence in the past 12 months with an estimated cost of £3.9M. Long term sickness absence has been steadily decreasing throughout the organisation but there has been a slight increase in short term sickness. GHFT ranks second lowest for rolling sickness absence behind Northumbria in the ICS and below median average in NE&Y and amongst peer organisations.
Reduction in temporary staffing spend evidenced month on month reduction and no higher than 2.3 % of pay bill.	Agency spend remains under target at 0.6% and has been consistently under target in the past 12 months. Agency spend continues in hard to fill roles in Elderly Care, Surgery, Cardiac Diagnostics and QEF Pathology Transport. Agency is also being used for gaps in Healthcare Support Worker staffing due to high vacancy rates.

Strategic Objectives 2026/27

We will enhance our productivity and efficiency to make the best use of our resources

NHS Gateshead Health NHS Foundation Trust

Improve the quality of care delivery and accessibility for patients

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

Metric	Target	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Ass/Var	Trend
LEADING INDICATORS																	
Average Length of Stay Non-Elective ** *Reset April 2025 to align with operational guidance definitions*	<=4	8.38	8.65	7.66	7.66	7.75	8.13	7.51	7.59	8.14	7.92	8.25	8.45	7.61	7.24		
Achievement of the 4 hours trajectory ** *Standard reset April 2026 to align with 2026/27 plan*	>82%	79.0%	76.7%	82.2%	82.3%	77.4%	73.7%	77.6%	73.0%	69.1%	75.1%	75.1%	77.0%	74.3%	77.7%		
Achievement of the 52 week RTT standard **	0	1	18	35	55	52	41	33	25	20	26	17	9	8	2		
Achievement of financial Plan - Variance (£k)	Figure in brackets favourable	0.224	0.261	0.337	-0.027	-0.174	-0.185	-0.032	-0.007	-0.207	-0.041	-0.057	0.570	1.4	2.557		
Finance - Forecast Out-turn Deficit (Plan)	tbc	8,381	8,381	8,381	8,381	8,381	8,381	8,381	8,381	8,381	8,381	5,048	0	0	0		
BREAKTHROUGH OBJECTIVES																	
Achievement of the trajectory to reduce >12 hour total time in Emergency Department (Type 1) ** *Standard reset April 2026 to align with 2026/27 plan*	0	31	47	16	13	67	337	98	240	567	182	308	262	299	112		
	0.4%	0.5%	0.8%	0.3%	0.23%	1.19%	5.68%	1.61%	3.85%	9.59%	3.43%	5.13%	4.83%	5.10%	1.91%		
Reduce the number of patients with no Criteria to Reside **	<10	46	54	49	45	43	45	42	48	48	54	54	51	40	45		
Achievement of the trajectory to achieve RTA to Bed within 1 hour **	60.0%	16.1%	10.8%	19.1%	16.9%	10.3%	8.3%	13.5%	9.4%	5.9%	10.3%	8.7%	9.4%	6.5%	11.2%		
Reduce % of Follow up Outpatient without procedures *Reset April 2025 to align with 2025/26 operational guidance definitions*	<=67%	66.2%	64.6%	66.4%	66.7%	65.0%	65.1%	65.2%	65.7%	64.4%	63.8%	64.0%	67.1%	65.9%	68.1%		
CRP Delivery Variance	Figure in brackets favourable	523	19	0	0	0	0	0	0	0	0	0	1556	2846	4143		
No less than £5m cash as per forecast at year end	>=£5m	£28m	£16m	£24m	£31m	£22m	£24m	£18m	£19.3m	£19.9m	£31m	£30m	£30m	£28m	£24m		

Validated data unavailable at time of report

** improvement workstream in place

Strategic Objectives 2026/27	We will enhance our productivity and efficiency to make the best use of our resources

Improve the quality of care delivery and accessibility for patients

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

Measures requiring focus this month

Measure		Summary
1	**Average Length of Stay Non-Elective <4 days**	Length of stay has decreased during June. The discharge sprint activity work is now moving to a third ward. The 21 day review MDT continues to have a positive effect.
	Achievement of the 4 hours trajectory	ED 4-hour performance recovered within J77.7% which placed us 7 out of 22 in the Northern Region, however it remains below the >82% target, attendances increased again in month despite attendance avoidance work with GPs.
	Achievement of the trajectory to reduce >12 hour total time in Emergency Department	12-hour waits remain high but steady. This reflects high bed occupancy and a further piece of work around Decision to Admit time has been implemented. However positive progress was made within June.
	Achievement of the trajectory to achieve 60% RTA to Bed within 1 hour	Performance improved with further improvement activity in scheduled during July and August.
	Reduce the number of patients with no Criteria to Reside	The number of patients without criteria to reside has reduced, although levels remain well above the target of <10, indicating continuing discharge flow challenges including procurement of beds and package of cares for P2/3 patients.
	Achievement of the 52 week RTT standard and delivery of the waiting list trajectory	The number of patients waiting over 52 weeks for treatment has reduced to two in June, both in Urology. 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, mutual aid, additionality from current workforce and wider work within the alliance.
	Increase in New Outpatient activity	We continue to scope alternative ways of working to ensure we achieve the standard through the elective care transformation group with the aim to achieve the required standard consistently.
2	**Evidence achievement of the financial plan**	The Trust planned deficit for 2026-27 financial year is breakeven, and breakeven at month 3. Actual performance was £2.557m deficit which is an adverse variance of £2.557m. This is largely driven by unmet planned CRP, and unidentified gap being consistent with plan submission offset in part by non-recurrent MIS CNST rebate, higher than planned vacancies and internal mitigations. Risks remain around overspending against delegated budgets and identification and delivery of CRP on both a recurrent and non-recurrent basis. The Trust planned year-to-date CRP target at May was £6.408m and actual performance of £2.265m. Focus remains on identifying recurrent savings schemes to support future financial sustainability. Cash was £24.310m at 30th June 2026 which is above the £5m target set within the trust plan. However, the headroom between current cash balance and future run rate commitments ,particularly capital expenditure, should CRP plans not be cash releasing in 2026-27 is challenging and forecasts suggest cash shortage towards the end of Q2.
3	**Review & revise the green plan & align with the group structure**	Plans to embed the Green plan governance structure and align with group governance. 10 workstreams will provide update reports aligned to our sustainability objectives. Work plan priorities include: waste, active travel, fleet, procurement, estates & facilities, workforce/communications, sustainable care, medicine, digital transformation and adaptation. Plans include a survey of understanding across the Board/EMT and Senior Leadership Group members.

Strategic Objectives 2026/27

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

NHS Gateshead Health NHS Foundation Trust

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

Metric	Target	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Ass/Var	Trend
BREAKTHROUGH OBJECTIVES																	
Increase in the number of digital devices repurposed to the local community	>300	30	64	0	0	66	0	164	0	0	0	0	0	0	0		
Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients *Reset September 2025 to align with National definitions*	>=98%	88.8%	94.1%	95.5%	93.7%	91.0%	90.9%	89.2%	89.8%	90.5%	90.3%	90.3%	90.6%	90.0%	90.8%		
Reduction in the wait for gynaecology outpatients to no more than 26 weeks	<=26	31.1	31.7	33.0	32.0	32.0	32.0	29.9	29.0	29.0	28.9	27.0	27.0	27.3	29.6		
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30	<=30	52	65	42	69	38	27	62	58	32	61	40	89	59	56		

Measures requiring focus this month

Measure	Summary
Evidence a reduction in the number of 'fragile' and 'vulnerable' services as a direct outcome of Alliance working	This will be reviewed quarterly as part of the Provider Collaborative Sustainability review. Outputs and products from this work will be reviewed to inform the annual planning process and is contained in the Project Plan for 2025/26 to support planning for 2026/27.
Evidence in an improvement in health inequalities in the key focus areas linked to the determinants of Health for Gateshead	Key determinants of Health for Gateshead are to be defined through the Health Inequalities Group workstream. Evidence/measures and controls will be implemented as part of the focused work to progress in 2026/27.
Increase in the number of digital devices repurposed to the local community	Digital exclusion is where members of the population have inadequate access and capacity to use digital technologies that are essential to participate in society. The risk to this target is that the quantity of devices being made available for recycling and repurposed is dependant on Trust usage and need. This is therefore entirely variable throughout the course of the year. In 24/25 318 devices reached end of life, the Trust will continue to recycle equipment as swiftly and efficiently as possible with 324 devices being recycled in 2025/26.
Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients	June compliance 90.8%, these figures now take into account patients that are admitted and discharged on the same day following review of national guidance. Previously only patients with an overnight stay were included in this calculation. The numbers have reduced given the challenges of collecting the smoking status for patients admitted and discharged same day - many of these patient have only been an inpatient for possibly as low as an hour or two. GHNFT has the highest performing smoking status recorded on admission in the NENC ICB region, this has been consistent for >12 months. Ongoing actions to improve compliance are - Training of all staff on Nervecentre. Regular focused Tobacco dependency training on wards both ad hoc and planned. Communication Strategy. The Tobacco Dependency Treatment Service is providing an equitable service for all patients with 7 day a week coverage although sickness absence is a temporary challenge to this. Weekend working for the QUIT team was due to be introduced to ensure smoking status collection on weekends, however due to low staffing levels this has not yet been implemented.
Reduction in the wait for gynaecology outpatients to no more than 26 weeks	The median wait for 1st OP appointment in Gynaecology increased slightly to 29 weeks in June due to pressures in antenatal capacity where we have prioritised resources. We continue to focus on reducing waits through the elective care transformation group with key workstreams on increasing PIFU, A&G, Reducing DNA's and clinic template review to increase new patient capacity. New single point of access model now live following a successful pilot to focus on demand and ensuring patients are seen at the right place by the right team.
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 weeks	Current median wait has decreased to 56 weeks. Overall waiting list size has increased slightly due to a reduction in capacity- sickness/ leavers within the service and a workshop took place in June to review the operational delivery model. Continues to be monitored weekly through Access & Performance meetings.

Strategic Objectives 2026/27

We will develop and expand our services within and beyond Gateshead

NHS Gateshead Health NHS Foundation Trust

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

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

Metric	Target	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Ass/Var	Trend
LEADING INDICATORS																	
0.5% increase in QEF externally generated turnover from previous financial year	>=0.5%	7.5%	19.3%	24.0%	28.6%	22.9%	20.0%	19.0%	11.1%	11.0%	9.2%	13.3%	18.8%	12.3%	-4.9%		

Measures requiring focus this month

Measure	Summary
0.5% increase in QEF externally generated turnover	Impact in June of IT Procurement framework income being down by £222k YTD compared with 2025-26. This is expected to be timing. Work is currently ongoing within QEF to target increases in external income as part of Business Efficiency plans within the service, this is across VAT Consultancy, Logistics services and Pharmacy in the first instance. Pharmacy is up compared to prior year with high revenue YTD in External Homecare due to a number of new contracts with Northumbria and North Cumbria.

NHS
Gateshead Health
NHS Foundation Trust

Constitutional Standards 2026/27

Reporting Period: June 2026

Constitutional standards 2026/27	Constitutional Standards metrics Assurance Heatmap

NHS Gateshead Health NHS Foundation Trust

	P	?	F	
Improving		Achievement of the 6 week diagnostic standard	Achievement of the 18 week RTT standard	
Neither improving or deteriorating		Achievement of the 31 day cancer standard 12 hour trolley waits (DTA to left department) Ambulance handover delays 30 - 60 minutes Ambulance handover delays 45 minutes+ Achievement of the A&E 4 hour standard % of ED attendances >12 hours in department		
Deteriorating		Achievement of the 28 day cancer standard Achievement of the 62 day cancer standard	Achievement of the 52 week RTT standard	
	Consistency in PASSING the target	**Inconsistency in HITTING, PASSING and FALLING SHORT of the target**	**Consistency in FAILING the target**	

Constitutional Standards 2026/27

Metrics

NHS Gateshead Health NHS Foundation Trust

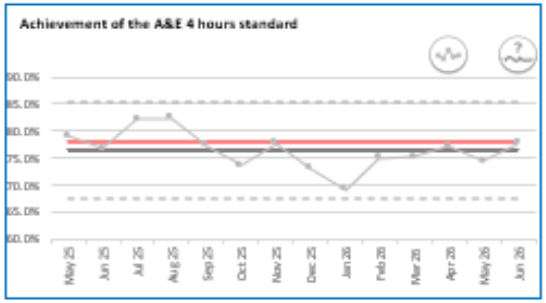
Metric	Target	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Ass/Var
Achievement of the A&E 4 hour standard **	>82%	79.0%	76.7%	82.2%	82.3%	77.4%	73.7%	77.6%	73.0%	69.1%	75.1%	75.1%	77.0%	74.3%	77.7%	
12 hour trolley waits (DTA to left department)	0	1	2	1	0	2	21	6	2	12	1	1	0	3	5	
% of ED attendances > 12 hours in department (Type 1) ** *Reset April 2025 to align with 2025/26 operational guidance definitions* *Standard reset April 2026 to align with 2026/27 plan*	<4%	0.52%	0.77%	0.25%	0.23%	1.19%	5.68%	1.61%	3.85%	9.59%	3.43%	5.13%	4.83%	5.10%	1.91%	
Ambulance handover delays 30-60 minutes	0	4	16	5	1	8	21	7	23	72	15	27	23	31	26	
Ambulance handover delays over 45 minutes **	0	1	5	0	0	0	8	1	15	37	6	15	16	14	5	
Achievement of the RTT 18 week standard **	>92%	68.5%	68.3%	68.6%	67.4%	68.3%	67.9%	69.5%	70.1%	71.4%	71.6%	77.5%	76.4%	78.4%	78.0%	
Achievement of the 52 week RTT standard **	0	1	18	35	55	52	41	33	25	20	26	17	9	8	2	
Achievement of the 6 week diagnostic standard (DM01) **	>95%	74.2%	77.3%	74.8%	71.1%	81.6%	86.3%	96.6%	95.8%	94.6%	96.2%	95.2%	92.9%	92.2%	92.7%	
Achievement of the Cancer 28 day standard ** *Reset April 2025 to align with operational guidance standard*	>80%	69.9%	77.2%	76.0%	75.6%	64.9%	74.7%	80.3%	72.2%	39.4%	55.2%	60.8%	42.8%	45.0%	47.1%	
Achievement of the Cancer 31 day standard **	>96%	99.5%	97.9%	100.0%	97.9%	96.7%	100.0%	97.2%	92.2%	91.5%	99.0%	97.4%	97.9%	100.0%		
Achievement of the Cancer 62 day standard ** *Reset April 2026 to align with 2026/27 operational guidance standard*	>80%	67.7%	72.7%	75.3%	70.8%	71.1%	72.7%	69.3%	60.1%	52.0%	63.0%	65.7%	65.7%	65.2%		

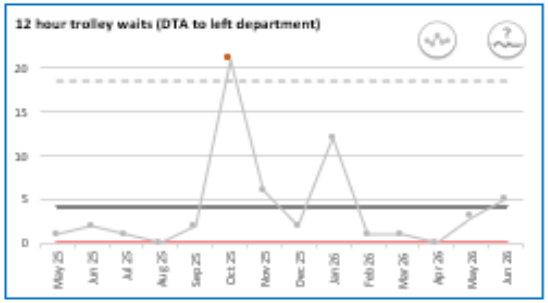
Validated data unavailable at time of report

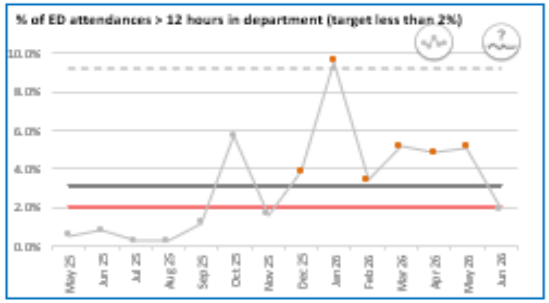
NHS Gateshead Health NHS Foundation Trust

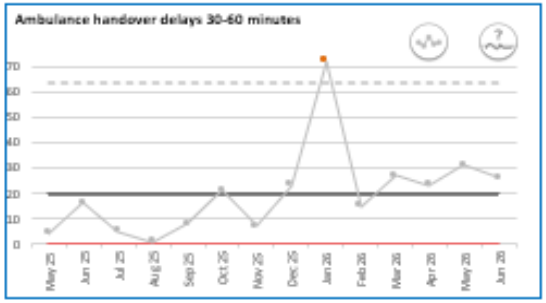
Constitutional Standards 2026/27

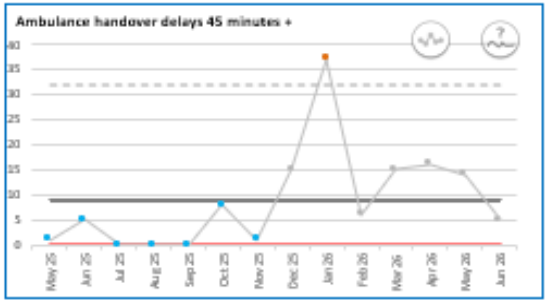
Metrics (SPC)

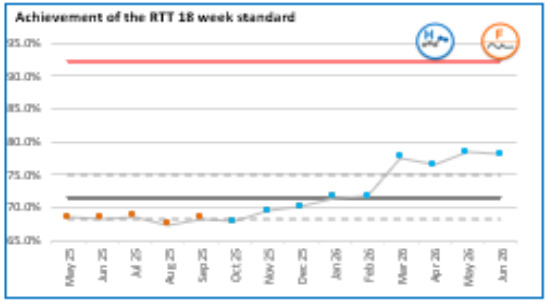


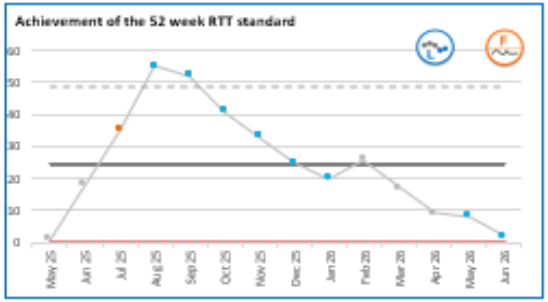


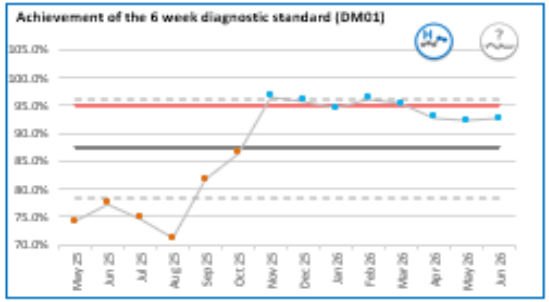


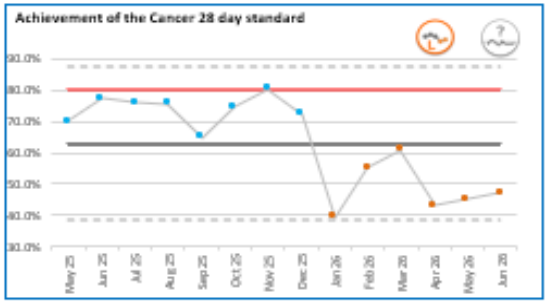


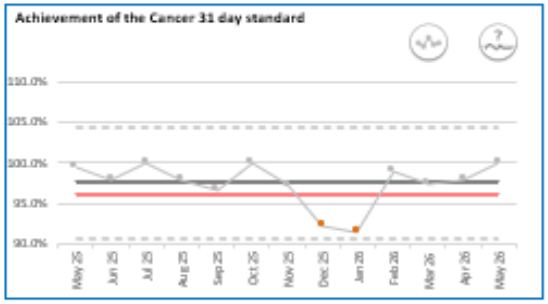


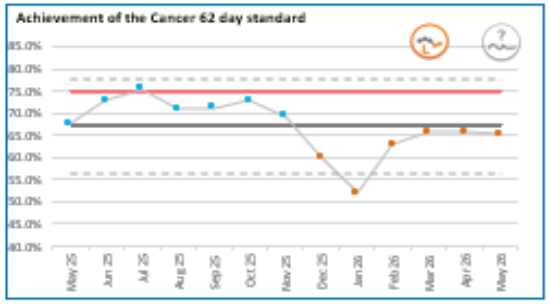












2026/27 High Level Plan Summary

Planning Domain	Planning Metric	2026/27 Target	2026/27 Plan	M1 Plan	M1 Actual	M1 Variation	M1 Position	M2 Plan	M2 Actual	M2 Variation	M2 Position	M3 Plan	M3 Actual	M3 Variation	M3 Position
Finance	Surplus/Deficit Position	Breakeven	Breakeven	£0	£570,000	-£570,000		£0	£ 1,400,000	-£1,400,000		£0	£ 2,557,000	-£2,557,000	
	CIP as % of allocation/ operating expenses	6%	£ 27,667,000	£2,135,000	£579,000	-£1,556,000		£4,272,000	£1,426,000	-£2,846,000		£6,408,000	£2,265,000	-£4,143,000	
Reducing the time people wait for elective care	Percentage of RTT Waiting List < 18 weeks	82%	82%	74.0%	76.40%	2.40%		75.0%	78.4%	3.40%		76.20%	78%	1.30%	
	Patients waiting > 52 weeks for treatment	Zero	Zero	0	9	9		0	10	8		0	2	2	
	Total Waiting List*	Reduce	11,028	11,873	11,812	-61		11,781	12,037	256		11,680	11,681	1	
	28 Day Faster Diagnosis Standard	80%	80%	80%	42.8%	-37.2%		80%	45.0%	-35.0%		80%	47.10%	-32.90%	
	31 day treatment standard	94%	96.30%	96.0%	97.9%	1.9%		96.30%	100.0%	3.7%		96.30%	95.80%	-0.50%	
	62 day first definitive treatment standard	80%	75.2%	73.6%	65.7%	-7.9%		73.90%	65.2%	-8.7%		74.00%	58.70%	-15.30%	
	DM01 Diagnostic Waits > 6 weeks	Reduce	9.90%	12.9%	7.1%	-5.8%		12.6%	7.8%	-4.8%		12.4%	7.3%	-5.1%	
	DM01 Diagnostic Waiting List*	Reduce	5,560	5,636	6,178	542		5,481	6,176	695		5,467	6,139	672	
Improving UEC waiting times	4-Hr A&E performance	82%	84.70%	81.7%	77%	-4.7%		81.7%	74.30%	-7.4%		82%	77.70%	-4.30%	
	4-Hr Paediatric performance *	95%	95%	95%	95.20%	0.20%		95%	96.30%	1.30%		95%	96.10%	1.10%	
	% 12-hr time in department breaches	4%	4%	4%	4.80%	0.80%		4%	4.10%	0.10%		4%	1.90%	-2.10%	
	12- hr DTA Breaches	Zero	4%	0	0	0		0	3	3		0	5	5	
	Average Hand over times*	<00:15:00	<00:15:00	00:15:00	00:14:40	00:00:20		00:15:00	00:14:36	00:00:24		00:15:00	00:14:32	00:00:28	
	Handover delay +45 mins*	0	0	0	16	16		0	14	14		0	4	4	
	Handover delays +60 mins*	Zero	38.8%	0	5	5		0	3	3		0	2	2	
Improving community services waiting times	Rapid Response < 2 hrs*	80%	80%	80%	78.2%	-1.8%		80%	73.50%	-6.50%		80%	68.04%	-11.96%	
	Community RTT < 18 weeks	78%	84%	73.4%	74.50%	1.1%		74.7%	73.00%	-1.7%		75.70%	73.50%	-2.20%	
	Community RTT C&YP		74.70%	65.9%	77.7%	11.8%		67.3%	75.5%	8.2%		68.60%	79.30%	10.70%	
	Community RTT Adults		87.90%	76.30%	73.30%	-3.00%		77.30%	72.10%	-5.20%		78.20%	71.40%	-6.80%	
	Community > 52 week waiters	Zero	Zero	0	139	139		0	176	176		0	198	198	
Workforce	Total Workforce (WTE)	-	4,866	4,937.1	4,911.64	-25.46		4,924.9	4881.68	-43.2		4,924.9			
	Substantive workforce (WTE)	-	4,706	4,780.1	4,734.24	-45.86		4,755.8	4723.33	-32.4		4,755.8			
	Bank workforce (WTE)	-	151	143	155.88	12.88		135.5	134.07	-1.5		135.5			
	Agency workforce (WTE)	-	10	13.9	21.52	7.62		13.7	24.28	10.6		13.7			

** Planning supporting metrics*

Provisional Positions

NHS England Performance Dashboard

	RTT < 18 weeks Rank 118	RTT > 52 weeks Rank 118	Cancer FDS Rank 118	Cancer 31 Day Rank 117	Cancer 62 Day Rank 117	Diagnostics DM01 Rank 118	A&E 4-hr Rank 118	A&E 12-hr Rank 118
	May-26	May-26	May-26	May-26	May-26	May-26	Jun-26	Jun-26
Gateshead Health NHS FT	78.40%	0.10%	45%	100%	65.20%	7.80%	77.70%	1.80%
	3	12	118	1	85	20	32	8
Northumbria Healthcare NHS FT	83%	0.00%	83.10%	97.20%	80.60%	0.70%	91.20%	0.10%
	2	1	29	31	13	1	1	1
Newcastle Upon Tyne Hospitals NHS FT	76.30%	0.80%	85.00%	83.40%	65.10%	20.50%	76.70%	2.20%
	13	43	16	112	86	68	43	9
North Cumbria Integrated Care NHS FT	65.90%	1.40%	72.80%	98.00%	67.10%	21.70%	68.30%	7.80%
	54	71	102	26	79	73	94	41
South Tyneside & Sunderland NHS FT	76.70%	0.00%	80.40%	98.70%	69.50%	20.70%	76.30%	1.30%
	5	1	57	18	61	70	47	4
North Tees & Hartlepool NHS FT	72.30%	0.90%	69.30%	95.50%	46.60%	4.10%	85.00%	1.20%
	14	50	110	56	116	6	5	3
County Durham & Darlington NHS FT	67.10%	1.50%	66.90%	96.30%	70.40%	15.60%	75.40%	9.20%
	39	76	114	50	55	50	52	50
South Tees Hospitals NHS FT	66.20%	1.20%	80.80%	83.00%	70.40%	15.70%	79.00%	1.40%
	49	62	55	114	56	51	25	5

6. ITEMS FOR INFORMATION / MEETING GOVERNANCE

a - Cycle of Business 2026/27

Presented by the Company Secretary

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

	Lead	Type of item	Public/Private	Jul-26	Sep-26	Nov-26	Jan-27	Mar-27
Standing Items			Part 1 & Part 2					
Apologies	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√
Declaration of interests	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√
Minutes	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√
Action log	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√
Matters arising	Chair	Standing Item	Part 1 & Part 2	√	√	√	√	√
Chair's Report	Chair	Standing Item	Part 1	√	√	√	√	√
Chief Executive's Update Report	Chief Executive	Standing Item	Part 1 & Part 2	√	√	√	√	√
Cycle of Business	Company Secretary	Standing Item	Part 1 & Part 2	√	√	√	√	√
Patient & Staff Story	Company Secretary	Standing Item	Part 1	√	√	√	√	√
Questions from Governors	Chair	Standing Item	Part 1	√	√	√	√	√
Items for Decision			Part 1 & Part 2					
Annual Declarations of Interest	Company Secretary	Item for Decision	Part 1					√
Standing Financial Instructions, Delegation of Powers, Constitution and Standing Orders - annual review	Company Secretary / Group Director of Finance	Item for Decision	Part 1					√
Calendar of Board Meetings	Company Secretary	Item for Decision	Part 1		√			
Winter Plan	Chief Operating Officer	Item for Decision	Part 1	deferred	√			
Responsible Officer Report	Medical Director	Item for Decision	Part 1		√			
Board Committee Annual Reviews of Effectiveness and Terms of Reference Update	Company Secretary	Item for Decision	Part 1					√
Green Plan	QEF Managing Director	Item for Decision	Part 1		√			
Premises Assurance Model	QEF Managing Director	Item for Decision	Part 1	√				
CQC Statement of Purpose and Registration	Chief Nurse	Item for Decision	Part 1					√
Items for Assurance			Part 1 & Part 2					
Board Committee Assurance Reports	Committee Chairs	Item for Assurance	Part 1	√	√	√	√	√
Board Assurance Framework - updates	Company Secretary	Item for Assurance	Part 1		√		√	√
Organisational Risk Register	Chief Nurse	Item for Assurance	Part 1	√	√	√	√	√
Strategic Communications Report	Chief Executive / Head of Comms	Item for Assurance	Part 1	√		√	√	
Annual Staff Survey Results	Group Director of People & OD	Item for Assurance	Part 1 & Part 2				√	√
Finance Report	Group Director of Finance	Item for Assurance	Part 1	√	√	√	√	√
Strategic Objectives and Constitutional Standards Report	Group Director of Finance	Item for Assurance	Part 1	√	√	√	√	√
Maternity Integrated Oversight Report	Chief Nurse	Item for Assurance	Part 1	√	√	√	√	√
Maternity Safety Champion Report	Maternity Safety Champion	Item for Assurance	Part 1	√	√	√	√	√
Maternity Staffing Report	Chief Nurse	Item for Assurance	Part 1		√			√
Nurse Staffing Exception Report	Chief Nurse	Item for Assurance	Part 1	√	√	√	√	√
Bi-annual Inpatient Safer Nursing Care Staffing Report	Chief Nurse	Item for Assurance	Part 1		√			√
Learning from Deaths (quarterly report)	Group Medical Director	Item for Assurance	Part 1	√		√		√
EPRR Core Standards Self-Assessment Report	Chief Operating Officer	Item for Assurance	Part 1		√		√	
CNST Maternity Compliance Report	Chief Nurse	Item for Assurance	Part 1				√	
Freedom to Speak Up Guardian Report	Group Director of People & OD	Item for Assurance	Part 1	√			√	
WRES and WDES Report	Group Director of People & OD	Item for Assurance	Part 1		√			
Great North Healthcare Alliance Progress Report and notes	Director of Strategy and Partnerships	Item for Assurance	Part 1 & Part 2	√	√	√	√	√
Items for Information			Part 1 & Part 2					
Register of Official Seal	Company Secretary	Item for Information	Part 1		√			
Ad Hoc Items (i.e. items emerging during the year)			Part 1 & Part 2					
Charitable Funds Audited Financial Performance	Group Director of Finance	Item for Board of Trustees	Part 1				√	

b - Questions from Governors in Attendance

c - Any Other Business

d - Date and Time of Next Meeting - 09:30am on Tuesday 29 September 2026

Meeting Closure and Exclusion of the Press and Public