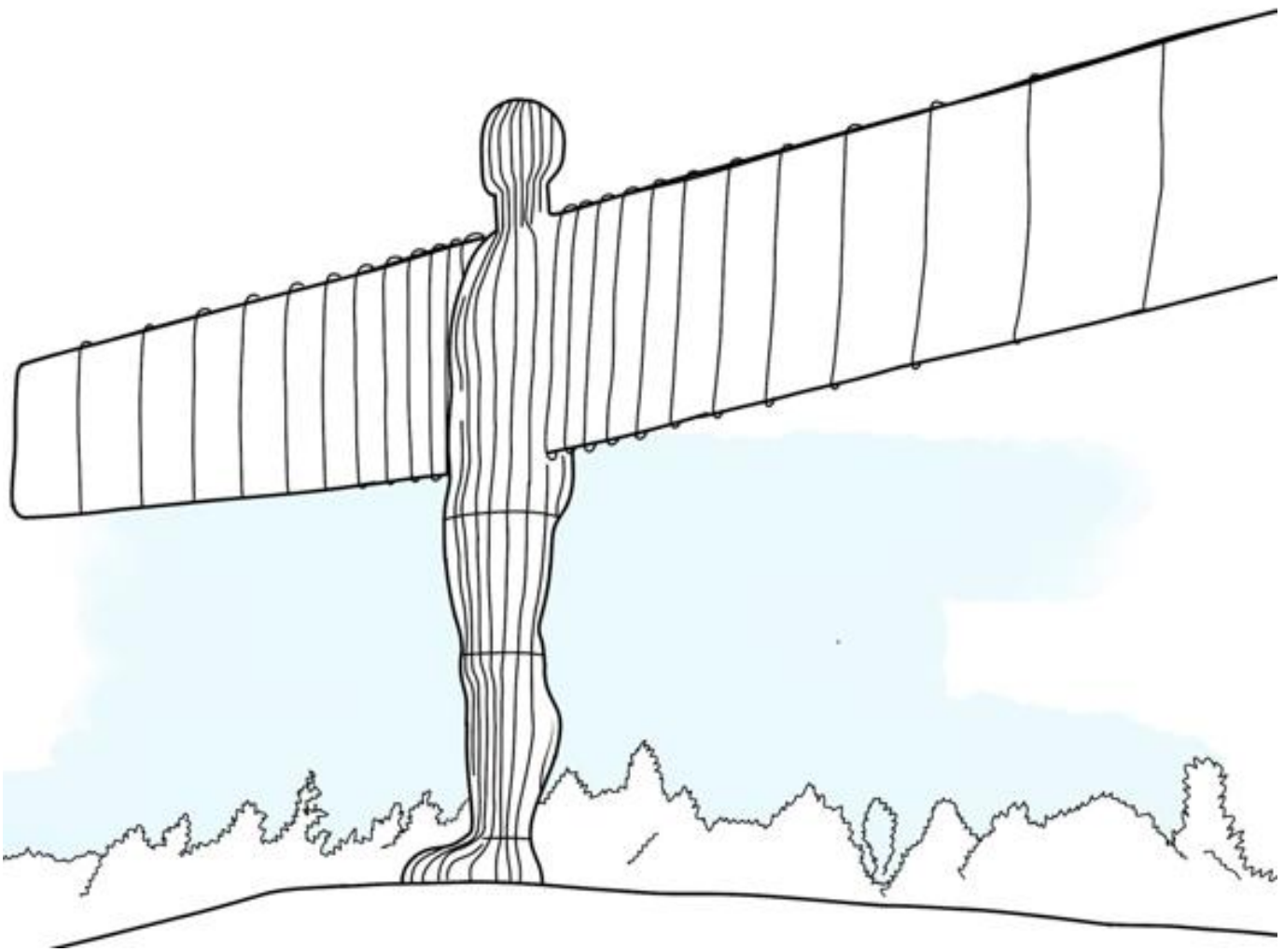
NHS
Gateshead Health
NHS Foundation Trust



Quality Account

Gateshead Health NHS Foundation Trust 2025/26

Contents

Part 1

Quality Account – Chief Executive's Statement

Statement on Quality from the Chief Executive

I am pleased to introduce the Quality Account for Gateshead Health NHS Foundation Trust for 2025/26, which reflects our continued commitment to delivering safe, effective and compassionate care for the communities we serve. This year has taken place in the context of an exceptionally challenging NHS environment, with sustained high demand across urgent and emergency care, ongoing workforce pressures, and increasing financial constraints across the system. These challenges have required us to work differently, to prioritise carefully, and to maintain a relentless focus on quality and safety while operating within the resources available to us and working within our Alliance to maximise these.

Against this backdrop, I want to begin by recognising the outstanding dedication, professionalism and resilience of our staff. Across all areas of the organisation including QE Facilities, colleagues continue to go above and beyond to deliver high-quality care for patients, often under significant pressure. Their commitment, compassion and teamwork remain the strongest asset of this Trust, and I am deeply grateful for everything they have contributed this year.

Despite the challenges, we have made meaningful progress in a number of important areas. In urgent and emergency care, we have delivered a significant improvement in patient flow, reducing the proportion of patients experiencing waits over 12 hours in our Emergency Department to 2.5%, compared with 4.68% the previous year. This improvement reflects the impact of a sustained, clinically led programme of work focused on flow, discharge processes, bed utilisation and improving decision-making across the hospital. While this progress is welcome, we recognise the need to continue this work to ensure improvements are sustained and embedded.

Alongside this, we have continued to develop our approach to patient flow and system capacity more broadly. Work across the organisation to improve discharge processes, strengthen multidisciplinary working, and optimise use of hospital beds has supported better patient progression through our services. This has been particularly important in managing sustained demand pressures and ensuring that patients receive care in the most appropriate setting.

We have also made strong progress in maternity and neonatal services, which remain a particular area of excellence for the Trust. We are proud that our service has been rated first nationally in the Picker CQC maternity survey for 2024 and 2025, reflecting sustained improvement over recent years. This achievement is underpinned by strong leadership, a highly engaged multidisciplinary workforce, and a clear focus on safety, personalised care and co-production with women and families. The continued embedding of national safety programmes and investment in workforce development has further strengthened both safety and experience for families using our services.

We have also made important progress in strengthening partnerships beyond the Trust, particularly with voluntary and community sector organisations. As an anchor institution within Gateshead, we are increasingly working alongside partners to better understand and respond to the wider determinants of health. This collaboration is helping us to support more holistic, joined-up care and to improve awareness of the community-based support available to patients and families.

Digital transformation continues to be another key enabler of improvement. The expansion of digital care planning and the implementation of improved observation systems have supported safer, more consistent care and reduced administrative burden on clinical staff. These developments are helping to free up time for care, improve access to information, and support better clinical decision-making at the point of need. Although work has progressed, there is more to do in this area.

We have also continued to make progress in addressing health inequalities, including the early rollout of Making Every Contact Count in pilot areas, improvements in health literacy approaches, and the introduction of reasonable adjustment flags to support more inclusive care. While this work is still in its early stages, it is an important foundation for reducing variation in access and outcomes across our communities.

Looking ahead, we know there is more to do. We will continue to build on the progress made this year while addressing the areas where improvement is still required. Our Quality Account reflects both the progress we have made and the scale of the challenges we continue to face. I want to close by again recognising our staff, whose commitment, professionalism and compassion continue to underpin everything we achieve. Their work makes a real difference every day to patients and families across Gateshead, and I am extremely proud of what they continue to deliver in such challenging circumstances.

Signed

Date: 24th June 2026

Dr Sean Fenwick
Chief Executive
Gateshead Health NHS Foundation Trust

What is a Quality Account?

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

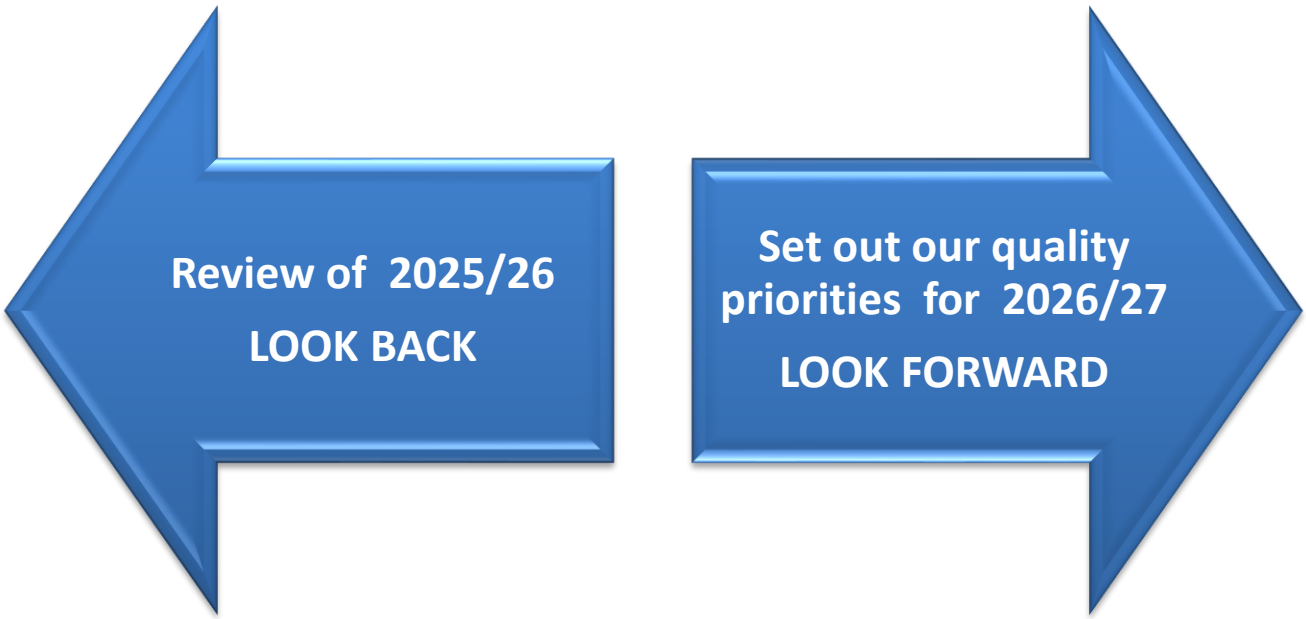
At Gateshead Health, we are proud of the care our teams deliver every day and equally proud of the culture of learning, honesty and continuous improvement that sits behind it. This report allows us to celebrate the achievements of our staff, recognise the experiences of our patients and communities,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

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

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

The dual functions of a Quality Account are to:

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



About us and the service we provide

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

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

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

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

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

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

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

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

NHS

121,113

A&E Attendances

66,028

Inpatient Spells

1,817

Births

15,587

Same Day Emergency Care

(SDEC) Attendances

284,513

Outpatient Attendances

Local Population

over 200,000

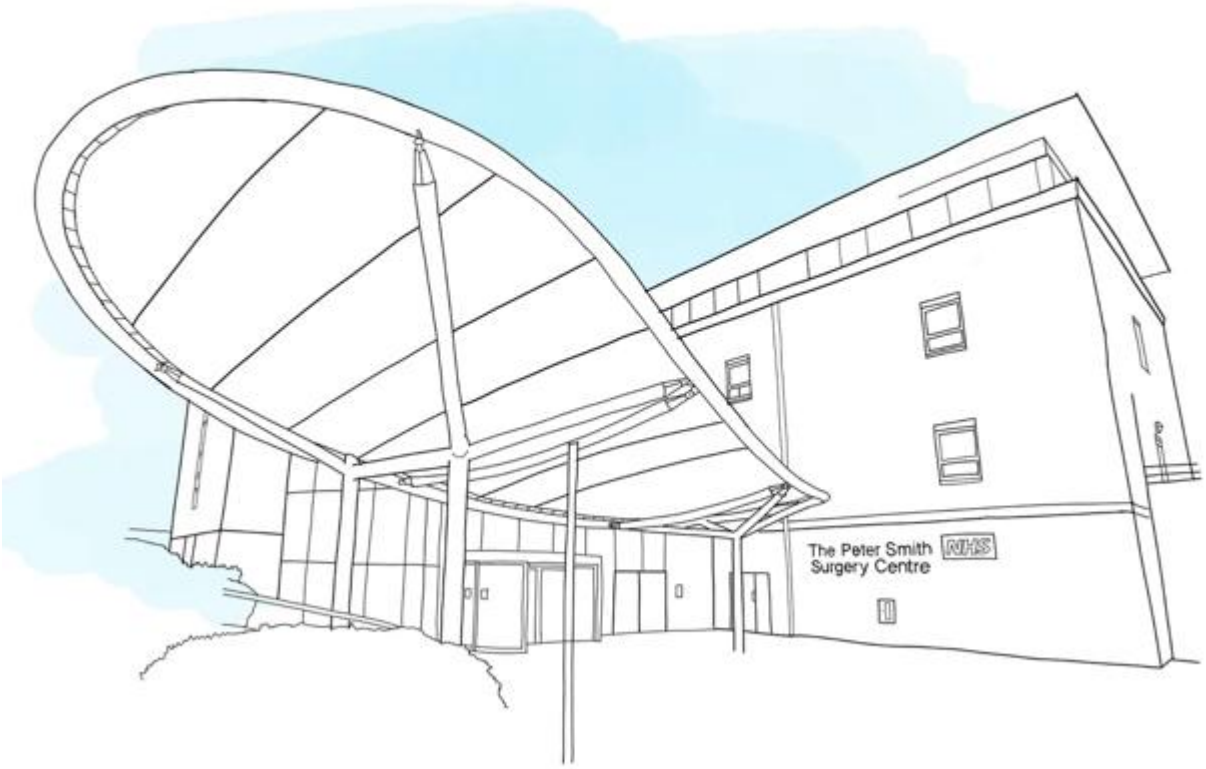
Employ around 4,500 staff

Inspected and rated

Good with Outstanding for Caring

CareQuality Commission

Part 2
Quality Priorities



2. Priorities for Improvement

2.1 Reporting back on our progress in 2025/26

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

PATIENT SAFETY:

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

What did we say we would do?

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

Impact for patients

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

Did we achieve this?

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

How we achieved it:

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

Evidence of achievement:

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

Next steps:

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

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

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

Cancer Performance Overview

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

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

What did we say we would do?

- We will implement a delivery plan based on national guidance which sets out how the NHS will make Maternity care safer, more personalised and more equitable, with twelve objectives identified based on four nationally mandated high-level themes:
  - listening to women and families with compassion.
  - supporting our workforce to develop their skills and capacity,
  - developing and sustaining a culture of safety, and
  - meeting and improving standards and structures

Impact for patients

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

Did we achieve this?

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

How we achieved it:

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

Evidence of achievement:

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

Next steps:

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

PATIENT EXPERIENCE:

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

What did we say we would do?

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

Impact for patients

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

Did we achieve this?

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

How we achieved it:

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

Evidence of achievement:

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

Next steps:

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

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

What did we say we would do?

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

Impact for patients

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

Did we achieve this?

- We have made good progress against this priority particularly in relation to women's health. Key partnerships have been strengthened, and there has been increased engagement with VCS organisations in the delivery of services. Representatives from key partner organisations were invited to join the Trust's Patient Experience Group, helping to strengthen shared learning, insight and understanding of community needs. Stakeholder mapping was also refreshed to support more effective engagement across the voluntary and community sector landscape.
- Voluntary, community and social enterprise (VCSE) partners were involved in the development of the Trust's corporate strategy.
- Focusing specifically on women's health and as part of our women's health hub offer, we have worked in partnership with voluntary and community groups to improve access to

services with a particular focus on closing the gap on health inequalities and in providing an alternative offer for individuals who tend not to access services in traditional healthcare settings. This has included a programme of pop-up services.

- Recognising the impact of the wider determinants of health and levels of deprivation in Gateshead, we have signed the Tackling Poverty Partnership Statement of Intent that aims to address inequality and disadvantage.
- We have also strengthened engagement with Healthwatch to support improved patient insight and two-way dialogue with communities. The Trust has maintained regular attendance at the Health and Wellbeing Board alongside wider system partners.
- At the provider collaborative level, agreement has been reached to replicate The Newcastle upon Tyne Hospitals NHS Foundation Trust model for waiting list patient surveys. Preparatory work has also been completed to support delivery of a Trust-wide waiting list patient survey in partnership with Patient Perspective.
- While this work is still developing, including via the neighbourhood health model early indications suggest improved collaboration and stronger foundations for more integrated, community-focused approaches.

How we achieved it:

- We actively engaged with VCS partners throughout 2025/26, recognising our role as an anchor institution. Key VCS representatives were invited to attend the Patient Experience Group, enabling shared learning, improved understanding of community needs, and more aligned priorities.
- In partnership with the ICB, we began mapping the VCS landscape across Gateshead to better understand available services, identify gaps, and support more effective signposting and collaboration. This has supported stronger relationships between Trust services and community organisations and increased awareness of the role VCS partners play in supporting patient outcomes.
- With a collective ambition to improve women's health, our women's health hub work is an example of system wide transformation involving a wide range of organisations across the statutory and voluntary and community sector.
- We also strengthened engagement with Healthwatch and continued regular attendance at the Health and Wellbeing Board alongside wider partners across health, local government and the voluntary sector.
- At provider collaborative level, work progressed to develop a consistent approach to waiting list patient experience surveys, with preparatory work completed to support implementation of a Trust-wide survey model in partnership with Patient Perspective.

Evidence of achievement:

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

Next steps:

- Complete and regularly update the VCS mapping to ensure it remains a useful and accessible resource for staff and partners.

- Further embed VCS involvement in service design, co-production, and decision-making forums.
- Strengthen mechanisms for capturing and evidencing the impact of VCS collaboration on patient outcomes and experience.
- Increase visibility of VCS support options for patients and staff to enable more holistic, person-centred care.
- Build on our women's health work as we move forward with neighbourhood health in line with the NHS 10 Year Plan and our corporate and clinical strategies
- Continue working with partners across health, local government and the voluntary and community sector to support integrated neighbourhood working and more joined-up care closer to home.

STAFF EXPERIENCE:

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

What did we say we would do?

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

Impact for patients and staff

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

Did we achieve this?

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

How we achieved it:

- Consistent, structured messaging through existing internal channels
- Empower managers to share and gather information in two-way conversations, with regular reinforcement through team briefings, CEO updates and Gateshead Health Weekly
- Stopping incivility programme of work – encouraging politeness, respect, and tackling bullying and harassment, working closely with our staff networks, Staff Side partners and FTSU Guardian to promote a culture of civility and respect

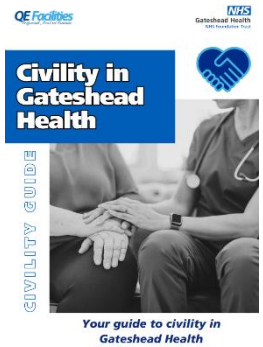
- Promoting engagement programme of work – raising awareness of Health and Wellbeing (HWB) support and helping staff stay well.
- Used the "You Said, We Did" approach to respond to feedback received within the staff survey communications plan.
- Used the recently launched Staff Experience and Inclusion Oversight Group to review staff feedback, monitor actions, and coordinate cross-Trust responses to issues raised.
- Implemented the culture triangulation meeting, to ensure that various people data sources are being effectively triangulated and escalated where concerns are raised.

Evidence of achievement:

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

Next steps:

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



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

What did we say we would do?

- We will review our staffing models

Impact for patients

Having the right staff in the right place at the right time is fundamental to delivering safe, effective and compassionate care. Appropriate staffing levels help ensure patients receive timely assessments, treatment and support from skilled professionals who are able to meet their individual needs. Safe staffing is closely linked to improved patient outcomes, reduced risk of harm, better patient experience and higher standards of care quality. It also supports

staff wellbeing and retention, helping to maintain a stable and sustainable workforce. By reviewing and improving staffing models across the Trust, the organisation aims to ensure services are responsive to patient demand, staff have the capacity to provide high-quality care, and patients receive safe and consistent care at all times

Did we achieve this?

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

How we achieved it:

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

Evidence of achievement:

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

Next steps:

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

CLINICAL EFFECTIVENESS:

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

What did we say we would do?

- Care planning
- Record keeping/noting
- Observations

Impact for patients

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

Did we achieve this?

- Yes

How we achieved it:

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

Evidence of achievement:

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

Next steps:

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

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

What did we say we would do?

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

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

Impact for patients

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

Did we achieve this?

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

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

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

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

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

How we achieved it:

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

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

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

Evidence of achievement:

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

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

Staff attendance at health literacy training and participation in Train the Trainer programmes to support sustainability.

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

Next steps:

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

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

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

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

2.2 Our Quality Priorities for Improvement 2026/27

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

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

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

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

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

Priority 1 – Patient Experience

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

Why is this a priority?

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

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

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

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

What are our aims for 2026/27?

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

What will we do?

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

Priority 2 – Patient Safety

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

Why is this a priority?

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

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

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

What are our aims for 2026/27?

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

What will we do?

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

Priority 3 – Clinical Effectiveness

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

Why is this a priority?

Delivering clinically effective care means ensuring patients consistently receive care that is safe, evidence based and achieves the best possible outcomes. Understanding variation in outcomes across services allows us to identify opportunities for improvement and ensure patients receive high-quality care regardless of where they access services.

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

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

What are our aims for 2026/27?

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

What will we do?

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

Priority 4 – Staff Experience

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

Why is this a priority?

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

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

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

What are our aims for 2026/27?

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

What will we do?

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

Priority 5 – Women's Health

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

Why is this a priority?

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

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

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

What are our aims for 2026/27?

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

What will we do?

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

Priority 6 – Timely Access to Care

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

Why is this a priority?

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

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

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

What are our aims for 2026/27?

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

What will we do?

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

2.3 Statements of Assurance from the Board

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

Participation in National Clinical Audits 2025/26

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

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

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

Audit title	Participation	% of cases submitted/number of cases submitted
National Audit - Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	200 Cases submitted up to Feb 26 – no minimum requirement
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	6 Cases submitted – no minimum requirement
National Audit - National Emergency Laparotomy Audit (NELA)	Yes	124 Cases submitted – no minimum requirement
National Audit - Elective Surgery (PROMS)	Yes	No minimum requirement HIP -237 Cases submitted Knees -430 Cases submitted
National Audit - Falls & Fragility Fractures Audit Programme (FFFAP) Inpatient Falls	Yes	43 Cases submitted – no minimum requirement
National Comparative Audit of Bedside Transfusion Practice	Yes	16 Cases submitted – no minimum requirement
National Audit - National Pulmonary Rehabilitation	Yes	338 Cases submitted – no minimum requirement
National Audit - National Cardiac Rehabilitation	Yes	680 Cases submitted – no minimum requirement
National Audit - National Pregnancy in Diabetes Audit	Yes	Data for 2025/26 not published as yet. Submission Deadline 31st May
National Audit - National Joint Registry (NJR)	Yes	Data for 2025/26 not published as yet.(mid-May)

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

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

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

The reports of 10 national clinical audits were reviewed by Gateshead Health NHS Foundation Trust in 2025/26, and Gateshead Health NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

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

Action Points:

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

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

Action Points:

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

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

Action Points:

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

Heart Failure National Audit

The Trust continues to submit data into the National Heart Failure Audit (NHFA) which captures data on clinical indicators proven to improve outcomes for heart failure patients, while encouraging the increased use of clinically recommended diagnostic tools, disease modifying treatments and appropriate referral pathways/follow up pathways.

Data for the 2025 reports is collected from the beginning of April 2024 to the end of March 2025. Submission reflects care in QEH: Overall - high standards in specialist input for Heart failure with reduced ejection fraction patients and patients discharged on beta blockers. Prompt follow up with HF specialist team. Decline and areas for improvement in other areas: other pillars (ACEi/ARB/ARNI, MRA + SGLT2i), care on a cardiology ward. Likely contributing factors: staffing levels and capacity to meet national targets/care needs, bed pressures, early discharge to HF ambulatory unit/HF follow up before patients are started on 4 pillars, training and education (ward doctors/ward teams' familiarity with 4 pillars and when/how to initiate these), early referral to HF team vs referral on discharge

Action points:

- Share findings
- Arrange education sessions for ward staff and encourage early referral to HF team if patients meet the criteria
- Review HF SOP and assess how this can be more rapidly implemented in an inpatient setting

National Hip Fracture Database (NHFD)

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

Action Points:

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

National Cardiac Arrest Audit

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

Action Points:

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

National Sentinel Stroke Audit (SNNAP)

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

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

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

In the 3 quarters that are available from the new scoring system, Queen Elizabeth Hospital has consistently scored a D overall.

However, as a team we have improved since the first production of the new figures and for the latest period (Oct-Dec25), the QE scored as follows in the 4 team-centred domains in which we are rated –

Specialist pathway – B
Therapy intensity – C (dropped from A in Jul-Sept)
Therapy frequency – C
Standards by discharge - C (improved from D in July-Sept)
In addition, we consistently score an A in both Case Ascertainment & Audit Compliance.

Action Points:

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

National Audit of Care at the End of Life

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

Action Points:

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

National Paediatric Diabetes Audit (NPDA)

Real time data is collected and reviewed locally 3 monthly by the diabetes team and 6 monthly by the regional NENC CYP Diabetes network. Quarterly data has also been submitted to the NPDA. We have submitted data on 138 patients to the NPDA 2025-26: 133 of these patients had Type 1 diabetes (3 patients have Type 2 diabetes and 2 patients have monogenic diabetes.) 89.5% of Type 1 diabetes patients are on insulin pump therapy

(88.7% are on HCL systems); 10.5% are on an intensive multiple daily injection regime; 99.2% are on CGM (continuous glucose monitoring) with alarms. The overall health care completion rate is 94% (100% of patients had a HbA1C; 100% had a BMI; 98% had their thyroid function tests; 100% had a blood pressure; 99% had a urinary albumin; 94% had their feet examined; 83% were recommended influenza immunisation; 92% were given sick day rules advice, 93% had their smoking status screened; 91% had psychology screening. 100%(9/9) new patients had thyroid screening and coeliac screening within 90 days diagnosis, 89% (8/9) newly diagnosed patients had dietetic support with carbohydrate counting within 14 days diagnosis. Based on Q4 data - Median HbA1C 54mmol/mol (mean 55mmol/mol)
Based onQ3 data: HbA1C <48mmol/mol - 19.2% (prev 2024/25 12.8%). HbA1C <58mmol/mol – 70.5% (prev 2024/25 56.8%). HbA1C >69mmol/mol – <4% (prev 2024/25 7.2 %). HbA1C >80mmol/mol – <4% (prev 2024/25 3.2%). This is an ongoing and significant improvement year on year. There is no significant inequalities gaps in access to technology or health care completion rates. There is a slight difference in median HbA1C in our ethnic minority children (56.5mmol/mol compared to 54mmol/mol.)
Over the last year 2025-26 the CYP Diabetes team has:

- Continued to work collaboratively with our regional diabetes and adult diabetes colleagues and diabetes pharmacists to improve patient pathways for 16-19yr CYP living with diabetes and to optimise care particularly around Type 2 diabetes management. The CYP diabetes team completed Seamless Transition training.
- Continued to implement strategies recommended following a Poverty Proofing Project with Children North East and Type 1 Kidz patient support group to increase awareness of HCPs and the trust of the difficulties those CYP and families living with T1D face and to enable strategies to be put in place to facilitate equitable access to health care and diabetes technologies.
- Continued to deliver standardised new patient education programme from diagnosis and are also regular education of staff and students (DKA, sick day rules and general CYP diabetes).
- Continued to support ongoing diabetes MDT education on diabetes technologies. We have transferred the majority of patients who are eligible and wished to move onto HCL systems through our access to diabetes tech regional project and reduced the inequalities gaps. We have developed a technology SOP to support accountability and shared responsibility between diabetes MDT, CYP and families and technology companies to ensure cost effective appropriate use of NHS funding for diabetes technology and to minimise waste and ensure failed technology is replaced under warranty.
- Updated our diabetes clinical data base in line with the new NPDA data set and technology updates and to facilitate timely clinic letters.
- We continue to value the voice of children and young people and their families in service delivery and improvements and have been awarded an “Investing in children membership award”

Action Points:

- To continue to support CYP and their families and carers to improve or maintain optimal glucose levels measured by HbA1C and Time in Range to ensure CYP have the best possible health outcomes and life chances.
- Raised concerns at management level re outstanding actions from regional CYA GIRFT consultation which took place January 2025.
- To continue to deliver ward staff diabetes training to enable the staff to offer safe optimal care including use of diabetes technologies to newly diagnosed patients and known diabetes patients with a diabetes related admission or any other illness.

- To continue to work across multi agencies to support the significant number of CYP requiring local authority support, mental health/MDT psychology services and /or safeguarding.
- To continue to improve education for CYP and their carers/ families and school staff to enable them to use new technology and ensure CYP with diabetes are fully included in all aspects of school life and achieve their full potential. Facilitating CYP and families to participate in the national schools PREM

Collaborative working with the adult service to improve care young people 16-19yrs and to improve patient pathways and address the lack of SDEC provision for 16-18yrs and to support implementation of the CYA GIRFT review recommendations and the Seamless Transition learning; to facilitate access to age appropriate education programmes for those with Type 1 & Type 2 Diabetes; to improve engagement - as complex needs prevent regular clinic attendance and potentially results in Did Not Attends (DNAs) and effectively early discharge from the adult service.

The Case Mix Programme (CMP)

The CMP is an audit of patient outcomes from adult and general critical care units (intensive care and combined intensive care/high dependency units) covering England, Wales, and Northern Ireland. The Intensive Care Audit and Research Centre (ICNARC) run it. Data is collected on all patients admitted to the Critical Care Unit.

Our most recent QQR, including data for Q3 25/26 shows good performance in all areas, with no measures showing performance worse than comparable units, and strong performance in some areas including potential mis triage to the ward, unplanned readmissions, delayed admissions, and non-clinical transfers to other units. Our overall standardised mortality rate was as expected (observed 16.8% v expected 15.6%), and mortality for patients with a low predicted mortality was very low.

Our data completeness remains excellent, with around 100% data completeness for all quality measures and very high levels of completeness for patient data. Our timeliness of data submission to ICNARC also remains excellent.

Our ICU data clerk and Consultant lead for ICNARC are both heavily involved in the Network Data group which focusses on ICNARC data submission and quality, and the Consultant Lead has been appointed Co-Chair of the group in the past year.

Action Points:

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

The reports of eight local clinical audits were reviewed by Gateshead Health NHS Foundation Trust in 2025/26, and Gateshead Health NHS Foundation Trust intends to take actions to

improve the quality of healthcare provided. Below are examples from across the Trust that demonstrate some of the actions taken to improve the quality of our services:

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

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

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

Participation in National Confidential Enquiries 2025/26

Enquiry	Participation	% of cases submitted
Pleural Procedures (organisational questionnaire)	Yes	100%
Acute Limb Ischemia (organisational questionnaire)	Yes	100%
Learning Disability (organisational questionnaire)	Yes	100%
Clinical questionnaires remain open for submission beyond 2025/26, submitted to date:		

Pleural procedures	Yes	63%
Stabilisation of the critically ill child	Yes	40%
Rib fractures	Yes	83%
Learning disability	Yes	50%

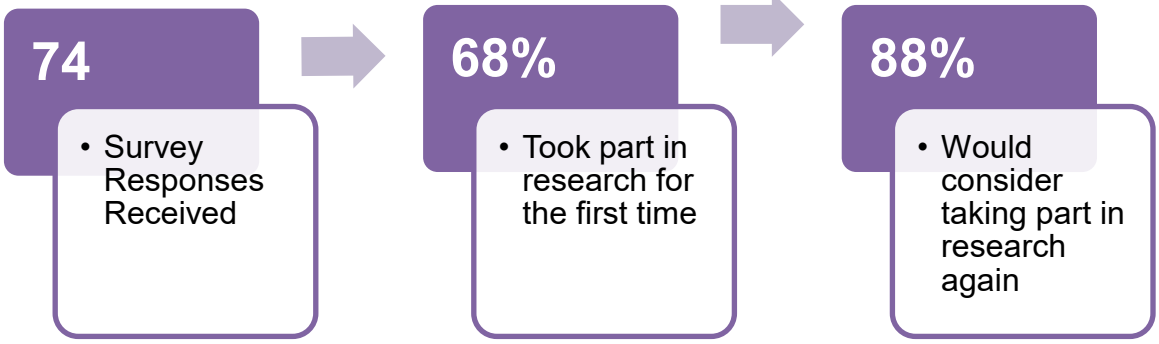
Participation in clinical research

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

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

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

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



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

The survey also found:-

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

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

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

Top 5 Recruiting Studies

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

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

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

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

INGR1D2 has recruited a total number of 362 participants.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Risk of Cancer and Hyperplasia in Thickened Endometrium Without PMB

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

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

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

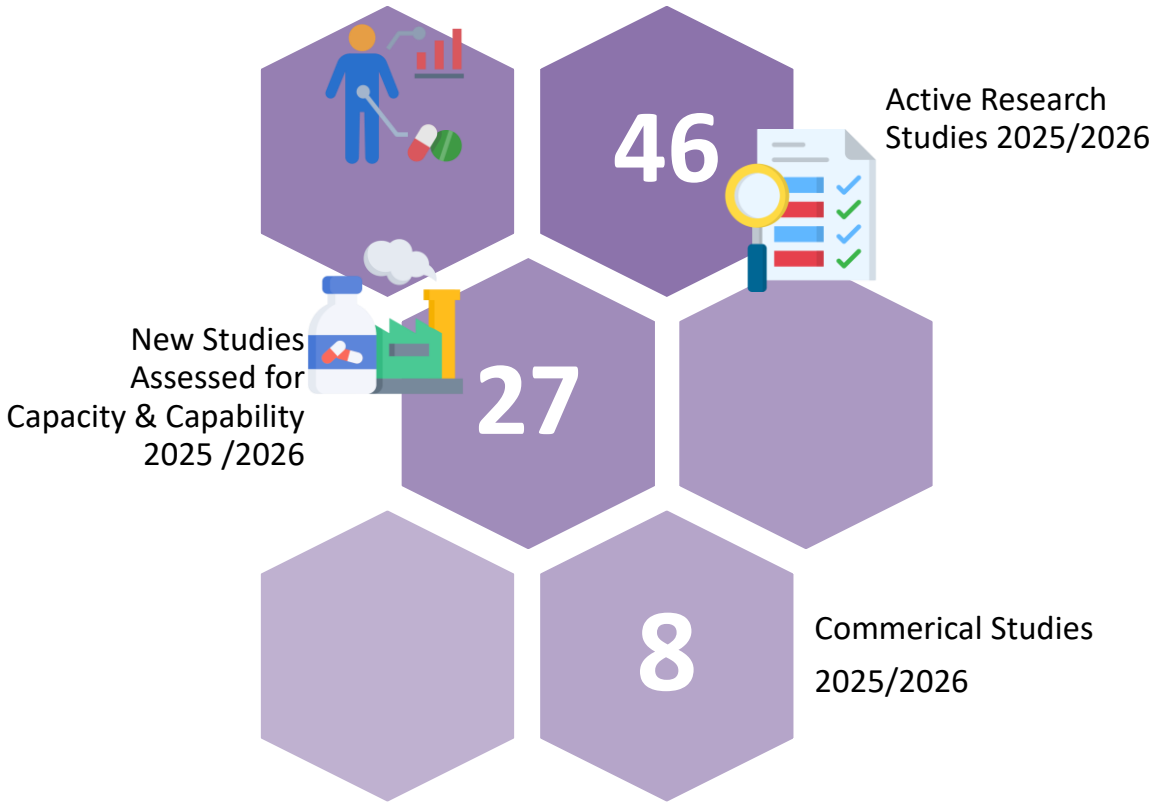
Many postmenopausal women without vaginal bleeding have internal scans for symptoms such as tummy pain or urinary problems. Some NHS hospitals offer a biopsy from the womb lining with or without a womb telescope test (hysteroscope) when the thickness is more than 4 mm while others use various thresholds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

RiCH has recruited a total number of 23 participants.

Performance

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

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



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

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

Conclusion

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

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

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

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

Registration with the Care Quality Commission (CQC)

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

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

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

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

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

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

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

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

Data Quality

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

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

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

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

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

Key

	The Trust % is equal or greater than the National % valid
	The Trust is up to 0.5% below the National % valid
	The Trust % valid is more than 0.5% below the National % valid

Information Governance Toolkit

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

Standards of Clinical Coding

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

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

Our data quality strategy is in place to support the continual improvement of data entry/quality/validity and, therefore, ensuring that Trust decision making is based on clean and accurate information. Reports are circulated to elicit action where data quality issues have been identified, and the organisation's data quality is discussed at the quarterly Digital Data & Technology Performance & Assurance Group Meeting to provide assurance over its ongoing position.

3.3 Learning from Deaths

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

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

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

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

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

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

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

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

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

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

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

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

Good Practice Identified:

Person-Centred and Inclusive Care

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

Clinical Responsiveness and Patient Safety

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

Leadership, Teamwork and Multidisciplinary Working

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

Communication and Information Sharing

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

End of Life and Palliative Care

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

Operational Effectiveness and Escalation

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

Learning Identified and actions taken:

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

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

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

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

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

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

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

2.5 Seven Day Hospital Services

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

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

2.6 Freedom to Speak Up

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

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

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

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

2.7 NHS Doctors and Dentists in training

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

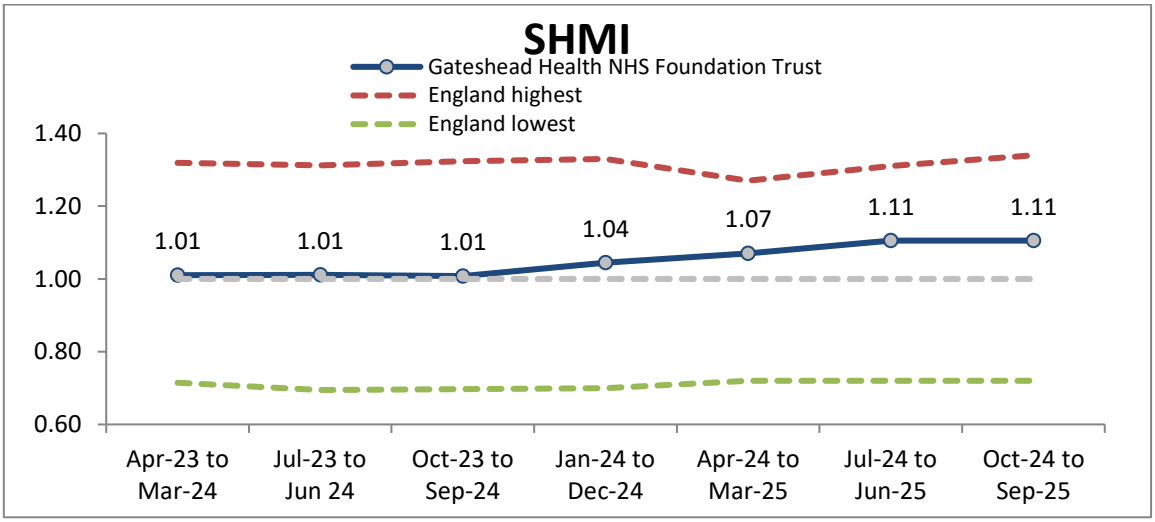
The Trust Board via the People and Organisational Development Committee receives an annual report from the Guardian of Safe Working which includes a consolidated report on rota gaps and actions taken by the Medical Workforce Group. This report is provided to the Local Negotiating Committee (LNC) by the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

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

2.8 Mandated Core Quality Indicators

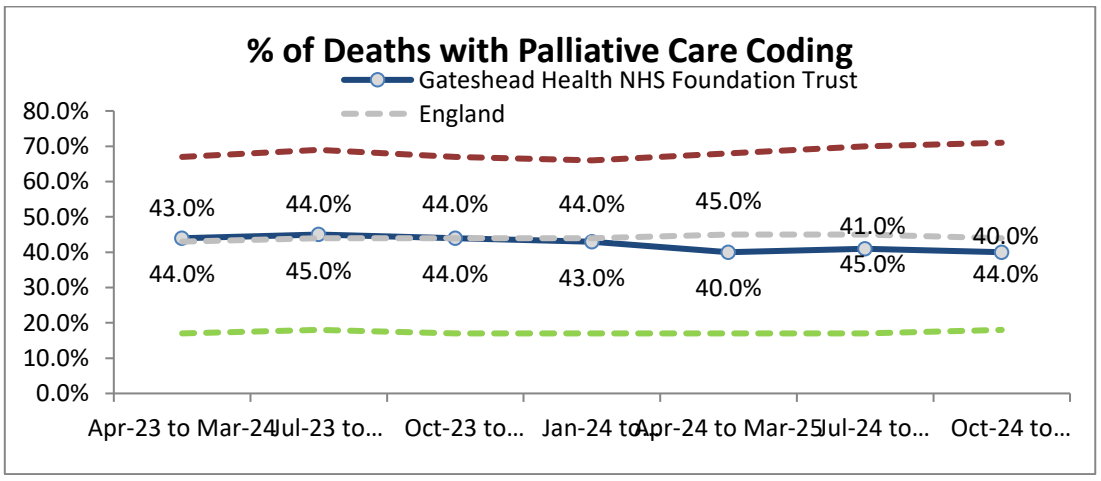
(a) SHMI (Summary Hospital-level Mortality Indicator)

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



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

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



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

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

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

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

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

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

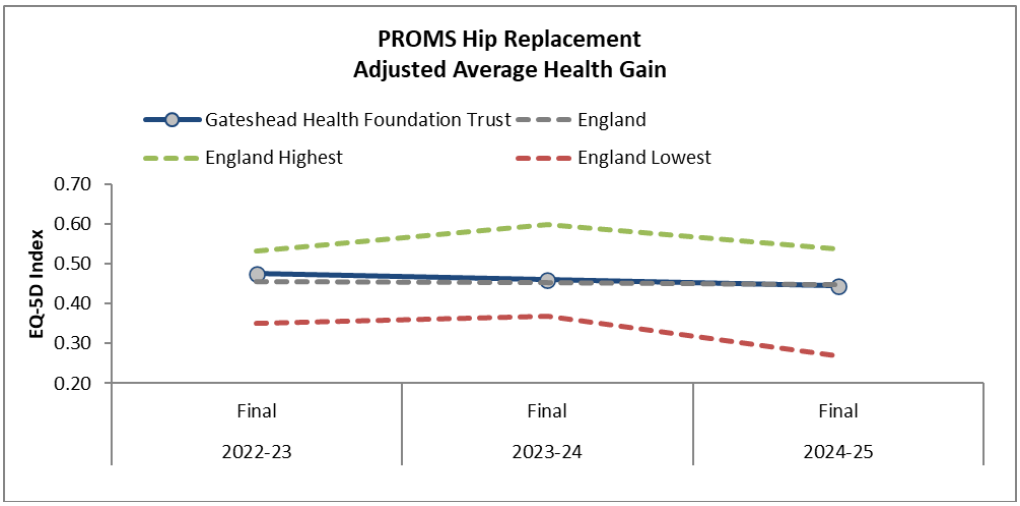
PROMs (Patient Reported Outcome Measures) for Hip Replacement and Knee Replacement:

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

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

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

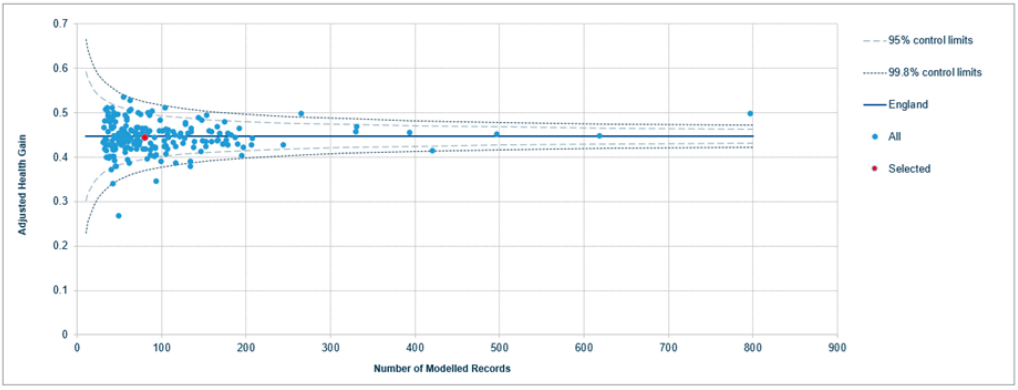
Source: https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms

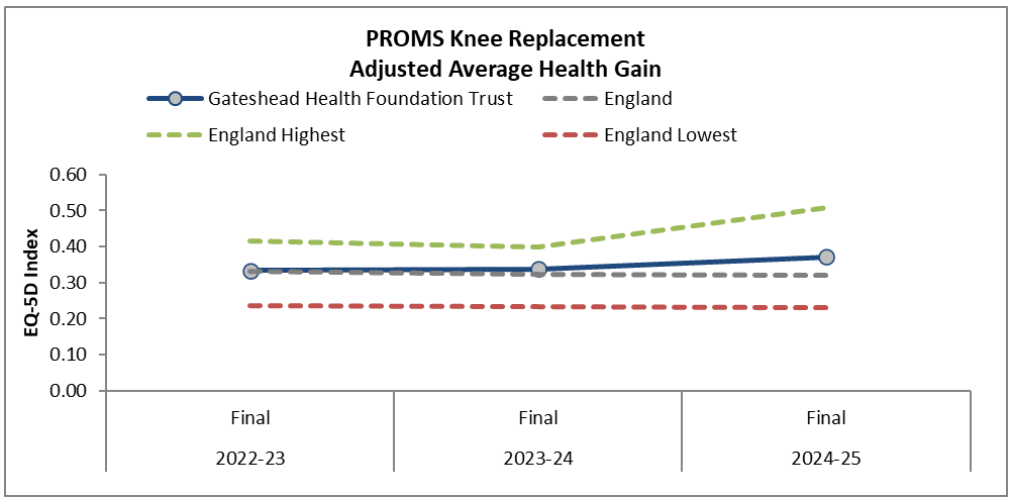


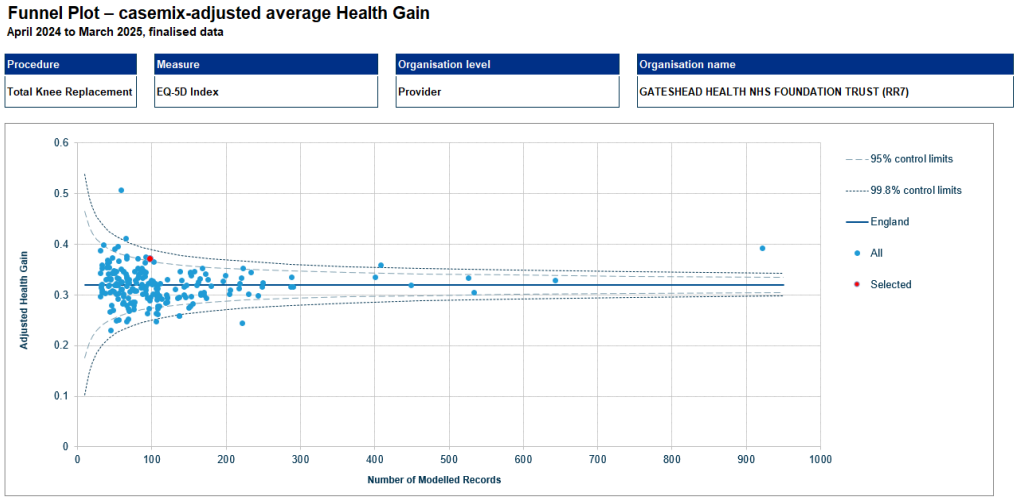
Funnel Plot – casemix-adjusted average Health Gain

April 2024 to March 2025, finalised data

Procedure	Measure	Organisation level	Organisation name
Total Hip Replacement	EQ-5D Index	Provider	GATESHEAD HEALTH NHS FOUNDATION TRUST (RR7)







Gateshead Health NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

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

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

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

Emergency Readmissions within 30 Days

- Aged 0 – 15yrs

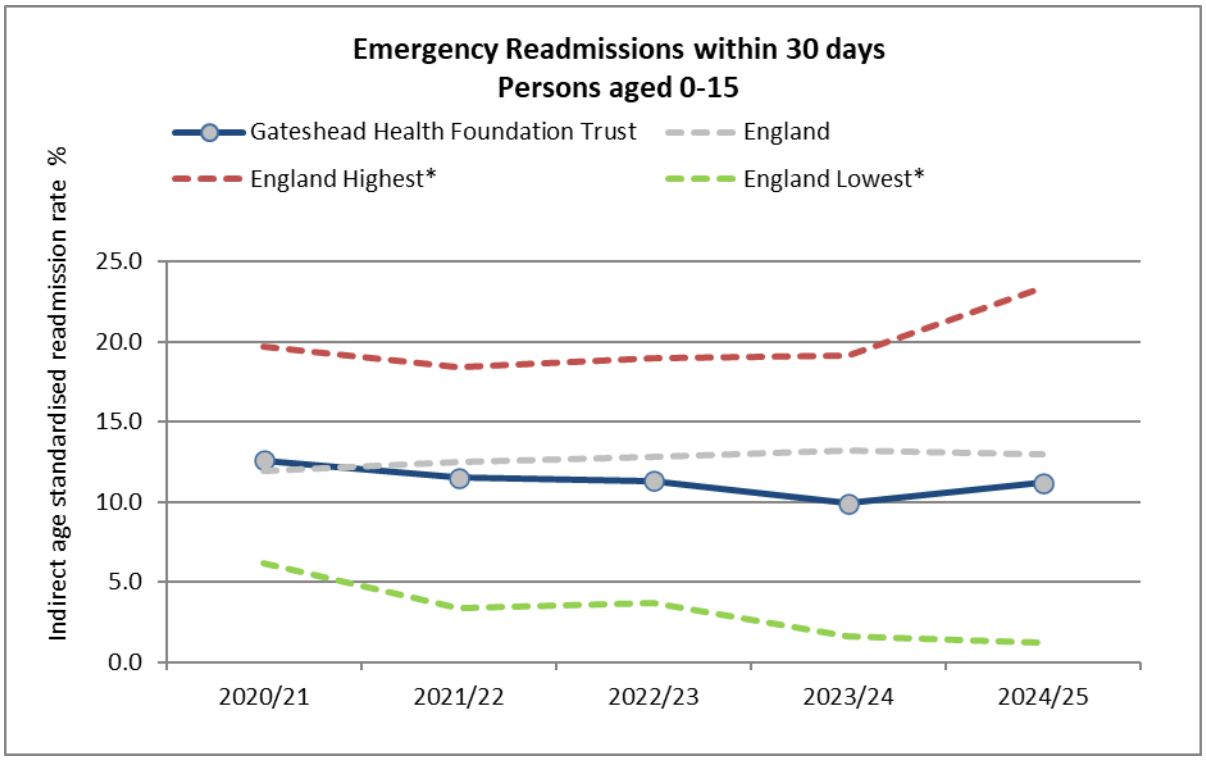
Emergency readmissions within 30 days of discharge from hospital Persons aged 0-15	2020/21	2021/22	2022/23	2023/24	2024/25
Gateshead Health Foundation Trust	12.6	11.5	11.3	9.9	11.2
Banding	W	W	W	B1	B5
England	11.9	12.5	12.8	13.2	13
England Highest*	19.7	18.4	19	19.1	23.4
England Lowest*	6.2	3.4	3.7	1.6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

W = National average lies within expected variation (95% confidence interval)

B5 = Significantly lower than the national average at the 95% level but not at the 99.8% level

B1 = Significantly lower than the national average at the 99.8% level

*Excluding caution in interpretation of data records. Numbers of patients discharged too small for meaningful comparisons (i.e. below 200).



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

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

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

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

Emergency Readmissions within 30 Days

- Aged 16 years or over

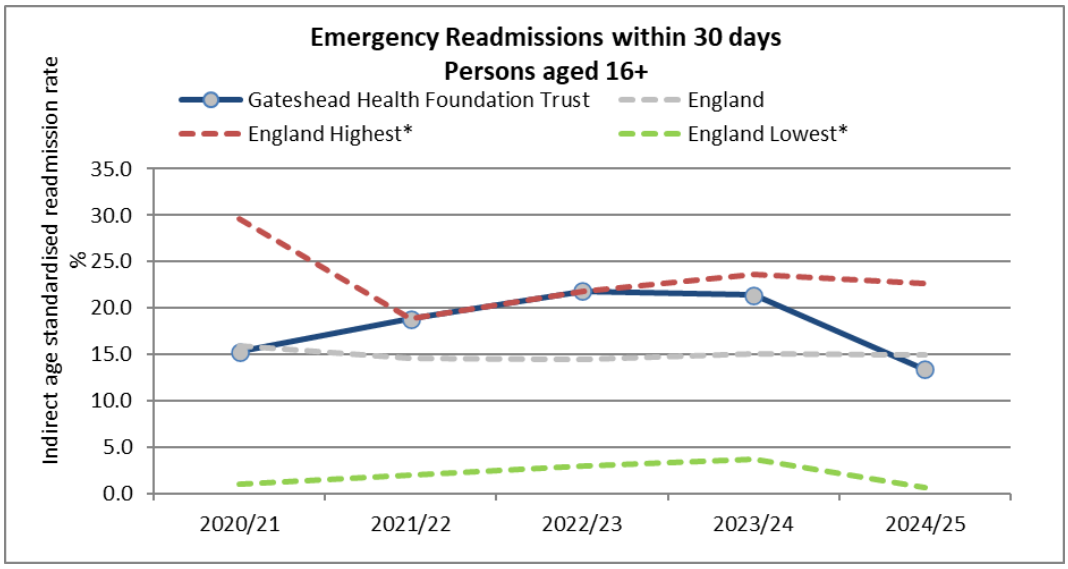
Emergency readmissions within 30 days of discharge from hospital Persons aged 16+	2020/21	2021/22	2022/23	2023/24	2024/25
Gateshead Health Foundation Trust	15.3	18.8	21.8	21.4	13.4
Banding	W	A1	A1	A1	B1
England	15.9	14.6	14.4	15.1	14.9
England Highest*	29.6	18.8	21.8	23.6	22.6
England Lowest*	1	2	3.0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

A1 = Significantly higher than the national average at the 99.8% level.

W = National average lies within expected variation (95% confidence interval)

B1 = Significantly lower than the national average at the 99.8% level

*Excluding caution in interpretation of data records. Numbers of patients discharged too small for meaningful comparisons (i.e. below 200).



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

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

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

- Local monitoring of readmissions by ward and speciality to ensure that there is oversight of outlying areas.
- Reviews of readmissions that highlight failed / inappropriate discharges to better understand where practices can be improved and help ensure lessoned are learned.

- Returned responsibility for discharge to the Clinical teams on the wards to ensure that this is overseen from a medical and nursing stance.

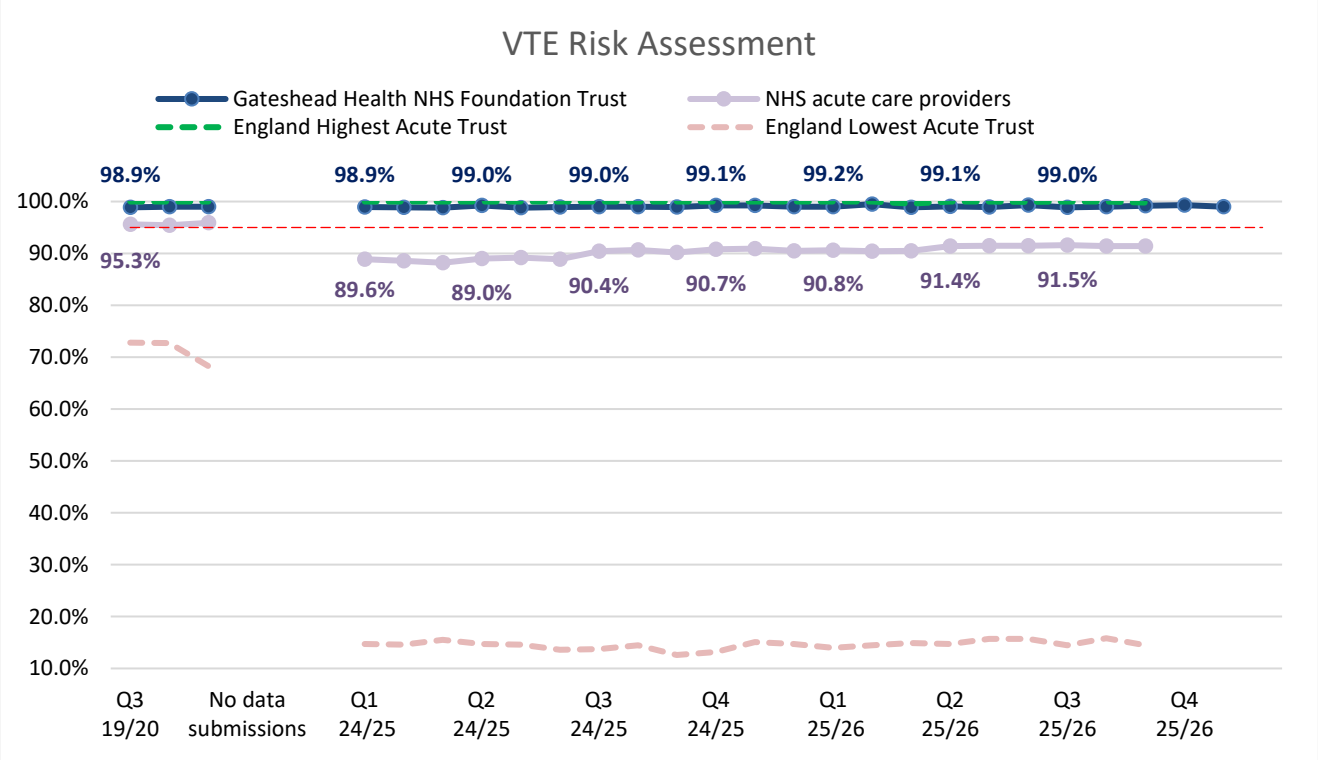
Trust's responsiveness to the personal needs of its patients

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

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

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

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



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

- Gateshead Health NHS Foundation Trust Compliance with DVT risk assessment has reached 95% in all areas of the hospital which use the JAC prescribing site and reassurance has been gained regarding a robust assessment in Critical Care which use a paper documentation.

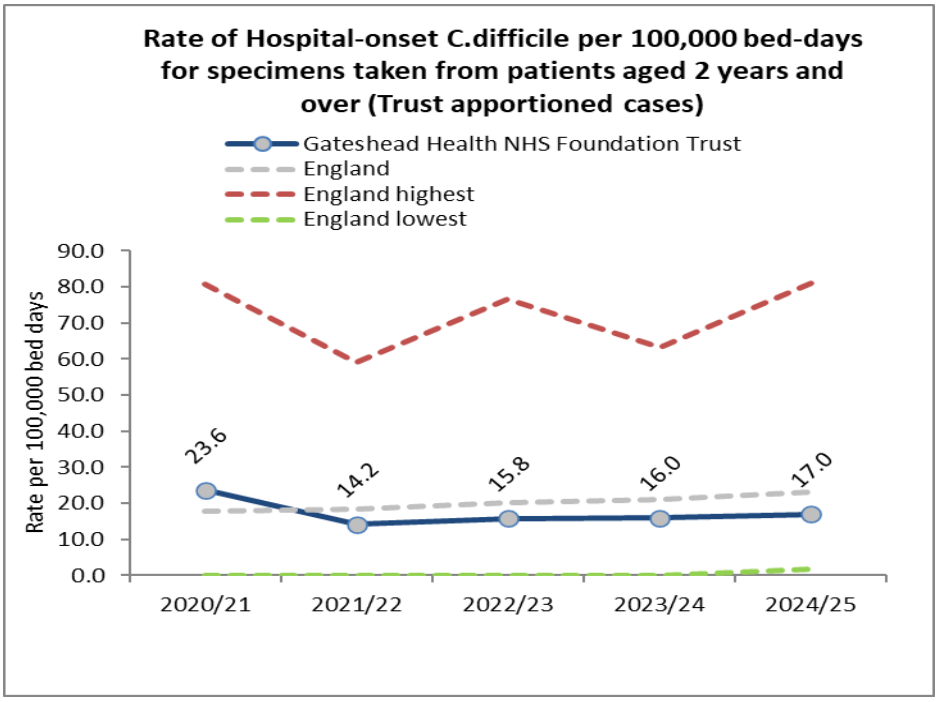
- VTE Risk assessment continued to be monitored by the Trust during the suspension of the national submission. Performance continues to exceed the 95% national objective.

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

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

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

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



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

- Clostridium difficile infection (CDI) remains an unpleasant, and potentially severe or even fatal, infection that occurs mainly in elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment. Reduction of CDI continues to present a key challenge to patient safety across the Trust, therefore ensuring preventative measures and reducing infection is very important to the high quality of patient care we deliver.
- The Trust reports Healthcare associated CDI cases to PHE via the national data capture system against the following categories:
    - Hospital onset healthcare associated (HOHA): cases that are detected in the hospital 2 or more days after admission (where day of admission is day 1)
    - Community onset healthcare associated (COHA): cases that occur in the community (or within 2 days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 4 weeks.
- Nationally the financial sanctions for CDI have been removed and the 'appeals' process no longer in use, and the expectation that organisations will perform local review of cases.
- The Trust is required under the NHS Standard Contract 2025/26 to minimise rates of Clostridium difficile (C. difficile) so that it is no higher than the threshold level set by NHS England and Improvement.
- For 2025/26 we reported forty-seven (47) cases of healthcare associated CDI against the threshold of thirty-six (36). Thirty (30) hospital onset healthcare associated, and seventeen (17) community onset healthcare associated cases.
- The Trust has reported a reduction in CDI cases of 2% for 2025/26 in spite of increased activity compared to 2024/25. The threshold for CDI's, which is calculated by Public Health England (PHE) from November to October was reduced by 2% for 2025/26 which made the threshold challenging.

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

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

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

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

Part 3

Review of Quality Performance

Review of quality performance

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

- Patient Safety
- Clinical Effectiveness
- Patient Experience

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

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

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

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

3.1 PATIENT SAFETY

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

Reducing Harm from Deterioration:

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

SHMI	1.01	1.07	1.08	<=1
SHMI Banding	As Expected	As Expected	As Expected	As expected or lower than expected
SHMI - Percentage of provider spells with palliative care coding(contextual indicator)	2.6%	2.8%	3.0%	N/A
Crude mortality rate taken from CDS	1.79%	1.77%	1.65%	<1.99%
Number of calls to the CRASH team	134	165	165	N/A
Number of calls to the CRASH team that were cardiac arrests	51	70	71	N/A
Of the calls to the arrest team what percentage were actual cardiac arrests	38.1%	42.4%	43.0%	N/A
Cardiac arrest rate (number of cardiac arrests per 1000 bed days)	0.28	0.40	0.42	N/A
Hospital Acquired Pressure Damage (grade 2 and above)	119	105	85	Year on year Reduction
Community Acquired Pressure Damage (grade 2 and above)	661	648	464	N/A
Number of Patient Slips, Trips and Falls	1344	1478	1615	N/A
Rate of Falls per 1000 bed days	7.77	8.38	**9.46**	Reduction (<8.5)
Number of Patient Slips, Trips and Falls Resulting in Harm	464	682	742	N/A
Rate of Harm Falls per 1000 bed days	2.68	3.87	**4.35**	Reduction (Less than <2.25)
Harm Falls Rate Change	23.6% Increase	44.3% Increase	12.4% Increase	N/A
Ratio of Harm to No Harm Falls (i.e. what percentage of falls resulted in Harm being caused to the patient)	34.5%	46.1%	45.9%	Year on Year reduction

Reducing Avoidable Harm:

Reducing Avoidable Harm		2023-24	2024-25	2025-26	Target
Medication Incidents	No Harm	671	583	870	N/A
	Low Harm	139	178	206	N/A
	Moderate Harm	2	9	1	<8
	Severe Harm	0	1	**1**	0
	Death	0	0	0	0
	Total	812	771	1078	N/A

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

Source: Trust incident reporting system -InPhase

Infection Prevention and Control:

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

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

Other Indicators:

Other Indicators	2023-24	2024-25	2025-26	Target
Percentage of Cancelled Operations from FFCE's†	0.29%	0.30%	0.26%	0.80%
Percentage of Patients who return to Theatre within 30 days (Unplanned / Planned / Unrelated)	4.21%	4.17%	4.35%	Improve Year on Year
Fragility Fracture Neck of Femur operated on within 48hrs of admission / diagnosis	91.9%	93.7%	90.8%	90%
Proportion of patients who are readmitted	13.57%	7.70%	7.52%	Improve year on year

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

* Figures taken from Healthcare Evaluation data (HED) and provide full financial years for 2023-24, 2024-25 and April to December 2025-26

† FFCE's refer to First Finished Consultant Episodes. A patient's treatment or care is classed as a spell of care. Within this spell can be a number of episodes. An episode refers to part of the treatment or care under a specific consultant, and should the patient be referred to another consultant, this constitutes a new episode

Linking these Patient Safety metrics to PSIRP and our future Quality Account priorities

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

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

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

Safeguarding Children and Adults

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.2 CLINICAL EFFECTIVENESS

Getting it Right First Time (GIRFT)

Three GIRFT visits took place involving the Trust within 2025/26, they are summarised below:

- **Frailty Virtual Ward Review**

The Frailty Virtual Ward Review found a well-established, consultant-led service delivering strong system integration, effective multidisciplinary collaboration, and positive patient flow outcomes. Notable strengths include close alignment across community services, the Urgent Community Response team, and the Acute Frailty Team, alongside consistent consultant geriatrician leadership with daily MDT board rounds and proactive emergency department support. The service operates a 24/7 model supporting admission avoidance and early discharge, with highly effective discharge processes achieving all patients leaving within 14 days. It also benefits from inclusive referral pathways, robust governance and continuous improvement practices, workforce development initiatives, and a strong focus on personalised, holistic care that meets diverse patient needs.

To further enhance performance and align fully with national Virtual Ward standards, several priority improvements were identified. These include extending operating hours, improving access to diagnostics and point-of-care testing, increasing digital and remote monitoring capacity, simplifying referral criteria, strengthening integration with social care, expanding clinical interventions, and continuing workforce development. Improvements in medicines management systems and data quality are also recommended. Overall, the Gateshead Virtual Ward is a high-quality, mature service with strong clinical leadership, and by addressing these areas it is well positioned to further improve patient experience, outcomes, and system efficiency.

- **Mental Health Urgent & Emergency Care (UEC MH) Further Faster Programme**

The Mental Health Urgent & Emergency Care (UEC MH) Further Faster Programme review at Queen Elizabeth Hospital (Gateshead Health NHS FT) and Cumbria, Northumberland, Tyne & Wear NHS FT identified a collaborative and steadily improving system, underpinned by strong partnership working between acute and mental health services. The programme has focused on enhancing patient flow, safety, and experience for individuals presenting to the Emergency Department in mental health crisis. Key strengths include well-established system-wide collaboration, alignment with national GIRFT clinical standards, and effective use of the 24-hour "red line" standard supported by local breach analysis. Additional good practice includes the introduction of a Mental Health Triage Tool to support structured risk assessment, robust escalation processes between ED and the Psychiatric Liaison Team, and innovative parallel working approaches that allow mental health assessments to take place alongside physical care. Further strengths include proactive demand management, workforce collaboration and shared learning, and regular multi-agency meetings to review system pressures and patient flows.

To build on these foundations and fully align with national expectations, several improvement actions were identified. These include strengthening breach analysis, reducing delays in Mental Health Act assessments, and improving management of high-risk patients awaiting admission. Opportunities also exist to enhance workforce responsiveness through shared rota models and digital booking systems, as well as to refine gatekeeping processes and the trusted assessor model. Additional priorities include improving data quality and digital connectivity, strengthening alternatives to ED—particularly NHS 111 option 2 and crisis team responsiveness—and enhancing governance, oversight, and frequent attender management. Exploration of technology and innovation, including Ambient Voice Technology, was also highlighted as a means to improve clinical productivity.

Overall, the Gateshead system demonstrates a strong foundation of collaboration and innovation, with clear opportunities to further improve patient flow, safety, and experience.

- **Urgent & Emergency Care**

The action plan highlights a series of system-wide improvements focused on reducing pressure in the Emergency Department (ED) and improving patient flow. Key priorities include introducing trust-wide Clinical Operational Standards to ensure timely specialty input and consistent decision-making, alongside developing a regional "call before convey" hub to avoid unnecessary ED attendances. The plan also emphasises reducing inappropriate hospital conveyance by using GIRFT assessment tools to expand alternatives to ED care and ensure patients are treated in the most appropriate setting.

Further actions focus on improving flow and reducing length of stay across the system, including enhancing Same Day Emergency Care (SDEC), extending senior decision-making capacity, and strengthening discharge processes such as increasing early (pre-10am) discharges and reviewing long-stay patients. The plan also highlights the need to optimise virtual ward capacity and reduce care home conveyances, alongside improving frailty pathways to minimise deconditioning and strengthen delirium management. Overall, the programme sets out a coordinated approach to improving efficiency, patient experience, and outcomes across urgent and emergency care

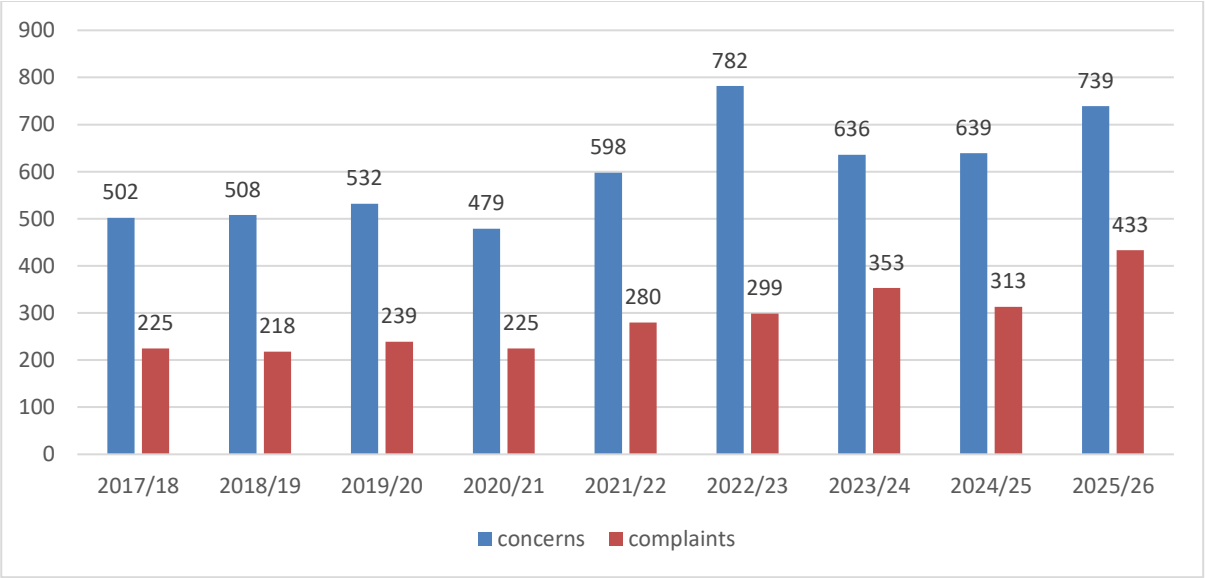
3.3 PATIENT EXPERIENCE

Listening to Concerns and Complaints, Compliments

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

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

Complaints and Concerns 2017 to 2026



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

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

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

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

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

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

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

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

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

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

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

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

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

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

- In response to a complaint regarding Maternity:

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

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

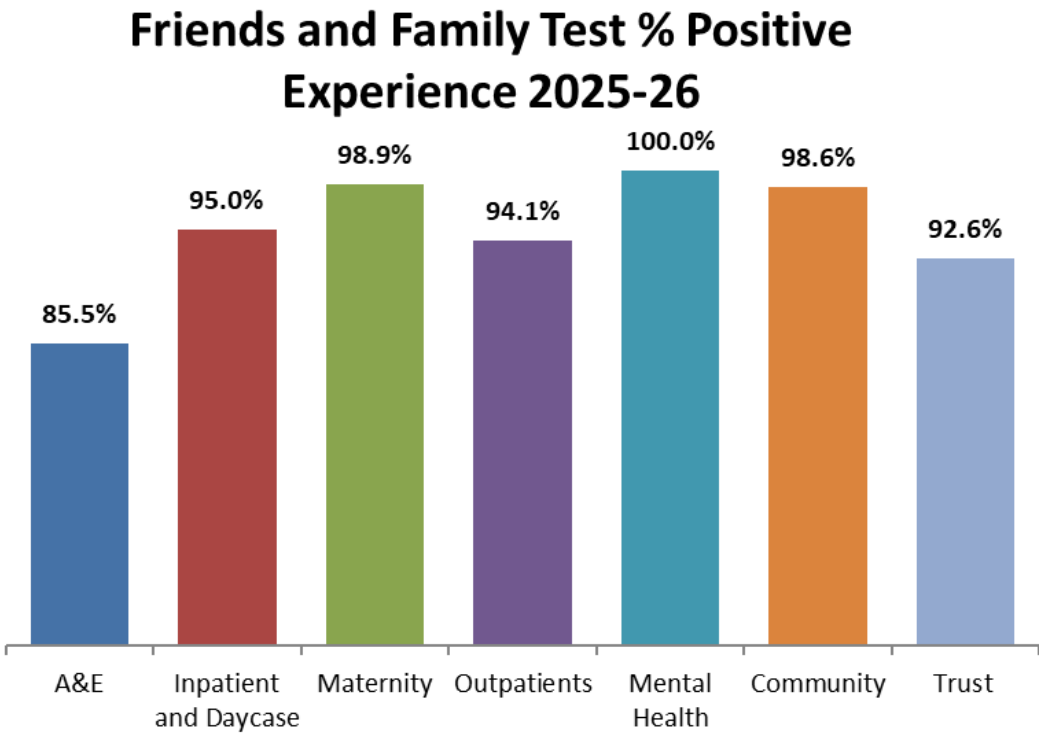
Friends & Family Test

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

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

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

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



3.4 Good News Stories

Year in Highlights

Celebrating Achievement, Innovation and Impact

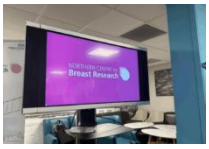
Celebrating staff achievement, recognition, and service milestones across the Trust.

🏆 Recognition & Awards




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

🚀 Innovation & Service Development


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

❤️‍🩹 Patient Experience & Quality





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

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

3.5 Focus on staff

During 2025/26, we continued to focus on strengthening how we support, develop and value our people. People & Organisational Development (OD) priorities were aligned to our strategic goal of being a great place to work, recognising that the delivery of high-quality, compassionate care is dependent on a supported, engaged and skilled workforce.

Throughout the year, emphasis was placed on establishing strong foundations for our workforce, ensuring core employment practices are effective, consistent and fair. Building on these foundations, we continue to strive to create an inclusive culture where colleagues feel valued, respected and heard.

Continued investment in training, leadership and development, supports staff to maintain and enhance the skills required to meet current and future service delivery needs, alongside leadership and management capabilities.

A range of initiatives were progressed during the year to improve the experience of working at the Trust, strengthen future workforce pipelines, and ensure that People and OD services remain responsive, sustainable and fit for the future.

Transforming how we support our workforce
A key focus during the year has been the development of a revised People & OD target operating model, which sets out how People and OD services are structured and delivered to best meet the needs of the organisation. This has focussed on value-adding, proactive, data-led approaches to workforce challenges.

We continue to work collaboratively at a regional level, and this is particularly relevant through our active participation in regional programmes to support scaling up of Recruitment and Occupational Health services. This approach supports shared learning across organisations, ensuring we can deliver services fit for the future. In addition, our Executive Director of People and OD is active at both a regional and national level, acting as Chair of the Managed Approach to Bank Services regional scaling up programme, as Vice Chair of the North East and North Yorkshire Chief People Officers' group and a member of the national Strategic CPO (Chief People Officer) Reference Group.

During 2025/26, a review of statutory and mandatory training was undertaken to ensure provision remains proportionate, risk based and aligned to national and local requirements. This work has helped to improve clarity for our people and managers, while supporting compliance and improving the efficiency of training delivery.

An increased focus on digital enablement and productivity took place within Library and Knowledge Services. Automation, data and digital solutions are now regularly used to enhance access to evidence, research and learning resources, supporting staff from day one of employment through role-based onboarding at corporate induction. Improved use of data has also enabled better insight into resource use and research activity, supporting more targeted, self-service access to knowledge across the organisation.

Supporting wellbeing, inclusion and engagement
The wellbeing of our workforce has remained a priority throughout 2025/26. A Supporting Attendance at Work Task Force was established to ensure a proactive, data-led approach to understanding and anticipating patterns in absence from work. This has enabled early,

preventative wellbeing interventions during operationally challenging periods and is now embedded as part of our approach to support staff to remain healthy at work.

We have continued to strengthen our focus on inclusion, ensuring all staff feel safe, supported and able to speak up. The Freedom to Speak Up arrangements remain a key component of this, providing confidential, independent routes for staff to raise concerns and contribute to a culture of openness and learning.

During the year, we launched a Route Map, a tool for staff and managers to use when raising concerns and providing staff with clear, accessible information and signposting on how to raise a concern either about their role, working environment, health, patient safety or the behaviours of others, with the aim of facilitating appropriate and timely resolution.

We also launched the Oliver McGowan Mandatory Training, to ensure staff have the knowledge and skills to provide safe, compassionate and informed care to people with a learning disability and autistic people. Delivery commenced in January 2026. The phased rollout prioritises staff working in higher risk roles, ensuring we continue to improve understanding, reasonable adjustments and care for patients with learning disabilities and autistic people.

Developing leaders and future workforce pipelines

Developing strong leadership capability and future workforce pipelines has continued to be a key People & OD priority. We relaunched the Leading Forward leadership programme, refreshed to reflect our future priorities and to support leaders at various stages of their development, building upon leadership and management capabilities in recognition of the important role a line manager undertakes within the organisation. We have also engaged in a Strategic Leadership Development Programme, hosted by Northumbria Healthcare, aimed at strengthening strategic leadership capability across the Alliance and enhancing system-wide collaboration.

The Practice Education team has a pivotal role in supporting the development of the future Nursing and Allied Health Professional workforce. Through strong pastoral support for students and educators, the team has contributed to improved wellbeing, confidence and retention of students, while promoting high-quality placement experiences in partnership with key stakeholders. This work supports longer term workforce sustainability through the creation of a pipeline of work ready graduates.

Celebrating our people and culture

Celebrating achievement and recognising the contribution of our people remains central to our culture. The annual Star Awards event welcomed approximately 290 attendees from a wide range of roles and services. Our approach to the awards was refreshed during the year to align closely with the strategic priorities, providing an opportunity to celebrate excellence, innovation and compassion across the organisation. Huge thanks to our partners and contacts for fully funding the event again.

3.6 National targets and regulatory requirements

The following indicators are all governed by standard national definitions

Indicator		2023/24	2024/25	Mar-26	Plan Target March 26	Constitutional standard	National Average / Benchmark
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway		68.8%	69.9%	**77.5%**	75.0%	92.0%	65.3%
A&E – maximum waiting time of four hours from arrival to admission / transfer / discharge		71.1%	71.7%	**75.1%**	80.3%	95.0%	77.1%
Cancer Faster Diagnosis Standard	Faster diagnosis standard (FDS): Maximum 28-day wait to communication of definitive cancer/not cancer diagnosis for patients referred urgently (including those with breast symptoms) and from NHS cancer screening	77.3%	80.0%	**60.8%**	84.2%	92.0%	80.5%*
	Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients	99.6%	99.4%	**97.4%**	99.5%	96.0%	93%*
	Maximum two-month (62-day) wait to first treatment from urgent GP referral (including for	66.5%	74.9%	**65.70%**	80.7%	85.0%	68.6%*

breast symptoms) and NHS cancer screening						
Maximum 6-week wait for diagnostic procedures	90.9%	85.2%	**96.4%**	99.3%	99.0%	78.8%

* February 2026 position

Annex 1: Feedback on our 2025/26 Quality Account

4.1 Gateshead Overview and Scrutiny Committee

The Trust invited commentary on this Quality Account from the relevant Health Overview and Scrutiny Committee, in line with statutory requirements. Following the local government elections in May 2026, the Committee was not in a position to consider the Quality Account within the required publication timetable. As a result, no commentary was received prior to publication.

The Trust remains committed to working closely with the Council and its scrutiny function and will continue to engage with elected members on quality and performance matters throughout 2026/27. A presentation to the Health Overview and Scrutiny Committee is planned for September 2026.

4.2 Northeast and North Cumbria Newcastle Gateshead Integrated Care Board

NHS North East and North Cumbria

Commissioner statement from NHS North East and North Cumbria Integrated Care Board for Gateshead Health NHS Foundation Trust (GHFT) Quality Account 2025/26

NHS North East and North Cumbria Integrated Care Board (NENC ICB) is committed to commissioning high quality services from GHFT. NENC ICB is responsible for ensuring that the healthcare needs of patients that they represent are safe, effective and that the experiences of patients are reflected and acted upon. The ICB welcomes the opportunity to review and provide comment on this 2025/26 Quality Account.

Overview
The ICB would like to thank GHFT for the openness and transparency reflected in this year's Quality Account. The ICB would like to commend all staff for their commitment and dedication demonstrated throughout these challenging times and for striving to ensure that patient care continues to be delivered to a high standard.

Achievements
The ICB would like to congratulate GHFT and its staff on the achievements made during this period. The ICB recognises the attainments detailed within the quality account, which include:

- The Trust has significantly reduced the number of patients waiting in ED more than 12 hours.

- Improvements in maternity and neonatal service resulting in ratings of 1st in 2024 & 2025 annual CQC Maternity Survey (Picker). The midwifery workforce is compliant with the latest Trust Birthrate+ workforce recommendations with additional administrative support in place to free up clinical time. GHFT has fully embedded the Saving Babies Lives Care Bundle, with the new Year 8 Maternity Incentive Scheme standards moving towards this as “business as usual”. The new national neonatal early warning track and trigger observation tool (NEWTT2) has been implemented into the neonatal care pathways.
- Review of staffing models in all Nursing adult in-patient areas.
- Effective digital systems which support more accurate and timely record keeping, improve communication between clinical teams, and help ensure important information is available when and where it is needed have been implemented. Daily use of digital Care plans on NerveCentre and Audit programme has been developed.
- GHFT has implemented and is delivering on a programme to help address health inequalities, including Making every contact count (MECC), health literacy and on track to launch reasonable adjustment flags.

Areas for Further Development

The ICB recognises the additional work required which has been identified within the quality account. In particular, the work to:

- reduce patients waiting 62 days for treatment on a cancer pathway. Although improvements noted in this area, performance is not expected to meet trajectories.
- implementation of a new complaints training package has been completed as well as a review of the effectiveness of a new complaints and concerns policy. This needs to be embedded to ensure consistent operational impact.
- mechanisms to listen to staff have been strengthened and used extensively, but survey results show that staff confidence, engagement and advocacy declined during 2025, indicating that further improvement is required

Future Priorities

The ICB is fully supportive of the identified Quality Priorities for 2026/27. The ICB welcomes the six priorities identified which are:

- Patient experience – strengthen patient and community engagement so that services are co designed, inclusive and responsive to the needs and experiences of the population.
- Patient safety – strengthen patient safety through data triangulation and learning so that risks are identified earlier, insights drive improvement and avoidable harm is reduced.
- Clinical effectiveness – strengthen clinical effectiveness through the use of outcomes data, evidence and research so that patient outcomes improve and unwarranted variation is reduced
- Staff experience - improve opportunities for career development so that staff have clear, equitable pathways to progress and can reach their full potential.
- Women's health – raise awareness of the importance of women’s health and make it easier for women and girls to access services.
- Timely access to care - strive to eliminate unnecessary waits, to ensure patients receive timely care and experience better outcomes.

The ICB can confirm that to the best of their ability the information provided within the

annual Quality Account is an accurate and fair reflection of GHFT performance for 2025/26. It is clearly presented in the required format, contains information that accurately represents GHFT quality profile and aspirations for the forthcoming year. NENC ICB remain committed to working in partnership with GHFT to assure the quality of commissioned services in 2026/27.

Yours sincerely,

Louise Mason-Lodge
Director of Nursing
NHS North East and North Cumbria Integrated Care Board

4.3 Gateshead Healthwatch

Gateshead Health NHS Foundation Trust
Annual Quality Account 2025/26

Thank you for sharing the draft Quality Account and for the continued hard work of your team.

Healthwatch Gateshead is pleased that Gateshead Health NHS Foundation Trust's continued commitment to improving quality, safety, and patient experience. We especially welcome your efforts to involve patients and communities more, handle complaints better, reduce waiting times and tackle, health inequalities. We value the Trust's focus on developing the Gateshead Patient Forum, improving information accessibility, and ensuring patient feedback informs service improvement and decision-making.

Healthwatch Gateshead welcomes the opportunity to comment on the Quality Account and recognises the Trust demonstrates strong governance and a clear commitment to quality improvement, with ongoing work around patient safety, staffing oversight, incident learning, discharge communication, and wider improvement programmes. We also welcome the inclusion of neurodiversity, learning disability, and mental health considerations, which align closely with Healthwatch Gateshead's priority topic in recent years.

Our Comments on Progress Made in 2025/26

- **Priority 1 – Wait times**

It is encouraging to see the progress made in cutting wait times especially by half over the winter period.

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

Strong progress has been made with maternity services, and this can be seen through its achievement in the last year. We welcome also the focus on supporting those with learning disabilities, neurodiversity and mental health. We would encourage the Trust to build on this positive work to ensure that the broader vulnerable groups they work with are also included.

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

The report highlights improvements were made in handling complaints, but response times did not improve, so there is a need for measurable change to be developed further by the Trust.

- **Priority 4 – Working with Voluntary and third sector organisations**

We are pleased to see the progress made in this priority and are grateful to be a part of these developments. Ensuring links are being strengthened with the voluntary and community sector partners is imperative as they play such a pivotal role in health and social care support at neighbourhood level in our Gateshead communities.

- **Priority 7 – Digital Developments**

The new systems developed show clear improvements in the service. It will be useful to see the outcome of the improvements in the audit.

- **Priority 8 – Addressing health inequalities**

The success of Making Every Contact Count (MECC) is a strong achievement for the Trust; this aligns greatly with some work we have conducted within Healthwatch and is a welcomed accomplishment.

Our Comments on Priorities for 2026/27

- **Priority 1 – Patient experience**

The importance of connecting organisational metrics with human experience is one of great value. Patients often judge care through communication, dignity, feeling listened to, and emotional safety, rather than through governance structures alone. We welcome your commitment to involving patients in service design and improvement plans, but wonder if we could ask for a more explicit commitment to ensuring patient and service user involvement in the development of Neighbourhood Health teams as required in the 10-year plan?

- **Priority 4 - Staff experience**

We are pleased to see a continued focus on staff training and development. However, the 2025/26 staffing priority could perhaps have been retained in part, given the reported limited impact of the actions taken and staff survey findings indicating declines in staff confidence, engagement, and advocacy during 2025.

- **Priority 5 – Women's Health**

We welcome the Trust's focus on women's health in Gateshead which helps to address and aligns with previous project work Healthwatch Gateshead assisted with around The Big Conversation and also Menopause and HRT.

- **Priority 6 – Timely Access to Care**

We were surprised that there is no explicit mention of cancer standards performance within this priority, especially as the latest performance data set states that 62-day pathway

performance is below standard (~63–70%). We would encourage a continued focus on this performance area.

In alignment with the Trust's quality priorities for 2026/2027, we would encourage continued focus on ensuring that people feel listened to when raising concerns or complaints, and that responses are timely, compassionate and lead to clear learning and improvement.

Final Comments:

We were sorry to hear that Trudie Davies, Chief Executive has departed during this Quality Account period and would like to express our sincere appreciation for the leadership, commitment and positive impact she has had, not only within your organisation but across our shared partnership. Please pass on our very best wishes to her for the future. We value the strong relationship between our organisations and look forward to welcoming in your new Chief Executive and continuing to build on our work together.

We would like to thank everyone at the Trust for their ongoing dedication to providing safe, high-quality services to our communities. We look forward to continuing our partnership with the Trust over the next year.

4.4 Council of Governors

The Council of Governors had the opportunity to contribute to the development of the Trust's Quality Account and quality priorities for 2026/27 through engagement and consultation during the year. The draft Quality Account was also shared with Governors as part of the consultation process, enabling us to review the content and provide feedback prior to finalisation.

Drawing on our knowledge of the Trust gained through attendance at Council of Governors meetings, Quality Governance Committee updates, engagement events and other opportunities throughout 2025/26, we have considered whether the Quality Account provides a fair and balanced reflection of the Trust's achievements, challenges, risks and opportunities during the year. We have also reviewed the proposed quality priorities for 2026/27 and considered whether they focus on areas that are important to patients, carers, staff and the wider communities served by Gateshead Health.

Overall, we believe the Quality Account presents a clear, balanced and informative overview of the Trust's performance during 2025/26. We welcome the honest reflection of both areas of success and those where further improvement is required. In particular, we recognise the significant progress made in maternity and neonatal services, the continued focus on reducing health inequalities, the development of digital solutions to support patient care, and improvements in urgent and emergency care performance. We also welcome the transparency shown in reporting areas where targets have not yet been fully achieved, including aspects of access to care and complaint response times.

We support the quality priorities identified for 2026/27. The focus on patient and community engagement, patient safety, clinical effectiveness, staff development, women's health and timely access to care reflects many of the themes raised by patients, staff, governors and partners throughout the year. We particularly welcome the emphasis on co-production, reducing inequalities and strengthening the use of learning and data to drive improvement.

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

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2021/22 and supporting guidance.
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2025 to March 2026
    - papers relating to quality reported to the board over the period April 2025 to March 2026
    - feedback from Northeast and North Cumbria Newcastle Gateshead Integrated Care Board dated – 27/05/2026
    - feedback from governors dated – 10/06/2026
    - feedback from local Healthwatch organisations dated – 08/06/2026
    - feedback from Overview and Scrutiny Committee dated – 18/06/2026
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 – not yet published
    - the 2025 national patient survey – March 2026
    - the 2025 national staff survey – March 2026
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated – TBC
    - CQC inspection report dated CQC Inspections and rating of specific services dated – 14/08/2019

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

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

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

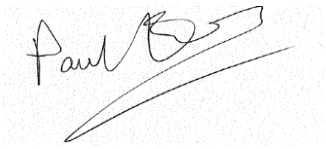
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and

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

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

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

By order of the board



24th June 2026
Date: Chairman:

24th June 2026
Date: Chief Executive:

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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