# Annual General Meeting / Annual Members Meeting

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| **Schedule** | Wednesday 30 September 2026, 9:30 — 11:00 BST |
| **Venue** | Lecture Theatre |
| **Organiser** | Diane Waites |

## Agenda

# Agenda

NHS Gateshead Health NHS Foundation Trust

# Annual General Meeting / Annual Members' Meeting

A meeting of the Annual General Meeting and Annual Members' Meeting will be held at 09:30am on Wednesday 30 September 2026, in the Lecture Theatre, Education Centre, Queen Elizabeth Hospital

## AGENDA

| No | Start time | Item | Purpose | Lead | Paper / Verbal |
|---|---|---|---|---|---|
| 1. | 09:30 | Apologies for absence | Information | Chair | Verbal |
| 2. | 09:31 | Declarations of interest | Information | Chair | Verbal |
| 3. | 09:32 | Chair's introduction and reflections | Information | Chair | Verbal |
| | | i) Minutes of the last meeting held on 24 September 2025 | Decision | Chair | Paper |
| | | ii) Our Board of Directors and Council of Governors – 2025/26 | Information | Chair | Presentation |
| ***PRESENTATION OF THE ANNUAL REPORT AND ACCOUNTS 2025/26*** | | | | | |
| 4. | 09:45 | Presentation of the Annual Report and Accounts 2025/26 | | | |
| | | i) Review of the Year | Assurance | Chief Executive | Presentation |
| | | ii) Showcase Presentation – Gateshead Women's Health Hub | Information | Director of Strategy, Planning and Partnerships / Former Strategy and Partnership Manager | Presentation |
| | | iii) Quality Accounts 2025/26 | Assurance | Chief Nurse | Presentation |
| | | iv) Financial Accounts 2025/26 and Audit Opinion | Assurance | Director of Finance | Presentation |
| | | v) Looking Ahead | Information | Chief Executive | Presentation |
| 5. | 10:30 | Questions and Answers | Discussion | Chair | Verbal |
| **ITEMS FOR INFORMATION / MEETING GOVERNANCE** | | | | | |
| 6. | 10:45 | Chair's Closing Remarks | Information | Chair | Verbal |
| 7. | 10:50 | Date and Time of Next Meeting – September 2027 – date to be communicated | Information | Chair | Verbal |
| | | | | | |

# 1. Apologies for Absence

# 2. Declarations of Interest

# 3. Chair's introduction and reflections
Presented by the Chair of the Board of Directors and Council of Governors

i - Minutes of the previous AGM held on 24 September 2025

Gateshead Health NHS Foundation Trust

# Annual General Meeting / Annual Members' Meeting

Minutes of a meeting of the Annual General Meeting / Annual Members' Meeting held at 11.00am on Wednesday 24th September 2025 in the Lecture Theatre, Education Centre, Queen Elizabeth Hospital.

| Name | Position |
|---|---|
| ***Members present*** | |
| Mrs A Marshall | Chair |
| Mr L Brown | Public Governor – Western |
| Mr S Connolly | Lead Governor/Public Governor – Central and Eastern |
| Mrs L Curry | Staff Governor |
| Mr R Dennis | Public Governor – Western |
| Professor B Hill | Appointed Governor |
| Mrs C Hindhaugh | Public Governor – Central and Eastern |
| Mr P Johnson | Public Governor – Central and Eastern |
| Mr M Loome | Deputy Lead Governor/Public Governor – Central and Eastern |
| Mrs S Sykes | Public Governor – Central and Eastern |
| Mrs K Tanriverdi | Public Governor – Central and Eastern |
| ***In Attendance*** | |
| Mr A Besford | Non-Executive Director |
| Mrs J Boyle | Company Secretary |
| Mrs N Bruce | Director of Strategy and Partnerships |
| Sir P Ennals | Incoming Chair |
| Mr G Evans | Managing Director for QE Facilities |
| Dr S Fenwick | Acting Chief Executive |
| Dr G Findley | Chief Nurse and Deputy Chief Executive |
| Mr N Halford | Medical Director of Strategic Relations |
| Mr M Hedley | Non-Executive Director |
| Dr C Howey | Group Medical Director |
| Mr R Hughes | Non-Executive Director |
| Mrs K Mackenzie | Group Director of Finance |
| Dr G Morrow | Non-Executive Director |
| Mrs H Parker | Non-Executive Director |
| Mrs M Pavlou | Vice Chair/Non-Executive Director |
| Ms D Waites | Corporate Services Assistant |
| ***Observers*** | |
| Trust members, staff and members of the public | |
| ***Apologies*** | |
| Ms H Adams | Staff Governor |
| Mr J Bedlington | Public Governor – Central and Eastern |
| Mr M Brown | Appointed Governor |
| Cllr D Burnett | Appointed Governor |
| Mr A Crampsie | Non-Executive Director |
| Mrs J Halliwell | Group Chief Operating Officer |
| Mrs H Jones | Public Governor – Central and Eastern |

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|---|---|
| Mr M Learmouth | Public Governor – Central and Eastern |
| Mrs J Perry | Appointed Governor |
| Mr A Sandler | Appointed Governor |
| Dr G F Spiers | Appointed Governor |
| Mr C Toon | Appointed Governor |
| Mrs B Webb | Public Governor – Central and Eastern |
| Mrs A Venner | Group Director of People & Organisational Development |

| Agenda Item No | | Action Owner |
|---|---|---|
| 25/09/01 | **Welcome and Chair's Business**<br><br>Mrs A Marshall, Chair, opened the Annual General Meeting by welcoming Board members, Governors, members of staff, and members of the public.<br><br>She reminded those present of the challenges faced by the Trust over the past year and felt that it was important to share some of the Trust's positive stories and innovations from our fantastic teams who have continued to work incredibly hard to look after our patients in Gateshead and beyond.<br><br>This will be Mrs Marshall's last Annual General Meeting as Chair of the Trust, and she introduced Sir Paul Ennals who will be taking over the position from 1st October 2025. Sir Paul is also the Chair for Newcastle Hospitals NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust, and he welcomed the opportunity to meet those present today and working with the Board and Governors in the future. | |
| | | |
| 25/09/02 | **Declarations of interest**<br><br>Mrs Marshall requested that members report any revisions to their declared interests or any declaration of interest in any of the items on the agenda. | |
| | | |
| 25/09/03 | **Apologies for absence:**<br><br>Apologies were received as per the attendance register. | |
| | | |
| 25/09/04 | **Minutes of the last meeting held on 25th September 2024:**<br><br>The minutes of the previous meeting held on 25th September 2024 were approved as a correct record. | |
| PRESENTATION OF THE ANNUAL REPORT AND ACCOUNTS 2023/24 | | |
| 25/09/05 | **Overview of the Year (including Council of Governors' Annual Report):** | |

| Agenda Item No | | Action Owner |
|---|---|---|
| | Dr S Fenwick, Acting Chief Executive, began his review by highlighting some of the performance metrics which demonstrates how services have been delivered to patients including laboratory testing and community visits. He also provided some details around the outcome of the Staff Survey in which 77% believe that patient care is the organisation's top priority and highlights the continued commitment from staff around patient centred care.<br><br>Dr Fenwick drew attention to some excellent service developments and improvements during the year which included our diabetes team being recognised for their commitment to digital inclusion by winning an award at the Health Service Journal Awards 2024 for the project which uses mobile phones and laptops donated by the Trust to support families to access new technologies for diabetes care. Collaboration and partnership work continues with the Great North Healthcare Alliance, and this will be further emphasised by Sir Paul in his position of Chair across Gateshead, Newcastle and Northumbria. Dr Fenwick will also now be taking over as Chair of the Gateshead Place Committee which is focussed on improving health access and outcomes for women and girls and reducing inequalities. | |
| | | |
| 25/09/06 | **Quality Report 2024/25:**<br><br>Dr G Findley, Chief Nurse and Deputy Chief Executive, introduced the Trust's Quality Report for 2024/25 and highlighted the work undertaken across the Trust in relation to the quality account priorities around patient experience, patient safety, and clinical effectiveness which demonstrates the work and commitment of staff and teams in their achievements.<br><br>She drew attention to the Trust's clinical audit participation and quality metrics and highlighted that the Trust has actively participated in 38 National Clinical Audits and 5 National Confidential Enquiries, which demonstrates a strong commitment to clinical governance and quality improvement. The Trust maintained high data quality standards and reflected the Trust's dedication to evidence-based practice, continuous learning and transparency in healthcare delivery.<br><br>Dr Findley introduced the quality priorities for improvement for 2025/26 which have been developed in consultation with key stakeholders including the Trust Governors. Priorities include plans to implement the Maternity and Neonatal Delivery Plan which focuses on safety, personalisation, workforce development and standards compliance and this will be supported by Dr Gerry Morrow as Non-Executive Director Maternity Safety Champion. Dr Findley also highlighted that patient experience improvements include timely complaint responses which will be managed by Dr Sean Fenwick, Acting Chief Executive, and supports patient feedback. | |

| Agenda Item No | | Action Owner |
|---|---|---|
| | The new priorities also include an underpinning priority for all domains and across the Alliance to develop and implement a systematic way to learn and improve from feedback. | |
| | | |
| 25/09/07 | **Financial Accounts 2024/25 and Audit Opinion:**<br><br>Mrs K Mackenzie, Group Director of Finance, presented an overview of the Trust's financial performance for 2024/25.<br><br>Mrs Mackenzie reported that the Group's outturn position for 2024/25 was a Group deficit of £2.6m compared to £8.8m in the previous year. She highlighted that total expenditure for the year was £441m however 66% of this relates to pay. The Group's capital expenditure was £17.430m which includes the Community Diagnostic Centre<br><br>Discussion took place around the work of the External Auditors, Mazars, and Mrs Mackenzie highlighted that the Trust received an unqualified audit opinion for the financial statements which confirms a true and fair view of the financial position of the Trust. On this occasion, a significant weakness in financial sustainability was identified which relates to the Trust's underlying deficit and reliance on non-recurrent income but Mrs Mackenzie explained that teams are working hard to address this and an increase in recurrent cost savings has been noted. | |
| | | |
| 25/09/08 | **Constitutional Amendment:**<br><br>Mr S Connolly, Lead Governor, reported that two constitutional amendments were approved by the Board and Council of Governors in the last 12 months in relation to the merger of Central and Eastern Gateshead constituencies and to replace the appointed Governor seat for Gateshead Diversity Forum with Gateshead Healthwatch. These changes have been enacted and the Council welcomed Mr Michael Brown to represent Gateshead Healthwatch.<br><br>Mr Connolly explained that any constitutional changes that impact on Governors are also required to be approved at the Annual Members Meeting and were therefore formally approved by the members present. | |
| | | |
| 24/09/09 | **Looking Ahead:**<br><br>Dr S Fenwick, Acting Chief Executive, provided an overview of future plans and shared a video to promote the official launch of the Trust's Corporate Strategy for 2025-2030.<br><br>Dr Fenwick highlighted that the strategy sets out a clear and ambitious vision for the future of healthcare in Gateshead. It is well aligned with | |

| Agenda Item No | | Action Owner |
|---|---|---|
| | national priorities and ambitions set out in the NHS 10 Year Plan and was developed with significant internal and external engagement with stakeholders. The Corporate Strategy sets out the framework for our continued success against four focus areas: excellent patient care, a great place to work, working together for healthier communities and being fit for the future. | |
| | | |
| 25/09/10 | **Questions and Answers:**<br><br>Mr P Johnson, Public Governor, queried whether feedback was given to staff in relation to Freedom to Speak Up (FTSU) cases and Dr G Findley, Chief Nurse and Deputy Chief Executive, explained that this is a confidential service however processes are in place which is overseen by a Non-Executive Director FTSU Champion. The Board receives an update on themes and trends, and this is also shared within the SafeCare Divisional meetings. | |
| | | |
| 25/09/11 | **Chair's Closing Remarks:**<br><br>Mrs Marshall closed the meeting by thanking those in attendance and formally thanking the work and efforts undertaken by staff, colleagues, Governors, volunteers, patients and local communities which continues to demonstrate the outstanding contributions across the organisation.<br><br>Mr S Connolly, Lead Governor, thanked Mrs Marshall, on behalf of the Council, for her outstanding leadership and commitment to the Trust and wished her well for the future. | |
| | | |
| 25/09/12 | **Date and Time of Next Meeting:**<br><br>The next meeting of the Annual General Meeting and Annual Members Meeting will be held on Wednesday 30th September 2026. | |
| | | |

# ii - Our Board of Directors and Council of Governors 2025/26

# 4. Presentation of the Annual Report and Accounts 2025/26


# Gateshead Health NHS Foundation Trust

# Annual Report and Accounts 2025/26

# Gateshead Health NHS Foundation Trust

# Annual Report and Accounts 2025/26

## Presented to Parliament pursuant to Schedule 7, paragraph 25(4)(a) of the National Health Service Act 2006

# Gateshead Health NHS Foundation Trust

# Annual Report and Accounts 2025/26

# (for the period 1 April 2025 to 31 March 2026)

## Contents

# Performance Report

## Overview of performance

### Chair and Chief Executive's statement

We are pleased to introduce our Annual Report and Accounts for the year ended 31 March 2026.

During 2025/26 we launched our new five-year corporate strategy, setting out a clear ambition to be recognised as a provider of safe, high-quality integrated health services, a leader in diagnostic services and a centre of excellence for women's health. This strategy, developed through extensive engagement with our people, patients, Governors and partners, has shaped our priorities and direction of travel throughout the year.

#### *Our performance*

The year has been characterised by sustained operational pressure across the NHS. Despite this, our teams have remained focused on recovering services, improving productivity and delivering high-quality care for our patients.

We have made progress against a number of key performance areas, including increasing our patient activity across elective, outpatient and diagnostic services.

In urgent and emergency care, we have improved patient flow and reduced delays for our patients through a range of initiatives, including enhanced front-door streaming and expanded Same Day Emergency Care capacity. Performance against the four-hour standard remains challenging, particularly during periods of high demand, and continues to be a key priority for the organisation.

In elective care, we have increased activity and reduced the overall size of the waiting list, although we strive to reduce our wait times further and this will continue to be a key focus for the year ahead.

Financially, we delivered a deficit position in line with our approved plan, maintaining strong financial control while continuing to invest in key clinical priorities and service developments.

#### *Service developments and achievements*

We have continued to make significant investment in our services and infrastructure to improve patient care and experience.

This includes the redevelopment of facilities for women and children, including a new paediatrics department and the Northern Gynaecological Oncology Centre, which provides a high-quality environment designed to enhance privacy, dignity and patient experience.

We marked one year since the opening of the Community Diagnostic Centre at the Metro Centre, which is improving access to tests, supporting earlier diagnosis and helping to reduce waiting times. Funding secured during the year will enable further expansion as part of phase two, increasing capacity and supporting system-wide recovery.

Our maternity services have again performed strongly, achieving high levels of patient satisfaction in national surveys, reflecting the commitment and professionalism of our teams.

In addition, we are proud to have seen national recognition for our clinical services, including an award-winning Secondary Prevention Service and innovations such as our breast care support resources for families.

### *Our people*

Our people remain at the heart of everything we do, showing strong commitment, compassion and professionalism throughout the year.

We have strengthened our focus on staff wellbeing, inclusion and cultural development, recognising the importance of creating a positive and supportive working environment. Initiatives such as civility training, strengthened Freedom to Speak Up arrangements and enhanced wellbeing support demonstrate our ongoing commitment to our workforce.

Listening to our people is important to us and we have committed to learning from our staff survey results and working with colleagues to make improvements and enhancements throughout the coming year.

We continued to invest in leadership development and workforce pipelines to ensure we are well placed to meet future challenges.

### *Partnership working and collaboration*

Collaboration remains central to our approach, particularly through the Great North Healthcare Alliance and our work at Place within Gateshead and across the Integrated Care System.

During 2025/26 we have seen increasing tangible benefits from partnership working, including improvements in clinical pathways, expanded diagnostic capacity and the development of shared workforce and service models.

The establishment of a shared Chair model and strengthened governance arrangements across partner organisations has further enhanced alignment and collective decision-making.

We have also continued to play a key role as an anchor institution, supporting local communities through employment, partnerships and targeted work to address health inequalities.

### *Looking ahead*

As we move into 2026/27, the pressures facing the NHS remain significant. Financial sustainability, improving productivity and recovering performance against national standards will continue to be our key priorities.

We will focus on delivering the ambitions set out in our new corporate and clinical strategies, including further development of women’s health services, expansion of diagnostic capacity and strengthening neighbourhood-based care.

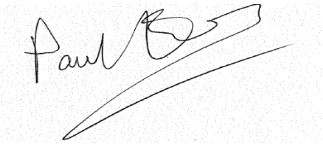
Addressing our principal risks — including financial sustainability, estates and digital capability — will remain a central part of our work.

Collaboration across the Alliance and wider system will be critical, as we continue to deliver integrated, patient-centred care and respond collectively to the challenges facing the NHS.

*Our thanks*

On behalf of the Board, we would like to record our sincere thanks to all colleagues, volunteers and Governors for their continued dedication, resilience and commitment throughout the year.

Their efforts ensure that we continue to deliver safe, high-quality care and make a positive difference to the communities we serve.



Sean Fenwick
Chief Executive
24 June 2026

Sir Paul Ennals
Chair
24 June 2026

## About us – our history, purpose and services

Established in 2005, Gateshead Health NHS Foundation Trust (the Trust) was among the first Foundation Trusts in the country. We have consistently delivered the highest standards of care for our patients over the past 20 years.

An integrated community provider, we provide a range of acute and community services to the population of Gateshead along with a number of specialist services to a wider population.

We deliver a wide range of screening services supported by our regional laboratory services.

Our main sites include Queen Elizabeth Hospital, Bensham Hospital, Metrocentre Community Diagnostic Centre (CDC) and Blaydon Primary Care Centre, alongside a number of smaller community sites across Gateshead.

Our wholly-owned subsidiary QE Facilities was formed in 2014. QE Facilities provides a diverse offering including estates and facilities services, financial advisory, pharmacy, and logistics services across the region and beyond.

We are one of four trusts which form the Great North Healthcare Alliance, a collaborative working arrangement which aims to leverage the best of each organisation to work together to deliver high quality, safe and reliable care for our population. Since January 2024 Gateshead Health, The Newcastle-upon-Tyne Hospitals NHS Foundation Trust, Northumbria Healthcare NHS Foundation Trust and North Cumbria Integrated Care NHS Foundation Trust have worked together in the Alliance.

In September 2025 we launched our new 5 year corporate strategy 2025 – 2030, which aligns with the NHS 10 Year Plan. The strategy was informed by extensive engagement with a broad range of stakeholders, including our people, Governors, patients and partners. The strategy sets out our purpose and vision for the future:

**Our purpose is to deliver excellent healthcare and play our part in improving population health by being a good partner and a great employer**

**Our vision is to be recognised as a provider of safe, high-quality integrated health services, diagnostics, and a centre of excellence for women's health**

Our values are the golden thread that runs through everything we do. Following a Trust-wide consultation with our people, they remain unchanged with feedback illustrating that our values continued to resonate across the organisation.

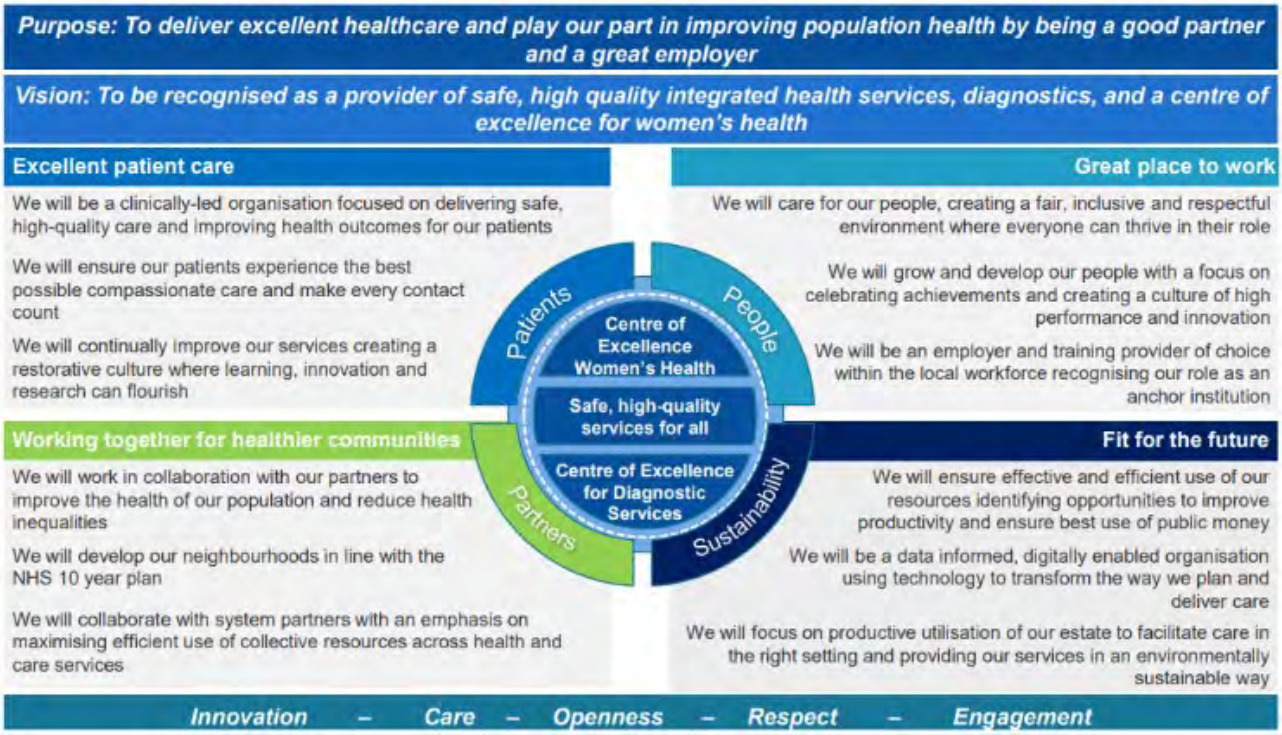

## About us – our strategic objectives and risks

Our corporate strategy outlines four strategic priorities with underpinning five year objectives / goals to support delivery.


In addition there are three areas of strategic intent with which the priorities and objectives align:

| | |
|---|---|
| To be a Centre of Excellence for Women's Health | Ensuring that women across Gateshead have access to personalised, evidence-based care throughout every stage of life. This reflects our ambition to close gaps in access, outcomes, and experience for women, with services designed to be inclusive, responsive, and delivered with compassion |
| To deliver safe, high-quality services for all | Delivering joined-up, patient-centred care. By working across teams and with our partners, we aim to provide seamless pathways that support people with complex needs, improve outcomes, and ensure care is delivered in the right place, at the right time |
| To be a Centre of Excellence for Diagnostic Services | •Providing safe, timely, and effective care across the organisation. By combining clinical expertise with the latest diagnostic technologies, we are improving accuracy, speeding up access to treatment, and providing a strong foundation for better patient outcomes |

The strategy is summarised in the following diagram:




We actively utilised our risk management framework and systems to proactively manage the principal risks faced during the year. Strategic and organisational-wide risks were recognised on the Organisational Risk Register (ORR), with cross-linkage to the Board Assurance Framework (BAF) to understand the potential impact of risks on the delivery of the strategic objectives.

The Executive Risk Management Group identified the top 3 / 4 organisational risks each month following review of the ORR. The top 3 / 4 risks were shared at each meeting of the Board, the Council of Governors and the Tier 1 Board committees to inform their work and strategic discussions. From Quarter 4 onwards the top risks were identified on a composite / thematic basis, recognising that there may be multiple risks with a linked subject matter recorded on the ORR.

At the year-end the top three risks were as follows:

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

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

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

Whilst mitigating actions were taken over the year these risks are by their nature long term risks and will remain top risks for the Trust into 2026/27.

Both the ORR and BAF were regularly reviewed and monitored by the Board and its committees throughout the year. This assisted in monitoring the effectiveness of mitigations and enabled additional actions to be taken to manage risks where required.

Further information on the principal risks and mitigations can be found in the Annual Governance Statement section of the Annual Report.

Despite the challenging operating environment and the identified risks, positive progress was made in delivering against the new 5 year objectives following the formal approval of the strategy in September 2025. Key achievements are outlined within this report, but include the opening of our new Northern Gynaecology and Oncology Centre and paediatrics department, as well as the establishment of the Northern Centre for Breast Research. We have worked with our partners at place and in the community to start to develop our approach to neighbourhood working, and this will continue into 2026/27.

Given that the new strategic objectives only commenced from September 2025, the following table demonstrates performance against the previous objectives using the metrics and indicators agreed by the Board:

| Objective 1: We will continuously improve the quality & safety of our services for our patients: | | | | |
|---|---|---|---|---|
| **Key Indicators:** | **Target** | **Start** | **End** | **Trend** |
| Achieve compliance with Ockenden recommendations | 100% | 100% | 100% | Same |
| Achieve compliance with Maternity Incentive Scheme | 100% | 100% | 100% | Same |
| Reduction in patient safety incidents linked to estate issues | <=4 | 9 | 4 | Improved |
| Compliance with Quality Improvement Plans | 100% | 76% | 84% | Improved |
| **Breakthrough Objectives:** | **Target** | **Start** | **End** | **Trend** |
| Risk score reduction linked to estates issues | - | 244 | 205 | Improved |
| Harm Rates from falls | <=3.20 | 3.5 | 4.6 | Deteriorated |
| C.Difficile per 100k bed days | <=3.2 | 28.7 | 34.9 | Deteriorated |
| Mental Health Act Training | 90.0% | 86.0% | 91.0% | Improved |
| Learning Disability & Autism Training | 85.0% | 68.3% | 87.2% | Improved |

| Objective 2: We will be a great organisation with a highly engaged workforce: | | | | |
|---|---|---|---|---|
| **Key Indicators:** | **Target** | **Start** | **End** | **Trend** |
| Maintain the vacancy rate at <=2.5% | <=2.5% | 3.2% | 7.2% | Deteriorated |
| Improve staff engagement score | >=7.3 | 6.17 | 5.88 | Deteriorated |
| **Breakthrough Objectives:** | **Target** | **Start** | **End** | **Trend** |
| Workforce Turnover | <=9.7% | 11.8% | 12.2% | Deteriorated |
| Sickness Absence Rates | 4.9% | 5.7% | 5.5% | Improved |
| Temporary Staffing Spend as % of pay bill | <=2.3% | 0.4% | 0.6% | Deteriorated |

| Objective 3: We will enhance our productivity and efficiency to make the best use of our resources: | | | | |
|---|---|---|---|---|
| **Key Indicators:** | **Target** | **Start** | **End** | **Trend** |
| Reduce the Average Length of Stay | <4 days | 8.7 | 8.25 | Improved |
| 4-Hr ED | >=78% | 72.5% | 75.1% | Improved |
| Achieve Zero 52 week waiters at year end | 0 | 16 | 17 | Deteriorated |
| Achieve the 2024/25 Financial Plan | - | 0.272 | -0.057 | Achieved |
| Out-turn deficit | - | 8,381 | 5,048 | Achieved |
| **Breakthrough Objectives:** | **Target** | **Start** | **End** | **Trend** |
| Reduce >12-hr in ED Dept. | 2% | 0.9% | 5.1% | Deteriorated |
| Reduce the no.of patients with no criteria to reside | <10 | 43 | 54 | Deteriorated |
| 1-hour to a Bed for NEL Admissions | 60% | 6.4% | 8.7% | Improved |
| Outpatients with Procedures | >=33% | 67.5% | 64.0% | Deteriorated |
| CRP | - | 517 | 0 | Achieved |
| Cash forecast | >£5m | £32m | £30m | Achieved |

| Objective 4: We will be an effective partner and be ambitious in our commitment to improving | | | | |
|---|---|---|---|---|
| **Key Indicators:** | **Target** | **Start** | **End** | **Trend** |
| **Breakthrough Objectives:** | **Target** | **Start** | **End** | **Trend** |
| Reduction in Gynaecology Outpatient Waits | <26 wks | 28.9 | 27 | Improved |
| Reduction in paediatric autism assessment | <30 wks | 61 | 40 | Improved |
| Recording of smoking status | >=98% | 90.6% | 89.7% | Deteriorated |
| Repurposing of digital devices | >300 | 0 | 0 | Same |

| Objective 5: We will develop and expand our services within and beyond Gateshead | | | | |
|---|---|---|---|---|
| **Key Indicators:** | **Target** | **Start** | **End** | **Trend** |
| 0.5% increase in QEF externally generated income | >=0.5% | 0.00% | 13% | Improved |
| **Breakthrough Objectives:** | **Target** | **Start** | **End** | **Trend** |

## Going concern

As an NHS Foundation Trust, the Directors are required to make an assessment as at the balance sheet date as to whether the Trust remains a going concern.

In summary following our assessment, these accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The Directors have a reasonable expectation that this will continue to be the case. In summary following our assessment, these accounts have been prepared on a going concern basis, in accordance with the definition as set out in section 4 of the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) which outlines the interpretation of International Accounting Standard 1 (IAS1) 'Presentation of Financial Statements' as *"the anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents".*

The Directors have considered whether there are any local or national policy decisions that are likely to affect the continued funding and provision of services by the Trust. The Trust is a member of the North East and North Cumbria Integrated Care System (NENC ICS). The Integrated Care Strategy for the North East and North Cumbria was published in December 2022 as a joint plan between the region's local authorities, the NHS and other partners. No circumstances were identified within the strategy that would cause the Directors to doubt or question the continued provision of NHS services by the Trust.

This year the Trust excluding the charity returned a deficit of £12.999m as reported in the Trust's Statement of Comprehensive Income.

2025/26 sees a continuation of the previous year's financial framework. This is a blended tariff approach which consists of fixed and variable payments, with most services being on a fixed payment. For those services on a variable tariff income will be earned based on volume of activity at national tariff and is consistent with the historic PbR (payment by results) funding model. The Trust has planned to achieve variable income based on a volume of activity aligned to published activity trajectories. We recognise achievement of activity trajectories and consequently planned income targets is potentially uncertain but as it amounts to 12% of total income to the Trust, we regard this as immaterial to the Going Concern assessment.

The Trust has produced its financial plans based on these assumptions which have been approved by the Trust Board.

The Trust has prepared a cash forecast modelled on the 2025-26 financial plan assumptions for funding during the going concern period to June 27. The cash forecast for the Trust confirms the Trust will require access to revenue cash support during this period.

In conclusion, these factors, and the anticipated future provision of services in the public sector, support the Trust's adoption of the going concern basis for the preparation of the accounts.

# Performance analysis

## Operational Performance

In 2025/26 we placed emphasis on recovering core services, improving performance and productivity to provide the highest possible care for patients, whilst continuing with all elements of our People Promise to improve working lives of our people.

### *Performance Management – Structure and Tools*

National priorities for NHS provider organisations were set out in the 2025/26 Operational Planning Guidance aligned to:

- Reducing the time people wait for elective care;
- Improving Accident and Emergency (A&E) waiting times and ambulance response times;
- Improving patients' access to general practice and improve access to urgent dental care;
- Improving patient flow through mental health crisis and acute pathways and improve access to children and young people's (CYP) mental health services;
- Driving the reform that will support delivery of our immediate priorities and ensure the NHS is fit for the future;
- Living within the budget allocated, reducing waste and improving productivity; maintaining our collective focus on the overall quality and safety of our services.

Progress against all objectives has been monitored by Tier 1 Board-level committees with weekly stringent performance monitoring and review processes in place to support our clinical and operational teams in recovery challenges, providing regular feedback through our governance structures to manage risk and uncertainty.

Some key statistics from the year are outlined below, which show both the context and the scale of the work our people during 2025/26:

*Operational performance*

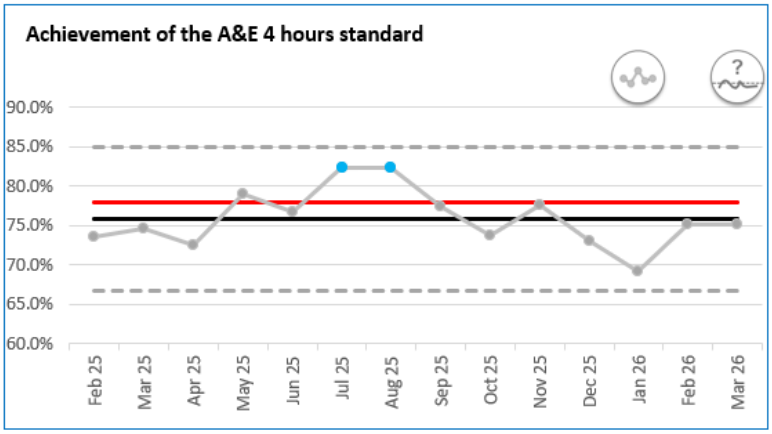
The table below details our key performance areas measured against the constitutional standards and our planning objectives as set out in the NHS planning guidance for 2025/26.

We have made positive strides against many of the key operational standards set out in the planning guidance although recognise that returning to constitutional standards remains challenging in some areas and is the focus for the coming year.

| Performance summary for 2025/26: Measured against Constitutional standards and Planning objectives | | | | | | |
|---|---|---|---|---|---|---|
| **Urgent and emergency care indicator** | | **Constitutional standard** | **Planning objective 25/26** | **2024/25** | **2025/26** | **Position** |
| A&E – maximum waiting time of four hours from arrival to admission / transfer / discharge | | 95% | 78.0% | 71.70% | 76.2% | Not achieved |
| 12 hours in department (Type 1) | | N/A | 2.0% | N/A | 2.5% | Not achieved |
| Ambulance handover & turnaround times within 15 | | N/A | <15 mins | 13 min 54 s | 14 min 13 s | Achieved |
| Ambulance handover within 45 minutes | | N/A | Zero | N/A | 91 | Not achieved |
| **Elective care indicator** | | **Constitutional standard** | **Planning objective 25/26** | **2024/25** | **2025/26** | **Position** |
| Maximum time of 18 weeks from point of referral to | | 92% | 75% | 69.9% | 77.5%* | Achieved |
| RTT: Eliminate long waits > 52 weeks | | Zero | Zero | Zero | 17* | Not achieved |
| Cancer | 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 | 92% | 80% | 80% | 60.4%* | Not achieved |
| | Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients | 96% | 96% | 99.4% | 99%** | Achieved |
| | Maximum two-month (62-day) wait to first treatment from urgent GP referral (including for breast symptoms) and NHS cancer screening | 85% | 75% | 74.9% | 63%** | Not achieved |
| Maximum 6-week wait for diagnostic procedures | | 99% | 99% | 85.2% | 96.4%* | Improved |
| * March 2026 position | | | | | | |
| ** February 2026 position | | | | | | |

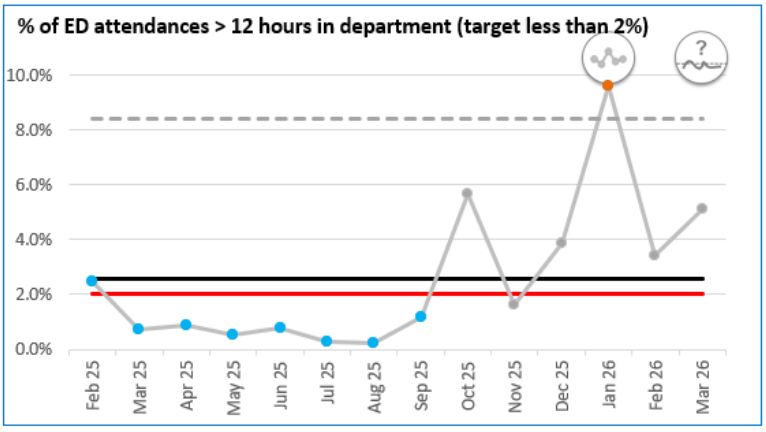
## Urgent and emergency care

The ability to deliver a smooth flow of patients through our services facilitate timely access to a bed has impacted on the 4-hour A&E standard with performance reported at 76.2% across the year against the national standard of 78%. Performance levels were highest over the summer period and deteriorated going into winter, with some improvements made towards the end of the year.




Improvements were supported by a number of initiatives implemented to improve patient flow at the front house including streaming patients to alternative services, ringfencing Same Day Emergency Care (SDEC) capacity, as well as securing additional funding to support front of house resourcing. Improving A&E performance remains one of our top priorities and we identified the risk of not doing so as one of our top risks at the year-end.

In the first half of the year significant improvements were made in reducing the time patients spend within the department however this became more challenging during the winter months. The percentage of patients spending more than 12 hours in the A&E department across the year was 2.5%.




Ambulance arrivals decreased slightly over the previous year with a 1.5% reduction. During 2025/26 handover times continued to perform better than the national standard of less than 15 minutes - taking an average of 14 minutes and 13 seconds to handover / transfer patient care from ambulance staff to hospital staff. This is important in supporting ambulance crews to be freed up as quickly as possible to support more patients in the region in need of emergency assistance.

Our rapid response teams provide urgent care to people in their own homes to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs receive access to health care professionals within 2 hours. During 2025/26 our teams achieved the target response times in 73.4% of the calls, with 96% of the patients avoiding hospital attendances / admission.

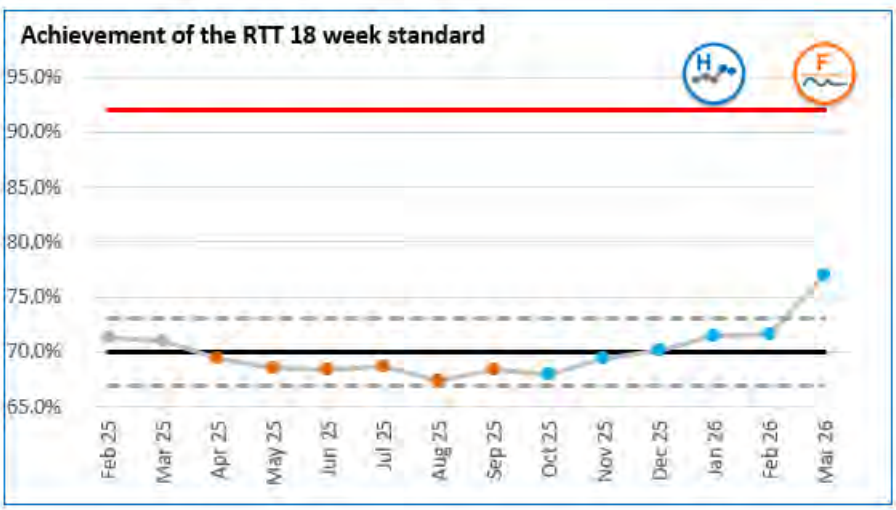
## Elective care

As in the previous year, our annual operating activity plans were based on recovering core services and increasing elective activity, whilst maintaining a balanced financial plan.

All activity delivery in 2025/26 increased upon the previous year, i.e. our people treated more patients during the year.

| | 2024/25 | 2025/26 | 2025/26 Plan | 2025/26 as % of plan |
|---|---|---|---|---|
| **Total Inpatient Activity** | **38,839** | **40,669** | **41,427** | **98.2%** |
| Daycase | 35,714 | 37,751 | 38,143 | 99.0% |
| Elective | 3,125 | 2,918 | 3,284 | 88.9% |
| **Non-Elective** | **21,300** | **21,626** | **21,292** | **101.6%** |
| Non-Elective 1+ LOS | 17,732 | 18,649 | 17905 | 104.2% |
| Non-Elective zero LOS | 3,568 | 2,977 | 3387 | 87.9% |
| **Outpatient Activity** | **269,623** | **283,283** | **245623** | **115.3%** |
| New Outpatient | 76,574 | 83,109 | | |
| Follow up Outpatient | 193,049 | 200,174 | | |
| **Diagnostics** | **105,761** | **110,672** | **113,722** | **97.3%** |

Treatment often requires a combination of outpatient attendances, diagnostic tests and inpatient care. The focus in year was to reduce our backlog of long waiters and deploy transformational approaches to reducing both waiting times and the waiting list. Whilst our overall Referral to Treatment (RTT) waiting list has reduced by circa 11%, long waiters have slightly increased with 17 patients waiting longer than 52 weeks at year end. RTT performance dipped during the year but has steadily increased in the latter part of the year.




Our performance within cancer diagnosis and treatments declined in Quarter 3 and Quarter 4 primarily due to additional demand from breast services (due to challenges elsewhere within our region) and capacity challenges in urology. We are working with the Northern

Cancer Alliance and other regional providers to identify the most appropriate solution to regional challenges.

### Productivity

We improved across a range of internal measures during 2025/26. Analysis using the Model Hospital national benchmarking tools identifies a number of areas to improve productivity. Our greatest area of opportunity and improvement are within our outpatient delivery.

| Productivity measures: | Planning Objective | Performance 2024/25 | Performance 2025/26 | Position |
|---|---|---|---|---|
| Advice & guidance as % of new outpatient attendances | Improve | 6.58% | 8.39% | Improved |
| DNA rates in outpatients | Improve | 7.50% | 6.30% | Improved |
| Ratio of new to follow up | Decrease | 2.5 | 2.4 | Improved |
| Patients placed on Patient initiated follow up (PIFU) pathways | Increase | 5% | 6.60% | Improved |
| Theatre utilisation rates capped | Improve | 87% | 84% | Deteriorated |

*DNA refers to Did Not Attend – i.e. where patients do not attend planned appointments.

A revised and realigned programme of elective care transformation will continue to oversee elective recovery, improving productivity whilst maintaining financial balance to provide excellent outcomes to patients.

## Financial performance

The financial framework for 2025/26 was broadly the same as 2024/25 whereby the Trust received a block payment allocation for most services from the commissioners of NHS Services. The Group returned a deficit in 2025/26 inclusive of QEF, our subsidiary company, and our Charitable Funds.

Emphasis on the achievement of overall financial breakeven for the North East and North Cumbria Integrated Care System (NENC ICS) was a priority.

The Trust and NHS England focus on the non-GAAP (Generally Accepted Accounting Principles) measure of surplus / (deficit) for the year, excluding impairments, revaluations and movements in charitable funds, as being the primary financial Key Performance Indicator (KPI), and against this measure the Group reported a deficit of £5.048m. The returned deficit was in line with our approved 2025/26 planned deficit.

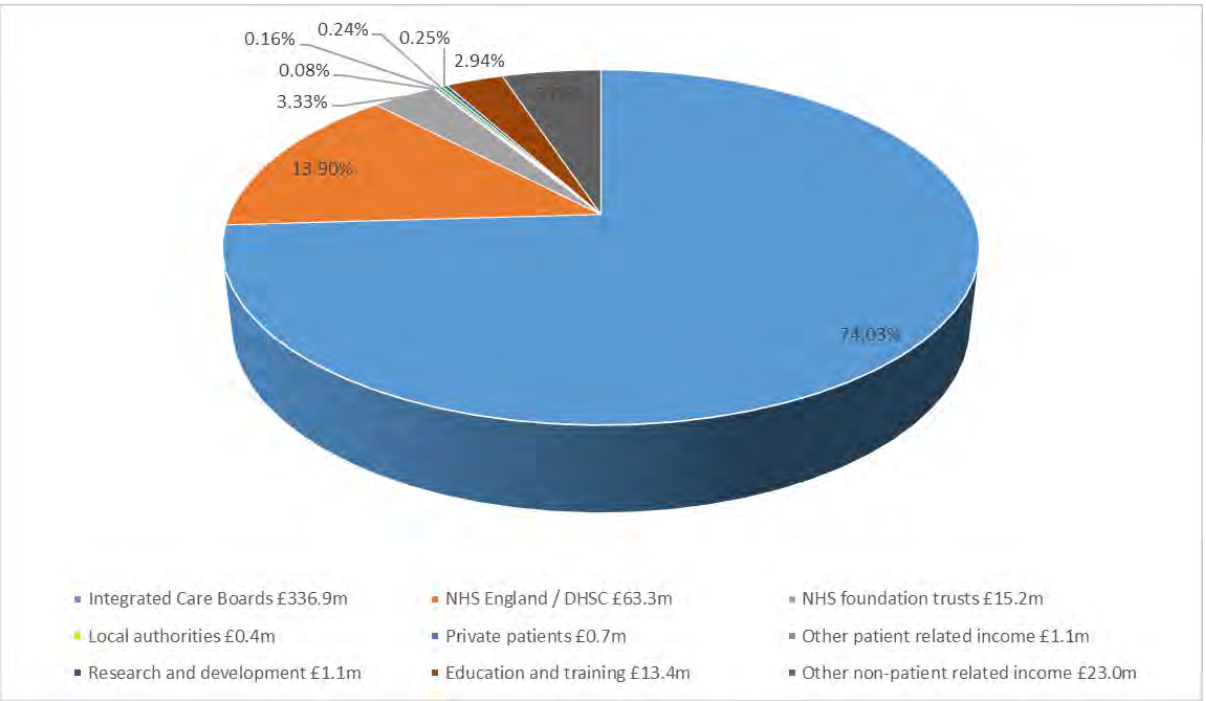
| | **Group £'000** |
|---|---|
| Income | 455,070 |
| Expenditure | (461,276) |
| **Operating Deficit** | **(6,206)** |
| Net Finance Costs | (4,476) |
| Other gains/(losses) | (643) |
| Corporation tax expense | (1,674) |
| **Deficit for the Financial Year** | **(12,999)** |
| I&E impairments/(reversals) | 7,646 |
| **Surplus/(deficit) before impairments and transfers** | **(5,353)** |
| Capital donations/grants | 305 |
| **Deficit for the year before impairments, revaluations and charitable funds** | **(5,048)** |

The Trust prepares the accounts under International Financial Reporting Standards (IFRS) and in line with the HM Treasury Financial Reporting Manual, Annual Reporting Manual and

approved accounting policies. The Group accounts include our wholly-owned subsidiary, QE Facilities, as well as the Trust's Charitable Funds.

### *Income*

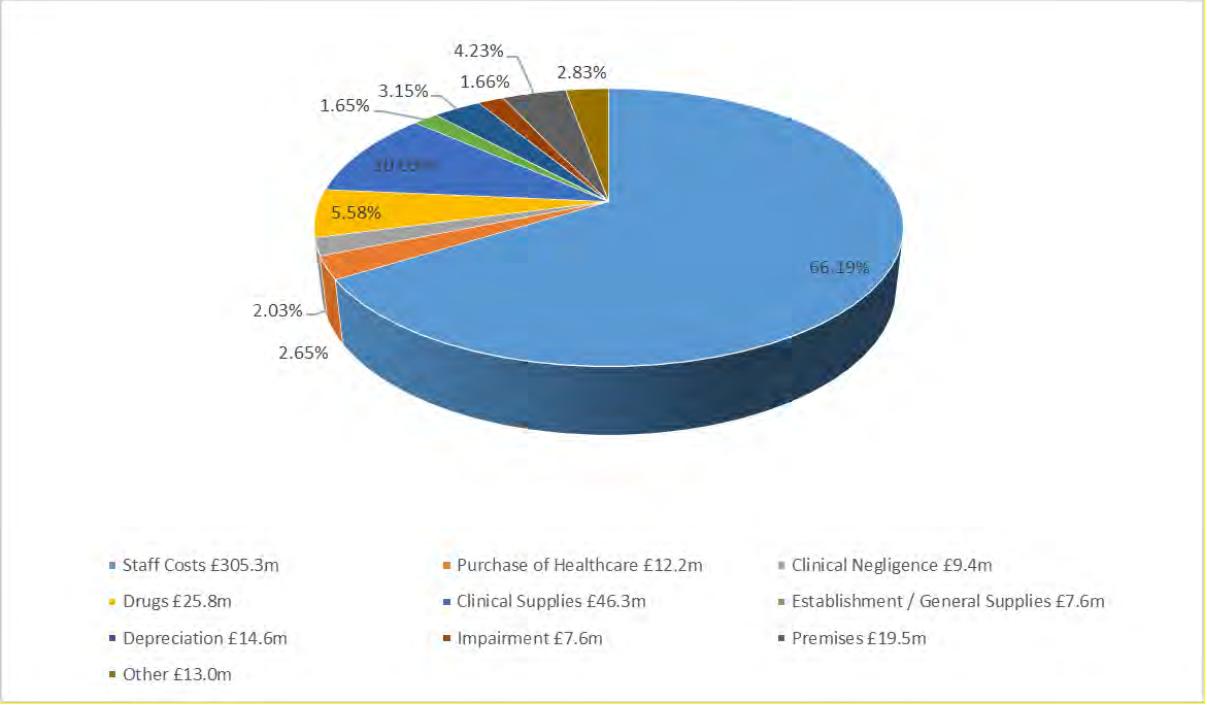
The Trust received £455.070m of total income for 2025/26, with income for patient care services amounting to £417.536m, of which £400.152m (95.8%) came directly from commissioners of NHS services including NHS England for specialised and public health screening contracts and the North East & North Cumbria Integrated Care Board (NENC ICB) for secondary and community care. An analysis of the total income received in 2025/26 is shown in the following chart.




For 2025/26 the Trust's private patient income was 0.16% of total income, marginally lower than previous years. Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The Trust has met this requirement.

### *Expenditure*

Total operating expenditure for the year was £461.613m. The largest proportion of operating expenditure is spending on pay and related expenses for our people which amounts to £304.412m (65.9%) of the total. Other material items of expenditure include medical and surgical consumables and drugs, amounting to £72.025m and premises costs of £19.508m. An analysis of total operating expenditure is shown in the following chart.



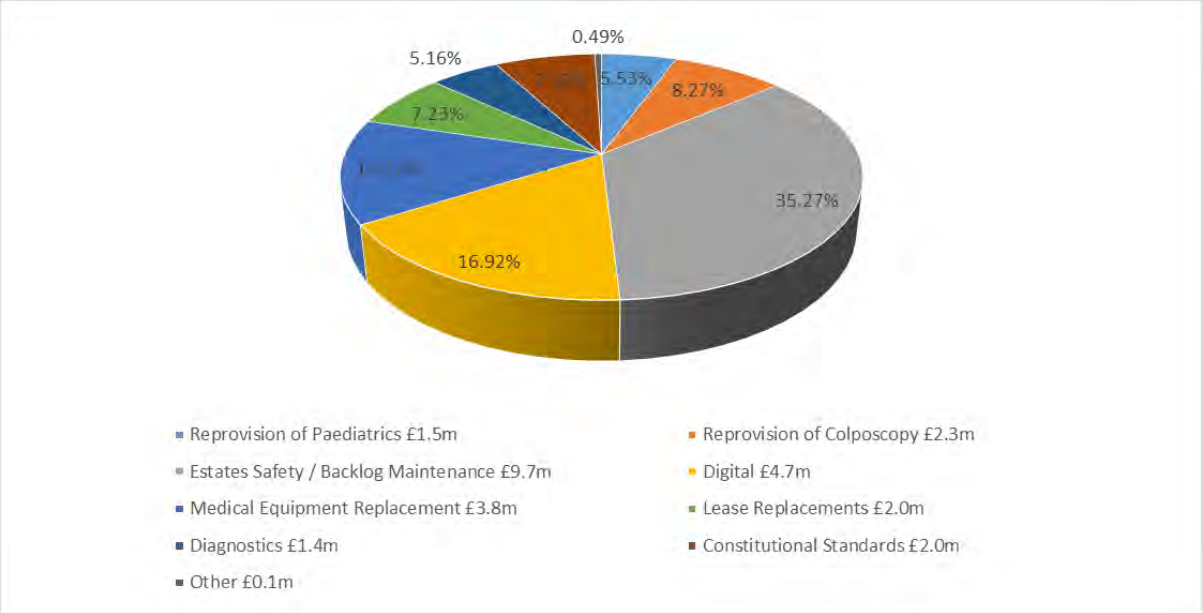

The Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance. This is relevant to areas such as Elective Recovery Funding, (the mechanism by which the Trust receives its variable tariff income from NHS Commissioners including Integrated Care Boards and NHS England) and the production of the annual cost return.

Fees and charges levied by the Group did not exceed £1m and were not otherwise material to the accounts. The total amount of paid interest for failing to pay invoices within the 30-day period was nil.

We continue to work towards compliance with the Better Payment Practice Code which requires the Trust to aim to pay all valid invoices by the due date of within 30 days of receipt of goods or a valid invoice. In 2025/26 91.3% of invoices (93.2% of value) met this standard. Detailed performance against the Code can be found in note 3.3 to the Financial Statements.

### *Capital Expenditure*

Capital expenditure for the year was £25.545m. Funding for the capital programme was made available from internal cash generated from depreciation, charitable funds, grant income and external funding of £20.522m. The main schemes being:




### *Audit of the accounts*

The full accounts are included at the end of this report. They have been prepared under the Direction issued by NHS England under the National Health Service Act 2006.

The accounts have been fully audited, and the appropriate certificate is included within the annual report.

The Board of Directors acknowledge their responsibilities for the financial statements included in this report. All of the accounting records have been made available to the auditors for the purpose of their audit and all transactions undertaken by the Trust have been properly reflected and recorded in the accounting records. All other relevant records and related information has been made available to the auditors.

The Board is also satisfied that there are no issues arising since the balance sheet date that would materially affect the 2025/26 accounts.

## QE Facilities

As outlined earlier in this report, our subsidiary company QE Facilities Ltd (QEF) provides non-clinical services to the Trust and other clients, with the aim of generating financial contributions to aid our overall sustainability, as well as supporting innovation and improvement.

QEF continued to deliver strong organisational, operational and financial performance throughout 2025/26, while further strengthening governance, leadership and commercial capability. As a wholly owned subsidiary of Gateshead Health NHS Foundation Trust, QEF remains focused on supporting the delivery of exceptional healthcare through high-quality estates, facilities, pharmacy, logistics and support services.

During the year, QEF launched its new Corporate Strategy, focused around three strategic priorities: Champion our People, Quality Focused and Fit for the Future. These priorities continue to shape organisational planning, workforce development, service improvement and commercial growth.

QEF ended 2025/26 in a strong financial position, delivering an operating surplus in excess of £5m and exceeding its Cost Reduction Programme target. Financial governance, liquidity and cash flow arrangements remained stable and effective throughout the year.

Operationally, QEF continued to deliver significant activity across its services, including estates repairs, pathology sample movements, outpatient prescriptions, and portering in support of frontline patient care.

QEF also continued to strengthen its regional and commercial presence through wider partnership working, logistics market engagement and new business development opportunities, including expansion within Pharmacy Homecare services and Consultancy services.

Governance and leadership arrangements continued to mature positively during the year, including approval of updated constitutional governance documents, adoption of QEF's first Governance Manual and establishment of the Corporate Services Directorate. Workforce engagement, leadership visibility and organisational development activity also continued to strengthen across the organisation.

QEF enters 2026/27 in a strong position, with clear strategic priorities, stable financial performance and continued focus on delivering high-quality, sustainable services that support excellent patient care across Gateshead and the wider NHS system.

## Environmental matters

### *Our commitment*

The Health and Care Act 2022 requires NHS bodies, including foundation trusts, to contribute to statutory emissions and environmental targets. We are aligned to the NHS ambition to reach Net Zero for emissions we control by 2040 and for emissions we influence by 2045, including through our supply chain.

- By 2040 the emissions we control will be Net Zero – these emissions form our 'Carbon Footprint'; and
- By 2045 the emissions we can influence will be Net Zero – these are emissions from all sources and can be referred to as our 'Carbon Footprint Plus'. This includes the requirement for our suppliers to have also reached Net Zero.

Our refreshed Green Plan 2025–2028, approved by the Trust Board in September 2025, builds on the previous plan and sets out actions and measures across ten focus areas, including waste and biodiversity, to support our journey to net zero.

The plan aligns with national NHS net zero guidance and covers ten areas: workforce and leadership, sustainable models of care, digital, travel and transport, estates and facilities, waste, medicines, procurement, food and nutrition, and climate adaptation.

### Workforce System & Leadership

A revised governance structure now oversees delivery of the Green Plan through the monthly Net Zero Delivery Group, with six-monthly reporting to the Greener NHS Group, chaired by the Medical Director, and onward reporting to the Finance and Performance Committee.

Named leads are now in place across all ten focus areas. Priorities for 2026/27 include raising staff awareness through a new intranet page, increasing completion of the Building a Net Zero NHS module, and delivering a Board development session.

### Sustainable Models of Care

Clinical pathways can significantly affect carbon emissions. Work in critical care, theatres and digital services has focused on reducing waste, limiting anaesthetic gases and expanding virtual consultations.

Next steps include further work with Emergency Care, wider clinical engagement and embedding sustainable quality improvement within existing improvement programmes.

### Digital Transformation

Digital work has focused on reducing printing, digitising records and rolling out the Patient Engagement Portal to reduce paper use. Further work is underway to understand the carbon impact of digital services and the benefits of remote monitoring in reducing hospital visits.

### Travel & Transport

We continue to decarbonise our fleet and secured funding through the NHS Charge Point Accelerator Scheme to install seven dual electric vehicle charge points at Spire House, Washington. Staff travel survey results show 27% of colleagues use sustainable travel. We have also signed a regional no-idling statement and continue to promote lower-carbon travel options for staff.

### Estates and Facilities

Heat decarbonisation plans are in place for our main sites. A key opportunity is connecting Queen Elizabeth Hospital to the Gateshead Geothermal Heat Network, but the estimated £26m cost and the end of national decarbonisation funding present a significant challenge. We will continue to pursue funding opportunities, including for LED lighting and building management upgrades.

### Waste and the Circular Economy

Waste segregation improvements delivered a 5% reduction in total waste and a 32% reduction in clinical waste in 2025/26, while achieving the national 60% offensive waste target. Reusable products are being introduced in theatres, and further work will focus on recycling, food waste and refurbishing equipment and furniture.

### Medicines

Medicines waste remains very low, with only 0.1% sent for disposal and a 20% reduction in pharmaceutical waste in 2025/26. NHS England funding has supported work to decommission nitrous oxide, and emissions from volatile anaesthetic gases have fallen by 81% since 2019/20. Regional work is also encouraging patients to bring their own medicines to hospital.

### Supply Chain and Procurement

Procurement processes continue to reflect national requirements on net zero and social value. This supports progress towards reducing supply chain emissions, although further work is needed to establish a robust scope 3 baseline using more detailed supplier data.

### Food and Nutrition

The Nutritional Steering Group continues to embed sustainability in food and nutrition planning. Priorities include reducing patient food waste and introducing a digital meal ordering system.

### Adaptation and Greening the Estate

A draft adaptation plan has been developed and circulated for consultation. Further work in 2026/27 will focus on establishing a working group, completing a maturity assessment

against the NHS Climate Change Adaptation Framework and carrying out climate risk assessments for key sites.

Climate risks are managed through established arrangements including the Adverse Weather Plan and business continuity plans, supported by EPRR and Estates teams. Biodiversity initiatives, including No Mow May, continue and the Pharmacy wellbeing garden has been recognised regionally as good practice.

### Taskforce on Climate related Financial Disclosures (TCFD)

NHS England's NHS foundation trust reporting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The phased approach incorporates the disclosure requirements of the governance, strategy, risk management and metrics and targets pillars for 2025/26. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts and in other external publications.

| **Governance** |
| --- |
| *Describe the Board's oversight of climate related issues.* |
| Our Trust provides six monthly updates on the Green Plan, sustainability and net zero progress to the Executive lead for sustainability and net zero, Greener NHS Group, Finance and Performance Committee, and Trust Board of Directors.<br><br>The Trust has in place an EPRR Risk Register, which allows for any Trust climate related issues/risks to be added. Risks at Gateshead Health are supported through a number of external documents such as the National Security Risk Assessment (NSRA), National Risk Register (NRR) and the Community Risk Register (CRR) which is produced by the Northumbria Local Resilience Forum (NLRF) of which the Trust is part of as a category 1 responder. All identified risks are recorded on the Inphase Risk Management system, with the EPRR Risk Register set to be featured as a distinct entity within the platform. Risk updates are provided monthly to Business Resilience Group by the Head of EPRR as well as the Trust Corporate and Clinical Risk Lead. These risks are then reported quarterly by the Chief Operating Officer to Executive Risk Management Group. Any findings, learning and progress are reported bi-annually to the Trust Board.<br><br>To date, there has been no material impact on the organisation. |
| *Describe management's role in assessing and managing climate-related issues.* |
| The Chief Executive has assigned net zero leadership to the Group Medical Director with the main authority delegated to QE Facilities Ltd who provide many of the key services regarding sustainability. This is led by an Executive Director for QE Facilities with primary responsibility delegated down to the Head of Safety, Health, Environment & Quality (Head of SHEQ) to ensure the development and implementation of the Green Plan and report against targets.<br><br>The Net Zero Delivery Group meet monthly and provides a forum of departmental leads to report on progress against each of the 10 key focus areas of the group green plan: |

workforce system and leadership; sustainable models of care; digital transformation; travel and transport; estates and facilities; waste and the circular economy; medicines; supply chain and procurement; food and nutrition; and adaptation and greening the estate. The group shares learning, highlight risks and bring proposals that might require funding from the Trust to implement.

The most common climate risks have specific actions to take should they occur and are covered within departmental and estates business continuity plans, and adverse weather plans.

The Greener NHS Group reviews the bi-annual Net Zero Delivery Group report and recommendations contained and produces an alert, advise and assure report to the Trust Finance and Performance Committee.

*Processes by which the relevant management structures are informed about climate related issues and how those structures monitor climate-related issues.*

Data around climate-related issues can be collated from various sources, such as the Inphase incident reporting system, which should capture events related to extreme weather. This will require additional risk classifications and training to embed the process.

Operational matters are directed to estates and facilities leads and, if necessary, escalated to senior management and directors via regular directorate management team meetings.

Climate-related issues identified should be reported at the monthly Net Zero Delivery Group meetings and included in the six-monthly reports on green plan progress to the Greener NHS Group. Metrics and targets are to be developed.

Going forward, the number of heat and flood events will be reported via the Estates Return Information Collection (ERIC) return.

**Strategy**

*Describe the climate-related risks and opportunities the organisation has identified over the short, medium and long term.*

A draft adaption plan has been developed and circulated for consultation with a working group to be established to formalise and review the plan. Once established the group will report into the Net Zero Delivery Group and the initial task will be to undertake a baseline maturity assessment against the NHS Climate Adaptation Framework which provides a consistent methodology for assessing climate risks and building organisational resilience. We will use this framework alongside the Climate Change Risk Assessment Tool to systematically identify climate related risks and identify adaptation responses.

Climate-related risks and opportunities have not yet been formally established but we plan to produce a Climate Change Risk Assessment by Q4 26/27 in line with our Green Plan.

The EPRR Team addresses the management of climate-related risks in collaboration with estates and other departments as this is very much a multi-disciplinary effort, ensuring all are onboard and aligned to provide assurance of preparedness and mitigation. This in return through incident response is supported through the use of the Incident Response Coordination Framework, Adverse Weather Plan and any applicable Business Continuity Plan.

| |
|---|
| *Describe the impact of climate-related risks and opportunities on the organisation's operations, strategy and financial planning and how these may materialise over the short, medium and long term, when considered against a global warming pathway of 2°C or lower.* |
| Climate-related risks and opportunities have not yet been formally established but we plan to produce a Climate Change Risk Assessment (CCRA) in 2026/27 in line with our Green Plan.<br><br>The findings of the CCRA will inform the further development of the Climate Adaptation Plan in line with our Green Plan. |
| **Risk management** |
| *Describe the organisation's processes for identifying and assessing climate-related risks.* |
| We are compliant with the NHS Core Standards Framework for EPRR.<br><br>Risks related to extreme weather will be incorporated within our emergency planning risk register; however, we recognise that a key step is to complete a climate change risk assessment (CCRA).<br><br>A CCRA would assess climate risks and impacts using a series of national and local tools, including the National Adaptation Programme (NAP) and Local Climate Adaptation Tool (LCAT).<br><br>The EPRR Manager attends the Health Resilience Sub-Group (HSRG) which also feeds into a Local Health Resilience Partnership (LHRP), where climate risks may be discussed and good practice shared. It is anticipated that information discussed at these forums and Integrated Care System Sustainability networks is shared at the Trust Net Zero Delivery Group. |
| *Describe the organisation's processes for managing climate-related risks.* |
| There has been no recorded material risk to the Trust to date.<br><br>Processes for recording climate events on our Inphase incident and risk reporting system will be embedded and included in the bi-annual update reports to the Greener NHS Group. |
| *Describe how processes for identifying, assessing and managing climate-related risks are integrated into the organisation's overall risk management approach.* |
| The NSRA, NRR and the NLRF CRR are examples of some of the documents utilised to consider climate related risks in a local context. Above and beyond these documents, the use of lessons and learning from internal or external incidents is also used through the sharing of good practice to consider any potential Trust risks or weakness in planning and preparedness. Finally the use of horizon scanning is also a useful tool to use to assess potential risks by looking at any potential threats, gaps, weaknesses within the system.<br><br>Once a climate related risk is established, this then follows a process of:<br><br>• Localised conversations within the department<br>• Addition to the Risk Register or EPRR / Estates Risk Register depending on the risk<br>• Mitigation Plans put in place and monitored with updates provided at appropriate groups such as Business Resilience Group or an Estates Related Group (Electrical Safety Group)<br>• Updates provided depending on the score associated to the risk<br>• Significant risks are reported into Executive Risk Management Group |

- Where needed, plans or action cards are created to support mitigation or response.

Preparedness, Resilience, Response and Planning options available are:

- Complete mitigation (often unlikely)
- Business Continuity Plan
- Action Cards
- Incident Response Coordination Framework
- Adverse Weather Plan.

The Trust is legally required under the Civil Contingencies Act 2004 to have provisions in place as part of the 6 Civil Protection duties as well as this being a requirement from NHS England as part of the Core Standards for EPRR.

The EPRR Team receives Weather Health Alerts from the Met Office and UK Health Security Agency as well as Flood Guidance Statements from the Environment Agency as part of a UK wide system to support preparedness and response to Adverse Weather Events.

Moving forward, the Trust plans to incorporate the following into the Adverse Weather Plan:

- Flood mapping metrics relevant to Trust sites
- Severe Space Weather
- Wildfires

**Metrics and targets**

*Disclose the metrics used by the organisation to assess climate-related risks and opportunities in line with its strategy and risk management process.*

We apply metrics and measurements as guided by NHS England, following a complete refresh of our Board-approved Green Plan to cover the period 2025 –2028. We report our performance against targets through the bi-annual Net Zero Delivery Report to the Greener NHS Group with escalations via an Advise, Alert and Assurance report to the Finance & Performance Committee (which in turn reports to the Trust Board of Directors) as well disclosing performance as part of our annual report.

Metrics and measurements are reported annually within the Estates Return Information Collection (ERIC) with kWh/m2 for energy, m2 / m3 for water, kg / m2 for waste, % of LED coverage and number of heat or flood events that triggered a risk assessment. ·

Green plan key performance indicators include the percentage reduction against our 2019/20 baseline carbon footprint, which we are working to establish and track through a new platform data base over 2026/27.

*Describe the targets used by the organisation to manage climate-related risks and opportunities and performance against targets.*

We have pledged to meet the NHS net zero target by 2040 for direct emissions (NHS carbon footprint) and 2045 for the wider NHS carbon footprint plus, in compliance with NHS requirements and the Health and Care Act 2022. We report our performance against targets and green plan actions through the bi-annual net zero delivery report to the Greener NHS Group and onwards through the governance structure as previously described.

## Emergency preparedness, resilience and response

It is a requirement that all NHS providers submit an annual self-assessment statement of assurance against Emergency Preparedness, Resilience and Response (EPRR) core standards to their Board of Directors.

The purpose of the EPRR annual assurance process is to assess the preparedness of the NHS, both commissioners and providers, against common NHS EPRR core standards. https://www.england.nhs.uk/ourwork/eprr/gf/#annual-process

The overall EPRR assurance rating is based on the percentage of core standards the organisation can self-assess as fully compliant. This is explained in more detail below:

| Organisational rating | Criteria |
|---|---|
| **Fully compliant** | The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards |
| **Substantial compliance** | The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards |
| **Partial compliance** | The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards |
| **Non- compliant** | The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards |

There were no significant changes to the core standards assurance process nationally in 2025, however there were changes to the local submission and check and challenge process.

The NENC Integrated Care Board (ICB) implemented a revised local check and challenge timeline and submission governance process that included:

- All organisations submitted their core standards self-assessments to the North East and North Cumbria Integrated Care Board (NENC ICB) for 2025;
- The focus was on the core standards where an organisation had assessed that their compliance had increased from red (non-compliant) or amber (partially compliant) to green (compliant); and
- This was complemented with a robust internal check and challenge process with executive oversight from the Accountable Emergency Officer prior to the submission.

Following this robust check and challenge process, the self-assessment of the EPRR core standards resulted in a compliance rating of **97% - substantial compliance**, an increase from the 94% substantial compliance rating in the previous year.

Our priority areas in 2026 include:

- Continued testing and amending of our plans to ensure that teams are familiar with their content and that they actively reduce clinical and organisational risk;
- A focus on sustaining a substantial compliance rating;
- A clear Trust ambition to continue to develop and enhance EPRR capabilities, capacity and strengthening quality of evidence;
- A continued focus on training and exercising across all domains;
- Implementation of the business continuity software solution to allow us to provide consistency to alleviate and assist with the day-to-day management of issues;
- A continued review of plans, frameworks and protocols to strengthen Trust arrangements;
- An embedding of identified organisational learning;
- Use of the self-assessment as a benchmark for prioritisation of our EPRR work-plan for 2026; and
- A trajectory to continue to work collaboratively with the NENC ICB and other health providers to identify best practice and enhance threshold of evidence.

Our annual assurance report for 2025, including the NHSE Core Standards final submission, was presented to Gateshead Health Board of Directors in January 2026.

## Addressing health inequalities

Health inequalities are avoidable, unfair and systematic differences in health between different groups of people. They are rooted deep within our society, and are widening, leading to disparate outcomes amongst our population.

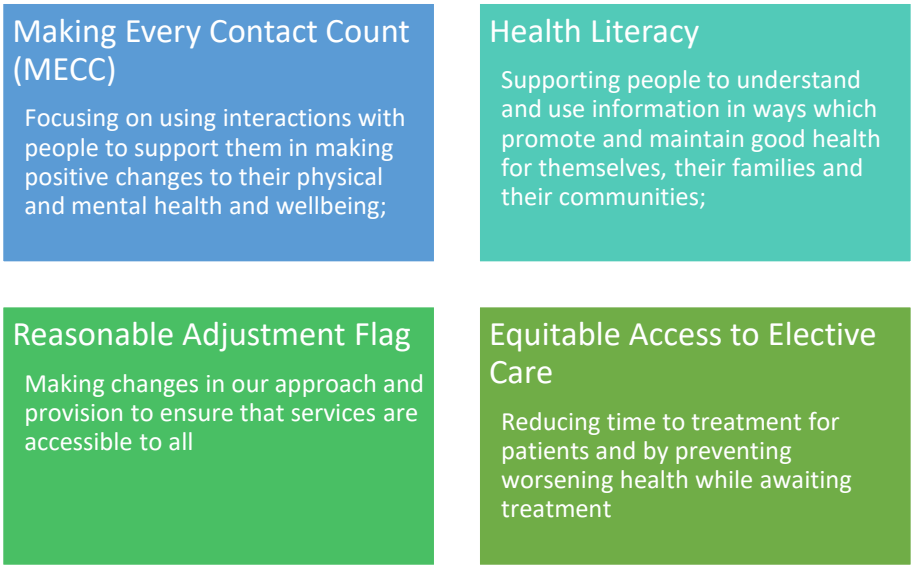
Within Gateshead we know:

- Premature mortality from cardiovascular disease is significantly worse in Gateshead than in England;
- Prevalence of cancer diagnoses are increasing; and
- The (age-standardised) rate of alcohol-related hospital admissions in Gateshead is 841 per 100,000 population, significantly above the regional and England average.

Our commitment to working with our partners to address health inequalities features strongly within the new 5 year corporate strategy. We recognise the importance of developing strong links with the communities we serve and working collaboratively with our partners to ensure that we are not only responsive, but proactive in our approach to meeting current healthcare and community needs.

In March 2026 the Board of Directors approved the new Clinical Strategy. This supports delivery of the overall corporate strategy and includes a significant focus on health inequalities and working with our patients and partners to address inequalities at both service and strategic levels. Our organisational input to the Local Authority Health and Wellbeing Strategy was valued, shaping the final version of this, and there is ongoing senior leadership commitment into the Health and Wellbeing Board.

Our Health Inequalities' Group continues to report good progress against the original four workstreams, which are:




Over 80 staff members have been trained in MECC with a plan to roll this out further using a train-the-trainer model. Health Literacy is becoming embedded as business as usual with the patient information review process now ensuring that health literacy principles are adopted across all new and reviewed leaflets. We will go live with the Reasonable Adjustments Flag launch in early 26/27. In our Equitable Access to Elective Care work stream we have now secured information and public health support to analyse DNA (Did Not Attend) / WNB (Was Not Brought) rates in our Trauma and Orthopaedic service to understand underpinning factors and adaptations which can have a positive impact.

At the end of 25/26 we started to consider how Health Inequalities impact our colleagues, acknowledging that a high proportion of our workforce live in Gateshead and our responsibility as an anchor institution to improving health inequalities for our community. More work against this priority is planned for 2026/27.

## Social, community, anti-bribery and human rights issues

We recognise the importance of developing strong links with the communities we serve and working collaboratively with our partners to ensure that we are not only responsive, but proactive in our approach to meeting current healthcare and community needs.

In respect of anti-bribery, there is a Counter-Fraud, Bribery and Corruption Policy in place with regular updates on activity and investigations provided to the Group Audit Committee. The policy was updated during the year to reflect the new ‘failure to prevent fraud’ corporate criminal offence which was introduced in September 2025. The Group Audit Committee sought assurance regarding compliance with the new legislation through the review of a self-assessment completed by management. The Chief Executive signed a Counter Fraud, Bribery and Corruption Statement to confirm our commitment to the prevention of fraud. A copy can be found on our website.

In addition the Counter Fraud Specialist (a service provided to the Group by AuditOne) ensures that fraud awareness is communicated and promoted to our people through regular articles in the weekly staff newsletter.

We are fully committed to meeting our obligations in respect of human rights, equality, diversity and inclusion (EDI). This is detailed further in the next section and in the Staff Report section of the Annual Report.

## Equality of service delivery

As an NHS organisation, we aim to provide our services to all groups equally. We are subject to the Public Sector Equality Duty, which was introduced as part of the Equality Act 2010 and requires NHS organisations to eliminate unlawful discrimination, advance equality of opportunity and foster good relations.

We have continued to meet our obligations in respect of the Public Sector Equality Duty by:

- Gathering specific and relevant data as per the Equality, Diversity and Inclusion (EDI) metrics for both the Workforce Race Equality and Workforce Disability Equality Standards (WRES and WDES);
- A specific detailed EDI action plan in respect of these metrics has been produced and has measurable outcomes; and
- We have revised our approach to supporting and delivering against the EDI agenda, via a refreshed Staff Experience and Inclusion Oversight Group which encompasses a wide range of stakeholders collaboratively working together to progress the EDI agenda.

We have four staff networks within the Trust – Global Ethnic Majority (GEM) network, D-Ability network for disability equality, LGBT+ (Lesbian, Gay, Bisexual and Transgender) network and our Women's network. Our staff networks have played a strategic role in shaping the Group Equality Strategy through informed and meaningful contribution. The systematic use of WRES and WDES EDI indicators, aligned with the EDI Strategy, has enabled the development of EDI action plans, clearly articulating priorities across the short, medium and long term.

Our staff networks also offer invaluable peer support, networking and development opportunities, and provide a safe space for sharing knowledge and experience. Their work supports positive organisational culture and played a key role in promoting and celebrating key events, awareness activities and training during the year.

EDI is a key component of the Group induction programme for all new employees. A number of bespoke EDI training sessions have been delivered across services. We signed up to the Anti Racism Charter and on the back of this commissioned an external training company, who have delivered a number of sessions around Show Racism the Red Card, which have evaluated well.

We ensure that colleagues have access to appropriate learning and development opportunities in respect of EDI. This ensures that we can support the needs of our service users with protected characteristics.

Following the Health and Care Act 2022, the Government introduced a requirement for CQC registered service providers to ensure their employees receive learning disability and autism training appropriate to their role. This is to ensure the health and social care workforce have the right skills and knowledge to provide safe, compassionate, and informed care to autistic people and people with a learning disability. As such we will be rolling out the Oliver McGowan training across the Group.

Some of our achievements in relation to EDI are as follows:

- The D-Ability network members have been instrumental in raising the Neurodiversity agenda at the Trust, resulting in a training session being provided to help colleagues understand neurodiversity, followed up by the Oliver McGowan training. For individuals who have sensory impairments, we have developed a sensory Garden;
- A number of drop-in sessions around disability awareness were held and more are planned for the coming year;
- Disability History Month and Black History Month were celebrated, including joining regional seminars around this agenda;
- The GEM network continue to proactively relay the message around zero tolerance and our 'it's not ok' campaign. Depending upon the service request specific advice around culture has been provided;
- LGBT History Month was celebrated with Members of the LGBTQ+ group continuing to be involved in the local Pride events;
- We have developed and delivered sessions around enabling managers and leaders across the Group to shape work environments and cultures where all staff feel safe and valued for their contributions;
- We continue to address and take proactive actions around incivility, zero tolerance and sexual safety; and
- All policies of interest to our networks are shared for discussion and each policy has an Equality Impact Assessment undertaken prior to being agreed.


Gateshead has a vibrant and significant Jewish community, and we work closely with volunteers from the community who help us to ensure that we are respectful of strict cultural practices and provide tailored support to our patients. One of the local community leaders is an appointed Governor on our Council of Governors and helps us ensure we are considerate of cultural challenges and opportunities.

There has also been proactive engagement with the GEM groups in and around Gateshead / Newcastle pertaining to religion and faith. Further information on our commitment to EDI can be found in the Staff Report section.

Sean Fenwick
Chief Executive
25 June 2026

# Accountability Report

## Directors' report

The Trust's Board of Directors is responsible for the overall leadership and strategic direction of the Trust. The Board is comprised of Executive and Non-Executive Directors.

The Board operates a committee structure, with each committee responsible for seeking assurance on matters within its remit. The Board delegates some of its powers to a committee of Directors or to an individual Executive Director and these are set out in the Trust's Scheme of Delegation. Decision making for the operational running of the Trust is delegated to the Executive Team.

Our Chair and Chief Executive have complementary roles in leadership. Our Chair, Sir Paul Ennals, leads the Board of Directors and ensures its effectiveness. The Chair of the Board also chairs our Council of Governors. The Chair is supported by the Vice Chair, Dr Gerry Morrow (from 1 October 2025, with Maggie Pavlou serving as Vice Chair prior to this date). Our Senior Independent Director is Martin Hedley. Our Chief Executive, Dr Sean Fenwick, leads the Executive Team and the organisation (Dr Fenwick was substantively appointed in May 2026, having been Acting Chief Executive since August 2025).

All Directors are required to comply with the requirements of the fit and proper persons test and make an annual declaration of compliance in this regard. All Directors also have a responsibility to declare relevant interests, as defined within our Constitution and conflicts of interest policy. A copy of the register of interests is available on request from the Company Secretary (contact details are contained at the end of the Annual Report).

## Board composition

The Board of Directors has a range of skills and experience gained from the public, private and voluntary sectors that complement our service delivery. This includes a wealth of senior experience in the NHS, finance, legal, people and organisational development and senior clinical experience and expertise. The Board of Directors is well-balanced and appropriately experienced and qualified to lead the Trust.

Our Non-Executive Directors bring strong, independent oversight to the Board and all our Non-Executive Directors are independent.

During 2025/26 there were some changes in the composition of the Trust Board.

The Trust's substantive Chief Executive, Trudie Davies, took on a secondment opportunity in August 2025 to become the Acting Chief Executive of our Alliance partner North Cumbria Integrated Care NHS Foundation Trust. She remained on secondment for the rest of the financial year. Dr Sean Fenwick joined the Board as Acting Chief Executive whilst Trudie Davies' was on secondment. His substantive post was Deputy Chief Executive and Director of Operations at South Tyneside and Sunderland NHS Foundation Trust. Sean has a wealth of experience both clinically and in senior leadership roles within the NHS. Post-year end it was confirmed that Trudie Davies has been appointed substantively as Chief Executive at North Cumbria Integrated Care. As outlined earlier Dr Fenwick was substantively appointed to the role in May 2026 (this will be covered fully in next year's report and is noted here for transparency given that Dr Fenwick signed the Annual Report in his capacity as substantive Chief Executive in June 2026).

Another key change during the year was the appointment of Sir Paul Ennals as Chair, following the completion of Alison Marshall's second term at the end of September 2025. Alison had served as Chair for 6 years, as well as being the first chair of the Great North Healthcare Alliance. Sir Paul was also appointed as Chair of Northumbria Healthcare NHS Foundation Trust and The Newcastle-upon-Tyne Hospitals NHS Foundation Trust (having previously held the role at Northumbria and been interim Chair at Newcastle). This introduced a new 'shared chair' model for the East Coast Alliance Trusts, with Sir Paul also chairing the Great North Healthcare Alliance meetings. The 'shared chair' model helps us to build on the strong existing collaboration and partnerships, and provides the opportunity to make a real impact within the communities served by the three Trusts. The Councils of Governors of the three Trusts were instrumental in delivering this important appointment.

Dr Gerry Morrow, one of our existing Non-Executive Directors, was appointed by the Council of Governors as the Vice Chair to support Sir Paul in his role at Gateshead.

Dr Gill Findley, Chief Nurse and Deputy Chief Executive left the Trust in October 2025 to take up the unique opportunity of a new joint role as Professor with the University of Cumbria and Chief Nurse at North Cumbria Integrated Care NHS Foundation Trust. Beth Swanson joined the Board as Interim Chief Nurse from North Tees and Hartlepool NHS Foundation Trust where her substantive role is Director of Nursing and Deputy Group Chief Nurse. Beth brings more than 30 years of nursing experience and a strong record in improving quality, safety and workforce resilience.

At the end of March 2026 we said a fond farewell to Dr Neil Halford, Medical Director of Strategic Relations, who retired from the Trust. Neil had been a consultant in the emergency department for 23 years as well as more recently taking up his Board role.

There were a number of changes amongst our Non-Executive Directors. In June 2025 Mike Robson left the Board following the end of his term. Mike had served on the Board for 7 years. In the same month Andrew Moffat left the Board following 5 years in post. In July we welcomed Rob Hughes as Chair of the Group Audit Committee. Rob is a chartered accountant with a background in internal and external audit, as well as extensive boardroom experience. We also welcomed Andrew Besford as Chair of the Digital Committee. Andrew has spent his entire career in the technology sector, with substantial digital and leadership experience.

In February 2026 the Council of Governors reappointed Adam Crampsie and Martin Hedley for a further term of 3 years, to commence on 1 July 2026.

In December 2025 Hilary Parker left Trust and QE Facilities' Boards, having been a Non-Executive Director with the Group for 5.5 years. A recruitment process was underway at the year end to seek a Non-Executive Director with legal experience and qualifications to replace Hilary.

With regards to the QE Facilities Board of Directors Maggie Pavlou was reappointed as Chair until 30 September 2027 (coterminous with her term as a Trust Non-Executive Director). In addition Simon Jefferson was appointed as a Non-Executive Director to replace Hilary Parker, with Simon due to take up post in early 2025/26. Simon brings significant commercial experience from the water industry.

Just prior to the year end, Gavin Evans, Managing Director of QE Facilities, tendered his resignation to take up a Board position at North Cumbria Integrated Care NHS Foundation

Trust. In March 2026 the Trust Board approved proposals to commence the search for his successor. Gavin will remain at QE Facilities until early 2026/27.

In March 2026 the Trust Board (as shareholder) approved the establishment of an Executive Director of Corporate Services role through the redesignation of the existing Director of Strategy, Planning and Performance post. The revised post will be effective from 1 April 2026 and Jane Taylor will join the Board in this role, bringing a wealth of experience in strategy, risk and governance.

We would like to formally record our sincere thanks to Alison Marshall, Trudie Davies, Gill Findley, Neil Halford, Mike Robson, Andrew Moffat and Hilary Parker for their significant commitment to the Board and Group during their years of service.

The Trust Board held 19 meetings in total in 2025/26 (counting public and private Board meetings separately). Where Board Members were not eligible to attend certain meetings, an adjusted denominator is shown (for example private Council of Governors' meetings or where a Board Member served on the Board for only part of the year).

| **Name and Position** | **Background** | **Board**<br><br>**19 meetings in total** | **Group Audit Committee**<br><br>**4 meetings in total** | **Group Remuneration Committee**<br><br>**8 meetings in total** | **Council of Governors**<br><br>**4 meetings in total** |
|---|---|---|---|---|---|
| ***Executive Directors*** | | | | | |
| **Trudie Davies, Chief Executive** (on secondment to North Cumbria Integrated Care NHS Foundation Trust from August 2025) | Trudie joined the Trust in March 2023 from Mid Yorkshire Hospitals NHS Trust where she had held the role of Deputy Chief Executive and Chief Operating Officer. Originally training as a nurse, Trudie has significant operational management experience and system leadership experience. | 6 of 6 | N/a | 2 out of 2 | 1 of 1 |
| **Dr Sean Fenwick, Acting Chief Executive (from 18 August 2025) and substantive Chief Executive from May 2026** | Sean Fenwick joined Gateshead Health NHS Foundation Trust in August 2025 as Acting Chief Executive. He has worked in the NHS for over 30 years, spending most of his career in the North East, with earlier periods in London and Liverpool. He is a consultant nephrologist by background and was most recently | 13 of 13 | N/a | 2 out of 3 | 2 of 3 |

| Name and Position | Background | Board<br><br>19 meetings in total | Group Audit Committee<br><br>4 meetings in total | Group Remuneration Committee<br><br>8 meetings in total | Council of Governors<br><br>4 meetings in total |
|---|---|---|---|---|---|
| | Deputy Chief Executive and Director of Operations at South Tyneside and Sunderland NHS Foundation Trust. | | | | |
| **Dr Gillian Findley, Deputy Chief Executive / Chief Nurse and Professional Lead for Midwifery and AHPs** (to 5 October 2025) | Gill trained as a Registered General Nurse and a Registered Sick Children's Nurse at Great Ormond Street in London. Since qualifying Gill has held various clinical, managerial and Board-level positions in both providers and commissioners. | 8 of 8 | 0 of 2 | N/a | 2 of 2 |
| **Joanne Halliwell, Chief Operating Officer** | Joanne Halliwell is a registered general nurse with a wealth of experience in various operational and leadership roles. She previously held the position of Director of Operations (Medicine) at the Trust from June to September 2023. Prior to this, she worked at Mid Yorkshire Hospitals NHS Trust, where she held several key positions including Deputy Chief Operating Officer and a number of Director level positions. | 15 of 19 | N/a | N/a | 2 of 4 |
| **Kris Mackenzie, Group Director of Finance and Digital** | Kris joined the Trust in 2018 as Assistant Director of Finance, having previously held the position of Senior Finance Lead at NHS Improvement. Kris became Deputy Director of Finance in 2019, was Acting Group Director of Finance during the 2021/22 financial year and substantively appointed to the role in September 2022. | 18 of 18 | 4 of 4 | N/a | 4 of 4 |
| **Amanda Venner, Director of** | Amanda Venner is a Chartered CIPD professional. Previously, she | 17 of 19 | N/a | 7 out of 8 | 2 of 4 |

| Name and Position | Background | Board<br><br>19 meetings in total | Group Audit Committee<br><br>4 meetings in total | Group Remuneration Committee<br><br>8 meetings in total | Council of Governors<br><br>4 meetings in total |
|---|---|---|---|---|---|
| **People and Organisational Development** | held the position of Deputy Director of People and Organisational Development at the Trust, where she was the senior operational lead for the function, overseeing the full range of services. Prior to this role, Amanda held senior workforce positions in the ICS and at Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust, | | | | |
| **Carmen Howey, Medical Director** | Dr Carmen Howey, a Consultant Paediatrician, graduated from Newcastle University in 2001 and following completion of training was appointed as a Consultant at Gateshead NHS Foundation Trust in 2012. Positions held within the Paediatric Team included College Tutor, Named and Designated Doctor for Safeguarding Children, and Clinical Lead Paediatrician. In 2021 she became Clinical Head of Service for the medicine Business Unit and became Medical Director in July 2024. | 14 of 19 | N/a | N/a | 4 of 4 |
| **Neil Halford, Medical Director for Strategic Relations** (non-voting member, retired March 2026) | Neil Halford was appointed as the Medical Director for Strategic Relations in July 2024 as a non-voting member of the Board. He was previously the Medical Director of Operations at the Trust and Interim Medical Director. | 16 of 17 | N/a | N/a | 3 of 4 |
| **Beth Swanson, Interim Chief** | Beth served as Director of Nursing and Deputy Group Chief Nurse at North Tees and Hartlepool NHS | 11 of 11 | 2 of 2 | N/a | 1 of 2 |

| Name and Position | Background | Board<br><br>19 meetings in total | Group Audit Committee<br><br>4 meetings in total | Group Remuneration Committee<br><br>8 meetings in total | Council of Governors<br><br>4 meetings in total |
|---|---|---|---|---|---|
| **Nurse** (from 20 October 2025) | Foundation Trust, part of the University Hospitals Tees Group and has 30 years of nursing experience. She has served as Chair and Nurse Advisor for the National Audit of Dementia and was a member of the Chief Nursing Officer's Excellence Advisory Forum. | | | | |
| **Gavin Evans, Managing Director, QE Facilities (non-voting attendee)** | Gavin was appointed as Managing Director of QE Facilities in February 2024. He has significant estates and facilities experience in the NHS and joined QE Facilities from Newcastle upon Tyne Hospitals NHS Foundation Trust where he was the Deputy Director of Estates. | 18 of 19 | N/a | N/a | 2 of 4 |
| | ***Non-Executive Directors*** | | | | |
| **Alison Marshall, Chair** (second term ended 30 September 2025) | Alison Marshall was Chair from October 2019 to September 2025, having previously been a non-executive director at Northumbria Healthcare NHS Foundation Trust. Before working in the NHS, Alison was a partner in a large law firm specialising in regulatory law and dispute resolution advising clients from both the public and private sector. | 8 of 8 | N/a | 5 out of 5 | 6 of 6 |
| **Sir Paul Ennals, Chair** (first term commenced on 1 October 2025) | Sir Paul brings vast leadership experience from large, complex organisations at both a national and local level. His professional career has been spent largely within services for vulnerable children and adults and included playing a key role in | 11 of 11 | N/a | 3 out of 3 | 5 of 5 |

| Name and Position | Background | Board<br><br>19 meetings in total | Group Audit Committee<br><br>4 meetings in total | Group Remuneration Committee<br><br>8 meetings in total | Council of Governors<br><br>4 meetings in total |
|---|---|---|---|---|---|
| | steering the Government's Every Child Matters programme during the 2000s. He was awarded a CBE in 2002 for services to children with special educational needs and was knighted in 2009 for services to children. Sir Paul is also president of VONNE and on the board of Net Zero North East England. | | | | |
| **Mike Robson, Deputy Chair and Senior Independent Director** (second term extension ended on 30 June 2025) | Mike is a public sector accountant. He worked in the NHS for over 34 years having been Director of Finance and Corporate Governance and Deputy Chief Executive at South Tyneside NHS Foundation Trust. He previously carried out a similar role at the Royal Victoria Infirmary, Newcastle. | 4 of 4 | N/a | 1 out of 1 | 0 of 1 |
| **Hilary Parker** (second term to 30 June 2026 – left the Board on 31 December 2025) | Hilary joined the Trust Board in July 2020. She joined the Board of QE Facilities in October 2020. She has a wide experience in both the public and private sectors. She was a partner in a solicitors' practice for 30 years and was also a non-executive director of the Newcastle Hospitals NHS Foundation Trust for many years. | 10 of 11 | 2 of 3 | 4 out of 6 | 3 of 3 |
| **Andrew Moffat** (second term to 30 June 2026 – left the Board on 30 June 2025) | During his executive career, Andrew has gained experience in the water, telecommunications and ports sectors, occupying senior financial, commercial and strategic roles both in the UK and internationally. He was Strategy Director at | 4 of 4 | 1 of 1 | 1 out of 1 | 1 of 1 |

| Name and Position | Background | Board<br><br>19 meetings in total | Group Audit Committee<br><br>4 meetings in total | Group Remuneration Committee<br><br>8 meetings in total | Council of Governors<br><br>4 meetings in total |
|---|---|---|---|---|---|
| | Orange, Chief Finance Officer at Three (Italy), CFO at Three (UK) and after joining the Port of Tyne as Finance and Commercial Director in 2007 became Chief Executive for 10 years until 2018. He has sat on several regional regeneration Boards including the North East LEP, where he also chaired its Investment Board. | | | | |
| **Maggie Pavlou** (reappointed for a second term to 30 September 2027 and reappointed as Chair of the QE Facilities Board to the same date) | Maggie joined the Trust in October 2021. Maggie is a qualified HR professional with extensive experience operating at Board level. Most recently Maggie was the Chief People Officer for Parkdean Resorts. Maggie also has significant experience of non-executive director and trustee roles and was the first female president and chair of the North East Chamber of Commerce. Maggie joined the Board of QE Facilities on 1 October 22 and became Chair on 1 October 2023. | 13 of 19 | 3 of 5 | 6 out of 8 | 3 of 4 |
| **Martin Hedley** (reappointed for a second term commencing on 1 July 2026) | Martin Hedley is the Managing Director of Vision Achievement Limited, a company which delivers specialised recruitment, learning and development services. He has extensive experience in transformation and change management, having delivered global change programmes for companies such as Citibank, Chase Manhattan Bank, and American Airlines. He is an | 11 of 19 | N/a | 5 out of 8 | 3 of 5 |

| Name and Position | Background | Board<br><br>19 meetings in total | Group Audit Committee<br><br>4 meetings in total | Group Remuneration Committee<br><br>8 meetings in total | Council of Governors<br><br>4 meetings in total |
|---|---|---|---|---|---|
| | experienced NHS Non-Executive Director in his final year at Royal Surrey NHS Foundation Trust and is also a Governor at Gateshead College. | | | | |
| **Adam Crampsie** (reappointed for second term commencing on 1 July 2026) | Adam Crampsie is a clinician by background. He has spent 18 years working in healthcare, starting in the NHS before moving into corporate healthcare, then becoming the Commercial and Clinical Development Director of Nuffield Health and now serves as the Chief Executive of Everyturn Mental Health, a charity that delivers specialist mental health services across the North East and England. He is also a Trustee of The Terrence Higgins Trust. | 11 of 19 | N/a | 4 out of 8 | 2 of 4 |
| **Dr Gerry Morrow** (First term commenced 2 December 2024) | Dr Gerry Morrow is a GP by Background. He has served as a Non-Executive Director at North East Ambulance Service NHS Foundation Trust for seven years. In addition, he is a medical director and editor at a healthcare technology company. He also contributes to the National Institute for health and Care Excellence (NICE) as an editor for Clinical Knowledge Summaries. | 18 of 19 | 3 of 4 | 7 out of 8 | 4 of 4 |
| **Andrew Besford** (first term commenced on 1 July 2025) | Andrew has built a substantial body of digital expertise and leadership experience. He has been a Non-Executive Director at Northumbria Healthcare NHS Foundation Trust since 2019 and is Chair of the Digital Committee. | 12 of 15 | N/a | 5 out of 7 | 2 of 3 |
| **Rob Hughes** (first term | Rob has a background in both internal and external audit and is a | 12 of 15 | 3 of 3 | 4 out of 7 | 1 of 3 |

| Name and Position | Background | Board<br><br>19 meetings in total | Group Audit Committee<br><br>4 meetings in total | Group Remuneration Committee<br><br>8 meetings in total | Council of Governors<br><br>4 meetings in total |
|---|---|---|---|---|---|
| commenced on 1 July 2025) | PriceWaterhouse Coopers (PwC) qualified Chartered Accountant as well as an active member of the Institute of Chartered Accountants England and Wales (ICAEW). He has experience as Chief Executive and Accounting Officer at a Multi-Academy Trust in Newcastle. | | | | |

## QE Facilities Board of Directors

The QE Facilities Board of Directors is chaired by Maggie Pavlou, Darren Warneford also serving as Non-Executive Director on the Board, to be joined by Simon Jefferson in early 2026/27.

Gavin Evans, Managing Director leads the Senior Leadership Team within QE Facilities and is a Board Member. Philip Glasgow is QE Facilities' Director of Finance and also forms part of the QE Facilities' Board of Directors. From 1 April 2026 Jane Taylor will join the Board as Executive Director of Corporate Services, as previously outlined.

## Trust Board appointments and performance

The appointment, re-appointment and, if appropriate, removal of the Chair and Non-Executive Directors is the responsibility of the Council of Governors. The Council of Governors delegates responsibility to its Governor Remuneration Committee to oversee these processes and make recommendations to the full Council of Governors. Chair and Non-Executive Director appointments are made based on three-year terms, with appointees serving no more than two terms unless exceptional circumstances arise.

Executive Directors are appointed by the Group Remuneration Committee. The Committee is chaired by the Senior Independent Director, with Non-Executive Director membership. The Executive Director of People and Organisational Development acts as the professional advisor to the Committee, which is also routinely attended by the Chief Executive (except during discussions on their own remuneration). Further information about the Group Remuneration Committee can be found within the Remuneration Report section.

A robust appraisal process is in place for all Directors. The Chair appraises the Chief Executive, and the Chief Executive carries out performance reviews of the other Executive Directors.

The Vice Chair undertakes the performance review of Non-Executive Directors on behalf of the Chair (given Sir Paul Ennals' role as Chair of the three Trusts), and the outcomes of these appraisals are reported to the Council of Governors. Under these new arrangements the Vice Chair continues to be appraised by the Chair.

The performance review of the Chair is led by the Senior Independent Director in accordance with a process agreed by the Council of Governors. The process aligned to the Code of Governance, NHS Leadership Competency Framework and NHS Fit and Proper Person Framework. In addition, it was ensured that the process for 2025/26 was broadly consistent across all three Trusts to support a unified approach to the Chair's appraisals. The outcome is then reported to the Council by the Senior Independent Director.

### Group Audit Committee

The Group Audit Committee is a formal committee of the Board with delegated responsibility to conclude upon the adequacy and effective operation of the overall internal control system including an effective system of integrated governance and risk management. The Audit Committee is a Group Audit Committee, overseeing the controls, governance and risk environment of Gateshead Health NHS Foundation Trust and QE Facilities.

The Committee receives the internal and external audit work plans and reports, as well as the counter-fraud work plan, updates and reports.

The Committee also routinely reviews and approves the schedule of losses and special payments, as well as receiving updates on the work of the Group's Executive Risk Management Group.

In 2025/26 the Committee:

- Reviewed the annual report, Annual Governance Statement, financial statements and other year-end submissions for the Trust and the Charitable Fund before making recommendations to the respective Boards on the approval of these key documents;
- Reviewed the year-end accounts for QE Facilities, and recommended them for approval at the QE Facilities Board;
- Reviewed the Charitable Funds Accounts.
- Sought assurance over the robustness of risk management processes including the Board Assurance Framework (BAF), with regular update reports from the Executive Risk Management Group. This also helped to provide assurance over the work of the Board committees;
- Reviewed Internal Audit updates throughout the year, including providing input on the draft plans presented at the beginning of the year. Progress in implementing audit recommendations was reviewed at each meeting;
- Approved the counter fraud annual work plan and received progress updates as well as updates on ongoing investigations;
- Sought assurance over the controls in place to support compliance with the new failure to prevent fraud corporate offence;
- Reviewed the external audit reports in respect of the 2024/25 year-end and reviewed progress made in implementing external audit recommendations throughout the year;
- Approved the losses and special payment reports;
- Received the Managing Conflicts of Interest policy compliance report;
- Received an update on compliance with the Non-Audit Services Policy;
- Received a report providing assurances on the process in place for the management of clinical audit across the organisation and the clinical audit annual report, seeking assurance over the processes and controls in place to develop and deliver the plan;
- Reviewed and approved the proposed approach to providing the Committee with assurance over litigation register, with full reporting to commence in 2026/27;

- Reviewed updates made to the Corporate Governance Manual (the Standing Orders, Standing Financial Instructions and Scheme of Delegation) and recommended the document to the Board for approval;
- Reviewed the Freedom to Speak Up processes and controls; and
- Reviewed the effectiveness of internal audit, external audit, counter-fraud and the effectiveness of the Committee itself. This was undertaken in a multi-disciplinary way with the aim of identifying good practice and any areas for consideration going forwards. This also included the alignment of the terms of reference for the Committee with the latest Healthcare Financial Management Association (HFMA) Audit Committee Handbook.

Forvis Mazars LLP are the Trust's external auditor, as appointed by the Council of Governors. The audit of the 2025/26 accounts is the fifth year of external audit contract (an initial three year contract which was extended by the Council of Governors for a further two years). Forvis Mazars LLP's fee for the core audit work for 2025/26 is proposed to be £115k.

Forvis Mazars LLP also undertake the audit of QE Facilities and a fee of £50k is proposed for 2025/26.

A procurement process to appoint external auditors for 2026/27 was commenced prior to the year-end (given that 2025/26 is the last year of Forvis Mazars LLP's contract), noting that this appointment will be made by the Council of Governors.

In line with the previous year Robson Laidler will complete the 2025/26 audit of the Charitable Fund before the statutory deadline of 31 January 2027. The fee for this work is proposed to be £6k.

During the year no non-audit services were provided, with the exception of the audit of the subsidiary company, QE Facilities. The audit of the subsidiary company is excluded from the National Audit Office's 70% threshold for non-audit services work.

The internal audit function for the Trust and QE Facilities continues to be provided by the NHS Audit Consortium AuditOne. AuditOne also provide the counter-fraud service to the Trust.

## Council of Governors

The Council of Governors is the accountability forum between the Board of Directors and the Trust's stakeholders. It represents local interests and holds Non-Executive Directors to account as well as exercising its statutory powers.

The Council is comprised of elected Governors and appointed Governors, who are all volunteers. Elected Governors (public and staff constituencies) may hold office for a period of up to three years and may stand for re-election twice. After nine years in the role, elected Governors must leave the Council of Governors.

There are 32 members of the Council of Governors, plus the Chair. The composition of the Council is as follows:

- Ten public governors representing the Central and Eastern Gateshead constituency (one vacancy at the year-end);
- Six public Governors representing the Western Gateshead constituency (one vacancy at the year-end);

- One public Governor representing the Patient / Out-of-Area constituency (one vacancy at the year-end);
- Six staff Governors representing the views and interests of the colleagues (one vacancy at the year-end); and
- Eight appointed Governors representing the Trust's key stakeholders and partners (one vacancy at the year-end).

The Council of Governors has several important statutory duties, including appointing and re-appointing the Chair and the Non-Executive Directors, determining their remuneration and terms of service, and approving the appointment of the Chief Executive.

The Council of Governors represents the interests of Foundation Trust public and staff members within the constituencies served, the public and more generally the interests of the stakeholders who hold a position at the Council.

The Council of Governors also holds the Non-Executive Directors to account for the performance of the Board. In setting the Trust's strategy and annual plans, the Board have regard for the views of the Council of Governors.

All Governors are required to comply with the Code of Conduct for Governors and to declare any interests which may result in a potential conflict of interest in their role. A copy of the register of interests can be obtained from the Company Secretary using the contact details at the end of the Annual Report.

The Council of Governors met four times in public and seven times in private during the year. The Council received regular email communications to inform Governor colleagues of the latest updates and developments throughout the year. Governor committees are in place to support and advise the Council.

The Membership, Governance and Development Committee is chaired by the Lead Governor. The Committee meets quarterly and all Governors are considered to be members and therefore receive invitations to attend. The Committee seeks to review a range of governance-related items and leads on membership engagement and recruitment on behalf of the Council, making recommendations to the Council where appropriate. It is also responsible for working with the Company Secretary to develop a training / development programme for Governors. During the year the Committee reviewed the Governor Handbook to ensure that the information for Governors is current and up to date and participated in the development of the Governor dashboard prior to adoption at the Council of Governors. The Committee also reviewed the results of the Council of Governors' effectiveness survey and continues to review the attendance rates for the Council of Governors meeting. The Committee received an update on progress against the objectives within the Membership Strategy and received membership profile information following the database cleanse exercises undertaken for all constituencies.

The Governor Remuneration Committee is responsible for making recommendations to the Council of Governors on the appointment of the Chair and Non-Executive Directors, having satisfied itself that its recommendations fulfil the Trust's needs in terms of skills and experience. It also sets the remuneration, allowances and terms of appointments of the Chair and Non-Executive Directors. The Committee works with the Senior Independent Director and the Chair to agree the process for the evaluation of the Chair and Non-Executive Directors and then subsequently reviews the outcomes of the performance appraisals, which inform remuneration and benefits decisions. The Committee took a lead role in the recruitment process of the shared Chair which included meeting with counterparts

at Newcastle and Northumbria as part of a Joint Nominations Committee (with members drawn from the Governor Remuneration Committee and equivalent bodies in the other two Trusts). The Committee met five times during the year to consider items within its remit, including Chair and Non-Executive Director remuneration, the recruitment of the Vice Chair and Non-Executive Directors, Non-Executive Director succession planning, and the Chair and Non-Executive Director appraisal process. The Committee made recommendations to the Council of Governors on these items.

During 2025/26 the Council of Governors considered a range of items, which included:

- Ratifying the appointment of the new Shared Chair – Sir Paul Ennals (the recruitment process itself commenced in the previous financial year);
- Approving the appointment of the new Vice Chair – Dr Gerry Morrow;
- Approving the appointment of two new Non-Executive Directors – Andrew Besford and Robert Hughes;
- Ratifying the recruitment process for a legal Non-Executive Director to replace Hilary Parker;
- Approving the appointment of the Lead Governor and Deputy Lead Governor;
- Approving the proposed timetable for the External Audit Tender Process; and planned appointment panel composition.
- Engaging and providing views on future models for engagement and representation following the proposals within the NHS 10 Year Plan to remove the requirement for Foundation Trusts to have Governors.
- Engaging and providing feedback on the consultation on the Gateshead Council Joint Health and Wellbeing Strategy
- Providing valuable input into the Quality Account priorities for 2026/27;
- Receiving Board committee presentations from each Non-Executive Director chair, supporting the Council in its role of holding Non-Executive Directors to account;
- Engaging in the medium term planning process and providing feedback on the draft plans;



- Receiving updates on the progress of the Great North Healthcare Alliance vision and work plan;
- Reviewing the outcome of the Council of Governors' effectiveness survey to shape future ways of working; and
- Receiving an assurance report on the outcome of the Chair and Non-Executive Director appraisals, with Governor input into the process via the Lead Governor and Deputy Lead Governor.

## Governor elections 2025/26

Elections in both public and staff constituencies were undertaken on behalf of the Trust by Civica Election Services who are engaged to act as the Returning Officer and Independent Scrutineer for the election process of Gateshead Health NHS Foundation Trust.

A by-election process took place during the year following Board and Council approval to merge the separate public constituencies of Central Gateshead and Eastern Gateshead to become Central and Eastern Gateshead which resulted in filling the three vacant seats. The results were as follows:

| Constituency | Available Seats | Outcome |
|---|---|---|
| Central & Eastern Gateshead | 3 | 4 nominations received and therefore a contested election was held. The following candidates received the most votes and were therefore elected:<br>• John Bedlington – elected to third term of office (1 June 2025 – 4 January 2027)<br>• Paul Johnson – elected to first term of office (1 June 2025 – 4 January 2028)<br>• Sheena Sykes – elected to first term of office (1 June 2025 – 4 January 2028) |

During the by-election process, Abe Rabin resigned from his Public Governor role therefore an additional seat became available and under the election rules, Brenda Webb was offered the remaining terms of office (up to 4th January 2026) as only candidate who had not been elected through the by-election process.

Abe Rabin had been a Public Governor since 2017 and served as Lead Governor during this time. He dedicated a lot of time to the role and to the wider Trust and his contribution to the Council was greatly appreciated by all.

Elections for the terms commencing on 5 January 2026 were held for nine public Governor positions and one staff Governor position. Following the resignation of Mark Learmouth, an additional seat within the Central and Eastern Gateshead Constituency became available for the remaining terms of office (2 years).

The results are as follows:

| Constituency | Available Seats | Outcome |
|---|---|---|
| Staff | 1 | 3 nominations received and therefore a contested election was held. The following candidate received the most votes and was therefore elected:<br>• Dr Kiran Singisetti – re-elected to second term of office (5 January 2026 – 4 January 2029) |
| Central & Eastern Gateshead | 4 | 4 nominations received and 3 candidates elected unopposed:<br>• Steve Connolly – re-elected to third term of office (5 January 2026 – 4 January 2029)<br>• Susan McKenna – elected to first term of office |

| | | |
|---|---|---|
| | | (5 January 2026 – 4 January 2029)<br>• Brenda Webb – re-elected to third term of office (5 January 2026 – 4 January 2029)<br><br>*A further candidate for Central & Eastern Gateshead was successfully elected but did not complete the induction and on-boarding process and therefore did not progress to become a Public Governor.* |
| Western Gateshead | 5 | 4 nominations received and therefore 4 candidates elected unopposed, with one vacancy remaining:<br>• Ray Dennis – re-elected to second term of office (5 January 2026 – 4 January 2028)<br>• Sarah Craig – elected to first term of office (5 January 2026 – 4 January 2029)<br>• Moira Ledger – elected to first term of office (5 January 2026 – 4 January 2028)<br>• Jon Twelves – elected to first term of office (5 January 2026 – 4 January 2029) |
| Patient / Out of Area | 1 | No valid nominations were received therefore one vacancy remains |

Some Governors left the Council in January 2026 at the end of their terms including Les Brown, Public Governor for Western Gateshead, who served as a Governor since January 2020 and Helen Jones, Public Governor for Central and Eastern Gateshead, who served as a Governor since January 2017. In addition Janet Thompson, Staff Governor, stood down from her role in February 2026.

During the year we also welcomed one new appointed Governor to the Council – Professor Barry Hill representing Northumbria University – replacing Professor Joanne Atkinson, who retired from her role at the University.

We would like to record our sincere thanks and appreciation to all those Governors who left during the year for their commitment and contributions to the Council and Trust.

Given the proposed legislation to remove Councils of Governors under the forthcoming NHS Modernisation Bill, we have taken the decision to pause forthcoming election for 2026/27 (i.e. for terms due to commence in January 2027). Continuing with an election cycle for a role that is intended to be phased out would create unnecessary confusion for members, candidates and the wider public. The decision to pause the elections was discussed at the February 2026 Council of Governors and Governors expressed support for the decision. The election process can be reinstated should the Modernisation Bill not be passed by Parliament. We are committed to working with our Council of Governors to identify ways in which the valuable input of the public, our people and partners can be best harnessed to continue to help us to shape our services. A workshop was held with Governors in March 2026 to begin to explore ideas.

The table below shows the composition of the Council during the 2025/26 financial year, including the term dates of Governors and their attendance at the Council of Governors meetings. Where Governors were not eligible to attend certain meetings, an adjusted

denominator is shown (for example where a Governor served on the Council for only part of the year). Those Governors shown in italics were no longer part of the Council of Governors on 31 March 2026.

| Constituency | Governor | Term | Council of Governors meetings attended (maximum of 11) |
|---|---|---|---|
| ***Central & Eastern*** | | | |
| | John Bedlington | First term: 5 January 2019 – 4 January 2022<br>Second term: 5 January 2022 – 4 January 2025<br>Third term: 1 June 2025 – 4 January 2027 | 4 of 8 |
| | Steve Connolly | First term was served as a staff Governor prior to a constitutional change.<br>Second term: 5 January 2023 – 4 January 2026<br>Third term: 5 January 2026 – 4 January 2029 | 11 of 11 |
| | Carol Hindhaugh | First Term: 5 January 2025 – 4 January 2028 | 11 of 11 |
| | Paul Johnson | First Term: 1 June 2025 – 4 January 2028 | 7 of 8 |
| | *Helen Jones* | *First term: 5 January 2017 – 4 January 2020*<br>*Second term: 5 January 2020 – 4 January 2023*<br>*Third term: 5 January 2023 – 4 January 2026* | *6 of 9* |
| | *Mark Learmouth* | *First term: 5 January 2025 – 4 January 2028 – resigned as of 25 September 2025* | *3 of 6* |
| | Michael Loome | First term: 5 January 2024 – 4 January 2027 | 11 of 11 |
| | *Abe Rabinowitz* | *First term: 5 January 2017 – 4 January 2020*<br>*Second term: 5 January 2020 – 4 January 2023*<br>*Third term: 5 January 2023 – 4 January 2026 – resigned as of 29 April 2025* | *n/a* |
| | Susan McKenna | First term: 5 January 2026 – 4 January 2029 | 2 of 2 |
| | Sheena Sykes | First term: 1 June 2025 – 4 January 2028 | 7 of 8 |
| | Karen Tanriverdi | First term: 5 January 2018 – 4 January 2021 | 11 of 11 |

| Constituency | Governor | Term | Council of Governors meetings attended (maximum of 11) |
|---|---|---|---|
| | | Second term: 5 January 2021 – 4 January 2024<br>Third term: 5 January 2024 – 5 January 2027 | |
| | Brenda Webb | First term: 5 January 2022 – 4 January 2025<br>Second term: 1 June 2025 – 4 January 2026<br>Third term: 5 January 2026 – 4 January 2029 | 2 of 8 |
| | *1 vacancy as at year-end* | | |
| ***Western*** | | | |
| | *Les Brown* | *First term: 5 January 2020 – 4 January 2023*<br>*Second term: 5 January 2023 – 4 January 2026 (did not stand for third term)* | *7 of 9* |
| | Sarah Craig | First term: 5 January 2026 – 4 January 2029 | 0 of 2 |
| | Ray Dennis | First term: 5 January 2023 – 4 January 2026<br>Second term: 5 January 2026 – 4 January 2028 | 9 of 11 |
| | Moira Ledger | First term: 5 January 2026 – 4 January 2028 | 2 of 2 |
| | Dr Lakkur Murthy | First term: 5 January 2024 – 4 January 2027 | 5 of 11 |
| | Jon Twelves | First term: 5 January 2026 – 4 January 2029 | 2 of 2 |
| | *1 vacancy as at year-end* | | |
| ***Patient / Out of Area*** | | | |
| | *1 vacancy as at year-end* | | |
| ***Staff*** | | | |
| | Helen Adams | First term: 5 January 2022 – 4 January 2024<br>Second term: 5 January 2024 – 4 January 2027 | 8 of 11 |
| | Lynsey Curry | First term: 5 January 2023 – 4 January 2024<br>Second term: 5 January 2024 – 4 January 2027 | 9 of 11 |
| | Andrew Lowes | First term: 5 January 2022 – 4 January 2025<br>Second term: 5 January 2025 – 4 January 2028 | 2 of 11 |
| | Adaeze Obiayo | First term: 5 January 2024 – 4 January 2027 | 6 of 11 |

| Constituency | Governor | Term | Council of Governors meetings attended (maximum of 11) |
|---|---|---|---|
| | Kiran Singisetti | First term: 5 January 2023 – 4 January 2026<br>Second term: 5 January 2026 – 4 January 2029 | 0 of 11 |
| | *Janet Thompson* | *First term: 5 January 2025 – 4 January 2028 – resigned as of 11 February 2026* | *6 of 9* |
| | *1 vacancy as at year end* | | |
| ***Appointed*** | | | |
| *Northumbria University* | *Joanne Atkinson* | *From September 2024 to August 2025* | *1 of 4* |
| Northumbria University | Professor Barry Hill | From August 2025 | 4 of 7 |
| Newcastle University | Dr Gemma Frances Speirs | From September 2023 | 8 of 11 |
| Gateshead College | Chris Toon | | 6 of 11 |
| Gateshead Jewish Community | Aron Sandler | | 9 of 11 |
| Gateshead Council | Cllr Dorothy Burnett | From July 2024 | 3 of 11 |
| Gateshead Voluntary Sector – Connected Voice | Julia Perry | From September 2024 *(note that a temporary pause in the position was enacted during the year in agreement with the Trust)* | 4 of 4 |
| Healthwatch Gateshead | Michael Brown | From January 2025 | 0 of 11 |
| *Gateshead Youth Assembly* | *Vacancy* | | |

## Governor training and development

During 2025/26 we provided our Governors with a number of training and development opportunities. Governor workshops were held in June 2025, October 2025, January 2026 and March 2026. This included opportunities to engage in the development of the Quality Account priorities for 2026/27; the medium term planning process and cost reduction plans; and engaging and providing views on future models for engagement and representation following the proposals within the NHS 10 Year Plan to remove the requirement for Foundation Trusts to have Governors.

Quarterly Governor workshops are diarised throughout 2026/27 to protect time for further training, development and engagement outside the Council meetings.

## Lead and Deputy Lead Governors

The Council of Governors appoints a Lead Governor and a Deputy Lead Governor on an annual basis. The process for 2026/27 commenced in February 2026 and due to the upcoming legislative changes, that may remove Councils of Governors by April 2027, an alternative option to the usual appointment process was considered and approved by the Council of Governors. It was agreed to extend the current appointments of Steve Connolly as Lead Governor and Michael Loome as Deputy Lead Governor to provide stability and continuity until the Council ceases to exist, until 18th May 2027 or until their Governor terms of office expire.

## The Board's relationship with the Council of Governors

The Board of Directors and the Council of Governors work together closely throughout the year. All Board Members are invited to attend all meetings of the Council of Governors. Non-Executive Directors are also invited to attend quarterly Governor workshops.

There are two Governor observers appointed to attend specific Board committees. The Governor observers have an opportunity to meet with the Non-Executive Director chairs of the committees to share feedback following the meeting. The Governor observers also share feedback privately with Governor colleagues, supporting them to discharge the role of holding Non-Executive Directors to account.

The Standing Orders detail the procedure through which the Council of Governors can raise concerns about the Board of Directors, as required by the Code of Governance for NHS Provider Trusts.

## Foundation Trust membership

Foundation Trust membership seeks to give local people and staff a greater influence on how our services are provided and developed. As part of the development of the annual plan, our Governors are invited to share the views of their communities and members through a series of workshops with the Board.

There are several different constituencies to which our members belong. Those eligible to become public members are people over the age of 16 who live in Gateshead and the immediate surrounding area which is divided into two constituencies: Western; and Central and Eastern Gateshead. We also have an Out-of-Area constituency, which is coterminous with the geographical boundaries of the North East and North Cumbria Integrated Care System (NENC ICS).

People over 16 years of age, living in these areas who wish to become a public member of Gateshead Health NHS Foundation Trust, must complete and have accepted a membership application form. Members can vote to elect Governors for their constituency and can choose to be nominated to stand for election as a Governor.

Patient membership is available to individuals who live outside constituency areas but who have used any of the Trust's services within the seven years immediately preceding the date of their application for membership. Patient members are included in the Out of Area constituency.

## Membership profile

All constituencies have undergone a database cleanse over the last two years to ensure that our membership database is accurate and up to date. The benefit of the exercise is that we

have an up-to-date membership database, and we can be assured that it accurately reflects those who wish to be current members and want to receive communications and opportunities to engage with the Trust. The outcome of the exercise has resulted in a reduced membership base and is outlined below.

As of 31st March 2026, the total number of public members was 2,780 compared to 5,524 at 31st March 2025 and equates to a 50% decrease. Our public membership profile is as follows:

| Population/Public Membership Ratio at 31 March 2026 | | | |
|---|---|---|---|
| | **Western** | **Central & Eastern** | **Out of Area** |
| **Population** | 77,471 | 134,443 | Unknown |
| **Membership** | 744 | 1,844 | 192 |
| **%** | **1.0** | **1.4** | Unknown |

The decrease in the membership base is highlighted below:

| Membership base for all constituencies | | | | |
|---|---|---|---|---|
| | **Western** | **Out of Area** | **Central & Eastern** | **Total** |
| **Membership prior to cleanse** | 3,184 | 499 | 8,635 | 12,318 |
| **Membership following cleanse** | 744 | 192 | 1,844 | 2,780 |
| **Decrease %** | **77%** | **62%** | **79%** | **77%** |

Following the cleanse, we now have 2,466 members who will receive email correspondence and 314 members who wish to remain postal members.

Whilst this is a significant decline in the overall number of members it means that we have assurance that those individuals who remain as members actively wish to receive information about the Trust and retain involvement and engagement.

Colleagues employed by the Trust or its subsidiary, QE Facilities, are automatically Foundation Trust members for the duration of their employment, unless they choose to ‘opt out’. Employees of the Trust cannot be public members.

Colleagues whose services are contracted for by the Trust, colleagues not employed by the Trust but who in effect work in and with the Trust for most of their time are given the same status as employees, if they wish, provided they have worked with the Trust for a minimum of one year.

The number of staff Foundation Trust members as at 31st March 2026 was 5,168 (compared to 5,347 members as at 31st March 2025). The reduction in numbers is purely due to changes in overall headcount between these dates.

The Council of Governors represents the views of members and helps to shape the way our services are delivered therefore are keen to hear from members. Our Governors have held some recent engagement events which has provided members with the opportunity to meet some of our Governors representing our constituencies.


## Get in touch

To contact a Governor, please send your enquiry to: ghnt.governors@nhs.net, alternatively you can submit your query to: Corporate Services Office, FREEPOST NAT14353, Gateshead Health NHS Foundation Trust, Queen Elizabeth Hospital, Sheriff Hill, Gateshead NE9 5BR

You can also visit https://www.gatesheadhealth.nhs.uk/about/governors/

## Mandatory declarations

The Directors consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

## Well-led arrangements

The Board has demonstrated due regard to well-led principles and the well-led framework throughout the year. This included a number of different workstreams / projects which align with well-led principles / key lines of enquiry, including:

- The review of the governance structure supporting the work of the Board and its committees. This included the establishment of an Executive Committee, adjustments to delegated decision-making and a revised group structure;
- Focussed work on organisational culture, including inclusivity and communications;
- Extensive engagement and involvement in the development of the corporate strategy and the clinical strategy;
- Reflective reviews against key external reports such as the Aubrey report into governance within breast services at a neighbouring trust;

- Completion of the Provider Capability Self-Assessment as defined by the NHS Oversight Framework; and
- Developing our partnership and collaborative working at place, neighbourhood and particularly through the Great North Healthcare Alliance.

Ensuring that we have effective governance in place enables our Board to be assured over the services we provide to our patients and the working environment we provide for our people.

There are no material inconsistencies between the annual governance statement, other parts of the annual report and reports arising from CQC inspections.

## Patient care

Delivering excellent patient care is one of our four key priorities, underpinned by three key objectives:

- We will be a clinically-led organisation focused on delivering safe, high-quality care and improving health outcomes for our patients
- We will ensure our patients experience the best possible compassionate care and make every contact count
- We will continually improve our services creating a restorative culture where learning, innovation and research can flourish

The delivery of excellent, safe, high-quality and innovative services is at the heart of everything we do.

### *Overview of performance against key quality targets*

The Quality Governance Committee and the Board of Directors monitor performance against several key quality targets through the *Strategic Objectives: Leading Indicators and Breakthrough Objectives* report. Trust performance is measured against a mixture of nationally mandated indicators and locally determined measures.

The Quality Governance Committee and Board of Directors also receive a dedicated maternity integrated oversight report, which includes detailed quality and performance information on our maternity services. This report is presented by the Associate Director of Midwifery / Special Care Baby Unit.

In addition, the Quality Governance Committee receives a suite of other reports providing assurance against key quality targets, including patient safety reports, patient experience reports, safeguarding reports, health inequalities reports and learning from deaths reports.

Our performance against a range of quality metrics is outlined in this section, although our Quality Account for 2025/26 provides more detail on our performance against a wider range of key quality targets across the three domains of patient safety, clinical effectiveness and patient experience.

With regards to key safety metrics:

- 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.  Since October 2011 the mortality of the Trust in

respect of the SHMI has been banded predominantly as ‘as expected’ and has never been banded as ‘higher than expected’. The latest SHMI for December 2024 to November 2025 is 1.07. (The England average is 1.00);

- The Trust reported 47 cases of **clostridium difficile infections (CDIs)** against the threshold of 36 (compared to 48 cases against a threshold of 37 cases the previous year). The threshold is calculated by Public Health England (PHE). Internal reviews of all healthcare associated cases are undertaken in accordance with the Patient Safety Incident Response Framework (PSIRF) to identify learnings and required actions;
- There was 1 **Methicillin-Resistant Staphylococcus Aureus** (**MRSA) bacteraemia** apportioned to the Trust post-48 hours of admission compared to 1 in the previous year;
- Our overall **rate of falls per 1000 bed days** increased from 8.38 in 2024/25 to 9.46 in 2025-26, above the threshold of 8.5;
- The **rate of harm falls per 1,000 bed days** was 4.35, above the threshold of 2.25, and the ratio of harm to no harm falls decreased from 46.1% in 2024/25 to 45.9% in 2025/26. We recognise the importance of reducing the rate of harm falls and this is priority area for 2026/27;
- We reported one **never event** in 2025/26, with one never event reported in 2024/25;
- Our **patient incidents per 1,000 bed days** increased to 46.9 compared to 39.5 in the previous year;
- The proportion of patients who are **readmitted within 28 days** across the Trust reduced from 7.70% to 7.52%, sustaining year-on-year improvement (note that these figures are taken from Healthcare Evaluation data (HED) and provide full financial years for 2023/24, 2024/25 and April to December 2025/26); and
- The percentage of patients who returned to theatre within 30 days increased slightly from 4.17% in 2024/25 to 4.35% in 2025-26.

*Monitoring quality compliance*

Gateshead Health NHS Foundation Trust are appropriately registered with the Care Quality Commission (CQC) and our current registration status is ‘registered without conditions’.

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

We have not participated in any special reviews or investigations by the CQC during the reporting period. There were no announced or unannounced inspections by the CQC during 2025/26.

The Trust received a Mental Health Act (1983) Monitoring visit during 2025/26 on Cragside ward in January 2026. Positive feedback was received both verbally and by way of a formal report to the Chief Executive noting areas of good practice and stating that improvements were noted in response to past concerns identified.

In the report CQC shared that patients were very complimentary about the care and support being provided to them, stating that they were treated with dignity and respect by staff. They

felt that they could always access support from staff if they needed help and reassurance. One patient who was to be discharged imminently told CQC he did not want to leave the ward and said that the nurses were like his family.

Feedback from carers was consistently positive, with carers expressing high levels of satisfaction with care, communication, staff attitudes, and the ward environment.

All carers reported that their relatives had either shown significant improvement or had stabilised since their admission, particularly in relation to aggression, distress, or hallucinations. They described staff as skilled, patient, and compassionate, particularly in challenging situations such as managing aggression and complex physical health needs. Carers felt confident that their relatives' mental and physical health needs were well managed, including conditions such as diabetes, epilepsy, heart failure, mobility issues, and personal care needs. One carer described the ward as having "saved [their] mam's life."

Carers described staff as friendly, welcoming, and caring, with strong relationships developed between staff and both patients and families. They told CQC that the ward doctor gave good explanations to carers and had a good understanding of the individual needs of patients. A carer noted that all staff "went the extra mile."

The carers CQC spoke with told them that they felt well informed and involved in care planning and decision-making. They said that staff regularly updated them, invited them to meetings, and that they were able to express their views, which they felt were listened to and respected. Carers described communication as timely and reliable.

Carers spoken with on Cragside praised the quality of care being provided to their loved one, stating that all staff were very good and genuinely caring. One carer added that communication with the ward was consistently good and regular updates were always provided and described the area as welcoming and comfortable for their relative and there was always flexibility with visiting times, with protected mealtimes for patients being clearly explained to the carer and their family.

Discharge planning was a key theme raised by carers. Carers told CQC that they appreciated being involved in discussions, though several noted delays in social work input and difficulties securing suitable placements. In some cases, ward staff took proactive steps to support families by identifying potential care homes and chasing referrals. One carer expressed sadness about their relative having to move on from the ward. They said that the ward staff knew their relative well, understood their care needs and provided highly individualised care.

Carers described the ward environment as clean, calm, and thoughtfully designed, with comfortable communal areas and personalised touches to support patients with dementia. Activities were viewed positively, including outings, visits from school children, access to books and music, and flexibility around family visits (including children and pets). These were felt to enhance patients' wellbeing.

### *Service developments and achievements*

We have continued to develop and enhance our services during the year to ensure that we provide the best possible care to our patients.

Continuous improvement work within the **Emergency Department and Same Day Emergency Care** (SDEC) has significantly improved our Emergency Department performance, allowing us to streamline delivery in line with current patient expectations.

Our **frailty services** continued to expand during the year, delivering measurable improvements in patient care, operational flow, and overall system efficiency.

The **Acute Frailty Service**, delivered by a highly skilled multidisciplinary team within A&E, is led by a Consultant Geriatrician and Specialist Frailty Practitioner. The team brings together expertise from medicine, therapy, and pharmacy to provide rapid Comprehensive Geriatric Assessments for patients aged 65 and over. Operating daily from 8:30am to 4:30pm, with consultant-led input each morning, the service ensures patients receive timely, holistic assessment and ongoing support through the Emergency Assessment Unit (EAU) and SDEC. This proactive approach is helping to avoid unnecessary admissions while maintaining patient safety and flow through the department.

In February 2026 alone, 173 patients were assessed, and through early intervention, 25 hospital admissions were avoided. This equates to approximately 250 bed days saved, demonstrating how early specialist input can significantly reduce the need for inpatient care while improving patient flow and experience.

Complementing this, the expansion of the **Frailty Virtual Ward** represents a major step forward in delivering care closer to home – a key principle of the NHS 10 Year Plan. Led by a Consultant Geriatrician and supported by a multidisciplinary team, the service provides hospital-at-home care for patients aged 65 and over across Gateshead. Managing both “step-up” (admission avoidance) and “step-down” (early discharge) patients, the service ensures continuity of care while reducing reliance on acute hospital beds. The team delivers a wide range of clinical interventions at home, including IV antibiotics, oxygen therapy, fluids, and regular clinical reviews.

Operating weekdays from 9am to 5pm, with rapid response support outside of these hours, the service is well integrated with partners including North East Ambulance Service, GP practices and community teams. Early data highlights strong and sustained utilisation, with the Frailty Virtual Ward maintaining an average daily caseload of 9.5 patients in January 2026. This demonstrates its vital role in supporting patients safely outside of hospital while easing pressure on acute services.

Together, our frailty services demonstrate a modern, integrated approach to frailty care—delivering the right care, in the right place, at the right time. By preventing avoidable admissions, reducing length of stay, and shifting care into the community, they are improving outcomes for patients while supporting more efficient use of hospital capacity.

Our **gastroenterology** service implemented a new advice and guidance model which has reduced waiting times for new patients. This allows an experienced Gastroenterologist to ring patients on receipt of referral, address any queries immediately, assess and prescribe appropriately and refer direct to test for those patients who require this. It has also resulted in a reduction over 450 patients on the waiting list.

Led by the gastroenterology team, all clinical teams within Medicine have reviewed their **18 week referral to treatment pathways** and developed models for enhanced triage which has allowed the teams to reduce the waiting times for first appointments and ensure that those patients who require tests before they can be diagnosed are referred promptly.

We were delighted to open **redeveloped facilities for women and children** in February 2026, following a £7.4 million investment to modernise our estate. The Northern Gynaecological Oncology Centre (NGOC) provides a modern, high quality, calm environment with enhanced privacy and dignity for patients.


The Children and Young People's Department has been designed to provide a calm, soothing environment to reduce anxiety. It includes age-appropriate play areas as well as wooden trees funded by a generous £18,000 donation from the legacy of Gwen Sells via our charity.

Colleagues in QE Facilities and Robertson Construction were integral in refurbishing two former wards in our 1930s building into modern, high-quality estate.

The project supported the local economy with 94% of spend with small and medium-sized businesses and 90% of the spend kept within 30 miles, ensuring local people who will benefit from these facilities also benefited throughout delivery.

Our **maternity services** have been ranked in the top five of all trusts nationally in the Care Quality Commission's (CQC) 2025 National Maternity Survey, receiving an overall positive score of 92.5%. Pregnant people and families consistently praised staff for their compassion, respect, and individualised care. This is fantastic news for our patients and local community and testament to our colleagues' commitment to the delivery of high-quality compassionate care.

Our **Breast Service** has launched a unique set of children's books, written by specialist breast care nurses Emily Turnbull and Rachel Lockerbie with illustrations from Kirsty Reilly. The books are designed to help explain cancer treatment to children whose parents have been diagnosed with breast cancer. The project was funded by the Women's Cancer Detection Society (WCDS) led by Kathryn Jobes, fundraising manager. The books are provided free of charge to patients at the hospital and have received excellent feedback from patients, their families and healthcare professionals. The books are available in Birtley, Gateshead and Whickham libraries and presentations have been delivered to local schools. The books have attracted interest nationally and we are incredibly proud of our team.


Our **Secondary Prevention Service** won the prestigious Health Service Journal (HSJ) Award for Medicine, Pharmacy and Prescribing Initiative of the Year. The service is the first team in the UK dedicated to looking after patients who have had a whole range of serious heart and circulation problems in a comprehensive manner. This specialist team works to manage all related heart, kidney and metabolic risk factors (like diabetes and obesity), to reduce chances of a repeat event, after people have experienced a heart attack, angina, a stroke, a mini-stroke (TIA), or poor circulation in the limbs. The service brings together a team of different consultants including a diabetes and cholesterol specialist, cardiologist, kidney specialist and stroke specialist, along with a specialist pharmacist and specialist nurses.

This collaborative and streamlined approach, which we implemented in 2023, has been shown to deliver better clinical results while providing value for money within the local health system, as patients receive a bespoke treatment plan addressing multiple risk factors, built on advice from a team of specialists while only needing to attend a single clinic.

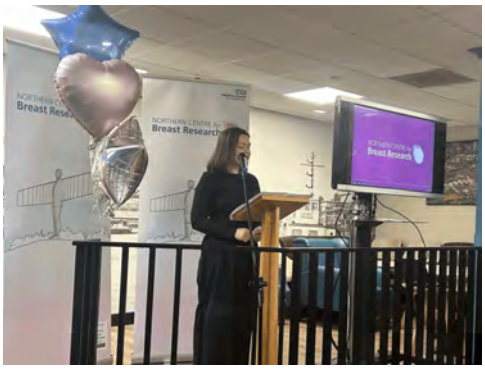
In October 2025 we celebrated the first anniversary of the **Community Diagnostic Centre** (CDC) in partnership with The Newcastle-upon-Tyne Hospitals NHS Foundation Trust. Since opening in October 2024, the Centre has already supported more than 75,000 patients to access scans and diagnostic checks in a convenient community location. That not only improves outcomes but also reduces demand on hospital sites. The CDC is an example of the NHS 10-Year Plan in action, by improving access to care, supporting earlier diagnosis and delivering services closer to home.

Towards the end of the year we were able to secure funds in excess of £10 million to enable us confirm the expansion into phase 2 of the CDC. The development will continue to:

- Help to meet rising demand for diagnostic tests;
- Support reduction of waiting times for diagnostic tests supporting diagnostic, cancer and referral to treatment targets; and
- Increase local system resilience and improve access to services whilst supporting the move towards neighbourhood healthcare provision.

The second phase of the CDC will be operated by Gateshead and will provide access to diagnostics to the wider region supporting the move to constitutional standards for a number of trusts in the NENC ICB region. Locating them in a community setting builds resilience into local service provision. Investment in NHS facilities in a retail setting supports the ‘Health on the High Street’ agenda, recognising that the NHS can support local communities to generate economic, social and health benefits.

Phase 2 will provide capacity for an additional 38,000 diagnostic procedures. The additional services will include an additional MRI scanner, an additional Non-Obstetric Ultrasound, an additional X-ray, outpatient hysteroscopy facilities and Outpatient and procedure rooms to support neighbourhood health and diagnostic / treatment pathways



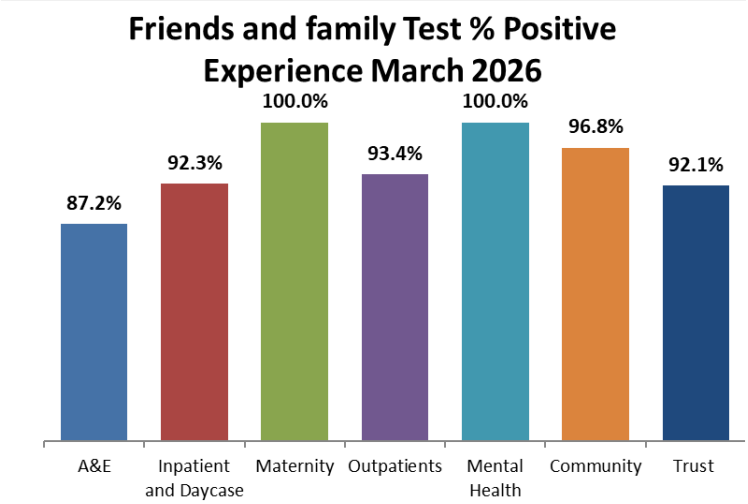
In September 2025 we were delighted to launch our **Northern Centre of Breast Research**. This marked a significant step in our ambition to become the Northern Centre of Excellence for Women's Health. The Centre brings together clinicians, researchers and academic partners to deliver world-class breast care research. Its work will focus on improving diagnosis, treatments, and broadening access to clinical trials, helping to embed research as part of standard patient care. The Centre forms part of our commitment to expanding research and innovation capacity across women's health.


Our Children's Bladder and Bowel department have been awarded the '**Gold Standard for Autism Acceptance**' from the North East Autism Society. Over the past year, the team has worked closely with NE Autism Society to enhance their environment, communication approaches, and care pathways to better support neurodivergent children and their families.

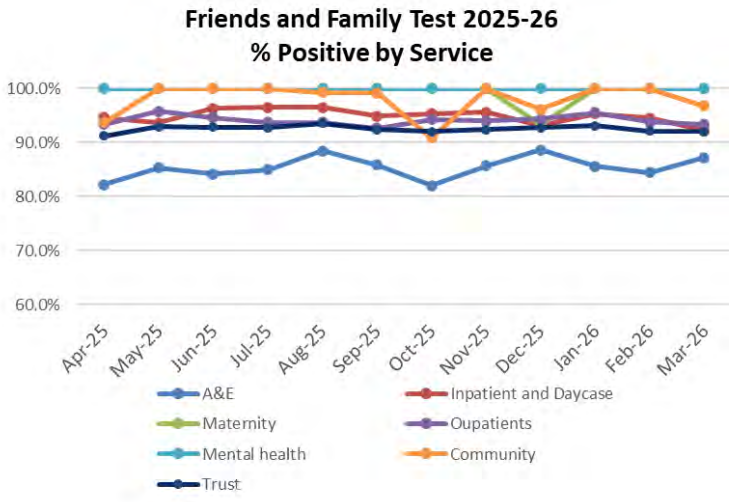
Two of our dedicated **Specialist Nutrition Nurses**, Amy Molloy and Louise Dudey, were recognised on the national stage for their outstanding work in community care. Amy and Louise are part of the Dietetic Home Enteral Feeding (HEF) team and were shortlisted for the prestigious 'Community Nutrition Professional of the Year' award at the 2025 Complete Nutrition (CN) Awards. They were nominated for their pioneering work on the Enteral Feeding Alert project, an innovative system designed to ensure that any patient with a feeding tube is quickly identified and supported upon arrival at the hospital. The HEF team's mission is simple yet powerful: to help people in Gateshead manage their enteral feeding needs safely at home with confidence and the proper support, thereby reducing avoidable hospital stays.

### *Service user feedback*

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. It offers valuable, real-time feedback from those who use our services, helping us to celebrate what we're doing well and identify areas where we can improve.




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




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

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

During the year we also received the results of a number of external surveys. Our cancer care was highly praised by patients in the National Cancer Patient Experience Survey. Patients gave the Trust a rating of 9.2 out of 10, above the national average of 8.9. We achieved above average scores across all areas, reflecting our commitment to delivering exceptional and compassionate care to our patients.

We also performed well in the Adult Inpatient Survey, which is conducted by Picker on behalf of 61 trusts. The survey captures feedback from patients who stayed overnight in our hospitals between January and April 2025. Overall we were ranked 12th out of 61

organisations. 98% of patients felt treated with respect and dignity and 98% had confidence and trust in our doctors. We improved our scores in areas such as helping patients eat meals and identified some areas for further focus, such as ensuring that colleagues explain the reasons for ward changes at night to our patients.

Our excellent outcomes in the CQC maternity survey were highlighted in the previous section.

In addition to gathering patient feedback through FFT and external surveys we have also undertaken the following public and patient involvement activities:

- Ward-based engagement supported by Patient Experience Volunteers;
- Involvement of volunteers and Governors in initiatives such as the 15 Steps Challenge, helping teams view services through a patient's perspective; and
- Targeted engagement activity supporting service development, including women's health, community services and screening services.

As outlined earlier in this report we also continued to work with Governors to support their engagement with members and local communities, ensuring public and patient views inform planning, quality improvement and strategy development.
Feedback gathered through these routes has been used to identify areas for improvement, shape service changes and recognise good practice. We remain committed to ensuring that patient and public voices continue to influence decision-making across the organisation.

### *Improvements in patient and carer information*

During 2025/26, we have continued to strengthen our approach to accessible patient and carer communication through the development of a comprehensive Health Literacy workstream. This work has focused on ensuring that information provided to patients, carers and families is easier to understand, more accessible, and supports people to make informed decisions about their care and treatment.

A significant area of progress has been the development of internal workforce capability. Three members of the Patient Experience Team successfully completed regional Health Literacy Awareness, How to Write Simply and Train the Trainer programmes. This has enabled us to establish internal expertise and create sustainable in-house training capacity, reducing reliance on external support and supporting the long-term embedding of health literacy principles across services.

During the year, we also developed and finalised a suite of Health Literacy resources designed to support our people in producing clear, consistent and accessible patient information. These resources were reviewed following feedback from the Health Inequalities Group and prepared for formal ratification through the Trust's governance processes. This work supports a more standardised approach to patient communication and strengthens the quality and consistency of patient-facing materials.

Further work has been undertaken to improve the development and review of Patient Information Leaflets. A new health literacy-informed leaflet development and approval process has been progressed to ensure that patient information is written in plain language, follows best practice guidance, and is accessible to a wider range of patients and carers. This work aligns with our wider ambitions around inclusion, reducing health inequalities and improving patient experience.

We have also continued to strengthen governance and organisational oversight for this work. Regular Health Literacy Strategic Meetings have taken place throughout the year, bringing together colleagues from clinical, operational and corporate services to support cross-Trust collaboration and alignment with wider organisational priorities.

To support sustainability and staff engagement, development work has also been completed on a dedicated Health Literacy intranet page. Once launched, this will provide colleagues with access to guidance, approved templates, training resources and examples of best practice, supporting the consistent application of health literacy principles.

Alongside this work, we have continued to provide interpreting and translation services through an external provider. These services include face-to-face interpretation, telephone and video interpreting, translation of written materials and British Sign Language (BSL) support. Wards and departments continue to have access to devices enabling rapid access to BSL interpretation where required.

Collectively, these improvements will help patients and carers to better understand their care, appointments, treatment options and discharge information. Improving the clarity and accessibility of communication supports patients to feel more informed, involved and confident in managing their health and wellbeing. This is particularly important for patients who may experience additional barriers to understanding healthcare information, including people with learning disabilities, cognitive impairment, sensory impairment, language barriers or lower levels of health literacy. By improving the accessibility of information and communication, we aim to reduce inequalities in access and experience, improve patient engagement and ultimately support safer, more person-centred care.

Over the coming year, we will focus on embedding health literacy principles into routine practice, including the wider roll-out of training, implementation of updated patient information processes, and continued evaluation of patient understanding and experience. This will support our commitment to improving accessibility, reducing communication barriers and ensuring patients and carers are better supported throughout their care journey.

### *Complaints handling*

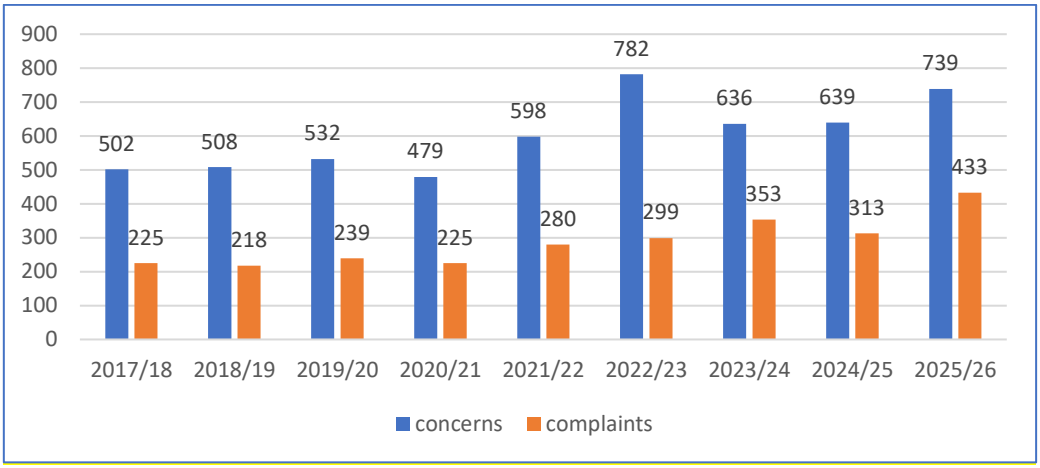
We acknowledge the value of feedback from patients and visitors and continue to encourage the sharing of personal experiences. This type of feedback is invaluable in helping us ensure that the service provided meets the expectations and needs of our patients through a constructive review.

For the year 2025/26 we received a total of 433 formal complaints. Promoting a culture of openness and truthfulness is a prerequisite to improving the safety of patients, staff and visitors as well as the quality of healthcare systems. It involves apologising and explaining what happened to patients who have been harmed as a result of their healthcare treatment when inpatients or outpatients in our care. 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, colleagues 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 Performance Indicators** | **Total 2025/26** |
|---|---|
| Complaints received | 433 |

| | |
|---|---|
| Acknowledged within three working days | 432 |
| Complaints closed | 393 |
| Closed within agreed timescale | 246 |
| Number of complaints upheld | 181 |
| Number of complaints partially upheld | 128 |
| Concerns received by PALS | 739 |

| **Outcome of complaints referred to Parliamentary & Health Service Ombudsman (PHSO)** | **Total 2025/26** |
|---|---|
| Considering whether to investigate | 5 |
| Currently investigating | 1 |
| Complaints upheld | 0 |
| Part upheld | 0 |
| Declined to be investigated | 6 |
| Agreed actions with Trust (incl as a result of learning) | 0 |




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

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

- Communication, confidentiality and consent
- Implementation of care
- Access, admission & discharge
- Car parking

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.

- A new vascular access pathway was introduced;

- Our MRI protocol was revised to support clearer explanations between the MRI team and the requesting clinician;

- Learnings in relation to the use of language and terminology when explaining provisional or uncertain diagnoses to patients and relatives, particularly when the word ‘cancer’ may be involved;

- Delivery of refresher training to colleagues about the administration of numbing spray for endoscopy procedures.

- Updated guidelines for our Pregnancy Assessment Unit (PAU) with clear escalation processes for midwives if a patient attends the PAU with the same symptoms on 2 or more occasions, to ensure timely review, management and ongoing care planning.

Further examples of learnings and improvements made as a result of patient feedback can be found in our Quality Account 2025/26.

### *Stakeholder relationships*

We know that partnership and collaborative working are crucial to support the delivery of services to the communities that we serve along with delivery of our strategy and the national priorities.

Partnership and collaborative working remain key strategic priorities for us and are crucial to support the delivery of services to the communities that we serve along with delivery of our strategy and the national priorities. Front and centre to this work is integrated neighbourhood health, the national framework and policy for which was published in March 2026.

Representatives from across the Trust play a significant role in a number of partnerships and alliances both in leading discussions and also horizon scanning to identify opportunities to further develop levels of integration. These include opportunities outlined within the NHS 10 Year Plan to deliver the three national shifts around hospital to community; treatment to prevention; and analogue to digital.

Through our membership of the North East and North Cumbria Health and Life Sciences Pledge and strong links to the North East and Health Innovation North East and North Cumbria we have opportunities to collaborate beyond statutory organisations to benefit patients and deliver our strategy.

At provider collaborative level, we contributed to discussions and pieces of work around ensuring a strategic approach to clinical services (SACS). We also worked 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.

We recognise the role we play as an anchor institute with the ability to go beyond our role as a healthcare provider and large employer of the local population. This includes our broader responsibility for creating wider societal benefits, promoting health careers, creating jobs, tackling the climate emergency and reducing inequalities. Through our Great North Healthcare Alliance and the single Community Promise framework we contributed to developing a plan of work aligned to the five pillars:


Drawing out education and employment, and recognising the crucial role schools, colleges and universities play in our workforce pipeline, we actively partnered with local education institutions to develop our future workforce. By raising awareness of health careers, expanding apprenticeships and supporting alternative entry routes, we aim to create accessible pathways into employment and growing a diverse, skilled pipeline for the future.

Through our flagship Community Diagnostic Centre (CDC) at the Metrocentre we have strengthened ties with leaders of local businesses and recognise the role our services make to the local economy. We actively contributed to plans around the development of Gateshead via the Area Action Plan.

### Gateshead Place

We are an active member of the Gateshead Health and Wellbeing Board which oversees the delivery of the Gateshead Health and Wellbeing Strategy. We contributed to the refresh of the strategy which included additional objectives aligned to the Marmot principles with an emphasis on tackling racism and discrimination along with addressing environmental sustainability and health equity.

Our Chief Executive, Sean Fenwick along with the Chief Executive of Gateshead Council co-chairs the Integrated Neighbourhood Health Committee. Set up as a sub committee of the Gateshead Health and Wellbeing Board this group brings together leaders from across Gateshead Place with the aim of setting strategic priorities at Place and strengthening the role and impact of neighbourhood health.

Our Director of Strategy and Partnerships, Nicola Bruce, continued to work closely with partners across health and social care including voluntary community and social enterprise

organisations (VCSE) and faith leaders and groups to maximise access and health outcomes for the populations that we serve. We also strengthened our engagement with Healthwatch Gateshead to support improved patient insight and two-way dialogue with communities. We joined Gateshead Strategic Partnership which brings together leads from a wide range of industry and organisations to connect, regenerate and grow Gateshead.

Recognising the impact of the wider determinants of health and levels of deprivation in Gateshead, we signed the Tackling Poverty Partnership Statement of Intent that aims to address inequality and disadvantage.

Our clinicians continued to work closely with colleagues in primary care supported by a monthly interface group that brings together representatives from the Trust and primary care including Primary Care Networks (PCNs), the GP Federation, the Local Medical Committee (LMC) and the ICB to discuss and address issues of strategic importance with the objective of improving access and outcomes for patients.

Our Palliative Care team played a significant part in Compassionate Gateshead events that brought together individuals, families schools, workplaces, faith and community groups to develop a civic-wide compassionate community model, embedding end-of-life care within the fabric of community life.

We aim to continue to grow our presence and role as an anchor institute at Place as the role of neighbourhood health services increases.

### Women's Health

In line with our corporate strategy, our women's health work continued through 2025/26 as we looked to improve access to services with a particular focus on closing the gap on health inequalities and providing an alternative offer for individuals who tend not to access services in traditional healthcare settings. This included a programme of pop-up services in community settings.

We were delighted to welcome Professor Dame Lesley Regan, Women's Health Ambassador for England to Gateshead to see first hand the work our clinical teams are doing in partnership with Change Grow Live – a health and social care charity supporting people affected by drugs and alcohol.

Change Grow Live

Working in partnership with primary care we developed the women's health gateway that looks to streamline pathways of care for women affected by a wide range of clinical conditions.


Aligned to our strategic intent of becoming a centre of excellence for women's health, we once again participated in the Accelerating FemTech programme (2025/26), providing clinical insights and assessments of emerging technologies with the potential to improve women's health outcomes both within the Trust and across the wider community. Our people have contributed as expert panellists at programme events, supporting the national conversation around innovation in women's health and helping shape the future of FemTech within the NHS.

### Great North Healthcare Alliance (GNHA)

During 2025/26, the Great North Healthcare Alliance has continued to strengthen, focussing on delivery within our collaboration with Newcastle Hospitals, North Cumbria Integrated Care and Northumbria Healthcare NHS Foundation Trusts. Building on the foundations established in the two previous years, the Alliance has increasingly translated its strategic

intent into improved relationships between organisations and tangible improvements for patients, such as improved waiting times and easier access.

A defining feature of progress in 2025/26 has been the increased focus on operational collaboration, particularly through a series of bilateral partnerships between Trusts. These bilaterals have provided a pragmatic and flexible mechanism to accelerate delivery in areas of shared priority, allowing organisations to work together in depth where there is the greatest opportunity for impact. While each bilateral reflects the specific needs and strengths of the organisations involved, collectively they represent a positive change in how the Alliance is delivering improvement.

Across the bilaterals there has been significant progress in clinical pathway redesign. Trusts have worked together to review and align pathways across specialties, with a focus on reducing unwarranted variation, improving access, and ensuring patients are treated in the most appropriate setting. This includes supporting services under pressure and supporting more consistent standards of care across the Alliance footprint. A key milestone during the year was the refresh of the Alliance's strategic intent which was approved by all Boards in March 2026. This has sharpened the collective focus on working together to deliver excellent tertiary and secondary hospital services, while strengthening neighbourhood care closer to patients' homes.

The Alliance has also reviewed and begun to share learnings from each of its offers to primary care and developing neighbourhood services. Bilateral and multi-lateral discussions have helped to align approaches by each trust locally to working with neighbourhood partners, with a focus on developing more integrated pathways that support care closer to home.

Collaboration on Community Diagnostic Centres (CDCs) has been a particular area of operational focus. Trusts have worked together to share learning on delivery models, optimise capacity, and improve patient access. There is increasing alignment on how CDCs can be used as a system asset, supporting both elective recovery and earlier diagnosis, particularly in areas of higher deprivation. This work is linked to the Alliance's wider focus on prevention and reducing inequalities which is increasing.

Workforce collaboration particularly has also been a major area of focus. Bilateral partnerships have supported the development of more flexible workforce models, including shared approaches to recruitment, joint appointments, and opportunities for staff to work across organisational boundaries. This has helped address workforce pressures in key specialties while also supporting professional development and retention. Work is also being undertaken with provider partners across the wider North East and North Cumbria area on longer term opportunities around some people support functions.

There has also been progress in exploring shared approaches to corporate services and productivity. Within estates and facilities teams have been collaborating on electronics and medical engineering, plans to reduce carbon and coordination of capital planning. Trusts have also played an important part in designing an Alliance Construction Programme seeking to develop a long term programme of projects to improve our estate for our teams and the communities they serve. In the last year this has involved significant market engagement and work with regional and national colleagues to shape the approach.

The year has also seen important developments in leadership and governance. In particular, the appointment of a shared Chair across Gateshead, Newcastle and Northumbria FTs and the move to a single Alliance Steering Group meeting across all four FTs, including the chief

executives, chairs and vice chairs have enhanced alignment and supported strategic oversight while maintaining the accountability to individual Trust Boards. These leadership arrangements have enabled a more consistent approach to decision-making and prioritisation across the Alliance. Changes in Chief Executive appointments with two acting appointments to Newcastle and North Cumbria from within the existing Alliance family, and the appointment to Gateshead from a neighbouring trust, have been managed collaboratively, ensuring continuity and stability across the Alliance.

A dedicated session with the Integrated Care Board in July provided an important opportunity to align priorities and clarify the contribution of the Alliance to system-wide objectives.

Engagement has remained a priority throughout the year. A joint Governor event brought together representatives from across all four Trusts, providing an opportunity to share progress, build relationships, and gather feedback on future priorities. This has helped to strengthen understanding of the Alliance's role and to reinforce the importance of collaboration in delivering sustainable services.

Overall, 2025/26 has seen the Alliance move from primarily strategic alignment to increasingly tangible operational delivery. The use of bilateral partnerships as a core mechanism for collaboration has enabled more rapid and focused progress, while maintaining a clear collective ambition. Together, these developments position the Great North Healthcare Alliance strongly to deliver further improvements in quality, access, and value in the years ahead.

### QE Facilities – partnership working

Colleagues within QE Facilities have a number of important relationships and partnerships with key stakeholders which support the safety and sustainability of our estate and facilities for patients and colleagues. These include but are not limited to:

- Regular engagement with the **Environment Agency** encompassing annual environmental audits, inspections and compliance reporting. This helps to ensures safe and compliant waste handling, minimises environmental risks to healthcare environments and supports infection prevention and public health;
- Engagement with the **Tyne and Wear Fire and Rescue Service** including monthly inspections, fire safety liaison meetings and exception call-outs. This enhances patient safety through effective fire prevention, emergency preparedness and assurance of safe evacuation arrangements;
- Participation in the **Regional NHS Health and Safety Group**, where incidents, lessons learned and escalation of local issues occurs. This improves organisational learning, supports consistent safety standards and enhances patient and staff safety across healthcare settings;
- Participation in a range of range of **regional groups linked to the sustainability agenda**, as outlined earlier in the report. This includes the North East and North Cumbria Provider Collaborative Sustainability Leads Group, NHS Integrated Care System Biodiversity Subgroup and NHS Alliance Sustainability Leads; and
- Engagement in the **NHS North West and North East Yorkshire Estates Delivery Group** which includes collaboration on regional priorities and escalation of issues/opportunities locally. This supports safe, modern and resilient healthcare infrastructure, improving patient experience and continuity of care.

*Consultation with local groups, our patients and the local community*

During 2025/26 we continued to engage regularly with local groups, partner organisations and local authorities across the communities we serve.

We maintained an active relationship with Gateshead Council, including ongoing engagement with the Care, Health and Wellbeing Overview and Scrutiny Committee and the Gateshead Health and Wellbeing Board. These forums provided regular opportunities to share updates on our performance, service developments and priorities, and to receive feedback from elected members and partners.

Over the year, we provided briefings and updates on areas including:

- Women's health services and the development of women's health hubs;
- Health inequalities and data-led approaches to improving access and outcomes;
- Winter update;
- Trust performance and quality priorities, including Quality Accounts;
- Securing the sustainable future for Gateshead; and
- Wider system and partnership developments through Gateshead Place and the Integrated Care System.

We also continued to work closely with Healthwatch Gateshead, Connected Voice, and voluntary and community organisations to support engagement with local residents and seldom-heard groups. This included sharing information, supporting targeted engagement activity and using feedback to inform service improvement and planning.

Engagement with local authorities and partners played an important role in shaping our priorities and ensuring our plans reflect local need, system objectives and patient experience.

Sean Fenwick
Chief Executive
24 June 2026

# Remuneration Report

The Trust has in place two remuneration committees:

- In accordance with legislation, the Board has a Group Remuneration Committee which is responsible for approving Executive Director appointments and determining their remuneration, allowances and other terms and conditions of office. It is also responsible for approving recommendations on the composition and remuneration of particular roles on the QE Facilities' Board of Directors; and
- The Governor Remuneration Committee approves the remuneration, allowances and other terms and conditions for the Chair and Non-Executive Directors. The Committee formulates recommendations regarding appointments for the consideration of the Council of Governors.

Our subsidiary company, QE Facilities, also has its own Remuneration Committee. This makes recommendations to the Group Remuneration Committee on appointment, remuneration and terms and conditions of certain QE Facilities' Board Members.

Within this report the term 'senior manager' is used. Guidance issued by NHS England defines senior managers as '*those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS Foundation Trust*'. The guidance states that the Board of Directors should be treated as senior managers as a matter of course. As this report is prepared on a group basis, this also includes members of the QE Facilities' Board of Directors. No other members of staff are defined as senior managers for the purposes of this report in the context of Gateshead Health NHS Foundation Trust.

In accordance with the NHS Foundation Trust Annual Reporting Manual 2025/26 this remuneration report is divided into three parts:

- **Annual Statement on Remuneration**, which sets out the major decisions on senior managers' remuneration as well as any substantial changes to senior managers' remuneration which were made during the year and the context in which those changes occurred and decisions have been taken;
- **Senior Managers' Remuneration Policy**, which sets out information about our policy; and
- **Annual Report on Remuneration**, which includes details about the directors' service contracts and other related matters.

## Annual statement on remuneration

Our remuneration committees aim to ensure that both Non-Executive and Executive Directors' remuneration is set appropriately, taking into account relevant market conditions. As Senior Independent Director, I chair the Group Remuneration Committee.

I attend the Governor Remuneration Committee and make recommendations in relation to the remuneration and appointment of the Chair, whilst the Chair routinely attends and makes recommendations in relation to the Non-Executive Directors. The Governor Remuneration Committee is chaired by Chris Toon, Appointed Governor from Gateshead College.

### Governor Remuneration Committee

The Governor Remuneration Committee met five times during 2025/26. During the year the Committee:

- Led the recruitment process to identify Non-Executive Directors from financial / audit digital backgrounds resulting in the appointment of Rob Hughes and Andrew Besford;
- Received assurance that due process had been followed in relation to the Chair and Non-Executive Director appraisal process and outcomes;
- Led the appointment to the expanded Vice Chair role, which included expanded responsibilities on behalf of the Chair (given the Chair's role in chairing three trusts and the Alliance);
- Reviewing succession plans for Non-Executive Directors and using this to guide the recruitment decisions regarding the desired skills and experience of the Non-Executive Director vacancy which arose in December 2025;
- Led the recruitment process to identify a legal Non-Executive Director to replace Hilary Parker, who left the Board in December 2025. This involved several rounds of recruitment and the Committee made strategic recommendations to the Council to ultimately secure a successful candidate;
- Recommending to the Council the reappointment of Adam Crampsie and myself for a second term of three years, commencing on 1 July 2026;
- Considering the annual remuneration of the current Chair and Non-Executive Directors and endorsing the recommendation to maintain current rates pending a fuller review once NHS England guidance is published; and
- Reviewing the effectiveness of the meetings to ensure that the duties and responsibilities had been discharged in accordance with the terms of reference.

### QE Facilities' Remuneration Committee

The QE Facilities' Remuneration Committee met twice time during 2025/26.

During 2025/26, the QE Facilities Remuneration Committee continued to oversee executive remuneration arrangements and senior leadership appointments, ensuring alignment with organisational performance, leadership accountability and wider NHS Very Senior Manager (VSM) guidance.

Recommendations included application of the national VSM cost of living uplift and consideration of performance and contribution during the year. The Committee noted the importance of maintaining alignment with wider Group remuneration arrangements, whilst recognising the additional statutory and fiduciary responsibilities associated with leadership of a wholly owned subsidiary company.

At its meeting in September 2025, the QE Facilities Remuneration Committee considered and supported recommendations relating to the pay awards for the Managing Director and Finance Director. In doing so, the QE Facilities Remuneration Committee recognised continued strong leadership performance, delivery against organisational objectives and significant contribution to the ongoing development and financial sustainability of QEF.

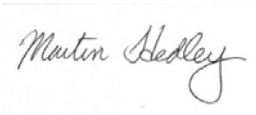
At its meeting in March 2025, the Committee reviewed two separate proposals. The first regarding the establishment of an Executive Director of Corporate Services Role and the second, a proposal for Managing Director Recruitment following the resignation of the existing Managing Director.

The recommendations were subsequently forwarded to the Group Remuneration Committee and Trust Board for approval and ratification.

## Group Remuneration Committee

The Group Remuneration Committee met eight times during 2025/26. During the year the Committee:

- Approved the proposal to extend the appointment of the Deputy Chief Executive for one year from 1 July 2025;
- Reviewed the NHS England Very Senior Manager (VSM) Pay Framework and considered the implications of this on the Group's Remuneration Policy;
- Approved the revised appraisal process for Executive Directors for 2024/25, which had been adjusted to align with the new NHS England guidance on board member appraisals;
- Approval of the secondment of the substantive Chief Executive to North Cumbria Integrated Care NHS Foundation Trust (NCIC) and the extension of the secondment through to 30 May 2026;
- Recruitment to the position of Acting Chief Executive and extension of this secondment to be coterminous with the secondment of the substantive Chief Executive;
- Approval of the proposals and plans for the recruitment to the substantive Chief Executive position in order to be in a position to act quickly should this be required (noting that this was required post-year end and will be covered in next year's report);
- Sought assurance regarding the outcome of the Chief Executive and Executive Director appraisal process;
- Approval of the extension of Maggie Pavlou at Chair of QE Facilities to 30th September 2027 (to be conterminous with her term as a Trust Non-Executive Director);
- Extension of the appointment of Hilary Parker as a Non-Executive Director on the QE Facilities Board for a period of 3 months to 31 December 2025;
- Approval of the recruitment of a Non-Executive Director for the QE Facilities Board to replace Hilary Parker;
- Recruitment to the position of Interim Chief Nurse to replace the Chief Nurse;
- On the recommendation of the QE Facilities Remuneration Committee approval of the recruitment proposals for the QE Facilities Managing Director position; and
- On the recommendation of the QE Facilities Remuneration Committee approval of the re-designation of the Director of Strategy, Planning and Performance role to become the Executive Director of Corporate Services.



Martin Hedley
Chair of the Group Remuneration Committee
24 June 2026

## Senior managers' remuneration policy

The table below sets out the component parts of our remuneration package for senior managers, excluding Non-Executive Directors.

| Component | Specific to: | Strategic Link | Maximum Possible | Description |
|---|---|---|---|---|
| Salary | All senior managers | To attract and retain suitably qualified individuals to lead and direct the Trust's activities. | Dependent on salary scale, mindful of the need to attract and retain suitable individuals, subject to periodic benchmarking and retention considerations. | Senior managers, clinical and non-clinical will attract an Agenda for Change / Medical and Dental nationally agreed salary.<br><br>All QEF employees employed in QE Facilities Ltd terms and conditions are covered by the company pay and grading structure.<br><br>Executive Directors are subject to a pay range for each post, which includes three pay zones dependent on experience.<br><br>QEF Executive Directors' remuneration will be determined through market analysis and comparison with similar posts in terms of job size and responsibility within the region. |
| Performance bonus | All senior managers | To attract and retain suitably qualified individuals to lead and direct the company's activities. | Not defined | There is no bonus scheme in place although the Committee reserves the right to award a bonus for exceptional performance as recommended by the Chief Executive or Chair. |

| Component | Specific to: | Strategic Link | Maximum Possible | Description |
|---|---|---|---|---|
| | | | | This is subject to an exceptional appraisal and all core skills training being up to date. This is in line with the NHS England VSM Pay framework (2025)<br><br>There is no Performance bonus scheme in place for QEF. |
| Lease car scheme | All staff | To attract and retain suitably qualified individuals to lead and direct the company's activities. | Not defined | We operate a salary sacrifice / salary deduction lease car scheme. There is no longer a car allowance payment for postholders. |
| Pension | All staff | To attract and retain suitably qualified individuals to lead and direct the Trust / company's activities. | In line with NHS pensions<br><br>In line with Nest scheme for QEF staff | NHS pension scheme and set contribution rates<br><br>QEF provides its employees with the Nest pension scheme. |
| Expenses | All staff | Reimbursement of necessary business expenses | No limit | Reimbursed in line with the Trust's travel and subsistence policy and national terms and conditions.<br><br>For QEF expenses are reimbursed in line with applicable policy. |
| Relocation expenses | Newly appointed staff | To attract and retain suitably qualified individuals to lead and direct the company's activities. | Reasonable vouched and receipted expenses associated with relocation up to an overall | Paid, at the Trust's discretion, to newly appointed permanent staff who need to change their main residence to take |

| Component | Specific to: | Strategic Link | Maximum Possible | Description |
|---|---|---|---|---|
| | | | maximum of £8,000. | up their post. There is no automatic entitlement, and support is normally limited to consultant, senior management or specialist roles, or where recruitment and retention challenges exist. |
| On call allowance | Senior managers | To attract and retain suitably qualified individuals to lead and direct the Trust / company's activities. | None | Reimbursed in line with the Local On Call Agreement. |
| Additional duties enhancement | Senior managers | To attract and retain suitably qualified individuals to lead and direct the Trust's activities. | Discretionary – non-consolidated, non-pensionable pay premium of up to 10% of base pay. | Where a VSM assumes temporary responsibility for a role usually undertaken by a separate VSM or a significant increase in portfolio responsibilities (such as taking on a deputy chief executive role or significant work at a national level, as agreed with NHS England).<br><br>QEF provides acting up payments for time limited periods and subject to Managing Director approval. |

The policy in respect of the Non-Executive Directors and Chair is reviewed annually by the Governor Remuneration Committee. The Committee sets remuneration having regard for benchmarking information and guidance issued by NHS England, as outlined in the Group

Remuneration Committee Chair's statement on remuneration. The key components are set out in the below table:

| Component | Specific to: | Strategic Link | Maximum Possible | Description |
|---|---|---|---|---|
| Fees | Chair and Non-Executive Directors | To attract and retain suitably qualified individuals to Non-Executive Director positions | As determined by the Council of Governors based on national guidance and local benchmarking. | The fees are set by the Council of Governors having regard to guidance issued by NHS England and local benchmarking.<br><br>Non-Executive Directors do not participate in any performance-related schemes, nor do they receive any pension or private medical insurance or taxable benefits. |
| Other fees payable to Non-Executive Directors or items considered to be remuneration in nature | Chair and Non-Executive Directors | To attract and retain suitably qualified individuals to Non-Executive Director positions | Vice Chair - £13,000 per annum from 1 October 2025 (i.e. under the new expanded scope of the role) and £1,583 per annum prior to this date<br><br>Senior Independent Director - £1,583 per annum<br><br>Group Audit Committee Chair – nil from July 2025 (previously £3,165 per annum) | Enhancements were applied on appointment to the additional role. |
| QE Facilities fees | QE Facilities Non-Executive Directors including the Chair | To attract and retain suitably qualified individuals to Non-Executive | Salary levels determined by independent benchmarking | Payment reflects the company Non-Executive Director role. |

| Component | Specific to: | Strategic Link | Maximum Possible | Description |
|---|---|---|---|---|
| | | Director positions | | |

As outlined in the table we have complied with the requirements of the NHS VSM Framework during the year.

All posts are permanent (whilst recognising that there are some interim / acting appointments in place at year-end), and may be terminated by mutual agreement, resignation or dismissal. The notice period for Executive Directors is three months. The Trust currently has no provision for compensation for early retirement or payments for loss of office (subject to audit). No payments were made to past senior managers and no payments were made in respect of loss of office.

In setting the remuneration policy for senior managers, consideration was given to the pay and conditions of employees on Agenda for Change and relevant national guidance. In determining non-incremental pay uplift for executive directors and other senior managers, consideration is given to any national pay award decisions and to appropriate national guidance (VSM Pay Framework).

We are committed to the principles of diversity and inclusion, and we recognise the importance of having a Board that is reflective of the population that we serve. We recognise as part of our WRES that there are no Board Members from the Global Ethnic Majority (GEM) community (although other protected characteristics are represented at Board), and this remains an area of focus. Our recruitment processes encourage the emergence of candidates from diverse backgrounds, and we ensure that diversity and inclusion are taken into consideration when evaluating the skills, knowledge and experience needed for each Board-level vacancy. This is in line with our wider recruitment processes for the Trust. Directly and through the support of recruitment consultants have actively encouraged applications from a wide range of candidates, including those with protected characteristics. We will continue to do this as part of any forthcoming recruitment to seek to ensure that the Board is representative of the population served.

## Annual report on remuneration

The attendance statistics for those Board Members who are members / regular attendees at the Group Remuneration Committee are shown in the table within the Directors' Report section of the Accountability Report.

The Governor Remuneration Committee met five times during 2025/26 and the Governor membership and attendance can be seen in the below table:

| Member | Number of meetings attended (out of a maximum of 5) |
|---|---|
| Chris Toon – Appointed Governor and Committee Chair | 5 |
| Steve Connolly, Lead Governor and Public Governor for Central and Eastern Gateshead | 5 |
| Michael Loome, Deputy Lead Governor and Public Governor for Central and Eastern Gateshead | 5 |
| Les Brown – Public Governor for Western Gateshead (to 4 January 2026) | 1 out of 4 |
| Helen Jones – Public Governor for Central and Eastern Gateshead (to 4 January 2026) | 2 out of 4 |
| Lynsey Curry – Staff Governor | 4 |
| Adaeze Okereke, Staff Governor | 0 |

The QE Facilities' Remuneration Committee met twice times during the year and was attended by all eligible members / attendees on each occasion.

| Member | Number of meetings attended (out of a maximum of 2) |
|---|---|
| Maggie Pavlou, Chair | 2 |
| Hilary Parker, Non-Executive Director (to 31 December 2025) | 1 of 1 |
| Darren Warneford, Non-Executive Director | 2 |
| Trudie Davies, Shareholder representative (to August 2025) | 1 of 1 |
| Sean Fenwick, Shareholder representative (from August 2025) | 1 of 1 |
| Gavin Evans, Managing Director (in attendance) | 2 |

## Director and governor expenses

There were 26 Governors in post at 31 March 2026 (compared to 23 as at 31 March 2025) and 1 Governor claimed expenses totalling £70.70 during the year (compared to 1 Governor claiming expenses totalling £137.30 during 2024/25).

As at 31 March 2026 there were 16 voting Board Members on the Trust and QE Facilities' Boards (noting that individuals who sit on both Boards are only counted here once), compared to 18 as at 31 March 2025. 4 Directors claimed expenses totalling £5,070.24, compared to 7 Directors claiming expenses totalling £3,761.74 in the previous year.

## Remuneration tables (subject to audit)

The remuneration tables on the following pages are subject to audit.

| 2024/25 | | | | | | Name and Title | 2025/26 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Salary and fees | Expense payments & BiK | Performance Bonus | Long Term Performance Bonus | Pension-related Benefits | Total | | Salary and fees | Expense payments & BiK | Performance Bonus | Long Term Performance Bonus | Pension-related Benefits | Total |
| (bands of £5,000) £000 | Rounded to the nearest £100 | (bands of £5,000) £000 | (bands of £5,000) £000 | (bands of £2,500) £000 | (bands of £5,000) £000 | | (bands of £5,000) £000 | Rounded to the nearest £100 | (bands of £5,000) £000 | (bands of £5,000) £000 | (bands of £2,500) £000 | (bands of £5,000) £000 |
| 50 - 55 | 0 | 0 | 0 | 0 | 50 - 55 | Mrs AR Marshall Chairman (left 30th September 2025) | 25 - 30 | 0 | 0 | 0 | 0 | 25 - 30 |
| N/A | N/A | N/A | N/A | N/A | N/A | Sir P Ennals Chairman (from 1st October 2025) | 10 - 15**** | 0 | 0 | 0 | 0 | 10 - 15 |
| 210 - 215 | 1,200 | 0 | 0 | 7.5 - 10.0 | 220 - 225 | Mrs T Davies Chief Executive (outwards secondment from 28th July 2025) | 65 - 70 | 100 | 0 | 0 | 302.5 - 305.0 | 370 - 375 |
| N/A | N/A | N/A | N/A | N/A | N/A | Mr S Fenwick Acting Chief Executive (from 18th August 2025) | 120 - 125 | 0 | 0 | 0 | 87.5 - 90.0 | 210 - 215 |
| 150 - 155 | 2600 | 0 | 0 | 90.0 - 92.5 | 240 - 245 | Mrs J Halliwell, Chief Operating Officer | 155 - 160 | 0 | 0 | 0 | 55.0 - 57.5 | 210 - 215 |
| 155 - 160 | 400 | 0 | 0 | 32.5- 35.0 | 190 - 195 | Mrs K Mackenzie Group Director of Finance | 160 - 165 | 0 | 0 | 0 | 70.0 - 72.5 | 230 - 235 |
| 145 - 150 | 0 | 0 | 0 | 90.0 - 92.5 | 235 - 240 | Mrs A Venner Director of People & OD | 150 - 155 | 0 | 0 | 0 | 45.0 - 47.5 | 195 - 200 |
| 160 - 165 | 0 | 0 | 0 | 67.5 - 70.0 | 225 - 230 | Dr G Findley, Chief Nurse and Deputy Chief Executive (outwards secondment from 6th October 2025) | 85 - 90 | 0 | 0 | 0 | 140 – 142.5 | 225 - 230 |
| N/A | N/A | N/A | N/A | N/A | N/A | Mrs E Swanson Interim Chief Nurse (from 20th October 2025) | 60 - 65 | 0 | 0 | 0 | 250.0 - 252.5 | 310 - 315 |
| 120- 125* | 1,500 | 0 | 0 | 137.50 - 140.0 | 260 - 265 | Mrs C Howey Medical Director (from 1st July 2024) | 205 - 210* | 0 | 0 | 0 | 165 - 167.5 | 370 - 375 |
| 200 - 205** | 300 | 0 | 0 | 90.0 - 92.5 | 290 - 295 | Mr N Halford, Interim Medical Director (from 1st April 2024 to 30th June 2024) | N/A | N/A | N/A | N/A | N/A | N/A |
| 110 - 115 | 700 | 0 | 0 | 0 | 110 - 115 | Mr P Glasgow, Finance Director QE Facilities Ltd | 115 - 120 | 400 | 0 | 0 | 0 | 115 - 120 |
| 155 - 160 | 2300 | 0 | 0 | 0 | 155 - 160 | Mr G Evans, Managing Director QE Facilities Ltd | 160 - 165 | 0 | 0 | 0 | 0 | 160 - 165 |
| 0 - 5 | 0 | 0 | 0 | 0 | 0 - 5 | Mr D Warneford Non Executive Director QEF (started 17th June 2024) | 0 - 5 | 0 | 0 | 0 | 0 | 0 - 5 |
| 0 - 5 | 0 | 0 | 0 | 0 | 0 - 5 | Mr G Morrow, Non Executive Director (started 2nd December 2024) and Trust Vice Chair (from 1st October 2025) | 20 - 25 | 700 | 0 | 0 | 0 | 20 - 25 |
| 10 - 15 | 0 | 0 | 0 | 0 | 10 - 15 | Mr M Robson, Non Executive Director (left 30th June 2025) | 0 - 5 | 0 | 0 | 0 | 0 | 0 - 5 |
| N/A | N/A | N/A | N/A | N/A | N/A | Mr A Besford, Non Executive Director (started 1st July 2025) | 10 - 15 | 0 | 0 | 0 | 0 | 10 - 15 |
| 10 - 15 | 0 | 0 | 0 | 0 | 10 - 15 | Mr M Hedley, Non Executive Director and Senior Independent Director | 15 - 20 | 0 | 0 | 0 | 0 | 15 - 20 |
| 15 - 20 | 0 | 0 | 0 | 0 | 15 - 20 | Mr A Moffat, Non Executive Director (left 30th June 2025) | 0 - 5 | 0 | 0 | 0 | 0 | 0 - 5 |
| N/A | N/A | N/A | N/A | N/A | N/A | Mr R Hughes, Non Executive Director (started 1st July 2025) | 10 - 15 | 0 | 0 | 0 | 0 | 10 - 15 |
| 15 - 20 | 0 | 0 | 0 | 0 | 15 - 20 | Mrs H Parker, Non Executive Director for the Trust and QE Facilities (left 31st December 2025) - no replacement for the remainder of 2025/26 | 10 - 15 | 0 | 0 | 0 | 0 | 10 - 15 |
| 110 - 115*** | 400 | 0 | 0 | 82.5 - 85.0 | 195 - 200 | Mrs J Fay, Acting Group Director of Finance (from 27th January 2025 until 4th May 2025) | 10 - 15 | 0 | 0 | 0 | 50.0 - 52.5 | 60 - 65 |

| 2024/25 | | | | | | Name and Title | 2025/26 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Salary and fees | Expense payments & BiK | Performance Bonus | Long Term Performance Bonus | Pension-related Benefits | Total | | Salary and fees | Expense payments & BiK | Performance Bonus | Long Term Performance Bonus | Pension-related Benefits | Total |
| (bands of £5,000) £000 | Rounded to the nearest £100 | (bands of £5,000) £000 | (bands of £5,000) £000 | (bands of £2,500) £000 | (bands of £5,000) £000 | | (bands of £5,000) £000 | Rounded to the nearest £100 | (bands of £5,000) £000 | (bands of £5,000) £000 | (bands of £2,500) £000 | (bands of £5,000) £000 |
| 10 - 15 | 0 | 0 | 0 | 0 | 10 - 15 | Mr A Crampsie, Non Executive Director | 10 - 15 | 0 | 0 | 0 | 0 | 10 - 15 |
| 5 - 10 | 0 | 0 | 0 | 0 | 5 - 10 | Ms M Stabler, Non Executive Director (left 18th October 2024) | 0 | 0 | 0 | 0 | 0 | 0 |
| 15 - 20 | 0 | 0 | 0 | 0 | 10 - 15 | Ms M Pavlou, Trust Non Executive Director and Chair of QE Facilities | 20 - 25 | 0 | 0 | 0 | 0 | 20 - 25 |

* In 2025/26 £25k - £30k (2024/25 £65k - £70k) relates to Ms C Howey role as a medical consultant.

** In 2024/25 £160k - £165k relates to Mr N Halford's role as a consultant. Mr Halford in the role of Medical Director role from 1st April 2024 to 30th June 2024 so there is no equivalent disclosure for 2025/26

*** In 2024/25 £85k - £90k relates to Mrs J Fay's non Executive Director role. Mrs Fay commenced in the role of Acting Group Director of Finance from 27th January 2025 and ended the role on 4th May 2025.

**** Sir P Ennals is shared Chair across 3 organisations from 1st October 2025. The costs relate to a 1/3rd shared contribution.

## *Pension entitlements (subject to audit)*

| Name and title | Real increase in pension at pension age | Real increase in lump sum at pension age | Total accrued pension at pension age at 31 March 2026 | Lump sum at pension age related to accrued pension at 31 March 2026 | Cash Equivalent Transfer Value at 1 April 2025 | Real Increase in Cash Equivalent Transfer Value | Cash Equivalent Transfer Value at 31 March 2026 | Employers Contribution to Stakeholder Pension |
|---|---|---|---|---|---|---|---|---|
| | (bands of £2,500) £000 | (bands of £2,500) £000 | (bands of £5,000) £000 | (bands of £5,000) £000 | £000 | £000 | £000 | £000 |
| Mrs T Davies, Chief Executive until commencement of her secondment on 28th July 2025 | 2.5 - 5.0 | 7.5 - 10.0 | 85.0 - 90.0 | 215.0 - 220.0 | 1,553 | 96 | 1,894 | 0 |
| Mr S Fenwick, Acting Chief Executive from 18th August | 2.5 - 5.0 | 2.5 - 5.0 | 65.0 - 70.0 | 170.0 - 175.0 | 1,442 | 55 | 1,588 | 0 |
| Mrs J Halliwell, Chief Operating Officer | 2.5 - 5.0 | 0.0 - 2.5 | 60.0 - 65.0 | 155.0 - 160.0 | 1,373 | 67 | 1,482 | 0 |
| Mrs K Mackenzie, Group Director of Finance | 2.5 - 5.0 | 2.5 - 5.0 | 45.0 - 50.0 | 110.0 - 115.0 | 841 | 62 | 936 | 0 |
| Mrs Jane Fay, Acting Director of Finance until 4th May 2025 | 0.0 - 2.5 | 0.0 - 2.5 | 50.0 - 55.0 | 125.0 - 130.0 | 1,079 | 0 | 1,171 | 0 |

| Name and title | Real increase in pension at pension age | Real increase in lump sum at pension age | Total accrued pension at pension age at 31 March 2026 | Lump sum at pension age related to accrued pension at 31 March 2026 | Cash Equivalent Transfer Value at 1 April 2025 | Real Increase in Cash Equivalent Transfer Value | Cash Equivalent Transfer Value at 31 March 2026 | Employers Contribution to Stakeholder Pension |
|---|---|---|---|---|---|---|---|---|
| | (bands of £2,500) £000 | (bands of £2,500) £000 | (bands of £5,000) £000 | (bands of £5,000) £000 | £000 | £000 | £000 | £000 |
| Ms Carmen Howey, Medical Director from 1st July 2025 | 5.0 - 7.5 | 10.0 - 12.5 | 50.0 - 55.0 | 130.0 - 135.0 | 900 | 108 | 1,088 | 0 |
| Mrs A Venner, Director of People & OD | 2.5 - 5.0 | 0.0 - 2.5 | 30.0 - 35.0 | 65.0 - 70.0 | 590 | 40 | 659 | 0 |
| Dr G Findley, Chief Nurse and Deputy Chief Executive until 6th October 2025 | 2.5 - 5.0 | 0.0 - 2.5 | 100.0 - 105.0 | 125.0 - 130.0 | 1,744 | 69 | 1,929 | 0 |
| Ms E Swanson, Interim Chief Nurse from 20th October 2025 | 5.0 - 7.5 | 10.0 - 12.5 | 45.0 - 50.0 | 110.0 - 115.0 | 730 | 103 | 1,012 | 0 |

Mr G Evans is not included as he participates in a defined contribution scheme not a defined benefit scheme.
Mr P Glasgow is not included as he participates in a defined contribution scheme not a defined benefit scheme.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

| Name and title | Real increase in pension at pension age | Real increase in lump sum at pension age | Total accrued pension at pension age at 31 March 2025 | Lump sum at pension age related to accrued pension at 31 March 2025 | Cash Equivalent Transfer Value at 1 April 2024 | Real Increase in Cash Equivalent Transfer Value | Cash Equivalent Transfer Value at 31 March 2025 | Employers Contribution to Stakeholder Pension |
|---|---|---|---|---|---|---|---|---|
| | (bands of £2500) £000 | (bands of £2500) £000 | (bands of £5000) £000 | (bands of £5000) £000 | £000 | £000 | £000 | £000 |
| Mrs T Davies, Chief Executive | 0.0 - 2.5 | Nil | 70.0 - 75.0 | 180.0 - 185.0 | 1,243 | 0 | 1,258 | 0 |
| Mrs J Halliwell, Chief Operating Officer | 5.0 - 7.5 | 5.0 - 7.5 | 55.0 - 60.0 | 155.0 - 160.0 | 1,033 | 17 | 1,137 | 0 |
| Mrs K Mackenzie, Director of Finance | 2.5 - 5.0 | Nil | 40.0 - 45.0 | 105.0 - 110.0 | 626 | 0 | 642 | 0 |
| Mrs J Fay, Acting Director of Finance from 27th Jan 25 to 31st Mar 25 | 0.0 - 2.5 | 0.0 - 2.5 | 45.0 - 50.0 | 120.0 - 125.0 | 796 | 0 | 888 | 0 |
| Ms C Howey, Medical Director from 1st Jul 2025 | 5.0 - 7.5 | 7.5 - 10.0 | 45.0 - 50.0 | 110.0 - 115.0 | 591 | 29 | 696 | 0 |
| Mr N Halford, Interim Medical Director from 1st Apr 24 to 30th Jun 24 | 0.0 - 2.5 | 0.0 - 2.5 | 95.0 - 100.0 | 255.0 - 260.0 | 1,887 | 0 | 2,042 | 0 |
| Mrs A Venner, Director of People & OD | 5.0 - 7.5 | 7.5 - 10.0 | 25.0 - 30.0 | 65.0 - 70.0 | 352 | 8 | 401 | 0 |
| Mrs G Findley, Chief Nurse and Deputy Chief Executive | 2.5 - 5.0 | 0.0 - 2.5 | 90.0 - 95.0 | 120.0 - 125.0 | 1,366 | 0 | 1,457 | 0 |

Mr G Evans is not included as he participates in a defined contribution scheme not a defined benefit scheme.
Mr P Glasgow is not included as he participates in a defined contribution scheme not a defined benefit scheme.

*Fair pay multiple (subject to audit)*

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in our organisation in the financial year 2025/26 was £205k - £210k (in 2024/25 it was £210k - £215k). This is a decrease between years of -2%.

Total remuneration includes salary, non-consolidated performance-related pay and taxable benefits. It does not include severance payments, employer pension contributions (including payments in lieu of benefits) and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration in 2025/26 was from £20k- £25k to £335k - £340k (in 2024/25 the range was £20k - £25k to £270k - £275k). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 6.5%, due to pay awards and additional enhancements being paid. 6 employees received remuneration in excess of the highest-paid director in 2025/26, this compares with 19 in 2024/25.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

| 2025/26 | 25th Percentile | Median | 75th Percentile |
|---|---|---|---|
| Salary component of pay | £28,071 | £37,796 | £49,173 |
| Total pay and benefits excluding pension benefits * | £28,071 | £37,796 | £49,173 |
| Pay and benefits excluding pension: pay ratio for highest paid director | 7.4:1 | 5.5:1 | 4.2:1 |

*There are no material difference between salary component of pay and total pay and benefits excluding pension benefits as there is no significant BiK and no performance pay.

The median pay in 2025/26 is £37,796 (for 2024/25 it was £36,483). This is a change between years of +3.6% and is a result of pay awards. The median is 5.5 times the remuneration of the highest director, which remains static year-on-year with 2024/25 also being 5.8 times the remuneration of the highest director.

Sean Fenwick
Chief Executive
24 June 2026

# Staff Report

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.

## Analysis of staff costs and numbers (subject to audit)

An analysis of our average staff numbers for the year is shown below (in respect of whole-time equivalent numbers). The 'other' category includes apprentices.

| | Group | | | | Foundation Trust | | | |
|---|---|---|---|---|---|---|---|---|
| | 2025/26 total number | Permanently employed number | Other number | 2024/25 total number | 2025/26 total number | Permanently employed number | Other number | 2024/25 total number |
| Medical and dental | 555 | 537 | 18 | 544 | 555 | 537 | 18 | 544 |
| Ambulance staff | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Administration and estates | 968 | 953 | 15 | 1029 | 808 | 785 | 23 | 856 |
| Healthcare assistants and other support staff | 985 | 965 | 20 | 1,008 | 454 | 448 | 6 | 511 |
| Nursing, midwifery and health visiting staff | 1,475 | 1,367 | 108 | 1,533 | 1,475 | 1,367 | 108 | 1,533 |
| Healthcare scientists | 391 | 386 | 5 | 396 | 379 | 374 | 5 | 384 |
| Scientific, therapeutic and technical staff | 498 | 496 | 2 | 509 | 497 | 495 | 2 | 508 |
| Other | 8 | 8 | 0 | 12 | 3 | 3 | 0 | 5 |
| **Total** | **4,880** | **4,712** | **168** | **5,031** | **4,171** | **4,009** | **162** | **4,341** |

*Note that the table does not cast due to minor rounding differences

As at 31 March 2026 the gender split of the workforce was as follows (this table is not subject to audit):

| | Male | Female |
|---|---|---|
| Directors (voting Trust and QE Facilities' Board Members) | 10 | 6 |
| Other senior managers | 76 | 131 |
| Employees | 1,119 | 3,829 |

Information on sickness absence is collated nationally by NHS Digital and can be found at the following link https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates.

An analysis of our staff costs for the year is shown in the following table (subject to audit):

| | Group | | | | Foundation Trust | | | |
|---|---|---|---|---|---|---|---|---|
| | 2025/26 total | Permanently employed | Other | Total 2024/25 | 2025/26 total | Permanently employed | Other | Total 2024/25 |
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Salaries and wages | 234,005 | 226,155 | 7,850 | 227,546 | 210,164 | 202,667 | 7,497 | 205,476 |
| Capitalised salaries and wages | 987 | 987 | 0 | 90 | 48 | 48 | 0 | 0 |
| Social security costs | 27,980 | 26,909 | 1,071 | 21,983 | 25,071 | 24,045 | 1,026 | 20,006 |
| Apprenticeship levy | 1,134 | 1,095 | 39 | 1,112 | 1,016 | 979 | 37 | 1,004 |
| Pension costs -defined contribution plans. Employers' contributions to NHS Pensions | 24,161 | 23,221 | 940 | 23,916 | 23,513 | 22,549 | 964 | 23,210 |
| Pension cost – employer contributions paid by NHSE on provider's behalf (9.4%) | 15,785 | 15,243 | 542 | 15,687 | 15,356 | 14,793 | 563 | 15,217 |
| Pension costs – other | 407 | 407 | 0 | 362 | 35 | 35 | 0 | 42 |
| External bank | 1,150 | 0 | 1,150 | 1,200 | 1,150 | 0 | 1,150 | 1,200 |
| Agency / contract staff | 1,212 | 0 | 1,212 | 1,779 | 996 | 0 | 996 | 1,563 |
| NHS Charitable Funds staff | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Termination benefits | 528 | 528 | 0 | 97 | 526 | 526 | 0 | 97 |
| **Total** | **307,349** | **294,545** | **12,804** | **293,772** | **277,875** | **265,642** | **12,233** | **267,815** |

*Note that the table does not cast due to minor rounding differences

## Staff equality, diversity and inclusion (EDI)

We have continued to take steps to ensure that EDI considerations are part of everything that we do. Our Board Members are committed to creating a culture of equality, diversity and inclusion.

We operate within a legislative framework which is underpinned by the Equality Act 2010, which means we need to comply with a range of different requirements, including but not limited to:

- Public Sector Equality Duty;
- Human Rights – Mental Health Code of Practice;

- Equality Delivery System (EDS2);
- Workforce Race Equality Standard (WRES);
- Workforce Disability Standard (WDES);
- Gender Pay Gap; and
- Accessible Information Standard.

Ensuring equality for all is a core part of our organisational culture and compassionate leadership approach. Our policies help us to ensure that we embrace equality, diversity and inclusion both in service delivery and employment within the Group. As part of policy review and development, all policies must be accompanied by an equality and quality impact assessment (EQiA). The EQiA is reviewed by the Group's dedicated Policy Review Group and signed off by the EDI and Engagement Manager prior to a policy being approved. This ensures that there are no unintended negative consequences of a policy for staff with a protected characteristic.

### *Workforce Disability Equality Standard (WDES)*

The WDES was developed to help NHS organisations make a positive impact for all disabled colleagues working in the NHS and informs year-on-year improvements in reducing those barriers that impact most on the career opportunities and workplace experiences of disabled staff.

The D-Ability network has been integral to this work and has helped us to develop a greater understanding of the experiences of disabled staff. A detailed action plan has been developed, and this will enable us to measure our progress in this area.

Our latest staff survey results show disappointing increases in the following areas:

- Percentage of staff experiencing harassment, bullying or abuse from patients/ service users their relatives or other members of the public;
- Staff experiencing harassment, bullying or abuse from managers; and
- Staff experiencing harassment, bullying or abuse from colleagues.

The metric around disabled and non-disabled colleagues reporting experiences of harassment, bullying or abuse from the following groups of people is outlined in more detail below:

- Patients / service users, their relatives or other members of the public has decreased by 0.05% (24.9%) for Disabled staff, while for Non-Disabled staff this has decreased by 2.2% (17.3%);
- Managers – shows an increase by 0.4% for Disabled staff and increase of 0.1% for Non-Disabled staff;

The percentage of staff who indicated that they or a colleague reported an incident of harassment, bullying or abuse experienced at work was similar for Disabled staff, 49.4%, and for Non-Disabled staff, 50.7%. For both groups there has been a slight drop in this metric compared to the prior year.

In nearly all of these metrics, the decreases are minimal apart from the first bullet point. This is not a positive measure as individuals should feel safe to report incidents for appropriate actions to be undertaken.

The metric around equal opportunities for career progression or promotion has also shown a substantial drop for disabled staff by 9.7% and non-disabled staff 8.5%.

In respect of the WDES, there is still work to be done in relation to bullying and harassment at work and feeling pressure from managers to come to work. This will form part of our cultural development work with our people to ensure that we provide a supportive and inclusive workplace for all our colleagues.

Our Staff Experience and Inclusion Group continues to be focussed on the WDES results and improvement actions, but we recognise that it is the responsibility of every member of staff to embrace this.

We are a Disability Confident Level 2 employer which means that we are recognised for actively attracting and recruiting disabled people to help fill opportunities, providing a fully inclusive and accessible recruitment process and we offer guaranteed interviews to disabled people who meet the minimum criteria for roles.

We are flexible when assessing applicants to give disabled applicants the best opportunity to demonstrate that they can fulfil the role, and we commit to proactively offering and making reasonable adjustments.

### *Workforce Race Equality Standard (WRES)*

The WRES was developed with similar principles in mind, helping to ensure that NHS organisations make a positive impact for colleagues from the Global Ethnic Majority (GEM).

In respect of the WRES indicators the NHS staff survey data shows that:

- For GEM staff - the percentage of staff experiencing harassment, bullying or abuse from patient's relatives or public in the last 12 months decreased from 26.5% to 24.4% and for White staff this figure has dropped from 20.2% to 18.8%;
- For GEM staff - the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months decreased from 26.4% to 26.2% and for White staff has decreased from 19.3%to 18.8%;
- For both GEM and White staff - the percentage of staff experiencing discrimination at work from a manager / team leader or other colleagues rose from 17.1% to 17.3%, but for white staff remained at 5.8%; and
- For both GEM and White staff the figure for our staff believing that the Trust provides equal opportunities for career progression, decreased by 6.2% and 9.7% (respectively).

Detailed analysis is being undertaken to understand why there has been an increase in the percentage of our GEM colleagues experiencing these unacceptable behaviours compared to the previous year. Trained Cultural Ambassadors are available for any member of staff if and when a disciplinary and grievance processes is to be undertaken.

We routinely capture information around who has been successful in applying and being recruited within the Trust and are using this information to address and understand how we are reflective of the diverse communities we serve. This information is captured in our EDI KPI metrics which is reviewed as part of our Staff Experience and Inclusion Group meetings.

We have implemented practices to assess where the pitfalls are for candidates in respect of their protected characteristics using the data available. Within the recruitment and selection

training elements pertaining to conscious and unconscious bias in the recruitment process have been built in.

### *Gender Pay Gap*

In terms of gender pay gap reporting we are committed to creating an inclusive environment where all staff are rewarded fairly for their contribution. Our latest report shows a mean gender pay gap of 23.64% and a median gap of 13.57%, which we accept is not good enough. These figures are not a result of men and women being paid differently for the same work, but rather they reflect the current distribution of our workforce across different pay bands – with more highly paid men in our senior medical workforce and proportionately less men in our lowest paid roles.

We recognise that progress will take sustained effort over time, and that closing the gender pay gap requires continued focus on career pathways, access to opportunity and representation at senior levels. We remain committed to being transparent about our position and to taking meaningful action to improve outcomes for our people. For example, the EDI manager and the Communications Team are assessing how the imagery is reflective in terms of inclusivity when we promote / advertise roles and careers. Recognising that in the majority of cases women tend to have a caring role, we continue to encourage and role model flexible working arrangements and support senior medical workforce in applying for clinical impact awards on an equitable basis.

Further information on gender pay gap reporting can be found on the Cabinet Office website: Find and compare gender pay gap data - GOV.UK (www.gov.uk)

Further information on our approach to EDI can be found on our website via the following link: https://www.gatesheadhealth.nhs.uk/about/trust/equality-diversity

## Communicating, consulting and engaging with our colleagues

We continued to encourage the involvement of our people in shaping performance, improving services and identifying opportunities for improvement during 2025/26.

This included:

- Engagement with colleagues through discussions at team, service and divisional level;
- Use of feedback from the NHS Staff Survey, local pulse surveys and listening events to inform priorities and actions;
- Active promotion of Freedom to Speak Up arrangements, encouraging staff to raise concerns and contribute to organisational learning (which are outlined further in the following section); and
- Ongoing support for staff networks, enabling colleagues to influence culture, inclusion and workforce priorities

Colleagues' feedback and involvement continued to inform decision-making at senior level, with issues escalated through governance structures where appropriate. Involving staff in performance improvement remains a key part of our approach to improving patient care, experience and outcomes.

We have several consultative forums in place. Our Joint Consultation Committee and Local Negotiation Committee are the most formal arenas for consultation with staff side colleagues. They are also supported by several sub-committees (such as policy sub-committee) and working groups (for example the Medical Workforce Group). In addition, there are various forums such as Junior Doctor Forum. Staff side colleagues are involved in our staff network groups.

Where specific consultation was needed on changes to individual terms and conditions this was carried out in line with the Group Organisational Change Policy, in collaboration with staff side colleagues.

## Freedom to Speak Up

All NHS providers are required to have a Freedom to Speak Up Guardian (FTSUG). We remain committed to achieving the highest possible standards for patients and staff, and to fostering an open, transparent culture where all colleagues feel psychologically safe and confident to raise concerns.

### National Developments

Following the 2025 review led by Penny Dash, responsibility for Freedom to Speak Up is transitioning from the National Guardian's Office (NGO) to local organisations, with national coordination provided by NHS England. This transition will take effect from July 2026.

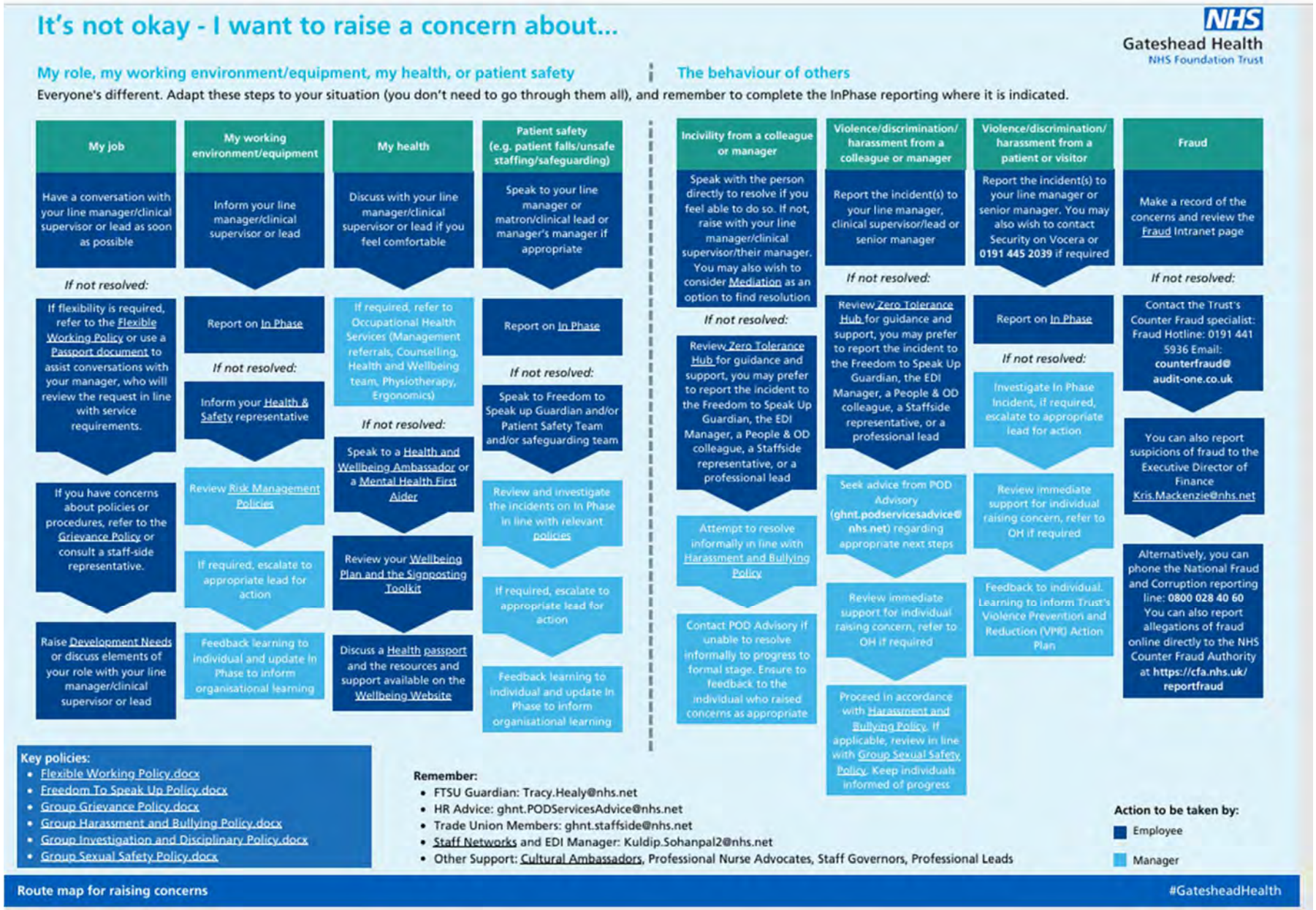
The FTSUG is employed by the Trust but operates independently while working in partnership with the leadership team. The Guardian reports twice yearly to the Board, the People and Organisational Development Committee and the Quality Governance Committee.

### Raising Concerns

In addition to speaking up via the FTSUG, staff can raise concerns through trade unions, professional bodies, or other internal routes, as outlined in the our Freedom to Speak Up Policy and Raising Concerns Roadmap.

When concerns are raised with the FTSUG, the Guardian commissions an investigation where appropriate and ensures feedback, outcomes, and learning are shared with the individual who raised the concern.

The FTSUG reports directly to the Chief Nurse and meets regularly with the Executive Director of People and Organisational Development and the Non-Executive Director responsible for Freedom to Speak Up. The Guardian also has direct access to the Chief Executive when required.


It's not okay - I want to raise a concern about...
NHS
Gateshead Health
NHS Foundation Trust
My role, my working environment/equipment, my health, or patient safety
The behaviour of others
Everyone's different. Adapt these steps to your situation (you don't need to go through them all), and remember to complete the InPhase reporting where it is indicated.
My job
Have a conversation with your line manager/clinical supervisor or lead as soon as possible
If not resolved:
If flexibility is required, refer to the Flexible Working Policy or use a Passport document to assist conversations with your manager, who will review the request in line with service requirements.
If you have concerns about policies or procedures, refer to the Grievance Policy or consult a staff-side representative.
Raise Development Needs or discuss elements of your role with your line manager/clinical supervisor or lead
My working environment/equipment
Inform your line manager/clinical supervisor or lead
Report on In Phase
If not resolved:
Inform your Health & Safety representative
Review Risk Management Policies
If required, escalate to appropriate lead for action
Feedback learning to individual and update in Phase to inform organisational learning
My health
Discuss with your line manager/clinical supervisor or lead if you feel comfortable
If required, refer to Occupational Health Services (Management referrals, Counselling, Health and Wellbeing team, Physiotherapy, Ergonomics)
If not resolved:
Speak to a Health and Wellbeing Ambassador or a Mental Health First Aider
Review your Wellbeing Plan and the Signposting Toolkit
Discuss a Health passport and the resources and support available on the Wellbeing Website
Patient safety (e.g. patient falls/unsafe staffing/safeguarding)
Speak to your line manager or matron/clinical lead or manager's manager if appropriate
Report on In Phase
If not resolved:
Speak to Freedom to Speak up Guardian and/or Patient Safety Team and/or safeguarding team
Review and investigate the incidents on In Phase in line with relevant policies
If required, escalate to appropriate lead for action
Feedback learning to individual and update in Phase to inform organisational learning
Incivility from a colleague or manager
Speak with the person directly to resolve if you feel able to do so. If not, raise with your line manager/clinical supervisor/their manager. You may also wish to consider Mediation as an option to find resolution
If not resolved:
Review Zero Tolerance Hub for guidance and support, you may prefer to report the incident to the Freedom to Speak Up Guardian, the EDI Manager, a People & OD colleague, a Staffside representative, or a professional lead
Attempt to resolve informally in line with Harassment and Bullying Policy
Contact POD Advisory if unable to resolve informally to progress to formal stage. Ensure to feedback to the individual who raised concerns as appropriate
Violence/discrimination/ harassment from a colleague or manager
Report the incident(s) to your line manager, clinical supervisor/lead or senior manager
If not resolved:
Review Zero Tolerance Hub for guidance and support, you may prefer to report the incident to the Freedom to Speak Up Guardian, the EDI Manager, a People & OD colleague, a Staffside representative, or a professional lead
Seek advice from POD Advisory (ghnt.podservicesadvice@nhs.net) regarding appropriate next steps
Review immediate support for individual raising concern, refer to OH if required
Proceed in accordance with Harassment and Bullying Policy. If applicable, review in line with Group Sexual Safety Policy. Keep individuals informed of progress
Violence/discrimination/ harassment from a patient or visitor
Report the incident(s) to your line manager or senior manager. You may also wish to contact Security on Vocera or 0191 445 2039 if required
Report on In Phase
If not resolved:
Investigate In Phase incident, if required, escalate to appropriate lead for action
Review immediate support for individual raising concern, refer to OH if required
Feedback to individual. Learning to inform Trust's Violence Prevention and Reduction (VPR) Action Plan
Fraud
Make a record of the concerns and review the Fraud Intranet page
If not resolved:
Contact the Trust's Counter Fraud specialist: Fraud Hotline: 0191 441 5936 Email: counterfraud@audit-one.co.uk
You can also report suspicions of fraud to the Executive Director of Finance Kris.Mackenzie@nhs.net
Alternatively, you can phone the National Fraud and Corruption reporting line: 0800 028 40 60 You can also report allegations of fraud online directly to the NHS Counter Fraud Authority at https://cfa.nhs.uk/reportfraud
Key policies:
Flexible Working Policy.docx
Freedom To Speak Up Policy.docx
Group Grievance Policy.docx
Group Harassment and Bullying Policy.docx
Group Investigation and Disciplinary Policy.docx
Group Sexual Safety Policy.docx
Remember:
FTSU Guardian: Tracy.Healy@nhs.net
HR Advice: ghnt.PODServicesAdvice@nhs.net
Trade Union Members: ghnt.staffside@nhs.net
Staff Networks and EDI Manager: Kuldip.Sohanpal2@nhs.net
Other Support: Cultural Ambassadors, Professional Nurse Advocates, Staff Governors, Professional Leads
Action to be taken by:
Employee
Manager
Route map for raising concerns
#GatesheadHealth

## Promoting a Speaking Up Culture

During 2025/26, the FTSU service has continued to strengthen its visibility and impact. This has included:

- Delivering promotional events, education, and training sessions;
- Participating in Team Briefs to raise awareness of key issues; and
- Supporting initiatives addressing discrimination, racial abuse, hate crime, and sexual safety.

This work has been undertaken in collaboration with the People and OD teams and governance groups. We have also reinforced our zero-tolerance approach through campaigns such as *"It's Not OK"*, while ensuring Freedom to Speak Up remains central to organisational culture.

Data from multiple sources is triangulated through the Culture, Insight and Triangulation Group. This approach supports:

- Amplifying staff voices;
- Informing service improvement;
- Promoting civility and psychological safety; and
- Ensuring concerns lead to meaningful action and feedback

We have continued to expand its network of Freedom to Speak Up Champions. Due to strong engagement from our people, there is now broad and diverse representation across services and departments.

Champions meet regularly to:

- Stay informed of current developments
- Share concerns and insights
- Disseminate information and feedback within their areas

This network plays a vital role in embedding a culture where speaking up is encouraged and becomes part of everyday practice.

We have also increased ways of reporting concerns with the introduction of an electronic system, the InPhase FTSU App, where staff can raise their concerns anytime.

We have a consistent number of concerns reported, building since 2024 through to 2026. Most concerns relate to people rather than patient safety / quality, which is consistent with regional and national trends, however we must be mindful that if people do not feel psychologically safe to speak up this will have consequences for patient safety - *"civility saves lives"* research demonstrates this. We are continuing to develop our services and act on what our people are sharing with us to improve both colleague and patient safety and wellbeing.

## Health and safety performance

We are committed to ensuring the health, safety and wellbeing of our people, patients, contractors and members of the public who are in any way affected by the activities of the Trust or QE Facilities across all locations.

We ensure the provision of appropriate resources, including staff, finance and equipment in a timely manner so as to conduct our activities in accordance with all statutory and regulatory requirements, seeking to exceed such requirements wherever reasonably practicable.

Our key objectives are to:

- prevent accidents and cases of work-related ill health;
- manage health and safety risks in our workplace;
- provide clear instructions and information, and adequate training, to ensure our people are competent to do their work;
- provide suitable personal protective equipment;
- consult with our people on matters affecting their health and safety;
- provide and maintain safe plant and equipment;
- ensure safe handling and use of substances;
- maintain safe and healthy working conditions;
- implement emergency procedures, including evacuation in case of fire or other significant incident;
- review and revise the Health & Safety Policy on a regular basis;
- maintain a culture of co-operation, communication, competency and control for health and safety; and
- protect patients and people other than those at work against risks to their health and safety arising out of work activities.

The Board has identified and assigned roles and responsibilities to management, specialist support subject matter experts and individual staff members including bank and volunteering colleagues across the Group's organisational structure, to ensure the aims and objects of our Group Health & Safety Policy are achieved and maintained.

In delivering these aims, we expect all staff, bank staff, students and contractors to always conduct themselves in line with the policy and to fully engage in all identified health & safety initiatives to deliver continual health & safety improvements.

Assurance on all matters relating to health & safety continued to be achieved through the Group Health & Safety Group meetings and team structure. The terms of reference of the Group Health and Safety Group were reviewed and refreshed during the year. The Chief Executive currently chairs the Group, which provides visible leadership and reiterates the importance the Group places on effective health and safety.

The work of the Group Health and Safety Group is supported by a number of sub-groups within the governance structure. This sub-structure was under review at the year-end to ensure that it provides effective support and assurance flows to the Group Health and Safety Group.

We continue to promote and drive a safe working culture by providing additional education and awareness of shared learnings via internal communications, newsletters and staff social media forums.

## Occupational health & wellbeing

Our Occupational Health and Wellbeing team has continued to prioritise reducing waiting times for management referral nursing appointments, supported by the recruitment of an Occupational Health Nurse Specialist to increase clinical capacity and improve service responsiveness.

To further enhance appointment efficiency, a text message reminder system has been introduced for all Occupational Health bookings. This aims to reduce “Did Not Attend” rates and ensure that cancelled appointments can be reallocated more effectively.

The Physiotherapy service continues to meet KPIs for colleagues referred into treatment. Alongside this, the Physiotherapist has undertaken targeted work with teams experiencing high levels of musculoskeletal related sickness absence. This proactive, preventative approach—delivered across both hospital and community settings—has demonstrated measurable impact, with evaluation showing a reduction in musculoskeletal sickness absence following intervention.

In summer 2025, the team successfully achieved SEQOHS (Safe, Effective, Quality Occupational Health Service) revalidation. This accreditation assesses performance across six key domains: Governance & Finance; Resources and Processes; Outputs and Outcomes; Information and Communication; Quality Assurance and Improvement; and Sector Specific Standards, confirming the service’s commitment to high quality, safe, and effective practice.

We have strengthened our health and wellbeing offer through the relaunch of the *Guidance Around Tackling Stress at Work*, which now includes an updated individual stress risk assessment and the introduction of a team level stress risk assessment. Additional guidance has also been developed to support managers and colleagues in responding to mental health needs and in supporting colleagues with Attention Deficit Hyperactivity Disorder (ADHD). Colleagues have access to an in-house counselling service, for any work-related issues, and are also able to access psychological support from the North East and North Cumbria Staff Wellbeing Hub, via self-referral, where appointments are available within one week.

To improve early intervention, a Supporting Attendance at Work Task Force was established to analyse data trends, anticipate periods of increased absence, and deliver proactive wellbeing initiatives ahead of high-risk times. This predictive, preventative approach has now been embedded into business-as-usual activity within the Health and Wellbeing Manager role.

The overall Health and Wellbeing approach has been redesigned to focus on prevention, with expanded outreach activities such as workshops, health needs analyses, and targeted engagement. This work has culminated in the launch of the 2026 Wellbeing Action Plan, marking a shift toward a new strategic direction and moving away from the previous three year strategy model.

## Countering fraud and corruption

Counter Fraud Specialist Services (CFS) were provided under contract arrangements with AuditOne. As referred to in the *Performance Report* a Counter-Fraud, Bribery and Corruption Policy is in place with regular updates on activity and investigations provided to the Group

Audit Committee. The Trust's Conflicts of Interest policy also includes reference to bribery. The Counter Fraud Specialist ensures that fraud awareness is regularly communicated and promoted to colleagues through regular articles in the staff newsletter.

## Expenditure on consultancy

The Group spent £0.272m on consultancy during 2025/26 (2024/25: £0.815m).

## Exit packages (subject to audit)

Exit packages during 2025/26 are detailed in the following table. All payments made were due to contractual or legal obligations.

| Exit package cost band | 2025/26 Group | | | | 2024/25 Group | | | |
|---|---|---|---|---|---|---|---|---|
| | Number of compulsory departures agreed | Cost of compulsory departures agreed £000 | Number of other departures agreed | Cost of other departures agreed £000 | Number of compulsory departures agreed | Cost of compulsory departures agreed £000 | Number of other departures agreed | Cost of other departures agreed £000 |
| <£10,000 | 0 | 0 | 18 | 111 | 2 | 10 | 0 | 0 |
| £10,001 - £25,000 | 0 | 0 | 22 | 379 | 1 | 11 | 0 | 0 |
| £25,001 - £50,000 | 0 | 0 | 6 | 194 | 1 | 49 | 0 | 0 |
| £50,001 - £100,000 | 0 | 0 | 0 | 0 | 1 | 73 | 0 | 0 |
| £100,001 - £150,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| £150,001 - £200,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| >£200,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **0** | **0** | **46** | **684** | **5** | **143** | **0** | **0** |
| Redundancy | 0 | 0 | 0 | 0 | 5 | 143 | 0 | 0 |
| Voluntary Severance Scheme | 0 | 0 | 46 | 684 | 0 | 0 | 0 | 0 |
| **Total** | **1** | **0** | **46** | **684** | **5** | **143** | **0** | **0** |

## Off-payroll transactions

The Trust makes every effort to minimise the use of off-payroll arrangements, which are only used as a last resort, for example where recruitment has failed for critical posts. Only in very exceptional circumstances would off-payroll engagements be undertaken for highly paid staff. When off-payroll engagements arise we strictly apply NHS England requirements to ensure protocols are followed and disclosures made.

The following table shows all off-payroll engagements as of 31 March 2026:

| **Number of existing arrangements as of 31 March 2026** | **0** |
|---|---|
| Of which: | |
| Number that have existed for less than one year at time of reporting | 0 |

| | |
|---|---|
| Number that have existed for between one and two years at time of reporting | 0 |
| Number that have existed for between two and three years at time of reporting | 0 |
| Number that have existed for between three and four years at time of reporting | 0 |
| Number that have existed for four or more years at time of reporting | 0 |

The following table shows all new off-payroll engagements, or those that reached six months in duration, in between 1 April 2025 and 31 March 2026, for more than £245 per day that last longer than six months.

| **Number of existing arrangements as of 31 March 2026** | **0** |
|---|---|
| Of which: | |
| Number that have existed for less than one year at time of reporting | 0 |
| Number that have existed for between one and two years at time of reporting | 0 |
| Number that have existed for between two and three years at time of reporting | 0 |
| Number that have existed for between three and four years at time of reporting | 0 |
| Number that have existed for four or more years at time of reporting | 0 |

There were no off-payroll engagements of Board Members and / or senior officials with significant financial responsibility between 1 April 2025 and 31 March 2026, as shown by the following table.

| | |
|---|---|
| Number of off-payroll engagements of Board Members, and/or, senior officials with significant financial responsibility, during the financial year. | 0 |
| Number of individuals that have been deemed 'Board Members and/or senior officials with significant financial responsibility' (defined as voting rights to approve significant financial decisions) during the financial year. This figure must include both off-payroll and on-payroll engagements. | 25 |

## Staff survey report

### Statement of approach

The annual NHS Staff Survey is the primary way in which we understand the experience of our colleagues. This is supported by a range of additional listening channels, including quarterly National Quarterly Pulse Surveys (NQPS), Freedom to Speak Up (FTSU), staff networks, local team and divisional engagement activity, and workforce intelligence such as turnover, sickness absence and appraisal compliance.

Progress against agreed actions is monitored through established People and Organisational Development governance arrangements, with assurance provided to the Board.

## Summary of performance – NHS Staff Survey results

Our most recent NHS Staff Survey (2025) achieved a 42% response rate (2,155 responses), compared to an average response rate of 48% for comparable organisations. While lower than the previous year, this provides sufficient data to assess trends and themes.

Headline results show a decline in several areas compared to 2024. In 2025:

- 54% of respondents recommended the Trust as a place to work.
- 64% were happy with the standard of care provided to friends or relatives.
- 68% agreed that patient care is the Trust's top priority.

Across the NHS People Promise framework, results present a mixed picture when compared with the prior years. Scores relating to compassionate and inclusive culture, safety, and protection from harassment and discrimination remained relatively stable. However, scores have declined in areas relating to staff engagement, morale, recognition and reward, learning and career development, and organisational advocacy.

| Indicators People Promise elements and themes | 2025/26 | | 2024/25 | | 2023/24 | | 2022/23 | |
|---|---|---|---|---|---|---|---|---|
| | Trust | Average score | Trust | Average score | Trust | Average score | Trust | Average score |
| We are compassionate and inclusive | **7.2** | **7.3** | 7.4 | 7.2 | 7.5 | 7.3 | 7.5 | 7.2 |
| We are recognised and rewarded | **5.8** | **5.9** | 5.9 | 5.9 | 6.1 | 6.0 | 5.9 | 5.7 |
| We each have a voice that counts | **6.4** | **6.6** | 6.7 | 6.7 | 6.9 | 6.7 | 6.8 | 6.6 |
| We are safe and healthy | **6.0** | **6.1** | 6.1 | 6.1 | 6.2 | 6.1 | 6.0 | 5.9 |
| We are always learning | **5.4** | **5.6** | 5.8 | 5.6 | 5.9 | 5.6 | 5.5 | 5.4 |
| We work flexibly | **6.0** | **6.2** | 6.4 | 6.2 | 6.4 | 6.3 | 6.1 | 6.0 |
| We are a team | **6.5** | **6.7** | 6.8 | 6.7 | 6.8 | 6.8 | 6.8 | 6.6 |
| Staff Engagement | **6.5** | **6.7** | 6.8 | 6.8 | 7.0 | 6.9 | 6.9 | 6.8 |
| Morale | **5.6** | **5.8** | 5.9 | 5.9 | 6.0 | 5.9 | 5.8 | 5.7 |

The most significant areas of concern identified through the 2025 survey included:

- Perceptions of limited career development opportunities;
- Reduced confidence that the organisation acts on feedback and concerns; and
- Low scores relating to feeling valued, particularly through appraisal.

## Action plans to address areas of concern

In response to these findings, we have agreed priority actions focused on improving staff engagement, reinforcing confidence that patient care remains the Trust's top priority, and addressing the areas of greatest dissatisfaction. These are underpinned by three core actions:

1. We will improve opportunities for career development.
2. We will continue to support opportunities for colleagues to speak up and ensure we close the loop on concerns raised.
3. We will support teams to build cohesion through civility and respect.

Our future priorities are to improve staff engagement and confidence, enhance development opportunities, and strengthen local leadership behaviours. Progress will be monitored through pulse surveys, workforce metrics, and FTSU reporting, with regular review through People and OD governance arrangements and assurance provided to the Board.

**Progress since 2024 survey:**

Following the 2024 survey, we prioritised:

Promoting a culture of speaking up:

- ✓ Developing the 'We Are a Team' People Promise through civility and respect; and
- ✓ Tackling bullying, harassment, discrimination and abuse via the Zero-Tolerance Working Group.

Key actions included:

- **Civility and Respect**
  - Standardised 'Civility' training piloted and delivered to nearly 300 staff;
  - Launch of the Civility Gateshead guide;
  - Integration of civility training into corporate induction;
  - Development of local civility questions now included in the National Quarterly Pulse Survey;
  - Zero-Tolerance Approach to bullying, harassment, discriminatory or uncivil behaviours;
  - Bullying and Harassment policy revised to include a behavioral framework;
  - Sexual Safety Charter signed and new policy introduced; and
  - Culture & experience day included as a compulsory part of Leading Forward (leadership) programme.

- **Health & Wellbeing (HWB)**
  - Retention and staff experience workshops delivered to teams;
  - A Health Needs Assessment completed to inform a new HWB Strategy;
  - Absence Taskforce launched to ensure data-led, prevention focused and accessible support;
  - Commendation received for wellbeing integration in SEQOHS accreditation and "Better Health at Work Award" Continuing Excellence accreditation attained;
  - Bespoke wellbeing support offered to address local absence and wellbeing issues; and
  - Raising Concerns route map launched for all staff to ensure concerns are escalated quickly and effectively.

**Looking ahead: priorities for 2026**

Building on this progress, our upcoming priorities include:

- ✓ Continued action on speaking up, with particular attention to the experiences of under-represented groups;
- ✓ Enhanced visibility and accessibility of career development;
  - ✓ Ongoing promotion of civility, to encourage respectful behaviour, kindness, and appreciation across all teams; and
  - ✓ Improved communication and opportunities for leadership interactions.

In response to the 2025 NHS Staff Survey findings, we have identified a focused set of priorities for 2026 aimed at addressing areas of greatest staff dissatisfaction while sustaining progress in safety, inclusion and respectful workplace behaviours.

Our priorities for 2026 are to rebuild staff engagement and confidence, improve experiences of career development and feeling valued, and strengthen voices and involvement at all levels. This includes continued action to support staff to speak up, with particular attention to the experiences of under-represented groups.

Improving the visibility and consistency of career development opportunities, including the quality and impact of appraisal and development conversations, will be a key focus during 2026.

# Code of Governance for NHS Provider Trusts

Gateshead Health NHS Foundation Trust has applied the principles of the Code of Governance for NHS Provider Trusts on a comply or explain basis.

The Code sets out a common over-arching framework for the corporate governance of NHS providers.

## Mandatory disclosures

| Code Section Ref | Code of Governance – Mandatory Disclosure Requirements – Schedule A | Annual Report Section Reference |
|---|---|---|
| A 2.1 | The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy. | This is referred to in the Performance Report and also within the Stakeholder Relationships section |
| A 2.3 | The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce. | This is referred to within the Staff Report section – specifically in the Staff Survey and Freedom to Speak Up sections. |
| A 2.8 | The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other | This is referred to within the Stakeholder Relationship section. |

| Code Section Ref | Code of Governance – Mandatory Disclosure Requirements – Schedule A | Annual Report Section Reference |
|---|---|---|
| | organisations and any associated risk management arrangements. | |
| B 2.6 | The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director:<br>• has been an employee of the trust within the last two years<br>• has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust<br>• has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme<br>• has close family ties with any of the trust's advisers, directors or senior employees<br>• holds cross-directorships or has significant links with other directors through involvement with other companies or bodies<br>• has served on the trust board for more than six years from the date of their first appointment<br>• is an appointed representative of the trust's university medical or dental school.<br>Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why. | This is referred to in the Board composition section |
| B 2.13 | The annual report should give the number of times the board and its committees met, and individual director attendance. | This is referred to in the Board composition and Directors' report section. Individual attendance statistics are provided for |

| Code Section Ref | Code of Governance – Mandatory Disclosure Requirements – Schedule A | Annual Report Section Reference |
|---|---|---|
| | | those committees which the Code mandates must exist. |
| B 2.17 | For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors. | This is included in the Board's Relationship with the Council of Governors section |
| C 2.5 | If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors | This is included in the Annual Statement on Remuneration |
| C 2.8 | The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference. | This is included in the Council of Governors section of the Directors' Report, as well as in the Annual Statement on Remuneration. The terms of reference for the Governor Remuneration Committee are available on the Trust's website as part of the Council of Governors' papers. |
| C 4.2 | The board of directors should include in the annual report a description of each director's skills, expertise and experience | This is referred to in the Board composition table in the Directors' report section. |
| C 4.7 | All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors | This is referred to in the Well-led Arrangements section of the Directors' Report |
| C 4.13 | The annual report should describe the work of the nominations committee(s), including:<br>• the process used in relation to appointments, its approach to succession planning and how both | This is included in the Annual Statement on Remuneration and Senior Managers' Remuneration Policy sections. |

| Code Section Ref | Code of Governance – Mandatory Disclosure Requirements – Schedule A | Annual Report Section Reference |
|---|---|---|
| | support the development of a diverse pipeline<br>• how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition<br>• the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives<br>• the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served<br>• the gender balance of senior management and their direct reports. | |
| C 5.15 | Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied. | This is included in the Foundation Trust Membership section. |
| D 2.4 | The annual report should include:<br>• the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed<br>• an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans<br>• where there is no internal audit function, an explanation for the | This is included in the Group Audit Committee section within the Directors' Report. |

| Code Section Ref | Code of Governance – Mandatory Disclosure Requirements – Schedule A | Annual Report Section Reference |
|---|---|---|
| | absence, how internal assurance is achieved and how this affects the external audit<br>• an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services | |
| D 2.6 | The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy | This is included in the Audit of the Accounts section of the Performance Report |
| D 2.7 | The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report. | This is included in the About Us – Our Strategic Objectives and Risks section of the Performance Report, as well as being covered in the Annual Governance Statement. |
| D 2.8 | The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report. | This is included in the About Us – Our Strategic Objectives and Risks section of the Performance Report, as well as being covered in the Annual Governance Statement. |
| D 2.9 | In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare. | This is included in the Going Concern section of the Performance Report. |
| E 2.3 | Where a trust releases an executive director, e.g. to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to | No Executive Directors have been released to serve as a Non-Executive Director elsewhere. |

| Code Section Ref | Code of Governance – Mandatory Disclosure Requirements – Schedule A | Annual Report Section Reference |
|---|---|---|
| | whether or not the director will retain such earnings. | |
| Appendix B 2.14 | The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. | This is included in the Council of Governors section of the Directors' Report |
| Appendix B 2.14 | The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report. | This is included in the Foundation Trust Membership section of the Directors' Report |
| Appendix B 2.15 | The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, e.g. through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations. | This is included in the Board's Relationship with the Council of Governors section of the Directors' Report |
| FT ARM | If, during the financial year, the Governors have exercised their power under paragraph 10C of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012 | Governors have not exercised this power and therefore no disclosure is required. |

## Comply or explain

We have complied with the "comply or explain" disclosures of the Code of Governance.

# NHS Oversight Framework

NHS England's NHS Oversight Framework 2025/26 is the framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to 1 of 5 'segments'.

Segmentation indicates performance and whether improvement is required, from high-performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to segment 5.

NHS England's oversight response to an organisation is based on:

- Its segment derived from scored metrics under 5 performance domains (being access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity)
- considering financial override which may limit a segment to be no better than 3
- contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality)
- capability assessments which consider the organisation's leadership and governance.

### *Segmentation*

Gateshead Health NHS Foundation Trust is currently placed in segment 3. Due to our planned deficit position the segment is capped at 3. As our medium term plan reflects an anticipated breakeven position across the three years we are striving to improve our segmentation position in 2026/27.

This segmentation information is the Trust's position as at Quarter 3 2025/26 (published by NHS England on 18 March 2026 and still the most current position available as at 21 May 2026). Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website. The Trust is included on the acute trust dashboard.

# Modern Slavery and Human Trafficking Act 2015 Annual Statement 2025/26

Gateshead Health NHS Foundation Trust offers the following statement regarding its efforts to prevent slavery and human trafficking in its supply chain.

Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains and in any part of its own business or supply chain.

### *The Organisation*

Gateshead Health NHS Foundation Trust provides a range of acute and community services to the population of Gateshead along with a number of specialist services to a wider population. We deliver a wide range of screening services supported by our regional laboratory services. We operate a wholly-owned subsidiary - QE Facilities Limited. QE Facilities provides a diverse offering including estates and facilities services, financial advisory, pharmacy, and logistics services across the region and beyond. Our group annual turnover is around £455m and we have a workforce of around 4,900 people.

### *Our Commitment*

We consider the potential social impact and effect of its supply chain prior to the commencement of a procurement.  We are committed to ensuring our suppliers adhere to the highest standards of ethics and undertake due diligence when considering new suppliers as well as regularly reviewing existing suppliers.

We recognise that we have a responsibility to take a robust approach preventing and addressing any concerns to slavery and human trafficking.

We are committed to preventing slavery and human trafficking in our corporate activities and to ensuring that our supply chains are free from slavery and human trafficking.

We are committed to acting ethically and with integrity and transparency in all business dealing and to putting effective systems and controls in place to safeguard against any form of modern slavery taking place within the business of our supply chain.

### *Training*

Advice and training regarding modern slavery and human trafficking is available to colleagues through our safeguarding children and adults training programmes, our safeguarding policies and procedures and our safeguarding lead.

Although specific training has not been undertaken, our colleagues undertake safeguarding training as part of core training which references Modern Day Slavery and informs them how to raise concerns regarding any vulnerable adult.

Members of the Procurement senior team are Chartered Institute of Purchasing and Supply (CIPS) qualified and abide by the CIPs code of professional conduct.

### *Our Policy Framework*

We have several policies in place which support this agenda including-

a Recruitment and Selection policies

b Safeguarding policies

c Raising Concerns – Freedom to Speak Up

d Managing Conflicts of Interest

### *Our Due Diligence*

As part of our efforts to monitor and reduce the risk of slavery and human trafficking occurring within our supply chain we have taken the following steps:

- Gathered information from the business concerning existing suppliers;
- Identified tier 1 suppliers to our business; and
- Sought confirmation from those suppliers of their own compliance with the Modern Slavery Act (where appropriate) and their commitment to ethical business practices and transparency in their own supply chains.

These steps have been taken to enable us to:

- Establish and assess areas of potential risk in our business and supply chains;
- Monitor potential risk areas in our business and supply chains;
- Train our employees on what to look for (the signs of modern slavery);
- Reduce the risk of slavery and human trafficking occurring in our business and supply chains; and
- Provide adequate protection for whistle blowers.

As a result, we undertake a process of due diligence to provide assurance to all relevant interested parties (i.e. our people and our customers) that we work alongside reputable organisations.

We also confirm the identities of all new employees and their right to work in the United Kingdom in line with NHS employment check standards within our recruitment and selection practices and pay all our employees above the National Living Wage.

Our core values give a platform for our employees to raise concerns about poor working practices or behaviours not in line with those expected.

### *Risk and Compliance*

We have taken steps to evaluate the nature and extent of our exposure to the risk of modern slavery occurring within our supply chain, measured against legislative and regulatory requirements.

Sean Fenwick
Chief Executive
24 June 2026

# Statement of Accounting Officer's Responsibilities

**Statement of the chief executive's responsibilities as the accounting officer of Gateshead Health NHS Foundation Trust**

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS foundation trust accounting officer memorandum issued by NHS England.

NHS England has given accounts directions which require Gateshead Health NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Gateshead Health NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the accounting officer is required to comply with the requirements of the Department of Health and Social Care Group accounting manual and in particular to:

- observe the accounts direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS foundation trust annual reporting manual (and the Department of Health and Social Care Group accounting manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy; and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS foundation trust accounting officer memorandum.

Sean Fenwick
Chief Executive
24 June 2026

# Annual Governance Statement

## Scope of responsibility

As accounting officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS foundation trust accounting officer memorandum.

## The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Gateshead Health NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Gateshead Health NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

## Capacity to handle risk

### Risk management leadership

As Accounting Officer, I have ultimate accountability and responsibility for leading our risk management arrangements on behalf of the Board of Directors. Executive leadership for risk management is delegated to the Interim Chief Nurse, as outlined within our risk management framework. The Interim Chief Nurse is responsible for providing leadership for the development and implementation of the Group's risk management strategy, ensuring that we constantly monitor and evaluate the effectiveness of our systems of internal control. This includes ensuring that there is central support in terms of resource and systems in place to deliver the risk management strategy. The Interim Chief Nurse, along with the Medical Director, also leads on all aspects of clinical risk.

Each executive director has responsibility for leadership in respect of risks relating to their own portfolio areas. As an example, the Chief Operating Officer had specific responsibility for operational risk, performance and Emergency Preparedness, Resilience and Response (EPRR)-related risks in 2025/26.

Professional support in respect of the implementation of the risk management strategy and risk systems is provided by the Corporate and Clinical Risk Lead (who reports to the Interim Chief Nurse), with the Company Secretary providing support in relation to the Board Assurance Framework (BAF).

The Executive Risk Management Group is a dedicated group within our governance structure which seeks assurance over the effective risk management within both the Trust and its wholly-owned subsidiary, QE Facilities (which provides a range of functions including estates, facilities, transport and procurement). The Group is chaired by the Chief Executive, which demonstrates the importance placed on risk management by the senior leadership team.

The Group met 12 times during the year and reviewed the Organisational Risk Register (ORR) at each meeting, as well as the risk registers for each division (corporate and operational) and QE Facilities on a cyclical basis. The work of the Group provides constructive challenge and debate on the completeness of risk registers, the appropriateness of risk scores and the frequency and robustness of risk review. The Group formally reports into the Group Audit Committee, with assurance reports provided to every meeting of the Committee to demonstrate the impact of the Group and provide an insight into the risk management control environment.

The work of the Group also informed the risk reporting to other key forums within the governance structure, with relevant extracts of the ORR being presented to the Tier 1 Board Committees throughout the year (alongside the BAF extracts). The ORR was presented in full to the Board of Directors at every Board meeting held in public throughout the year, with the BAF presented four times.

### Risk management training

We ensure through our management structures that we provide training and support on the delivery of risk management activities.

Our statutory and mandatory training programme supports staff in risk identification and assessment through subject-specific modules including health and safety, fire safety, moving and handling and falls training, for example.

The Group risk management policy (which applies to the Trust and QE Facilities) provides detailed information on risk reporting, risk register usage, risk review and risk escalation. The Trust's intranet includes additional guidance and information on how to implement the policy.

The Corporate and Clinical Risk Lead has also delivered one-to-one and group training throughout the year as well as holding bespoke risk review sessions with risk owners.

The Board undertook a risk management development session in August 2025. The session was focussed on the alignment of the BAF to the new five year corporate strategy, including the agreement of summary risks and their respective target scores (for delivery by 31 March 2027) and current scores mapped to each objective.

## The risk and control framework

The Trust's risk management policy sets out the framework for the management of risk including how risks are being identified, evaluated and controlled. The risk management strategy for the Group was reviewed and approved by the Board of Directors in May 2023. At the year end this strategy was in the process of being reviewed with the aim of launching a revised strategy by September 2026.

The risk management policy was updated in October 2024 (and is due for a full review again by October 2027, in line with our timescales for policy reviews). It describes how we use the National Patient Safety Agency (NPSA) risk matrix as a tool to assist in assigning a consequence and likelihood level to risks (using a 5x5 matrix). A standardised approach to risk assessment, scoring and grading is used, with risks being assigned an initial, current and target score. Our response to risk is in proportion to the level of risk identified and in accordance with the risk appetite and tolerance levels set by the Board of Directors.

The Board of Directors set an escalation level of 15, which means that any risks with a current risk score of 15 or above are reported to the Executive Risk Management Group to be considered for inclusion on the ORR. The risk management policy includes a full risk

management governance framework to outline how risks escalate from ward to Board. Risks scored at 12 or above on divisional or corporate risk registers are also shared with the Group for completeness and information as part of the cyclical presentation of risk registers, alongside the risks of 15 or above. This enables assurance to be sought regarding the consistency of the application of risk scores across the Group.

Another key part of the risk and control framework is the BAF. The BAF provides a method for seeking assurance over the management of the principal strategic risks to meeting the Trust's strategic objectives. The BAF identifies key controls and assurances, as well as any gaps and corresponding action plans. Each of the Board's committees has responsibility for seeking assurance over the delivery of specific Board-priority strategic objectives and consequently reviews the related BAF extracts at every committee meeting. As outlined earlier the BAF was fully refreshed during the year to align with the Trust's new five year corporate strategy.

During the year committees have tracked the actions taken to address control and assurance gaps, which helped to mitigate risks which may have impacted upon the ability to deliver the strategic objectives. Trend analysis graphs track the current summary risk score against the target set at the beginning of the year. This shows the movement in the current risk score throughout the year and supports the review.

The detailed reviews of the committees informed the Board's review of the full BAF document during year. A summary narrative against each BAF risk is presented to the Board as part of the BAF reporting – this provides an overview of the discussions at each Board committee, including the rationale for maintaining or changing the summary risk score.

Our internal auditors undertake an annual review of risk management and the BAF. The 2025/26 review of Trust arrangements concluded that '*governance, risk management and control arrangements provide a good level of assurance that the risks identified are managed effectively. A high level of compliance with the control framework was found to be taking place'*. This provides good external assurance around the risk and control framework in place during 2025/26.

### Governance processes and structures

Our broader governance processes and structures help to ensure that there are effective controls and escalation mechanisms in place to support decision-making and risk management.

Our Board of Directors is supported by the work of six core Board committees (also referred to as Tier 1 committees):

- Group Audit Committee;
- Finance and Performance Committee;
- Quality Governance Committee;
- People and Organisational Development Committee;
- Group Remuneration Committee; and
- Digital Committee.

In addition the Great North Healthcare Alliance Committee in Common and Joint Committee are both constituted as committees of the Board. Both are chaired by Sir Paul Ennals, Chair of Gateshead Health NHS Foundation Trust and Chair of the Great North Healthcare Alliance.

Each committee has delegated authority from the Board to review matters outlined with the terms of reference. The committees are chaired by Non-Executive Directors and are assurance-focussed committees. Each committee chair presents a report to the next Board meeting outlining key items for alerting, advising or assuring the Board. The '3A' report is a risk-based approach to reporting into the next tier within the governance structure.

The Trust's subsidiary, QE Facilities, reports into the Finance and Performance Committee in respect of its financial performance (which is consolidated to form the group position). The Chair of QE Facilities presents an assurance report to every Trust Board meeting in the 3A format, reporting on the key items emerging from each QE Facilities Board meeting. In addition QE Facilities also provides six monthly reports on performance to the Board of Directors to provide a more in-depth overview of strategic developments and performance. Where the Trust is required to report its performance on a group basis, specific assurance reports are presented to the Trust's committees by QE Facilities, for example with respect to some of the People and Organisational Development metrics.

Some revisions were made to the supporting governance and decision-making structures in 2025/26. This included the establishment of a weekly decision-making Executive Committee into which the Tier 2 governance groups report. The Executive Committee is accountable to the Board of Directors and ensures timely and transparent decision-making to support the delivery of the strategic objectives. Gateshead Health Leadership Group (GHLG), which had previously held decision-making responsibilities, was reformulated into Gateshead Health Leadership Forum, an information sharing forum to enable timely communication, discussion and support for key emerging issues. At the year end work continues to finalise the adjustments to the sub-structure to support the work of the Executive Committee and Tier 2 groups.

The Group Audit Committee has a key role in seeking assurance over the effectiveness of systems of internal control within both the Trust and QE Facilities. It therefore has an important role to play in respect of the governance structure.

As referred to earlier within the annual report, the Board has demonstrated due regard to well-led principles and the well-led framework throughout the year. This included a number of different workstreams / projects which align with well-led principles / key lines of enquiry, including:

- The review of the governance structure supporting the work of the Board and its committees. This included the establishment of an Executive Committee, adjustments to delegated decision-making and a revised group structure;
- Focussed work on organisational culture, including inclusivity and communications;
- Extensive engagement and involvement in the development of the corporate strategy and the clinical strategy;
- Reflective reviews against key external reports such as the Aubrey report into governance within breast services at a neighbouring trust;
- Completion of the Provider Capability Self-Assessment as defined by the NHS Oversight Framework; and
- Developing our partnership and collaborative working at place, neighbourhood and particularly through the Great North Healthcare Alliance.

Ensuring that we have effective governance in place enables our Board to be assured over the services we provide to our patients and the working environment we provide for our people.

Having an effective governance structure supports in the identification and management of principal risks to compliance with the NHS provider licence section 4 (FT governance). Where we have identified potential control weaknesses or opportunities for improvement during the year, we have proactively undertaken reviews and project work to strengthen governance.

The reviews undertaken and the actions implemented as a result support our compliance with this licence condition. The following actions taken during the year are examples of the actions we have taken to mitigate risks to compliance:

- Implementing revisions to our governance structure to ensure effective and clear assurance, risk management, escalation and decision-making processes are in place;
- Strengthening our contracting functions to enable greater monitoring, accountability and reporting; and
- Strengthening the focus on speaking up and raising concerns, providing earlier insight into emerging issues enabling timely action to be taken to mitigate risk.

As well as formal governance processes and structures, culture is key to ensuring that risk management principles are embedded into the everyday activity of the Trust. Risk management is also embedded into the activity of the organisation through incident reporting and the Patient Safety Incident Response Framework (PSIRF).

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. We are committed to complying with the general and specific duties of the Public Sector Equality Duty and monitoring risks and the potential impact on people with protected characteristics. Equality and Quality Impact Assessments (EQIAs) are completed for service changes and policy reviews, which demonstrates an important focus on the wider aspects of risk. We work closely with our staff networks in assessing EDI-related risks and mitigating action plans to help us to continue to improve our services and offerings for both patients and colleagues.

## Quality governance

The Quality Governance Committee leads on seeking assurance over all aspects of the quality of clinical care; quality and clinical governance systems; clinical risk issues; research and development; and compliance with regulatory standards of quality and safety.

The Quality Governance Committee is supported by the Tier 2 sub-group SafeCare Steering Group which is chaired by the Interim Chief Nurse.

The quality of performance information is assessed through a rolling multi-year programme of audit, data quality spot checks and reviews against updated guidance.

The Trust is fully compliant with the registration requirement of the Care Quality Commission (CQC). The CQC last fully inspected the Trust in April 2019, when the Trust received an overall rating of 'good'. During 2023/24 our maternity service received a 'good' rating from the CQC. There were no announced or unannounced inspections by the CQC during 2025/26.

The Trust received a Mental Health Act (1983) Monitoring visit during 2025/26 on Cragside ward in January 2026. Positive feedback was received both verbally and by way of a formal report to the Chief Executive noting areas of good practice and stating that improvements were noted in response to past concerns identified.

## Key risks during 2025/26

Based on a review of the Organisational Risk Register and the identification of key themes the Executive Risk Management Group agrees the top composite risks for the organisation each month. These are thematic risks which are then reported to the Board and its committees at every meeting.

As at 31 March 2026 the top composite risks were:

| Theme | Key risk | Mitigating actions |
|---|---|---|
| Financial sustainability | Risk of inability to invest in staff and clinical services, including supporting financial collaboration with partners | • Comprehensive sustainability and transformation programmes developed to support the delivery of the medium term plan and the return to financial balance.<br>• Equality and Quality Impact Assessment (EQIA) process in place to safeguard quality.<br>• Collaborative working with Great North Healthcare Alliance partners to support sustainable delivery of services. |
| Estates | Risk to sustainability of core infrastructure and to invest in clinical advances and working environment for our staff | • Additional external capital funding secured to invest in estates improvement / risk mitigation, including maternity, maintenance and aged equipment replacements.<br>• Business continuity plans in place and under further review.<br>• Theatre ventilation risks reducing as phased capital works progress.<br>• Progression of key capital works to address the highest risk estate – fully refurbished paediatrics and Northern Gynaecology and Oncology Centre opened during the year.<br>• Collaborative working with Great North Healthcare Alliance partners to explore estates opportunities.<br>• Estates development plan under preparation at year-end. |
| Digital | Risk of an inability to sustain and advance our digital offer impacting on our staff and ability to deliver transformation | • Chief Digital Officer in place in a shared leadership role across the three east coast Alliance trusts to support identification of synergies and opportunities for collaborative approaches.<br>• Digital plan in place to support delivery of the corporate strategy.<br>• Picture Archiving and Communications (PACS) upgrades completed to provide stability and reduce clinical risk.<br>• Records Management Optimisation Programme developed.<br>• Acute Clinical Electronic Patient Record outline business case approved. |

A number the contributory risks (which come together to form the composite risks) will remain live into 2025/26 with the implementation of mitigating actions to reduce the risks

down to their target scores, in line with our risk appetite. Our most significant risks will continue to be reported and monitored at every Board committee and Board of Directors meeting.

## Safe staffing

We adhere to the principles of safe staffing, as defined in the national guidance, *Developing Workforce Safeguards*. We use evidence-based tools and data such as the Safer Nursing Care tool, Birthrate Plus, eRostering and Model Hospital. Alongside this we use professional judgement and other key forms of information (such as patient and staff feedback) to ensure workforce planning is responsive to need and proactive in relation to forward planning.

Nurse staffing is reported to the Board of Directors at every meeting and reported to the Quality Governance Committee on those months when a Board meeting is not held. This ensures that there is Non-Executive Director scrutiny on a monthly basis. At the end of 2025/27 the reporting line was adjusted to the People of Organisation Development Committee, with Board oversight remaining in place.

The People and Organisational Development Committee oversees our wider workforce planning, metrics and talent management. The Committee has received regular updates on workforce including sickness absence, turnover, vacancy rates and strategic updates / contributions in relation to the regional workforce programme.

## Data security

The Digital Committee receives assurance on data security as part of key reports presented throughout the year. The Digital Data and Technology Steering Group supported the work of the Committee. The Committee receives a key performance indicator (KPI) report at every meeting which provides assurance over several indicators. This includes KPIs relating to cyber security, health records management, IT service effectiveness, Information Governance, clinical coding, systems adoption and data coding.

## Mandatory disclosures

The Foundation Trust is fully compliant with the registration requirements of the CQC.

The Foundation Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Foundation Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

## Review of economy, efficiency and effectiveness of the use of resources

We have robust arrangements in place for ensuring that resources are used economically, efficiently and effectively. In 2025/26 these included:

- Approval of annual budgets by the Board;
- Approval of the medium term plan by the Board;
- Approval of the five year corporate strategy and the monitoring of risks to its achievement through the Board Assurance Framework;
- Reporting to Board committees and the Board of Directors on key aspects of performance via the *Strategic Objectives: Leading Indicators and Breakthrough Objectives* report. This enabled triangulation of performance across several different metrics and areas;
- Monthly group financial reporting to the Finance and Performance Committee, enabling close monitoring and scrutiny of performance against revenue and capital plans;
- Reporting on financial performance at every Board meeting;
- Delivery of Executive-led Tier 2 Groups in the governance structure to strengthen governance, scrutiny, oversight and accountability at the sub-Board committee level;
- Implementation of a new Executive Committee to strengthen decision-making and accountability;
- Implementation of a robust financial sustainability programme and delivery as part of future planning; and
- Effective use of external reviews and internal audit to seek independent assessments of control environments, enabling actions to be taken to strengthen controls and streamline our governance and processes.

## Information governance

The Trust reported three incidents to the Information Commissioner's Office (ICO) during 2025/26, primarily as a result of administrative and procedural issues with actions taken to reduce the risk of reoccurrence through process evaluations, comprehensive staff training, and enhanced awareness practices.

## Data quality and governance

We recognise that all our decisions – whether clinical, managerial or financial – should be based on information which is of the highest quality.

The Digital Committee seeks assurance over data quality, with data quality KPIs routinely reported to the Committee as part of the KPI report. Significant work has also been undertaken around the accuracy of counting and coding of data, alongside waiting list validation.

Processes are in place to validate our performance data and external monitoring returns. Divisions and the information team work closely to review exceptions and validate data. The Trust scored above the national average on the Data Quality Maturity Index (DQMI).

Internal audit also undertake a number of audits each year which provide an independent assessment of data quality processes and controls.

## Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed

by the work of the internal auditors, clinical audit, Executive Directors, clinical and non-clinical managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Group Audit Committee and Executive Risk Management Group and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Maintaining and reviewing the effectiveness of the system of internal control has been undertaken with consideration of the following:

- The BAF provides evidence of the effectiveness of controls and assurances in respect to the principal risks to the achievement of our strategic objectives. The Tier 1 Board committees review the BAF extract at every meeting and the Board reviews the BAF four times a year;
- The Board, Tier 1 Board committees and the Executive Committee advise me of key assurances, risks and issues, which enable actions to be taken to address identified weaknesses;
- Our corporate governance structure and meeting calendar is planned to enable timely escalation of issues;
- Clinical audit processes are a key element of maintaining and reviewing the effectiveness of the system of internal control. We have an annual clinical audit programme, and the Quality Governance Committee reviews the content and outcomes of the programme throughout the year. The Group Audit Committee has a key role in seeking assurance over the process for developing and delivering the programme;
- Internal audit deliver an annual plan for the group, which is developed in conjunction with the Group Audit Committee, Committee Chairs and Executive Directors with a goal of seeking assurance over controls and processes across several key areas and systems;
- The Group Audit Committee, with full support of executive management, plays a key role in monitoring the implementation of audit recommendations, holding owners to account to ensure that recommendations are implemented (which ultimately should strengthen the control environment); and
- Two internal audits were issued with a ‘limited assurance’ rating. The first related to a follow-up audit on Do Not Attempt Cardiopulmonary Resuscitation. The Quality Governance Committee raised concerns on this matter as an ‘alert’ on its assurance report to Board. The Committee then received a detailed deep dive report into the reasons for the limited assurance follow-up report, with the report also describing the actions and monitoring proposed to ensure the new actions are tracked to deliver change. I am assured that learnings have been recognised and that this will lead to governance improvements to strengthen the controls around the implementation of audit recommendations.
- The second ‘limited assurance’ audit related to a follow-up audit on patient monies and property, which was received just prior to the formal signing of this statement. I am assured that actions are being taken to implement the recommendations contained within the report to improve the controls in this key area.

Whilst recognising that there are areas for us to improve on, the Head of Internal Audit Opinion for the period 1 April 2025 to 31 March 2026 provides ‘good assurance’ in respect of the systems of internal control.

## Conclusion

Taking into account the above, my review confirms no significant control issues have been identified.

Sean Fenwick
Chief Executive
24 June 2026

# Independent auditor's report to the Council of Governors of Gateshead Health NHS Foundation Trust

## Report on the audit of the financial statements

### Opinion on the financial statements

We have audited the financial statements of Gateshead Health NHS Foundation Trust ('the Trust') and its subsidiaries ('the Group') for the year ended 31 March 2026 which comprise the Group and Trust Statements of Comprehensive Income for the year ended 31 March 2026, the Group and Trust Statements of Financial Position as at 31 March 2026, the Group and Trust Statements of Changes in Taxpayers' Equity, the Group and Trust Statements of Cashflows for the year ended 31 March 2026, and notes to the financial statements, including material accounting policy information.

The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2025/26 as contained in the Department of Health and Social Care Group Accounting Manual 2025/26, and the Accounts Direction issued under the National Health Service Act 2006.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust and Group as at 31 March 2026 and of the Trust's and the Group's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2025/26; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

### Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the "Auditor's responsibilities for the audit of the financial statements" section of our report. We are independent of the Trust and Group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

### Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, and taking into account the requirements of the Department of Health and Social Care Group Accounting Manual, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's or the Group's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

### Other information

The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. The Directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in these regards.

## Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The Accounting Officer is required to comply with the Department of Health and Social Care Group Accounting Manual 2025/26 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another public sector entity. The Accounting Officer is responsible for assessing each year whether or not it is appropriate for the Trust and Group to prepare financial statements on the going concern basis and disclosing, as applicable, matters related to going concern.

## Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

Based on our understanding of the Trust and Group, we did not identify any laws and regulations that have an indirect effect on the preparation of the financial statements where non-compliance might have a material effect on the financial statements.

To help us identify instances of non-compliance with these laws and regulations, and in identifying and assessing the risks of material misstatement in respect to non-compliance, our procedures included, but were not limited to:

- gaining an understanding of the legal and regulatory framework applicable to the Trust and Group, the environment in which it operates, and the structure of the Trust and Group, and considering the risk of acts by the Trust and Group which were contrary to the applicable laws and regulations, including fraud;
- inquiring with management and the Audit Committee, as to whether the Trust and Group is in compliance with laws and regulations, and discussing their policies and procedures regarding compliance with laws and regulations;
- inspecting correspondence, if any, with relevant licensing or regulatory authorities;
- reviewing minutes of relevant meetings in the year;

- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the Trust and Group which were contrary to applicable laws and regulations, including fraud.

We also considered those laws and regulations that have a direct effect on the preparation of the financial statements, such as the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

In addition, we evaluated management's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, in particular in relation to accruals and provisions; revenue recognition (which we pinpointed to the cut off assertion); expenditure recognition (which we pinpointed to the cut-off assertion); and significant one-off or unusual transactions.

Our audit procedures in relation to fraud included, but were not limited to:

- making enquiries of management, Head of Internal Audit and the Audit Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud; and
- addressing the risks of fraud through management override of controls by performing journal entry testing.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with both management and the Audit Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom, (Revised 2024) and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in November 2024.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at **www.frc.org.uk/auditorsresponsibilities**. This description forms part of our auditor's report.

## Report on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

### Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in March 2026, we have identified the following significant weakness in the Trust's arrangements for the year ended 31 March 2026.

In June 2025 we identified a significant weakness in relation to financial sustainability for the year ended 31 March 2025. In our view this significant weakness remains for the year ended 31 March 2026:

| Significant weakness in arrangements – issued in a previous year | Recommendation |
|---|---|
| In our view the Trust's increasing underlying deficit, underperformance in recurrent savings and continuous reliance on receipt of deficit support funding is evidence of a significant weakness in arrangements in the financial sustainability criteria - how the body plans to bridge its funding gaps and identifies achievable savings. Without an improvement in arrangements the Trust risks being unable to deliver services in an affordable way. | The Trust should continue to work with local ICS partners to develop a medium-term plan to address the underlying deficit position. |

### Responsibilities of the Accounting Officer

The Chief Executive as Accounting Officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

### Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in March 2026.

## Report on other legal and regulatory requirements

### Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2025/26; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

### Matters on which we are required to report by exception under the Code of Audit Practice

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2025/26; or
- we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006; or
- we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.

We have nothing to report in respect of these matters.

## Use of the audit report

This report is made solely to the Council of Governors of Gateshead Health NHS Foundation Trust as a body in accordance with Schedule 10(4) of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust as a body for our audit work, for this report, or for the opinions we have formed.

## Certificate

We cannot formally conclude the audit and issue an audit certificate until we have received confirmation from the NAO that the group audit of the Department of Health and Social Care has been completed and that no further work is required to be completed by us.

James Collins (Jun 25, 2026 11:21:44 GMT+1)

James Collins, Key Audit Partner
For and on behalf of Forvis Mazars LLP (Local Auditor)

The Corner
Bank Chambers
26 Mosley Street
Newcastle-upon-Tyne
NE1 1DF

25 June 2026

# FOREWORD TO THE ACCOUNTS

## Gateshead Health NHS Foundation Trust

These accounts for the year ended 31 March 2026 have been prepared, on a going concern basis, by Gateshead Health NHS Foundation Trust under Schedule 7 (paragraphs 24 and 25) of the National Health Service Act 2006 in a form which NHSIE has, with the approval of the Treasury, directed.

Sean Fenwick
Chief Executive

## STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2026

| ` | Note | Group 2025/26 | Foundation Trust 2025/26 | Group 2024/25 | Foundation Trust 2024/25 |
|---|---|---|---|---|---|
| | | £000 | £000 | £000 | £000 |
| **Revenue** | | | | | |
| Operating Income from patient care activities | 2 | **417,536** | **417,107** | 403,037 | 402,567 |
| Other operating income | 2 | **37,739** | **22,542** | 40,750 | 27,500 |
| Operating expenses | 3 | **(461,613)** | **(451,244)** | (441,338) | (432,752) |
| **Operating (deficit)/surplus from continuing operations** | | **(6,338)** | **(11,596)** | 2,449 | (2,685) |
| **Finance Costs** | | | | | |
| Finance income | 6 | **1,445** | **1,123** | 1,881 | 1,567 |
| Finance expense - financial liabilities | 6.1 | **(1,294)** | **(2,342)** | (714) | (1,882) |
| PDC Dividends payable | | **(4,542)** | **(4,542)** | (4,336) | (4,336) |
| **Net Finance Costs** | | **(4,391)** | **(5,761)** | (3,169) | (4,651) |
| Other Gains/ (Losses) | | **(643)** | **(528)** | 0 | 0 |
| Share of profit/(loss) of associates joint ventures | | **0** | **0** | 0 | 0 |
| Gains/(losses) from transfers by absorption | | **0** | **0** | 0 | 0 |
| Corporation tax (expense)/income | 5 | **(1,674)** | **0** | (1,849) | 0 |
| **(Deficit)/Surplus from continuing operations** | | **(13,046)** | **(17,885)** | (2,569) | (7,336) |
| Surplus / (Deficit) of discontinued operations | | **0** | **0** | 0 | 0 |
| **Surplus/(Deficit)for the financial year** | | **(13,046)** | **(17,885)** | (2,569) | (7,336) |
| **Other comprehensive income** | | | | | |
| Impairments | 7 | **(1,697)** | **(1,697)** | (509) | (509) |
| Revaluations | 7 | **571** | **1,226** | 0 | 0 |
| Other recognised gains and losses | | **0** | **0** | 0 | 0 |
| Actuarial gains/(losses) on defined benefit pension schemes | | **0** | **0** | 0 | 0 |
| Other reserve movements | | **(88)** | **0** | (43) | 0 |
| **Total Comprehensive (Expense)/Income for the year** | | **(14,260)** | **(18,356)** | (3,121) | (7,845) |

The notes on pages 140 to 183 form part of these accounts.

## STATEMENT OF FINANCIAL POSITION AS AT 31 March 2026

| | Note | Group 31 March 2026 | Foundation Trust 31 March 2026 | Group 31 March 2025 | Foundation Trust 31 March 2025 |
|---|---|---|---|---|---|
| | | £000 | £000 | £000 | £000 |
| **Non-current assets** | | | | | |
| Property, plant and equipment | 8.1-8.4 | **174,775** | **174,072** | 169,678 | 168,601 |
| Right of Use Assets | 9 | **12,826** | **6,845** | 13,825 | 6,846 |
| Investment Property | 8.5 | **80** | **0** | 80 | 0 |
| Investments in Subsidiaries | 8.9 | **0** | **16,824** | 0 | 16,824 |
| Loans to Subsidiaries | 8.9 | **0** | **0** | 0 | 0 |
| Other Investments (Charitable) | 22 | **1,315** | **0** | 1,362 | 0 |
| Trade and other receivables | 10.1 | **769** | **314** | 2,273 | 1,568 |
| **Total non-current assets** | | **189,766** | **198,056** | 187,218 | 193,839 |
| **Current assets** | | | | | |
| Inventories | 11.1 | **4,286** | **1,521** | 4,308 | 1,515 |
| Trade and other receivables | 10.1 | **22,688** | **18,543** | 29,339 | 26,251 |
| Other financial Assets | | **0** | **0** | 0 | 0 |
| Non-Current assets for Sale and Assets in disposal Groups | | **0** | **0** | 0 | 0 |
| Cash and cash equivalents | 12 | **31,933** | **29,631** | 26,960 | 17,367 |
| **Total current assets** | | **58,907** | **49,695** | 60,607 | 45,133 |
| **Current liabilities** | | | | | |
| Trade and other payables | 13.1 | **(61,934)** | **(51,892)** | (54,231) | (48,086) |
| Borrowings | 14.1 | **(4,273)** | **(18,798)** | (3,958) | (4,167) |
| Provisions | 15 | **(2,109)** | **(2,109)** | (2,573) | (2,503) |
| Other liabilities | 13.2 | **(1,489)** | **(1,414)** | (2,777) | (2,199) |
| **Total current liabilities** | | **(69,805)** | **(74,212)** | (63,539) | (56,955) |
| **Total assets less current liabilities** | | **178,868** | **173,539** | 184,286 | 182,017 |
| **Non-current liabilities** | | | | | |
| Trade and other payables | 13.1 | **0** | **0** | (146) | (146) |
| Borrowings | 14.1 | **(19,328)** | **(53,546)** | (21,760) | (54,713) |
| Provisions | 15 | **(1,777)** | **(1,778)** | (2,105) | (2,105) |
| Other Liabilities | 13.2 | **(1,647)** | **(272)** | (1,421) | (276) |
| **Total non-current liabilities** | | **(22,752)** | **(55,596)** | (25,432) | (57,240) |
| **Total assets employed** | | **156,117** | **117,943** | 158,854 | 124,777 |
| **Financed by taxpayers' equity** | | | | | |
| Public Dividend Capital | | **183,839** | **183,839** | 172,317 | 172,317 |
| Revaluation reserve | | **11,545** | **12,200** | 12,671 | 12,671 |
| Charitable Fund Reserve | | **2,222** | **0** | 2,357 | 0 |
| Other Reserves | | **99** | **99** | 99 | 99 |
| Income and expenditure reserve | | **(41,588)** | **(78,195)** | (28,590) | (60,310) |
| **Total taxpayers' equity** | | **156,117** | **117,943** | 158,854 | 124,777 |

The financial statements on pages 134 to 183 were approved by the Board on 24 June 2026 and signed on its behalf by:

Sean Fenwick
Chief Executive

## STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

| | Group | | | | | | Foundation Trust | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total | Public Dividend Capital | Revaluation Reserve | Charitable Fund Reserve | Other Reserves | Income and Expenditure Reserve | Total | Public Dividend Capital | Revaluation Reserve | Other Reserves | Income and Expenditure Reserve |
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Taxpayers' Equity at 1 April 2025** | 158,855 | 172,317 | 12,671 | 2,357 | 99 | (28,589) | 124,777 | 172,317 | 12,671 | 99 | (60,310) |
| **Changes in taxpayers' equity for 2025/26** | | | | | | | | | | | |
| Retained surplus/(deficit) for the year | (13,046) | 0 | 0 | (47) | 0 | (12,999) | (17,885) | 0 | 0 | 0 | (17,885) |
| Impairments | (1,697) | 0 | (1,697) | 0 | 0 | 0 | (1,697) | 0 | (1,697) | 0 | 0 |
| Transfer from Revaluation Reserve to I & E reserve | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluations Property, Plant and Equipment | 571 | 0 | 571 | 0 | 0 | 0 | 1,226 | 0 | 1,226 | 0 | 0 |
| Asset disposals | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Recognised gains / losses | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other reserve movements | (88) | 0 | 0 | (88) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 144,595 | 172,317 | 11,545 | 2,222 | 99 | (41,588) | 106,421 | 172,317 | 12,200 | 99 | (78,195) |
| Public Dividend Capital received | 20,522 | 20,522 | 0 | 0 | 0 | 0 | 20,522 | 20,522 | 0 | 0 | 0 |
| Public Dividend Capital repaid | (9,000) | (9,000) | 0 | 0 | 0 | 0 | (9,000) | (9,000) | 0 | 0 | 0 |
| **Taxpayers' Equity at 31 March 2026** | 156,117 | 183,839 | 11,545 | 2,222 | 99 | (41,588) | 117,943 | 183,839 | 12,200 | 99 | (78,195) |

## STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

| | Group | | | | | | Foundation Trust | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Total | Public Dividend Capital | Revaluation Reserve | Charitable Fund Reserve | Other Reserves | Income and Expenditure Reserve | Total | Public Dividend Capital | Revaluation Reserve | Other Reserves | Income and Expenditure Reserve |
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Taxpayers' Equity at 1 April 2024** | **154,194** | **164,536** | **13,180** | **2,499** | **99** | **(26,120)** | **124,841** | **164,536** | **13,180** | **99** | **(52,974)** |
| **Changes in taxpayers' equity for 2024/25** | | | | | | | | | | | |
| Retained surplus/(deficit) for the year | (2,569) | 0 | 0 | (99) | 0 | (2,470) | (7,336) | 0 | 0 | 0 | (7,336) |
| Impairments | (509) | 0 | (509) | 0 | 0 | 0 | (509) | 0 | (509) | 0 | 0 |
| Transfer from Revaluation Reserve to I & E reserve | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluations Property, Plant and Equipment | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Asset disposals | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Recognised gains / losses | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other reserve movements | (43) | 0 | 0 | (43) | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 151,073 | 164,536 | 12,671 | 2,357 | 99 | (28,590) | 116,996 | 164,536 | 12,671 | 99 | (60,310) |
| Public Dividend Capital received | 7,781 | 7,781 | 0 | 0 | 0 | 0 | 7,781 | 7,781 | 0 | 0 | 0 |
| Public Dividend Capital repaid | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Taxpayers' Equity at 31 March 2025** | **158,854** | **172,317** | **12,671** | **2,357** | **99** | **(28,590)** | **124,777** | **172,317** | **12,671** | **99** | **(60,310)** |

## STATEMENT OF CASHFLOWS FOR THE YEAR ENDED 31 March 2026

| | Note | Group 2025/26 | Foundation Trust 2025/26 | Group 2024/25 | Foundation Trust 2024/25 |
|---|---|---|---|---|---|
| | | £000 | £000 | £000 | £000 |
| **Cash flows from operating activities** | | | | | |
| Operating surplus /(deficit) from continuing operations | | (6,338) | (11,596) | 2,449 | (2,685) |
| Operating surplus /(deficit) of discontinued operations | | 0 | 0 | 0 | 0 |
| | | (6,338) | (11,596) | 2,449 | (2,685) |
| **Non-cash or non-operating income and expense:** | | | | | |
| Depreciation and amortisation | | 14,550 | 12,319 | 12,839 | 12,586 |
| Impairments and Reversals | | 7,646 | 7,646 | 255 | 255 |
| Non Cash Donations credited to Income | | (92) | (92) | (248) | (248) |
| Change in Trade and Other Receivables | | 7,557 | 8,572 | (8,092) | (1,409) |
| (Increase/decrease in Other assets | | 0 | 0 | (139) | 0 |
| Change in Inventories | | 22 | (6) | 1,102 | 837 |
| Change in Trade and other Payables | | 5,533 | 1,282 | 4,773 | (106) |
| Change in Other Liabilities | | (1,062) | (789) | (4,733) | (4,576) |
| Change in Provisions | | (839) | (769) | (3,069) | (2,505) |
| Corporation Tax (paid)/received | | (1,851) | 0 | (931) | 0 |
| Other movements in operating cash flows | | 0 | 18 | (1) | (127) |
| NHS Charitable Funds - working capital adjustments | 22 | 8 | 0 | 200 | 0 |
| **Net cash (outflows)/inflows from operating activities** | | 25,133 | 16,585 | 4,405 | 2,022 |
| **Cash flows from investing activities** | | | | | |
| Interest received | | 1,231 | 1,020 | 1,780 | 1,567 |
| Purchase of Property, Plant and Equipment | | (23,147) | (22,654) | (19,209) | (19,394) |
| Proceeds From the Sale of Property, Plant and Equipment | | 0 | 0 | 0 | 0 |
| Initial direct costs or up front payments in respect of right of use assets (lessee) | | 0 | 0 | 0 | 0 |
| Receipt of cash lease incentives (lessee) | | 0 | 0 | 0 | 0 |
| Lease termination fees paid (lessee) | | 0 | 0 | 0 | 0 |
| Receipt of cash grants/donations to purchase capital assets | | 0 | 0 | 65 | 65 |
| Finance lease receipts (principal and interest) | | 60 | 61 | 60 | 60 |
| NHS Charitable Funds - net cash flow from investing activities | 22 | 0 | 0 | 0 | 0 |
| **Net cash outflow from investing activities** | | (21,856) | (21,573) | (17,304) | (17,702) |
| **Net cash (outflow) / inflow before financing** | | 3,277 | (4,988) | (12,899) | (15,680) |
| **Cash flows from financing activities** | | | | | |
| Public dividend capital received | | 20,522 | 20,522 | 7,781 | 7,781 |
| Public dividend capital repaid | | (9,000) | (9,000) | 0 | 0 |
| Movement in Loans from the DHSC | | (999) | (999) | (999) | (999) |
| Working capital loan - intra group | | 0 | 15,607 | 0 | 0 |
| Capital element of lease liability payments | | (3,229) | (2,114) | (3,013) | (1,594) |
| Interest element of lease liability | | (637) | 0 | (215) | (31) |
| Movement in Finance Lease | | 96 | 0 | 0 | (746) |
| Loan Interest paid | | (404) | (404) | (447) | (447) |
| Finance Lease Interest | | 0 | (1,707) | 0 | (1,882) |
| PDC Dividend paid | | (4,653) | (4,653) | (4,012) | (4,012) |
| **Net cash inflow / (outflow) from financing activities** | | 1,696 | 17,252 | (905) | (1,930) |
| **(Decrease)/Increase in cash and cash equivalents** | | 4,973 | 12,264 | (13,804) | (17,610) |
| **Opening Cash and Cash equivalents at 1 April 2025** | | 26,960 | 17,367 | 40,764 | 34,977 |
| **Closing Cash and Cash equivalents at 31 March 2026** | | 31,933 | 29,631 | 26,960 | 17,367 |

## Notes to the Accounts

## 1 Accounting policies and other information

### Basis of preparation

NHS England has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury.

### Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment and certain financial assets and financial liabilities.

### Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

In summary following our assessment, these accounts have been prepared on a going concern basis, in accordance with the definition as set out in section 4 of the DHSC Group Accounting Manual (GAM) which outlines the interpretation of International Accounting Standard 1 (IAS1) 'Presentation of Financial Statements' as "the anticipated continuation of the provision of a service in the future, as evidenced by the inclusion of financial provision for that service in published documents".

The Directors have considered whether there are any local or national policy decisions that are likely to affect the continued funding and provision of services by the Trust. The Trust is a member of the North East and North Cumbria Integrated Care System (NENC ICS). The Integrated Care Strategy for the North East and North Cumbria was published in December 2022 as a joint plan between the region's local authorities, the NHS and other partners. No circumstances were identified within the strategy that would cause the Directors to doubt or question the continued provision of NHS services by the Trust.

This year the Trust excluding the charity returned a deficit of £12.999m as reported in the Trusts Statement of Comprehensive Income.

2025/26 sees a continuation of the previous year's financial framework. This is blended tariff approach which consists of fixed and variable payments, with most services being on a fixed payment. For those services on a variable tariff income will be earned based on volume of activity at national tariff and is consistent with the historic PbR (payment by results) funding model. The Trust has planned to achieve variable income based on a volume of activity aligned to published activity trajectories. We recognise achievement of activity trajectories and consequently planned income targets is potentially uncertain but as it amounts to less than 2% of income to the Trust, we regard this as immaterial to the Going Concern assessment.

The Trust has produced its financial plans based on these assumptions which have been approved by the Trust Board.

The Trust has prepared a cash forecast modelled on the 2025-26 financial plan assumptions for funding during the going concern period to June 27. The cash forecast for the Trust confirms the Trust will require access to cash support during this period.

In conclusion, these factors, and the anticipated future provision of services in the public sector, support the Trust's adoption of the going concern basis for the preparation of the accounts.

## Accounting policies and other information (continued)
## Consolidation

**NHS Charitable Fund**
The Foundation Trust is the corporate trustee to Gateshead Health NHS Foundation Trust Charitable Fund. The Foundation Trust has assessed its relationship to the Charitable Fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the Charitable Fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

• recognise and measure them in accordance with the Foundation Trust's accounting policies and
• eliminate intra-group transactions, balances, gains and losses.

**Other subsidiaries**
QE Facilities Limited is a wholly owned subsidiary of the Trust. Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines.

Where subsidiaries' accounting policies are not aligned with those of the trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation. The primary statements and notes to the accounts are presented with separate Group and Trust columns.

**Critical accounting judgements and key sources of estimation uncertainty**
In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimates is revised if the revision affects only that period or in the period of revision and future periods if the revision affects both current and future periods.

**Critical judgements in applying accounting policies**
The following are critical judgements, apart from those involving estimations (below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the Financial statements.

The Trust has made critical judgements, based on accounting standards, in the classification of leases and arrangements containing a lease. The Trust's view in accounting for leases is that when a lease is in place and no definition of term is in place, it is reasonable to assume that the Trust will occupy the property for the next five years as it needs to deliver its services in a local area and there is no intention for these services to be withdrawn. The Trust will review this each year with a view to immediately altering this approach where adjustments are known.

Under IFRS 16 and per the GAM, subsequent measurement of the ROU asset should be consistent with the principles for subsequent measurement of property, plant and equipment set out in IAS 16 as adapted by the FReM. Accordingly, the right of use assets should be measured at either fair value or current value in existing use. Where market data is not readily available a regular valuation is expected to be required to estimate the current value in existing use, although noted that there is a practical expedient in place for the cost model to be used where it results in a reliable proxy for current value. The Trust has made the judgement that the cost model is appropriate to use as the basis for representing the right of use assets current value.

The Trust has made critical judgements in relation to the Modern Equivalent Asset (MEA) revaluation as at 31st March 2026. Cushman & Wakefield as the Trust's valuer carries out a professional valuation of the modern equivalent asset required to have the same productive capacity and service potential as existing Trust assets. Judgements have been made by the Trust in relation to floor space, bed space, garden space, car parking areas and all areas associated with the capacity required to deliver the Trust's services as at 31st March 2026.

## 1 Accounting policies and other information (continued)

**Key sources of estimation uncertainty**

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

The Trust's revaluations of land and buildings are based upon the professional valuations provided by Cushman & Wakefield on a Modern Equivalent Asset basis and include estimates relating to the use of BCIS indices by the valuer which can fluctuate year on year. Impairments are recognised on the basis of these valuations.

## Consolidation

**Revenue from contracts with customers**

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

**Revenue from NHS Contracts**

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which replaced the National Tariff Payment System on 1 April 2023. The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts form the main payment mechanism under the NHSPS. In 2025/26 API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

In 2025/26 fixed payments were set at a level assuming the achievement of elective activity targets within aligned payment and incentive contracts. The Trust also receives income from commissioners under Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts. Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the trust contributes to system performance and therefore the availability of funding to the trust's commissioners.

## Accounting policies and other information (continued)

**Elective Recovery Fund (ERF)**
The ERF enables providers to earn income linked to the achievement of recovery trajectories and weighted activity.

**Grants and donations**
Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

**Apprenticeship service income**
The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

## Expenditure on employee benefits

**Short-term employee benefits**
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

**Pension costs**
*NHS Pension Scheme*
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employer, general practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore the scheme is accounted for as though it is a defined contribution scheme; the cost to the Trust is taken as equal to the employer's contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

The scheme is subject to a full actuarial valuation every four years and an accounting valuation every year.

*Other Pension Schemes*
The group also operates a defined contribution workplace pension scheme which is the National Employment Savings Trust Scheme (NEST). The amount charged to the Statement of Comprehensive Income represents the contributions payable to the scheme in respect of the accounting period.

**Ill Health Retirements**
There were three ill health retirements in 2025/2026 at a cost of £192,414

**Expenditure on other goods and services**
Expenditure on goods and services is recognised when, and to the extent that, they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

## Accounting policies and other information (continued)

**Discontinued operations**

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are 'machinery of government changes' and treated as continuing operations.

## Property, plant and equipment

**Recognition**

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year and
• the cost of the item can be measured reliably; and
· assets individually have a cost of at least £5,000, or collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

*Subsequent expenditure*

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

***Measurement***

*Valuation*

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured are fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would de determined at the end of the reporting period. Current values in existing use are determined as follows:

Land and non-specialist buildings - market value for existing use
Specialist buildings - depreciated replacement cost on a modern equivalent asset basis

For specialist assets, current value in existing use is interpreted as the present value of asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the local requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors and adopted by the Trust states that valuations are performed net of VAT where the VAT is recoverable by the entity.

## Accounting policies and other information (continued)

## Property, plant and equipment (continued)

*Depreciation*
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

*Revaluation gains and losses*
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historical cost where the assets have short useful lives or low values or both, as it is not considered to be materially different from current value in existing use.

## Accounting policies and other information (continued)

## Property, plant and equipment (continued)

*Impairments*
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

*De-recognition*
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. . Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

***Donated and grant funded assets***
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

## Investment property

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, to support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

## Accounting policies and other information (continued)

### Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and any overdraft balances are recorded at current values.

### Inventories

Inventories are valued at the lower of cost and net realisable value. Inventories are valued on a first in first out basis by reference to supplier information.

### Financial assets and financial liabilities

***Recognition***

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS. This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which performance occurs, i.e. when receipt or delivery of the goods or services is made.

***Classification and measurement***

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets), except where the asset or liability is measured at fair value through income and expenditure. The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

## Accounting policies and other information (continued)

***Impairment of financial assets***
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).
For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate. Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

***De-recognition***
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

## Leases
A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

***The Trust as lessee***
*Recognition and initial measurement*
At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

***Operating leases***
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

## Accounting policies and other information (continued)

***Leases of land and buildings***
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

*Subsequent measurement*
As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

**The Trust as lessor**
***Finance leases***
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.
***Operating leases***
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases. Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

## Accounting policies and other information (continued)

## Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the obligation. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

**HM Treasury's discount rates effective for 31 March 2026**
Up to 5 years nominal rate 3.64% (2025: 4.03%)
After 5 years up to 10 years nominal rate 4.22% (2025: 4.07%)
After 10 years up to 40 years nominal rate 5.32% (2025: 4.81%)
Exceeding 40 years nominal rate 5.07% (2025: 4.55%)

***Clinical negligence costs***
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 15 but is not recognised in the Trust's accounts.

***Non-clinical risk pooling***
The Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when they become due.

## Contingencies

Contingent liabilities are not recognised, but are disclosed in note 16.3, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

## Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

## Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

## Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and remunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

## Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32. The Secretary of State can issue new PDC to, and require repayment of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts. In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

## Value added tax

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

## Corporation tax

QE Facilities Limited is a wholly owned subsidiary of Gateshead Health NHS Foundation Trust and is subject to corporation tax on its profits.

Tax on the profit or loss for the year comprises current and deferred tax. Tax is recognised in the income statement except to the extent that it relates to items recognised directly in equity or other comprehensive income, in which case it is recognised directly in equity or other comprehensive income. Current tax is the expected tax payable or receivable on the taxable income or loss for the year, using tax rates enacted or substantively enacted at the balance sheet date, and any adjustment to tax payable in respect of previous years. Deferred tax is provided on temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for taxation purposes. The following temporary differences are not provided for: the initial recognition of goodwill; the initial recognition of assets or liabilities that affect neither accounting nor taxable profit other than in a business combination; and differences relating to investments in subsidiaries to the extent that they will probably not reverse in the foreseeable future. The amount of deferred tax provided for is based on the expected manner of realisation or settlement of the carrying amount of assets and liabilities, using tax rates enacted or substantively enacted at the balance sheet date. A deferred tax asset is recognised only to the extent that it is probable that future taxable profits will be available against which the temporary difference can be utilised.

The Finance Act 2021, was enacted in May 2021 and included the increase to the main rate of corporation tax continues to be 25%.

## Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

## Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

*IFRS 18 Presentation and Disclosure in Financial Statements:* The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

*IFRS 19 Subsidiaries without Public Accountability*: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

*Changes to valuation of property, plant and equipment (PPE) assets:* The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £174.8m as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for [some / all] of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £174.8m at 31 March 2026.

**Note 1.1 Segmental analysis**

The Foundation Trust operates within a single reportable segment i.e. healthcare. This primarily covers the provision of a wide range of healthcare related services to the community of Gateshead and additionally the provision of an increasing range of more specialised services to patients outside of the area.

The Board of Directors/Chief Executive acts as the Chief Operating Decision Maker for the Foundation Trust and the monthly financial position of the Foundation Trust is presented/reported to them as a single segment.

| | **Group** | | **Foundation Trust** | |
|---|---|---|---|---|
| | **2025/26 Total £000** | **2025/26 Healthcare £000** | **2025/26 Total £000** | **2025/26 Healthcare £000** |
| **Income** | | | | |
| Income from activities | **417,536** | **417,536** | **417,107** | **417,107** |
| Other operating income | **37,739** | **37,739** | **22,542** | **22,542** |
| **Total Operating Income** | **455,275** | **455,275** | **439,649** | **439,649** |

The majority of the Trust's total income from activities is received/derived from Integrated Care Boards and NHS England. Of the £417,536k reported in 2025/26 (2024/25: £402,567k), an amount of £400,152k i.e. 95.84% was attributable to Integrated Care Boards and NHS England (2024/25: £386,600k i.e. 96.03%)

| | Group | | Foundation Trust | |
|---|---|---|---|---|
| | 2024/25 Total £000 | 2024/25 Healthcare £000 | 2024/25 Total £000 | 2024/25 Healthcare £000 |
| **Income** | | | | |
| Income from activities | 403,037 | 403,037 | 402,567 | 402,567 |
| Other operating income | 40,750 | 40,750 | 27,500 | 27,500 |
| **Total Operating Income** | 443,787 | 443,787 | 430,067 | 430,067 |

**Note 2. Income**

| 2.1 Operating Income from activities by classification | Group | Foundation Trust | Group | Foundation Trust |
|---|---|---|---|---|
| | **2025/26** | **2025/26** | 2024/25 | 2024/25 |
| | **£000** | **£000** | £000 | £000 |
| Aligned payment & incentive (API) income - Fixed (not variable based on activity) | **288,059** | **288,059** | 264,829 | 264,829 |
| Aligned payment & incentive (API) income - Variable (based on activity) | **50,041** | **50,041** | 49,407 | 49,407 |
| High Cost Drug Income from Commissioners | **13,322** | **13,322** | 21,236 | 21,236 |
| Other NHS Clinical income | **15,166** | **15,166** | 14,868 | 14,868 |
| Community Income | **26,156** | **26,156** | 26,688 | 26,688 |
| Additional Income for the delivery of healthcare services | **380** | **380** | 310 | 310 |
| Private patient income | **722** | **722** | 722 | 722 |
| Elective Recovery Fund | **6,790** | **6,790** | 7,962 | 7,962 |
| Pay award central funding | **0** | **0** | 807 | 807 |
| Additional pension contribution central funding | **15,785** | **15,356** | 15,687 | 15,217 |
| Other clinical income | **1,115** | **1,115** | 521 | 521 |
| **Total Income from Activities** | **417,536** | **417,107** | 403,037 | 402,567 |
| Research and Development | **1,137** | **1,137** | 1,135 | 1,135 |
| Education and training | **12,401** | **12,401** | 12,229 | 12,182 |
| Non-patient care services to other bodies | **14,350** | **3,251** | 14,609 | 5,236 |
| Other income | **7,199** | **3,718** | 9,973 | 6,623 |
| Profit on disposal of other tangible fixed assets | **0** | **0** | 0 | 0 |
| Profit on disposal of land and buildings | **0** | **0** | 0 | 0 |
| Rental revenue from finance leases | **0** | **0** | 0 | 0 |
| Income in respect of staff costs | **1,010** | **1,048** | 924 | 982 |
| Notional Income from Apprentice Fund | **964** | **964** | 1,071 | 1,071 |
| Charitable and other contributions to expenditure - received from NHS charities | **0** | **0** | 183 | 183 |
| Cash donations for the purchase of capital assets - received from other bodies (including independent charities) | **92** | **0** | 65 | 65 |
| Donation/Grant of Physical Assets | **0** | **0** | 0 | 0 |
| Cash Grants for the Purchase of Physical Assets | **0** | **0** | 0 | 0 |
| Rental revenue from operating leases | **381** | **23** | 276 | 23 |
| NHS Charitable Funds Incoming resources excluding investment income | **205** | **0** | 285 | 0 |
| | **37,739** | **22,542** | **40,750** | **27,500** |
| **Total Operating Income** | **455,275** | **439,649** | 443,787 | 430,067 |

All services are commissioner requested except private patients

**2.1.1 Private patient income**

| | Group | |
|---|---|---|
| | **2025/26** | 2024/25 |
| | **£000** | £000 |
| Private patient income | **722** | 722 |
| Total patient related income | **417,536** | 403,037 |
| **Proportion (as percentage)** | **0.17%** | 0.18% |

| | Foundation Trust | |
|---|---|---|
| | **2025/26** | 2024/25 |
| | **£000** | £000 |
| Private patient income | **722** | 722 |
| Total patient related income | **417,107** | 402,567 |
| **Proportion (as percentage)** | **0.17%** | 0.18% |

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. The Foundation Trust has met this requirement.

**2.2 Operating lease income**

| | Group & Foundation Trust | |
|---|---|---|
| | **2025/26** | 2024/25 |
| | **£000** | £000 |
| Rents recognised as income in the period | **381** | 276 |
| **Total** | **381** | 276 |
| Future minimum lease payments due | | |
| - not later than one year | **360** | 373 |
| - later than one year and not later than two years | **77** | 77 |
| - later than two years and not later than three years | **77** | 77 |
| - later than three years and not later than four years | **77** | 77 |
| - later than four years and not later than five years | **77** | 77 |
| - later than five years | **1,306** | 1,388 |
| **Total** | **1,975** | 2,069 |

**2.3 Income from activities by source**

| | Group | Foundation Trust | Group | Foundation Trust |
|---|---|---|---|---|
| | **2025/26** | **2025/26** | 2024/25 | 2024/25 |
| | **£000** | **£000** | £000 | £000 |
| NHS Foundation Trusts | **15,166** | **15,166** | 14,868 | 14,868 |
| NHS Trusts | **0** | **0** | 0 | 0 |
| Integrated Care Boards and NHS England | **400,152** | **399,723** | 386,600 | 386,130 |
| Local Authorities | **380** | **380** | 310 | 310 |
| Department of Health - grants | **0** | **0** | 0 | 0 |
| Department of Health - other | **0** | **0** | 0 | 0 |
| Department of Health - social care | **10** | **10** | 7 | 7 |
| NHS Other | **0** | **0** | 0 | 0 |
| Non-NHS Private patients | **722** | **722** | 722 | 722 |
| Non-NHS Overseas patients (non-reciprocal) | **268** | **268** | 169 | 169 |
| NHS injury scheme | **643** | **643** | 340 | 340 |
| Non NHS other | **195** | **195** | 21 | 21 |
| Additional Income for the delivery of healthcare services | **0** | **0** | 0 | 0 |
| **Total Income from continuing Activities** | **417,536** | **417,107** | 403,037 | 402,567 |

Injury cost recovery income is subject to a provision for impairment of receivables of 24.62% to reflect expected rates of collection

**2.4 Other Operating Income**

| | Group | Foundation Trust | Group | Foundation Trust |
|---|---|---|---|---|
| | **2025/26** | **2025/26** | 2024/25 | 2024/25 |
| | **£000** | **£000** | £000 | £000 |
| Research and development | **1,137** | **1,137** | 1,135 | 1,135 |
| Education and Training | **12,401** | **12,401** | 12,229 | 12,182 |
| Charitable and other contributions to expenditure | **0** | **0** | 0 | 0 |
| Non-patient care services to other bodies | **14,350** | **3,251** | 14,609 | 5,236 |
| Re-imbursement and Top-Up funding | **0** | **0** | 0 | 0 |
| Rental revenue from operating leases | **381** | **23** | 276 | 23 |
| Income in respect of staff costs | **1,010** | **1,048** | 924 | 982 |
| Notional Income from Apprentice Fund | **964** | **964** | 1,071 | 1,071 |
| Charitable Funds NHS income excluding investing | **205** | **0** | 285 | 0 |
| Donated Equipment from DHSC for Covid response non cash | **0** | **0** | 0 | 0 |
| | | **0** | | |
| Contributions to expenditure - inventory donated by DHSC for Covid response | **0** | **0** | 0 | 0 |
| Contributions to expenditure - inventory donated by NHSE for Covid response | **0** | **0** | 0 | 0 |
| Charitable and other contributions to expenditure - received from NHS charities | **0** | **0** | 183 | 183 |
| Cash donations for the purchase of capital assets - received from other bodies (including independent charities) | **92** | **0** | 65 | 65 |
| Cash Grants for the Purchase of Physical Assets | **0** | **0** | 0 | 0 |
| Car Parking | **1,185** | **1,185** | 1,297 | 1,297 |
| Pharmacy Sales | **205** | **4** | 201 | 5 |
| Creche Services | **33** | **33** | 24 | 24 |
| Clinical Test Services | **0** | **0** | 313 | 313 |
| Catering | **847** | **0** | 842 | 0 |
| Other (note 2.4.1) | **4,929** | **2,496** | 7,296 | 4,984 |
| **Total Other Operating income** | **37,739** | **22,542** | 40,750 | 27,500 |

**2.4.1 Other Operating Income - Other**

| | Group | Foundation Trust | Group | Foundation Trust |
|---|---|---|---|---|
| | **2025/26** | **2025/26** | 2024/25 | 2024/25 |
| | **£000** | **£000** | £000 | £000 |
| Sponsorship | **0** | **310** | 0 | 0 |
| Salary sacrifice | **659** | **638** | 682 | 682 |
| Other | **4,270** | **1,548** | 6,614 | 4,302 |
| **Total Other Operating Income - other** | **4,929** | **2,496** | 7,296 | 4,984 |

## Note 3. Expenses

**3.1 Operating expenses comprise:**

| | Group 2025/26 £000 | Foundation Trust 2025/26 £000 | Group 2024/25 £000 | Foundation Trust 2024/25 £000 |
|---|---|---|---|---|
| Purchase of healthcare from NHS and DHSC Bodies | **10,152** | **10,152** | 10,654 | 10,653 |
| Purchase of healthcare from non NHS Bodies | **2,066** | **2,062** | 3,632 | 3,632 |
| Purchase of Social Care | **0** | **0** | 0 | 0 |
| Staff and Executive Director Costs | **304,232** | **275,808** | 292,120 | 266,253 |
| Employee Expenses - Non-executive directors | **180** | **169** | 181 | 171 |
| Supplies and services - clinical (excluding drugs costs) | **46,265** | **49,196** | 45,779 | 48,159 |
| Supplies and services - consumables donated from DHSC group bodies for Covid response | **0** | **0** | 0 | 0 |
| Supplies and services - general | **3,054** | **8** | 3,107 | 11 |
| Establishment | **4,546** | **2,956** | 4,047 | 2,582 |
| Research and development - (not included in employee expenses) | **35** | **35** | 3 | 0 |
| Research and development - (included in employee expenses) | **1,115** | **1,115** | 1,162 | 1,160 |
| Change in Provisions discount rates | **(49)** | **(49)** | 6 | 6 |
| Provisions arising / released in year | **407** | **407** | 0 | 0 |
| Transport (Business travel only) | **657** | **608** | 724 | 677 |
| Transport (Other) | **717** | **3,964** | 890 | 3,920 |
| Premises | **19,508** | **42,547** | 19,338 | 42,045 |
| Increase/(decrease) in bad debt provision | **(528)** | **(536)** | 234 | 237 |
| Drugs Inventories consumed | **25,760** | **24,993** | 24,890 | 24,010 |
| Inventories written down (consumables donated from DHSC group bodies for Covid response | **0** | **0** | 46 | 46 |
| Inventories written down (net including drugs) | **0** | **0** | 640 | 0 |
| Operating Lease Expenditure Net | **0** | **0** | 0 | 0 |
| Depreciation on property, plant and equipment | **14,550** | **14,067** | 12,839 | 12,586 |
| Net Impairments/(Revaluations) of Property, Plant & Equipment | **7,646** | **7,646** | 255 | 255 |
| Audit fees | | | | |
| * audit services- statutory audit | **188** | **138** | 165 | 115 |
| Other auditors' remuneration | | | | |
| Other services | **0** | **0** | 0 | 0 |
| Audit Fees payable to external auditor of charitable funds accounts | **6** | **0** | 7 | 0 |
| Clinical negligence | **9,362** | **9,362** | 8,794 | 8,794 |
| Legal Fees | **50** | **(3)** | 318 | 239 |
| Consultancy Costs | **300** | **117** | 815 | 224 |
| Internal Audit costs - (not included in employee expenses) | **273** | **201** | 288 | 218 |
| Training, courses and conferences | **2,003** | **1,864** | 2,067 | 1,881 |
| Lease expenditure - short term leases <= 12 months | **1,152** | **(1,270)** | 1,510 | (615) |
| Car parking & Security | **16** | **16** | 168 | 20 |
| Voluntary Severance Payments | **684** | **527** | 0 | 0 |
| Redundancy | **0** | **0** | 97 | 97 |
| Insurance | **666** | **187** | 605 | 323 |
| Other Services | **4,004** | **4,009** | 4,357 | 4,355 |
| NHS Charitable funds other resources expended | **331** | **0** | 478 | 0 |
| Losses, ex-gratia and special payments | **184** | **184** | 0 | 0 |
| Protective Clothing | **0** | **0** | 0 | 0 |
| Professional Fees | **0** | **0** | 0 | 0 |
| Other | **2,081** | **764** | 1,122 | 698 |
| | **461,613** | **451,244** | 441,338 | 432,752 |

* Forvis Mazars LLP There is no limitation on auditor's liability for external audit work carried out for the financial years 2025/26 and 2024/25

Statutory audit fees are shown as inclusive of VAT for the Trust and net of VAT for the subsidiary

### 3.2 The Late Payment of Commercial Debts (Interest) Act 1998/ Public Contract Regulations 2015

| | **2025/26** | 2024/25 |
|---|---|---|
| | **£000** | £000 |
| Total liability accruing in the year under this legislation as a result of late payments | 0 | 11 |

No claims were made against the Foundation Trust during the accounting period under this legislation. No compensation was paid to cover debt recovery under this legislation.

### 3.3 Better Payment Policy

| | **2025/26** | | 2024/25 | |
|---|---|---|---|---|
| | **Number** | **£000** | Number | £000 |
| Total bills paid in the year | **35,165** | **250,587** | 34,583 | **239,821** |
| Total bills paid within target | **32,111** | **233,589** | 32,427 | **235,150** |
| Percentage of bills paid within target | **91.3%** | **93.2%** | 93.8% | **98.1%** |

The Better Payment Practice Code recommends the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, with the exception of small to medium sized businesses which, under the recommendation of central government, are paid within 10 days of receipt of goods and services wherever possible.
The Group has not met the required standard by paying 93.2% of value of invoices (standard 95%) within 30 days.

**Note 4. Employee expenses, numbers and benefits**

**4.1 Employee expenses (Including Executive Directors' Costs)**

| | Group | | Foundation Trust | |
|---|---|---|---|---|
| | **2025/26** | 2024/25 | **2025/26** | 2024/25 |
| | **£000** | £000 | **£000** | £000 |
| Salaries and wages | **233,849** | 227,546 | **210,163** | 205,477 |
| Capitalised Salaries and wages | **987** | 90 | **48** | 0 |
| Social Security Costs | **27,980** | 21,983 | **25,071** | 20,006 |
| Apprenticeship levy | **1,134** | 1,112 | **1,016** | 1,004 |
| Pension costs - defined contribution plans | | | | |
| Employers' contributions to NHS Pensions | **24,161** | 23,916 | **23,513** | 23,209 |
| Pension cost - employer contributions paid by NHSE on provider's behalf (6.3% in 2023/2024; 9.4% in 2024/2025) | **15,785** | 15,687 | **15,356** | 15,217 |
| Pension costs - Other | **407** | 362 | **35** | 42 |
| External bank | **1,150** | 1,200 | **1,150** | 1,200 |
| Agency/contract staff | **1,212** | 1,779 | **996** | 1,563 |
| NHS Charitable Funds staff | **0** | 0 | **0** | 0 |
| Termination Benefits | **684** | 97 | **527** | 97 |
| **Total Gross Staff Costs** | **307,349** | 293,772 | **277,875** | 267,815 |

**4.2 Number of persons employed at 31st March**

**(The figures shown represent the Average Whole Time Equivalent as opposed to the number of employees)**

| | Group | | | | Foundation Trust | | | |
|---|---|---|---|---|---|---|---|---|
| | **2025/26 Total** | **Permanently Employed** | **Other** | 2024/25 Total | **2025/26 Total** | **Permanently Employed** | **Other** | 2024/25 Total |
| | **Number** | **Number** | **Number** | Number | **Number** | **Number** | **Number** | Number |
| Medical and dental | **555** | **537** | **18** | 544 | **555** | **537** | **18** | 544 |
| Ambulance staff | **0** | **0** | **0** | 0 | **0** | **0** | **0** | 0 |
| Administration and estates | **968** | **953** | **15** | 1,029 | **800** | **785** | **15** | 856 |
| Healthcare assistants and other support staff | **985** | **965** | **20** | 1,008 | **454** | **448** | **6** | 510 |
| Nursing, midwifery and health visiting staff | **1,475** | **1,367** | **108** | 1,533 | **1,475** | **1,367** | **108** | 1,533 |
| Healthcare scientists | **391** | **386** | **5** | 396 | **379** | **374** | **5** | 384 |
| Scientific, therapeutic and technical staff | **498** | **496** | **2** | 509 | **497** | **495** | **2** | 509 |
| Other * | **8** | **8** | **0** | 12 | **3** | **3** | **0** | 5 |
| Total | **4,880** | **4,712** | **168** | 5,031 | **4,163** | **4,009** | **154** | 4,341 |

* Other relates to Apprentices employed by the Trust

**4.3 Staff Exit Packages**

| | **2025/26 Group** | | | | 2024/25 Group | | | |
|---|---|---|---|---|---|---|---|---|
| **Exit package cost band** | **Number of compulsory departures agreed** | **Cost of compulsory departures agreed £000s** | **Number of other departures agreed** | **Cost of other departures agreed £000s** | **Number of compulsory departures agreed** | **Cost of compulsory departures agreed £000s** | **Number of other departures agreed** | **Cost of other departures agreed £000s** |
| < £10,000 | **0** | **0** | **18** | **111** | 2 | 10 | 0 | 0 |
| £10,001 - £25,000 | **0** | **0** | **22** | **379** | 1 | 11 | 0 | 0 |
| £25,001 - £50,000 | **0** | **0** | **6** | **194** | 1 | 49 | 0 | 0 |
| £50,001 - £100,000 | **0** | **0** | **0** | **0** | 1 | 73 | 0 | 0 |
| £100,001 - £150,000 | **0** | **0** | **0** | **0** | 0 | 0 | 0 | 0 |
| £150,001 - £200,000 | **0** | **0** | **0** | **0** | 0 | 0 | 0 | 0 |
| > £200,001 | **0** | **0** | **0** | **0** | 0 | 0 | 0 | 0 |
| **Total** | **0** | **0** | **46** | **684** | 5 | 143 | 0 | 0 |
| Redundancy | **0** | **0** | **0** | **0** | 5 | 143 | 0 | 0 |
| Voluntary Severance Scheme | **0** | **0** | **46** | **684** | 0 | 0 | 0 | 0 |
| **Total** | **0** | **0** | **46** | **684** | 5 | 143 | 0 | 0 |

| | **2025/26 Trust** | | | | 2024/25 Trust | | | |
|---|---|---|---|---|---|---|---|---|
| **Exit package cost band** | **Number of compulsory departures agreed** | **Cost of compulsory departures agreed £000s** | **Number of other departures agreed** | **Cost of other departures agreed £000s** | **Number of compulsory departures agreed** | **Cost of compulsory departures agreed £000s** | **Number of other departures agreed** | **Cost of other departures agreed £000s** |
| < £10,000 | **0** | **0** | **11** | **67** | 2 | 10 | 0 | 0 |
| £10,001 - £25,000 | **0** | **0** | **17** | **293** | 1 | 11 | 0 | 0 |
| £25,001 - £50,000 | **0** | **0** | **5** | **167** | 1 | 49 | 0 | 0 |
| £50,001 - £100,000 | **0** | **0** | **0** | **0** | 1 | 73 | 0 | 0 |
| £100,001 - £150,000 | **0** | **0** | **0** | **0** | 0 | 0 | 0 | 0 |
| £150,001 - £200,000 | **0** | **0** | **0** | **0** | 0 | 0 | 0 | 0 |
| > £200,001 | **0** | **0** | **0** | **0** | 0 | 0 | 0 | 0 |
| **Total** | **0** | **0** | **33** | **527** | 5 | 143 | 0 | 0 |
| Redundancy | **0** | **0** | **0** | **0** | 5 | 143 | 0 | 0 |
| Voluntary Severance Scheme | **0** | **0** | **33** | **527** | 0 | 0 | 0 | 0 |
| **Total** | **0** | **0** | **33** | **527** | 5 | 143 | 0 | 0 |

Notes to the Accounts

## 5. Corporation Tax

| | | Group | | Group |
|---|---|---|---|---|
| | | **2025/26** | | 2024/25 |
| | | **£000** | | £000 |
| UK corporation tax expense | | **1,510** | | 1,849 |
| Adjustments in respect of prior years | | **0** | | 0 |
| Current tax expense | | **1,510** | | 1,849 |
| Origination and reversal of temporary differences | **164** | | 0 | |
| Change in tax rate | **0** | | 0 | |
| Adjustment in respect of previous years | **0** | | 0 | |
| Deferred tax charge/(credit) | | **164** | | **0** |
| **Total corporation tax expense in Statement of Comprehensive Income** | | **1,674** | | 1,849 |

The Foundation Trust has no corporation tax expense (2024/25 £nil)

| **Reconciliation of effective tax rate** | **2025/26** | 2024/25 |
|---|---|---|
| | **£000** | £000 |
| Surplus for the year | **5,010** | 4,765 |
| Total tax expense | **1,674** | 1,849 |
| | **6,684** | 6,614 |
| Tax using the UK corporation tax rate of 25% (2024:25%) | **1,671** | 1,654 |
| Adjustments to current tax charge in respect of prior years | **3** | 195 |
| Tax exempt revenues | **0** | 0 |
| Recognition of previously unrecognised deferred tax asset | **0** | 0 |
| Change in tax rate | **0** | 0 |
| Other | **0** | 0 |
| Total tax (income)/expense | **1,674** | 1,849 |

## 6. Finance Income

| | **Group** | **Foundation Trust** | Group | Foundation Trust |
|---|---|---|---|---|
| | **2025/26** | **2025/26** | 2024/25 | 2024/25 |
| | **£000** | **£000** | £000 | £000 |
| Interest received on commercial bank accounts | **1,360** | **1,085** | 1,780 | 1,567 |
| NHS Charitable Funds Investment Income | **85** | **0** | 101 | 0 |
| Intragroup Loan Interest | **0** | **38** | 0 | 0 |
| | **1,445** | **1,123** | 1,881 | 1,567 |

| | Group | Foundation Trust | Group | Foundation Trust |
|---|---|---|---|---|
| **6.1 Finance Expense** | | | | |
| | **2025/26** | **2025/26** | 2024/25 | 2024/25 |
| | **£000** | **£000** | £000 | £000 |
| Finance Leases - external | **659** | **307** | 0 | 143 |
| Finance Leases - inter group | **0** | **1,400** | 0 | 1,241 |
| Loan Interest | **405** | **404** | 714 | 498 |
| Other interest - external | **230** | **231** | | |
| | **1,294** | **2,342** | 714 | 1,882 |

**Group & Foundation Trust**

**7. Impairment / Revaluation of Assets**

| | **2025/26** | 2024/25 |
|---|---|---|
| | **£000** | £000 |
| Gross Impairment | 9,393 | 0 |
| Gross Revaluation | **(50)** | 0 |
| (Reversal of Impairment)/Impairment SOCI Charge | **9,343** | (255) |
| Increase/(Decrease) in valuation of assets | **(1,697)** | (509) |
| Total (Impairment) / Revaluation in OCI | **7,646** | (764) |

In 2025/26 £7.646m has been charged to operating expenses and £1.697m debited as a revaluation in other comprehensive income.
The Foundation Trust had no recorded intangible assets at the Statement of Financial Position date nor in the prior period.

**8.1 Property, plant and equipment 2025/26 - Group**

| 2025/26 | Total | Land | Buildings excluding dwellings | Dwellings | Assets under construction and payments on account | Plant and Machinery | Transport Equipment | Information Technology | Furniture & fittings |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Cost or valuation at 1 April 2025** | 217,817 | 5,305 | 139,677 | 0 | 2,429 | 41,921 | 406 | 27,818 | 261 |
| Additions purchased | 25,453 | 0 | 9,931 | 0 | 4,711 | 5,898 | 111 | 4,802 | 0 |
| Additions donated | 92 | 0 | 92 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments | (9,393) | 0 | (9,393) | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 50 | 0 | 50 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 2,371 | 0 | (2,371) | 0 | 0 | 0 | 0 |
| Revaluations | (4,700) | 38 | (4,738) | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | (1,299) | 0 | (83) | 0 | 0 | (749) | (30) | (437) | 0 |
| **Cost or valuation at 31 March 2026** | **228,020** | **5,343** | **137,907** | **0** | **4,769** | **47,070** | **487** | **32,183** | **261** |
| **Accumulated Depreciation at 1 April 2025** | 48,134 | 0 | 75 | 0 | 0 | 26,874 | 251 | 20,673 | 261 |
| Provided during the year | 11,558 | 0 | 5,271 | 0 | 0 | 3,628 | 35 | 2,624 | 0 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluation | (5,271) | 0 | (5,271) | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluation surpluses | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transferred to disposal group as asset held for sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | (1,179) | 0 | (7) | 0 | 0 | (707) | (28) | (437) | 0 |
| **Accumulated Depreciation at 31 March 2026** | **53,242** | **0** | **68** | **0** | **0** | **29,795** | **258** | **22,860** | **261** |
| **Net book value - 31 March 2025** | | | | | | | | | |
| - Owned | 168,594 | 5,305 | 139,157 | 0 | 2,429 | 14,407 | 154 | 7,142 | 0 |
| - Finance lease | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| - Donated | 1,084 | 0 | 445 | 0 | 0 | 639 | 0 | 0 | 0 |
| **Total NBV at 31 March 2025** | **169,678** | **5,305** | **139,602** | **0** | **2,429** | **15,046** | **154** | **7,142** | **0** |
| **Net book value at 31st March 2026** | | | | | | | | | |
| - Owned | 173,997 | 5,341 | 137,434 | 0 | 4,769 | 16,899 | 229 | 9,323 | 0 |
| - Finance lease | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| - Donated | 779 | 0 | 402 | 0 | 0 | 377 | 0 | 0 | 0 |
| **Total NBV at 31 March 2026** | **174,776** | **5,341** | **137,836** | **0** | **4,769** | **17,276** | **229** | **9,323** | **0** |

**8.1 Analysis of tangible fixed assets**

| | Total | Land | Buildings excluding dwellings | Dwellings | Assets under construction and payments on account | Plant & Machinery | Transport Equipment | Information Technology | Furniture & fittings |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Net book value** | | | | | | | | | |
| - Protected assets at 31 March 2026 | 147,948 | 5,341 | 137,836 | 0 | 4,769 | 0 | 0 | 0 | 0 |
| - Unprotected assets at 31 March 2026 | 26,828 | 0 | 0 | 0 | 0 | 17,276 | 229 | 9,323 | 0 |
| **Total at 31 March 2026** | **174,776** | **5,341** | **137,836** | **0** | **4,769** | **17,276** | **229** | **9,323** | **0** |

Included within property, plant and equipment are fully depreciated assets that remain in use within the Group. These assets have a gross carrying amount and accumulated depreciation of £2,555k and a net book value of £nil at 31 March 2026.

**Note 8. Property, plant and equipment**

**8.2 Property, plant and equipment 2025/26 - Foundation Trust**

| 2025/26 | Total | Land | Buildings excluding dwellings | Dwellings | Assets under construction and payments on account | Plant and Machinery | Transport Equipment | Information Technology | Furniture & fittings |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Cost or valuation at 1 April 2025** | 216,152 | 5,305 | 138,875 | 0 | 2,429 | 41,597 | 64 | 27,621 | 261 |
| Additions purchased | 24,960 | 0 | 9,896 | 0 | 4,711 | 5,550 | 0 | 4,803 | 0 |
| Additions donated | 92 | 0 | 92 | 0 | 0 | 0 | 0 | 0 | 0 |
| Additions -transfer of assets from QEF Limited | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments | (9,393) | 0 | (9,393) | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 50 | 0 | 50 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 2,371 | 0 | (2,371) | 0 | 0 | 0 | 0 |
| Revaluations | (4,047) | 38 | (4,084) | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | (1,077) | 0 | 0 | 0 | 0 | (640) | 0 | (437) | 0 |
| **Cost or valuation at 31 March 2026** | **226,736** | **5,343** | **137,806** | **0** | **4,770** | **46,507** | **64** | **31,986** | **261** |
| | | | | | | | | | |
| **Accumulated Depreciation at 1 April 2025** | 47,551 | 0 | 0 | 0 | 0 | 26,729 | 64 | 20,497 | 261 |
| Provided during the year | 11,445 | 0 | 5,255 | 0 | 0 | 3,573 | 0 | 2,617 | 0 |
| Transfer of assests from QEF Limited | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluation | (5,255) | 0 | (5,255) | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluation surpluses | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transferred to disposal group as asset held for sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | (1,077) | 0 | 0 | 0 | 0 | 0 | 0 | (1,077) | 0 |
| **Net book value - 31 March 2026** | **52,663** | **0** | **0** | **0** | **0** | **30,302** | **64** | **22,037** | **261** |
| | | | | | | | | | |
| **Net book value - 31 March 2025** | | | | | | | | | |
| - Owned | 167,517 | 5,305 | 138,300 | 0 | 2,429 | 14,359 | 0 | 7,124 | 0 |
| - Finance lease | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| - Donated | 1,084 | 0 | 575 | 0 | 0 | 509 | 0 | 0 | 0 |
| **Total NBV at 31 March 2025** | **168,601** | **5,305** | **138,875** | **0** | **2,429** | **14,868** | **0** | **7,124** | **0** |
| | | | | | | | | | |
| **Net book value - 31 March 2026** | | | | | | | | | |
| - Owned | 173,294 | 5,343 | 137,404 | 0 | 4,770 | 16,468 | 0 | 9,310 | 0 |
| - Finance lease | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| - Donated | 779 | 0 | 402 | 0 | 0 | 377 | 0 | 0 | 0 |
| **Total NBV at 31 March 2026** | **174,072** | **5,343** | **137,806** | **0** | **4,770** | **16,845** | **0** | **9,310** | **0** |

**8.2 Analysis of tangible fixed assets**

| | Total | Land | Buildings excluding dwellings | Dwellings | Assets under construction and payments on account | Plant & Machinery | Transport Equipment | Information Technology | Furniture & fittings |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Net book value** | | | | | | | | | |
| - Protected assets at 31 March 2026 | 147,918 | 5,343 | 137,806 | 0 | 4,770 | 0 | 0 | 0 | 0 |
| - Unprotected assets at 31 March 2026 | 26,154 | 0 | 0 | 0 | 0 | 16,845 | 0 | 9,310 | 0 |
| **Total at 31 March 2026** | **174,072** | **5,343** | **137,806** | **0** | **4,770** | **16,845** | **0** | **9,310** | **0** |

Property is deemed “protected” if it is required for the purposes of providing either the mandatory goods and services or the mandatory education and training as defined in the Terms of Authorisation of the Trust.

Included within property, plant and equipment are fully depreciated assets that remain in use by the Trust. These assets have a gross carrying amount and accumulated depreciation of £2,555k and a net book value of £nil at 31 March 2026.

Notes to the Accounts

**8.1 Property, plant and equipment 2024/25 - Group**

| 2024/25 | Total | Land | Buildings excluding dwellings | Dwellings | Assets under construction and payments on account | Plant and Machinery | Transport Equipment | Information Technology | Furniture & fittings |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Cost or valuation at 1 April 2024** | 205,446 | 4,494 | 126,636 | 0 | 14,370 | 34,615 | 406 | 24,664 | 261 |
| Additions purchased | 17,183 | 0 | 10,734 | 0 | 2,429 | 1,843 | 0 | 2,177 | 0 |
| Additions donated | 248 | 0 | 76 | 0 | 0 | 172 | 0 | 0 | 0 |
| Impairments | (255) | 245 | (500) | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 8,102 | 0 | (14,370) | 5,291 | 0 | 977 | 0 |
| Revaluations | (4,805) | 566 | (5,371) | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Cost or valuation at 31 March 2025** | **217,817** | **5,305** | **139,677** | **0** | **2,429** | **41,921** | **406** | **27,818** | **261** |
| **Accumulated Depreciation at 1 April 2024** | 43,050 | 89 | 60 | 0 | 0 | 23,920 | 216 | 18,504 | 261 |
| Provided during the year | 9,385 | 0 | 4,222 | 0 | 0 | 2,955 | 36 | 2,172 | 0 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluation | (4,296) | (89) | (4,207) | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluation surpluses | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transferred to disposal group as asset held for sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Accumulated Depreciation at 31 March 2025** | **48,139** | **0** | **75** | **0** | **0** | **26,875** | **252** | **20,676** | **261** |
| **Net book value - 31 March 2024** | | | | | | | | | |
| - Owned | 161,275 | 4,405 | 126,194 | 0 | 14,370 | 9,955 | 190 | 6,161 | 0 |
| - Finance lease | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| - Donated | 1,121 | 0 | 382 | 0 | 0 | 739 | 0 | 0 | 0 |
| **Total NBV at 31 March 2024** | **162,396** | **4,405** | **126,576** | **0** | **14,370** | **10,694** | **190** | **6,161** | **0** |
| **Net book value at 31st March 2025** | | | | | | | | | |
| - Owned | 168,594 | 5,305 | 139,157 | 0 | 2,429 | 14,407 | 154 | 7,142 | 0 |
| - Finance lease | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| - Donated | 1,084 | 0 | 445 | 0 | 0 | 639 | 0 | 0 | 0 |
| **Total NBV at 31 March 2025** | **169,678** | **5,305** | **139,602** | **0** | **2,429** | **15,046** | **154** | **7,142** | **0** |

**8.1 Analysis of tangible fixed assets**

| | Total | Land | Buildings excluding dwellings | Dwellings | Assets under construction and payments on account | Plant & Machinery | Transport Equipment | Information Technology | Furniture & fittings |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Net book value** | | | | | | | | | |
| - Protected assets at 31 March 2025 | 147,336 | 5,305 | 139,602 | 0 | 2,429 | 0 | 0 | 0 | 0 |
| - Unprotected assets at 31 March 2025 | 22,342 | 0 | 0 | 0 | 0 | 15,046 | 154 | 7,142 | 0 |
| **Total at 31 March 2025** | **169,678** | **5,305** | **139,602** | **0** | **2,429** | **15,046** | **154** | **7,142** | **0** |

Notes to the Accounts

**Note 8. Property, plant and equipment**

**8.2 Property, plant and equipment 2024/25 - Foundation Trust**

| 2024/25 | Total | Land | Buildings excluding dwellings | Dwellings | Assets under construction and payments on account | Plant and Machinery | Transport Equipment | Information Technology | Furniture & fittings |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Cost or valuation at 1 April 2024** | 203,781 | 4,494 | 125,834 | 0 | 14,370 | 34,291 | 64 | 24,467 | 261 |
| Additions purchased | 17,183 | 0 | 10,734 | 0 | 2,429 | 1,843 | 0 | 2,177 | 0 |
| Additions donated | 248 | 0 | 76 | 0 | 0 | 172 | 0 | 0 | 0 |
| Additions -transfer of assets from QEF Limited | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments | (255) | 245 | (500) | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 8,102 | 0 | (14,370) | 5,291 | 0 | 977 | 0 |
| Revaluations | (4,805) | 566 | (5,371) | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Cost or valuation at 31 March 2025** | **216,152** | **5,305** | **138,875** | **0** | **2,429** | **41,597** | **64** | **27,621** | **261** |
| | | | | | | | | | |
| **Accumulated Depreciation at 1 April 2024** | 42,554 | 89 | 0 | 0 | 0 | 23,806 | 64 | 18,334 | 261 |
| Provided during the year | 9,293 | 0 | 4,207 | 0 | 0 | 2,923 | 0 | 2,163 | 0 |
| Transfer of assests from QEF Limited | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluation | (4,296) | (89) | (4,207) | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluation surpluses | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Transferred to disposal group as asset held for sale | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Net book value - 31 March 2025** | **47,551** | **0** | **0** | **0** | **0** | **26,729** | **64** | **20,497** | **261** |
| | | | | | | | | | |
| **Net book value - 31 March 2024** | | | | | | | | | |
| - Owned | 160,106 | 4,405 | 125,322 | 0 | 14,370 | 9,876 | 0 | 6,133 | 0 |
| - Finance lease | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| - Donated | 1,121 | 0 | 512 | 0 | 0 | 609 | 0 | 0 | 0 |
| **Total NBV at 31 March 2024** | **161,227** | **4,405** | **125,834** | **0** | **14,370** | **10,485** | **0** | **6,133** | **0** |
| | | | | | | | | | |
| **Net book value - 31 March 2025** | | | | | | | | | |
| - Owned | 167,517 | 5,305 | 138,300 | 0 | 2,429 | 14,359 | 0 | 7,124 | 0 |
| - Finance lease | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| - Donated | 1,084 | 0 | 575 | 0 | 0 | 509 | 0 | 0 | 0 |
| **Total NBV at 31 March 2025** | **168,601** | **5,305** | **138,875** | **0** | **2,429** | **14,868** | **0** | **7,124** | **0** |

**8.2 Analysis of tangible fixed assets**

| | Total | Land | Buildings excluding dwellings | Dwellings | Assets under construction and payments on account | Plant & Machinery | Transport Equipment | Information Technology | Furniture & fittings |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Net book value** | | | | | | | | | |
| - Protected assets at 31 March 2025 | 146,609 | 5,305 | 138,875 | 0 | 2,429 | 0 | 0 | 0 | 0 |
| - Unprotected assets at 31 March 2025 | 21,992 | 0 | 0 | 0 | 0 | 14,868 | 0 | 7,124 | 0 |
| **Total at 31 March 2025** | **168,601** | **5,305** | **138,875** | **0** | **2,429** | **14,868** | **0** | **7,124** | **0** |

Property is deemed “protected” if it is required for the purposes of providing either the mandatory goods and services or the mandatory education and training as defined in the Terms of Authorisation of the Trust.

**8.5 Investment property**

| ***Valuation*** | £000 |
|---|---|
| At 1 April 2025 | 80 |
| At 31 March 2026 | 80 |
| ***Net Book Value*** | |
| at 31 March 2026 | 80 |

| | Group | |
|---|---|---|
| | **2025/26** | 2024/25 |
| | **£000** | £000 |
| Carrying value at 1 April | **80** | 80 |
| Transfer from Property, Plant & Equipment | **0** | 0 |
| Fair value gains taken to I&E | **0** | 0 |
| Carrying value at 31 March | **80** | 80 |

**8.6 Economic life of property, plant and equipment**

| **Group & Foundation Trust** | Min Life Years | Max Life Years |
|---|---|---|
| Buildings excluding dwellings | 1 | 88 |
| Plant & Machinery | 5 | 6 |
| Transport Equipment | 5 | 7 |
| Information Technology | 5 | 5 |
| Furniture & Fittings | 5 | 5 |

**8.7 Profit /loss on disposal of fixed assets**

| | **Group & Foundation Trust** | |
|---|---|---|
| | **2025/26** | 2024/25 |
| | **£000** | £000 |
| Profit / Loss on the disposal of fixed assets is made up as follows: | | |
| Profit / Loss on disposal of Property, Plant & Equipment | **(116)** | **0** |
| Profit / Loss on disposal of Right to Use Asset (lease termination) | **(528)** | **0** |
| | **(643)** | **0** |

**8.8 Revaluation reserve - property, plant and equipment**

| | Group | Foundation Trust |
|---|---|---|
| | £000 | £000 |
| Revaluation reserve at 1 April 2025 | **12,671** | **12,671** |
| Impairments | **(1,697)** | **(1,697)** |
| Revaluations | **571** | **1,226** |
| Other reserve movements | **0** | **0** |
| **Revaluation reserve at 31 March 2026** | **11,545** | **12,200** |
| | | |
| Revaluation reserve at 1 April 2024 | 13,180 | 13,180 |
| Impairments | **(509)** | **(509)** |
| Revaluations | 0 | 0 |
| Other reserve movements | 0 | 0 |
| Revaluation reserve at 31 March 2025 | 12,671 | 12,671 |

**8.9 Investments in subsidiary undertakings**

| | **Foundation Trust** | Foundation Trust |
|---|---|---|
| | **2025/26** | 2024/25 |
| | **£000** | £000 |
| Shares in subsidiary undertakings | **16,824** | 16,824 |
| Loans to subsidiary undertakings > 1 Year | **0** | 0 |
| | **16,824** | 16,824 |
| Loans to subsidiary undertakings < 1 Year | **0** | 2,988 |
| | **16,824** | 19,812 |

The shares in the subsidiary company QE Facilities Limited comprises a 100% holding in the share capital consisting of 16,824,382 ordinary £1 shares.

The principal activity of QE Facilities Limited is to provide estate management and facilities services.

**Note 9.1 Right of use assets Group - 2025/26**

| Group | Property (land and buildings) £000 | Plant & machinery £000 | Transport equipment £000 | Total £000 | Of which: leased from DHSC group bodies £000 |
|---|---|---|---|---|---|
| **Valuation/gross cost at 1 April 2025 - brought forward** | **6,960** | **15,045** | **1,664** | **23,669** | **2,697** |
| Transfers by absorption | - | - | - | - | - |
| Additions | 797 | 608 | 639 | **2,044** | 737 |
| Remeasurements of the lease liability | - | - | - | - | - |
| Movements in provisions for restoration / removal costs | | | | - | |
| Impairments | - | - | - | - | - |
| Reversal of impairments | - | - | - | - | - |
| Revaluations | - | - | - | - | - |
| Reclassifications | - | - | - | - | - |
| Disposals / derecognition | (51) | - | - | **(51)** | - |
| **Valuation /gross cost 31 March 2026** | **7,706** | **15,653** | **2,303** | **25,662** | **3,434** |
| **Accumulated depreciation at 1 April 2025 - brought forward** | **1,689** | **7,146** | **1,009** | **9,844** | **981** |
| Transfers by absorption | - | - | - | - | - |
| Provided during the year | **858** | **1,572** | **562** | **2,992** | **371** |
| Impairments | - | - | - | - | - |
| Reversal of impairments | - | - | - | - | - |
| Revaluations | - | - | - | - | - |
| Reclassifications | - | - | - | - | - |
| Disposals / derecognition | - | - | - | - | - |
| **Accumulated depreciation at 31 March 2026** | **2,547** | **8,718** | **1,571** | **12,836** | **1,352** |
| **Net book value at 31 March 2026** | **5,158** | **6,935** | **732** | **12,826** | **2,082** |

| Group | Property (land and buildings) £000 | Plant & machinery £000 | Transport equipment £000 | Total £000 | Of which: leased from DHSC group bodies £000 |
|---|---|---|---|---|---|
| **Valuation/gross cost at 1 April 2024 - brought forward** | **6,398** | **7,586** | **1,164** | **15,148** | **2,250** |
| Transfers by absorption | - | - | - | - | - |
| Additions | 562 | **7,459** | **500** | **8,521** | 447 |
| Remeasurements of the lease liability | - | - | - | - | - |
| Movements in provisions for restoration / removal costs | - | - | - | - | - |
| Impairments | - | - | - | - | - |
| Reversal of impairments | - | - | - | - | - |
| Revaluations | - | - | - | - | - |
| Reclassifications | - | - | - | - | - |
| Disposals / derecognition | - | - | - | - | - |
| **Valuation /gross cost 31 March 2025** | **6,960** | **15,045** | **1,664** | **23,669** | **2,697** |
| **Accumulated depreciation at 1 April 2024 - brought forward** | **1,096** | **4,657** | **635** | **6,388** | **981** |
| Transfers by absorption | - | - | - | - | - |
| Provided during the year | **593** | **2,489** | **374** | **3,456** | **344** |
| Impairments | - | - | - | - | - |
| Reversal of impairments | - | - | - | - | - |
| Revaluations | - | - | - | - | - |
| Reclassifications | - | - | - | - | - |
| Disposals / derecognition | - | - | - | - | - |
| **Accumulated depreciation at 31 March 2025** | **1,689** | **7,146** | **1,009** | **9,844** | **1,325** |
| **Net book value at 31 March 2025** | **5,270** | **7,899** | **655** | **13,825** | **1,372** |

**Note 9.2 Right of use assets Trust - 2025/26**

| Trust | Property (land and buildings) £000 | Plant & machinery £000 | Transport equipment £000 | Total £000 | Of which: leased from DHSC group bodies £000 |
|---|---|---|---|---|---|
| **Valuation/gross cost at 1 April 2025 - brought forward** | **732** | **11,006** | **-** | **11,738** | **732** |
| Transfers by absorption | - | - | - | - | - |
| Additions | **664** | **160** | **49** | **873** | **664** |
| Remeasurements of the lease liability | - | - | - | - | - |
| Movements in provisions for restoration / removal costs | - | - | - | - | - |
| Impairments | - | - | - | - | - |
| Reversal of impairments | - | - | - | - | - |
| Revaluations | - | - | - | - | - |
| Reclassifications | - | - | - | - | - |
| Disposals / derecognition | - | - | - | - | - |
| **Valuation /gross cost 31 March 2026** | **1,396** | **11,166** | **49** | **12,611** | **1,396** |
| **Accumulated depreciation at 1 April 2025 - brought forward** | **208** | **4,684** | **-** | **4,892** | **208** |
| Transfers by absorption | - | - | - | - | - |
| Provided during the year | **104** | **757** | **12** | **874** | **104** |
| Impairments | - | - | - | - | - |
| Reversal of impairments | - | - | - | - | - |
| Revaluations | - | - | - | - | - |
| Reclassifications | - | - | - | - | - |
| Disposals / derecognition | - | - | - | - | - |
| **Accumulated depreciation at 31 March 2026** | **312** | **5,441** | **12** | **5,766** | **312** |
| **Net book value at 31 March 2026** | **1,084** | **5,724** | **37** | **6,845** | **1,084** |

**Note 9.3 Reconciliation of the carrying value of lease liabilities**

Lease liabilities are included within borrowings in the statement of financial position.

| A breakdown of borrowings is disclosed in note 14.1 | Group 2025/26 £000s | Trust 2025/26 £000s |
|---|---|---|
| **Carrying Value at 31 March 2025** | **14,689** | **7,060** |
| Transfers by absorption | - | - |
| Lease additions | **2,045** | **664** |
| Lease liability remeasurements | - | - |
| Interest charge arising in year | **659** | **307** |
| Early terminations | **(50)** | - |
| Lease payments (cash outflows) | **(3,869)** | **(1,228)** |
| Other changes | - | - |
| **Carrying Value at 31 March 2026** | **13,474** | **6,803** |

**Note 9.4 Maturity analysis of future lease payments at 31 March 2026**

| | Group | | Trust | |
|---|---|---|---|---|
| | **Total** | Of which leased from DHSC group bodies: | **Total** | Of which leased from DHSC group bodies: |
| | **31-Mar-26 £000s** | **31-Mar-26 £000s** | **31-Mar-26 £000s** | **31-Mar-26 £000s** |
| **Undiscounted future lease payments payable in:** | | | | |
| - not later than one year; | **3,246** | **683** | **1,365** | **361** |
| - later than one year and not later than five years; | **9,237** | **1,365** | **4,561** | **722** |
| - later than five years. | **3,805** | **0** | **2,092** | **0** |
| **Total gross future lease payments** | **16,288** | **2,048** | **8,018** | **1,082** |
| Finance charges allocated to future periods | **(2,814)** | **(288)** | **(1,215)** | **(106)** |
| **Net lease liabilities at 31 March 2026** | **13,474** | **1,760** | **6,803** | **977** |
| **Of which:** | | | | |
| - Current | 3,245 | 361 | 1,365 | 361 |
| - Non-Current | 10,229 | 1,399 | 5,438 | 616 |

Notes to the Accounts

## Note 10. Receivables

### 10.1 Trade and other receivables

| | 31st March 2026 | Financial assets | Non-financial assets | 31st March 2025 |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| **Current - Group** | | | | |
| NHS Contract Receivables * | **4,374** | **4,374** | **0** | 4,257 |
| Other receivables with related parties | **1,405** | **0** | **1,405** | 4,461 |
| Provision for impaired receivables | **(1,417)** | **(1,417)** | **0** | (1,744) |
| Prepayments | **5,170** | **0** | **5,170** | 7,358 |
| Accrued Income | **6,155** | **6,155** | **0** | 10,030 |
| Other receivables | **7,001** | **7,001** | **0** | 4,977 |
| **Total Current Trade and Other Receivables** | **22,688** | **16,113** | **6,575** | 29,339 |
| **Current - Foundation Trust** | | | | |
| NHS Contract Receivables * | **4,075** | **4,075** | **0** | 3,549 |
| Other receivables with related parties | **1,405** | **1,405** | **0** | 1,817 |
| Provision for impaired receivables | **(1,403)** | **(1,403)** | **0** | (1,738) |
| Prepayments | **4,525** | **0** | **4,525** | 6,508 |
| Accrued Income | **5,278** | **5,278** | **0** | 8,995 |
| Loan repayments from QEF Limited (note 8.9) | **0** | **0** | **0** | 2,988 |
| Other receivables | **4,663** | **4,663** | **0** | 4,132 |
| Total Current Trade and Other Receivables | **18,543** | **14,018** | **4,525** | 26,251 |

* The majority of NHS receivables are with Integrated Care Board and NHS England, as commissioners for NHS patient care services. NHS receivables that are neither past due date nor impaired are expected to be paid within their agreed terms.

| | | | | |
|---|---|---|---|---|
| **Non-Current Group** | | | | |
| NHS Contract Receivables * | **0** | **0** | **0** | 528 |
| Provision for impaired receivables | **0** | **0** | **0** | (201) |
| Deferred tax | **455** | **0** | **455** | 644 |
| Other receivables | **314** | **314** | **0** | 1,302 |
| **Total Non Current Trade and Other Receivables** | **769** | **314** | **455** | 2,273 |
| **Non-Current Foundation Trust** | | | | |
| NHS Receivables * | **0** | **0** | **0** | 528 |
| Provision for impaired receivables | **0** | **0** | **0** | (201) |
| Other receivables | **314** | **314** | **0** | 1,241 |
| **Non current trade and other receivables (excluding loans)** | **314** | **314** | **0** | **1,568** |
| Loan repayments from QEF Limited (note 8.9) | 0 | 0 | 0 | 0 |
| **Total Non Current Trade and Other Receivables** | **314** | **314** | **0** | **1,568** |

Notes to the Accounts

**Note 10.2 Allowances for Credit Losses - 2025/2026**

**Group & Foundation Trust**

| | Receivables and contract assets | All other |
|---|---|---|
| | £000's | £000's |
| At 1 April 2025 brought forward | **1,945** | 0 |
| Transfers by absorption | **0** | 0 |
| New allowances arising | **937** | 937 |
| Changes in existing allowances | **(1,132)** | (1,132) |
| Reversals of allowances | **(333)** | (333) |
| Utilisation of allowances (write offs) | **0** | 0 |
| Changes arising following modification of contractual cash flows | **0** | 0 |
| Foreign exchange and other changes | **0** | 0 |
| **At 31 March 2026** | **1,417** | (528) |
| Loss/(gain) recognised in expenditure | **(528)** | |

**Note 10.2 Allowances for Credit Losses - 2024/2025**

| | |
|---|---|
| At 1 April 2024 brought forward | 1,786 |
| Transfers by absorption | 0 |
| Transfers by absorption | 0 |
| New allowances arising | 407 |
| Changes in existing allowances | 329 |
| Reversals of allowances | (502) |
| Utilisation of allowances (write offs) | (76) |
| Changes arising following modification of contractual cash flows | 0 |
| Foreign exchange and other changes | 0 |
| **At 31 March 2025** | 1,944 |
| Loss/(gain) recognised in expenditure | **234** |

**Note 10.4 Deferred Tax Asset**

***Recognised deferred tax assets***

| *Deferred tax assets are attributable to the following:* | **Group** | *Group* |
|---|---|---|
| | **2025/2026** | *2024/2025* |
| | **£000** | *£000* |
| *Property, plant and equipment* | **434** | *598* |
| *Temporary tax differences* | **20** | *20* |
| *Total deferred tax asset* | **454** | *618* |

***Movement in deferred tax during the year***

| | **2025/2026** | *2024/2025* |
|---|---|---|
| | **£000** | *£000* |
| *Recognised in income* | **(164)** | *25* |
| *Property, plant and equipment* | **0** | *0* |
| *Prior Year Adjustment* | **0** | *0* |
| | **(164)** | *25* |

## Note 11. Inventory

### Note 11.1 Inventory Balances

| | Group | | Foundation Trust | |
|---|---|---|---|---|
| | **31 March 2026** | 31 March 2025 | **31 March 2026** | 31 March 2025 |
| | **£000** | £000 | **£000** | £000 |
| Drugs | **1,964** | 2,068 | **1,348** | 1,335 |
| Consumables | **2,223** | 2,141 | **173** | 180 |
| Energy | **99** | 99 | **0** | 0 |
| Work in Progress | **0** | 0 | **0** | 0 |
| **Total Inventories** | **4,286** | 4,308 | **1,521** | 1,515 |

### Note 11.2 Inventories Recognised as an Expense

| | Group | | Foundation Trust | |
|---|---|---|---|---|
| | **2025/2026** | **2024/2025** | **2025/2026** | **2024/2025** |
| | **£000** | £000 | **£000** | £000 |
| Inventories recognised in expenses | **31,299** | 36,741 | **11,544** | 15,191 |
| | **31,299** | 36,741 | **11,544** | 15,191 |

## Note 12. Cash and cash equivalents

| | Group | | Foundation Trust | |
|---|---|---|---|---|
| | **31 March 2026** | 31 March 2025 | **31 March 2026** | 31 March 2025 |
| | **£000** | £000 | **£000** | £000 |
| **At 1 April** | **26,960** | 40,764 | **17,367** | 34,977 |
| Net change in year | **4,973** | (13,804) | **12,264** | (17,610) |
| **At 31 March** | **31,933** | 26,960 | **29,631** | 17,367 |
| Broken down into: | | | | |
| Cash at commercial banks and in hand | **2,358** | 9,593 | **56** | 0 |
| Cash with Government Banking Service | **29,575** | 17,367 | **29,575** | 17,367 |
| Other current investments | **0** | 0 | **0** | 0 |
| **Cash and cash equivalents as in Statement of Financial Position** | **31,933** | 26,960 | **29,631** | 17,367 |
| Bank overdraft | **0** | 0 | **0** | 0 |
| **Cash and cash equivalents as in Statement of Cashflows** | **31,933** | 26,960 | **29,631** | 17,367 |

Notes to the Accounts

## Note 13. Payables and other Liabilities

### 13.1 Trade and other payables

| Group<br>Current | Total 31st March 2026<br>£000 | Financial liabilities<br>£000 | Non-financial liabilities<br>£000 | Total 31st March 2025<br>£000 |
|---|---|---|---|---|
| NHS payables and accruals | **6,933** | **6,933** | **0** | 8,567 |
| Trade Payables-Capital | **4,684** | **4,684** | **0** | 2,286 |
| Other payables | **22,299** | **11,596** | **10,703** | 15,173 |
| Corporation Tax | **776** | **0** | **776** | 1,146 |
| Accruals | **27,242** | **27,242** | **0** | 27,059 |
| **Total current trade and other payables** | **61,934** | **50,455** | **11,479** | 54,231 |
| **Non-Current** | | | | |
| Other payables | **0** | **0** | 0 | 146 |
| **Total current trade and other payables** | **0** | **0** | 0 | 146 |

| Trust<br>Current | Total 31st March 2026<br>£000 | Financial liabilities<br>£000 | Non-financial liabilities<br>£000 | Total 31st March 2025<br>£000 |
|---|---|---|---|---|
| NHS payables and accruals | **6,932** | **6,932** | **0** | 7,579 |
| Trade Payables-Capital | **4,684** | **4,684** | **0** | 2,286 |
| Other payables | **23,421** | **14,786** | **8,635** | 19,914 |
| Accruals | **16,855** | **16,855** | **0** | 18,307 |
| **Total current trade and other payables** | **51,892** | **43,257** | **8,635** | 48,086 |
| **Non-Current** | | | | |
| Other payables | **0** | **0** | 0 | 146 |
| **Total current trade and other payables** | **0** | **0** | 0 | 146 |

### 13.2 Other Liabilities

| | Group | | Foundation Trust | |
|---|---|---|---|---|
| | **31st March 2026** | 31st March 2025 | **31st March 2026** | 31st March 2025 |
| | **£000** | £000 | **£000** | £000 |
| **Current** | | | | |
| Deferred Income | **1,489** | 2,777 | **1,414** | 2,199 |
| **Total other current liabilities** | **1,489** | 2,777 | **1,414** | 2,199 |
| **Non-current** | | | | |
| Deferred Income | **1,647** | 1,421 | **272** | 276 |
| **Total other non current liabilities** | **1,647** | 1,421 | **272** | 276 |

## Note 14. Borrowings

| | Group | | Foundation Trust | |
|---|---|---|---|---|
| **14.1 Borrowings** | | | | |
| | **31 March 2026 £000** | 31 March 2025 £000 | **31 March 2026 £000** | 31 March 2025 £000 |
| **Current** | | | | |
| Loans from Independent Trust Financing Facility | **1,015** | 1,015 | **1,015** | 1,015 |
| Intra Group Working Capital Facility | **0** | 0 | **15,607** | 0 |
| Other loans | **12** | 0 | **12** | 0 |
| Revenue Support Working Capital Loans | **0** | 0 | **0** | 0 |
| Lease liabilities | **3,246** | 2,943 | **1,365** | 2,380 |
| Obligations under finance leases | **0** | 0 | **799** | 772 |
| **Total current borrowing** | **4,273** | 3,958 | **18,798** | 4,167 |
| **Non-current** | | | | |
| Loans from Independent Trust Financing Facility | **9,016** | 10,014 | **9,016** | 10,014 |
| Other loans | **84** | 0 | **84** | 0 |
| Revenue Support Working Capital Loans | **0** | 0 | **0** | 0 |
| Lease liabilities | **10,228** | 11,746 | **5,438** | 4,892 |
| Obligations under finance leases | **0** | 0 | **39,008** | 39,807 |
| **Total other non current liabilities** | **19,328** | 21,760 | **53,546** | 54,713 |

The Trust Finance Leases have been accounted for in accordance with the GAM.

The £39.008m obligation under finance leases in the Foundation Trust arises from the arrangements between the Foundation Trust and its subsidiary undertaking, QEF Ltd, for the supply of operational healthcare facilities. This liability and the associated property have both been recognised in the balance sheet of the Foundation Trust following a detailed consideration of the lease terms and the risks and rewards of the arrangement.

### 14.2 Finance lease obligations - Foundation Trust

| | **31 March 2026 £000** | 31 March 2025 £000 |
|---|---|---|
| Gross Lease Liabilities | **39,807** | 40,579 |
| Of which liabilities are due:- | | |
| - Not later than one year | **2,173** | 2,173 |
| - Later than one year and not later than five years | **8,690** | 8,690 |
| - Later than five years | **82,693** | 84,868 |
| Finance charges allocated to future periods | **(53,749)** | (55,152) |
| Net Lease Liabilities | **39,807** | 40,579 |
| - Not later than one year | **799** | 772 |
| - Later than one year and not later than five years | **3,488** | 3,370 |
| - Later than five years | **35,519** | 36,437 |
| | **39,807** | 40,579 |

**Note 15. Provisions for liabilities and charges - Group**

| | Current | | Non Current | |
|---|---|---|---|---|
| | **31 March 2026** | 31 March 2025 | **31 March 2026** | 31 March 2025 |
| | **£000** | £000 | **£000** | £000 |
| Pensions early departure costs | **133** | 134 | **452** | 567 |
| Pensions injury benefits | **126** | 124 | **1,011** | 1,118 |
| Restructuring | **0** | 0 | **0** | 0 |
| Equal pay | **0** | 0 | **0** | 0 |
| Redundancy | **0** | 0 | **0** | 0 |
| 2019/20 clinicians' pension reimbursement | **19** | 18 | **314** | 420 |
| Legal claims | **128** | 60 | **0** | 0 |
| Other | **1,703** | 2,237 | **0** | 0 |
| | **2,109** | 2,573 | **1,777** | 2,105 |

| | Pensions early departure costs £000 | Pensions injury benefits £000 | Legal claims £000 | Restructuring | Equal Pay £000 | Redundancy £000 | Clinician's Pension £000 | Other £000 | **Total £000** |
|---|---|---|---|---|---|---|---|---|---|
| At 1 April 2025 | **701** | **1,242** | **60** | **0** | **0** | **0** | **438** | **2,237** | **4,678** |
| Change in the discount rate | **(10)** | **(39)** | **0** | **0** | **0** | **0** | **(26)** | **0** | **(75)** |
| Arising during the year | **12** | **33** | **92** | **0** | **0** | **0** | **0** | **1,048** | **1,185** |
| Utilised during the year | **(135)** | **(129)** | **(10)** | **0** | **0** | **0** | **(19)** | **(818)** | **(1,111)** |
| Reclassified | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| Reversed unused | **0** | **0** | **(14)** | **0** | **0** | **0** | **(81)** | **(764)** | **(859)** |
| Unwinding of discount | **17** | **30** | **0** | **0** | **0** | **0** | **21** | **0** | **68** |
| At 31 March 2026 | **585** | **1,137** | **128** | **0** | **0** | **0** | **333** | **1,703** | **3,886** |

**Expected timing of cash flows:**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| -not later than one year; | **133** | **126** | **128** | **0** | **0** | **0** | **19** | **1,703** | **2,109** |
| -later than one year and not later than five years; | **373** | **444** | **0** | **0** | **0** | **0** | **51** | **0** | **868** |
| -later than five years; | **79** | **567** | **0** | **0** | **0** | **0** | **263** | **0** | **909** |
| | **585** | **1,137** | **128** | **0** | **0** | **0** | **333** | **1,703** | **3,886** |

| | Pensions early departure costs £000 | Pensions injury benefits £000 | Legal claims £000 | Restructuring | Equal Pay £000 | Redundancy £000 | Clinician's Pension £000 | Other £000 | Total £000 |
|---|---|---|---|---|---|---|---|---|---|
| At 1 April 2024 | 980 | 1,255 | 62 | 0 | 0 | 0 | 413 | 4,983 | 7,693 |
| Change in the discount rate | 2 | 4 | 0 | 0 | 0 | 0 | (4) | 0 | 2 |
| Arising during the year | 60 | 80 | 41 | 0 | 0 | 0 | 14 | 454 | 649 |
| Utilised during the year | (139) | (128) | (28) | 0 | 0 | 0 | (6) | (901) | (1,202) |
| Reclassified | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversed unused | (225) | 0 | (15) | 0 | 0 | 0 | 0 | (2,299) | (2,539) |
| Unwinding of discount | 23 | 31 | 0 | 0 | 0 | 0 | 21 | 0 | 75 |
| At 31 March 2025 | 701 | 1,242 | 60 | 0 | 0 | 0 | 438 | 2,237 | 4,678 |

Expected timing of cash flows:

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| -not later than one year; | 134 | 124 | 60 | 0 | 0 | 0 | 18 | 2,237 | 2,573 |
| -later than one year and not later than five years; | 441 | 469 | 0 | 0 | 0 | 0 | 53 | 0 | 963 |
| -later than five years; | 126 | 649 | 0 | 0 | 0 | 0 | 367 | 0 | 1,142 |
| | 701 | 1,242 | 60 | 0 | 0 | 0 | 438 | 2,237 | 4,678 |

£70,113k is included in the provisions of the NHS Resolution at 31/03/2026 in respect of clinical negligence liabilities of the trust which are managed through the NHS risk pooling scheme on behalf of the Foundation Trust (31/03/2025 £72,768k).

i) Pensions relating to directors and other staff represents the present value of quarterly payments to the NHS Pensions Agency in respect of the unfunded element of the pensions of staff and directors who have taken early retirement. The provisions are uncertain to the extent that the period over which payments will be made is an estimate.

ii) Other Legal claims £128k relates to a provision for Employer Liability claims which are covered under the terms of the Trust's commercial insurance. The Trust is liable for excess payments against each claim under the terms of the commercial insurance.

iii) Pensions Injury Provisions £1,137k relate to Service Injury Benefit payments reimbursed to the NHS Pensions Agency in respect of former staff with service related injuries. The provision represents the present value of quarterly payments to the NHS Pensions Agency. The provisions are uncertain with regard to the value of the cash reimbursements and the period of time over which the contribution will be made.

Notes to the Accounts

**Note 15. Provisions for liabilities and charges - Foundation Trust**

| | Current | | Non Current | |
|---|---|---|---|---|
| | **31 March 2026** | 31 March 2025 | **31 March 2026** | 31 March 2025 |
| | **£000** | £000 | **£000** | £000 |
| Pensions early departure costs | **133** | 134 | **452** | 567 |
| Pensions injury benefits | **126** | 124 | **1,011** | 1,118 |
| Restructuring | **0** | 0 | **0** | 0 |
| Redundancy | **0** | 0 | **0** | 0 |
| 2019/20 clinicians' pension reimbursement | **19** | 18 | **314** | 420 |
| Legal claims | **128** | 60 | **0** | 0 |
| Other | **1,703** | 2,167 | **0** | 0 |
| | **2,109** | 2,503 | **1,777** | 2,105 |

| | Pensions early departure costs £000 | Pensions injury benefits £000 | Legal claims £000 | Equal Pay £000 | Redundancy £000 | Clinician's Pension £000 | Other £000 | **Total £000** |
|---|---|---|---|---|---|---|---|---|
| At 1 April 2025 | **701** | **1,242** | **60** | **0** | **0** | **438** | **2,237** | **4,678** |
| Change in the discount rate | (10) | (39) | 0 | 0 | 0 | (26) | 0 | **(75)** |
| Arising during the year | 12 | 33 | 92 | 0 | 0 | 0 | 1,048 | **1,185** |
| Utilised during the year | (135) | (129) | (10) | 0 | 0 | (19) | (818) | **(1,111)** |
| Reclassified | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Reversed unused | 0 | 0 | (14) | 0 | 0 | (81) | (764) | **(859)** |
| Unwinding of discount | 17 | 30 | 0 | 0 | 0 | 21 | 0 | **68** |
| At 31 March 2026 | **585** | **1,137** | **128** | **0** | **0** | **333** | **1,703** | **3,886** |

**Expected timing of cash flows:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| -not later than one year; | **133** | **126** | **128** | **0** | **0** | **19** | **1,703** | **2,109** |
| -later than one year and not later than five years; | **373** | **444** | **0** | **0** | **0** | **51** | **0** | **868** |
| -later than five years; | **79** | **567** | **0** | **0** | **0** | **263** | **0** | **909** |
| | **585** | **1,137** | **128** | **0** | **0** | **333** | **1,703** | **3,886** |

| | Pensions early departure costs £000 | Pensions injury benefits £000 | Legal claims £000 | Equal Pay £000 | Redundancy £000 | Clinician's Pension £000 | Other £000 | Total £000 |
|---|---|---|---|---|---|---|---|---|
| At 1 April 2024 | 980 | 1,256 | 62 | 0 | 0 | 413 | 4,348 | 7,059 |
| Change in the discount rate | 2 | 4 | 0 | 0 | 0 | (4) | 0 | 2 |
| Arising during the year | 60 | 80 | 41 | 0 | 0 | 14 | 454 | 649 |
| Utilised during the year | (140) | (128) | (28) | 0 | 0 | (6) | (880) | (1,182) |
| Reclassified | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversed unused | (225) | 0 | (15) | 0 | 0 | 0 | (1,755) | (1,995) |
| Unwinding of discount | 23 | 31 | 0 | 0 | 0 | 21 | 0 | 75 |
| At 31 March 2025 | 700 | 1,243 | 60 | 0 | 0 | 438 | 2,167 | 4,608 |

Expected timing of cash flows:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| -not later than one year; | 134 | 124 | 60 | 0 | 0 | 18 | 2,167 | 2,503 |
| -later than one year and not later than five years; | 441 | 469 | 0 | 0 | 0 | 53 | 0 | 963 |
| -later than five years; | 125 | 650 | 0 | 0 | 0 | 367 | 0 | 1,142 |
| | 700 | 1,243 | 60 | 0 | 0 | 438 | 2,167 | 4,608 |

£70,113k is included in the provisions of the NHS Resolution at 31/03/2026 in respect of clinical negligence liabilities of the trust which are managed through the NHS risk pooling scheme on behalf of the Foundation Trust (31/03/2025 £72,768k).

i) Pensions relating to directors and other staff represents the present value of quarterly payments to the NHS Pensions Agency in respect of the unfunded element of the pensions of staff and directors who have taken early retirement. The provisions are uncertain to the extent that the period over which payments will be made is an estimate.

ii) Other Legal claims £128k relates to a provision for Employer Liability claims which are covered under the terms of the Trust's commercial insurance. The Trust is liable for excess payments against each claim under the terms of the commercial insurance.

iii) Pensions Injury Provisions £1,137k relate to Service Injury Benefit payments reimbursed to the NHS Pensions Agency in respect of former staff with service related injuries. The provision represents the present value of quarterly payments to the NHS Pensions Agency. The provisions are uncertain with regard to the value of the cash reimbursements and the period of time over which the contribution will be made.

### 16.1 Contractual capital commitments - Group and Foundation Trust

Contractual capital commitments at 31 March 2026 not otherwise included in these financial statements:

| | **31 March 2026 £000** | 31 March 2025 £000 |
|---|---|---|
| Property, plant and equipment | **482** | 4,929 |
| **Total** | **482** | 4,929 |

### 16.2 Events after the reporting period - Group and Foundation Trust

There were no events after the reporting period.

### 16.3 Contingent liabilities - Group and Foundation Trust

There were no contingent liabilities at 31 March 2026 (31 March 2025: nil).

**16.4 Related Party Transactions - Group and Foundation Trust**

The Department of Health and Social Care is regarded as a related party. During the year the Group has had a significant number of material transactions with the Department and with other entities for which the Department is regarded as the parent Department in addition to those in the public sector. These entities are listed below:-

NHS England
North East and North Cumbria ICB
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
South Tyneside and Sunderland NHS Foundation Trust
The Newcastle upon Tyne Hospitals NHS Foundation Trust
HMRC
NHS Pension Scheme
Gateshead Council

**16.5 Related Party Transactions - Group and Foundation Trust**

Gateshead Health NHS Foundation Trust is required under IAS 24 to disclose material transactions undertaken with a related party.
During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with the Trust.
The Foundation Trust has received revenue and capital payments from the Gateshead Health NHS Foundation Trust Charitable Fund. The Foundation Trust acts as the Corporate Trustee for the Charitable Fund.
The total value of Funds Held on Trust at 31st March 2026 was £2,252k. The Foundation Trust owed the Charity £0k and the Charity owed the Trust £92k.

**16.6 Related Parties Transactions Subsidiaries**

Gateshead Health NHS Foundation Trust operates within Group structure and has one active wholly owned subsidiary company, QE Facilities Limited (QEF), established in 2014. The subsidiary is registered in the United Kingdom and their reporting period runs 1st April to 31st March.

QE Facilities Limited deliver a wide range of services including estates and facilities management, outpatient pharmacy, pharmacy distribution and transport, specialist cold-chain logistics, pathology sample collection and tracking, and a broad range of business consultancy services such as VAT, procurement, property management and business governance.

On 1 February 2026, the Group implemented an arrangement under which QE Facilities Limited may transfer surplus cash balances to the Trust for investment purposes. The Trust invests the funds on behalf of the Group in accordance with the Trust's treasury management and risk policies with the aim of generating enhanced interest returns. At 31st March 2026 the amounts transferred and held by the Trust were £15,607,000 which are repayable on demand.

The financial statements of QE Facilities Limited have been consolidated into the Group financial statements

**16.7 Related Parties Transactions Subsidiaries - Summary of Transactions**

The significant transactions that are included in the Foundation Trust Accounts are as follows:

| | 31 March 2026 | |
|---|---|---|
| | Income | Expenditure |
| | £000 | £000 |
| Fully Operational Healthcare Facility Unitary Charge | 667 | 71,832 |

| | Receivables | Payables | Borrowings | Cash borrowings |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| QE Facilities Limited | (8,653) | 62 | (39,807) | (15,607) |

**QE Facilities Limited closing transcations at 31st March 2026 -** *draft subject to QEF independent audit*

| | Gross Profit | Gross Assets | Gross Liabilities |
|---|---|---|---|
| | £000 | £000 | £000 |
| QE Facilities Limited | 5,010 | 76,993 | (23,404) |

**Note 17.1 Carrying Value of Financial Assets**

| | Group | | Foundation Trust | |
|---|---|---|---|---|
| **Assets as per Statement of Financial Position** | **Total £000** | **Loans and receivables £000** | **Total £000** | **Loans and receivables £000** |
| Trade and other receivables excluding non financial assets - Note 10 | **16,427** | **16,427** | **14,332** | **14,332** |
| Cash and cash equivalents at bank and in hand - Note 12 | **31,933** | **31,933** | **29,631** | **29,631** |
| Charitable Fund Financial Assets - Note 22 | **1,331** | **1,331** | **0** | **0** |
| **Total at 31 March 2026** | **49,691** | **49,691** | **43,963** | **43,963** |
| Trade and other receivables excluding non financial assets - Note 10 | 18,721 | 18,721 | 20,890 | 20,890 |
| Cash and cash equivalents at bank and in hand - Note 12 | 26,960 | 26,960 | 17,367 | 17,367 |
| Charitable Fund Financial Assets - Note 22 | 1,371 | 1,371 | 0 | 0 |
| **Total at 31 March 2025** | 47,052 | 47,052 | 38,257 | 38,257 |

**Note 17.2 Financial liabilities by category**

| | Group | | Foundation Trust | |
|---|---|---|---|---|
| **Liabilities as per Statement of Financial Position** | **Total £000** | **Other financial liabilities £000** | **Total £000** | **Other financial liabilities £000** |
| Borrowings excluding Finance lease liabilities - Note 14 | **10,127** | **10,127** | **25,734** | **25,734** |
| Obligations under leases - Note 14 | **13,474** | **13,474** | **46,610** | **46,610** |
| NHS Trade and other payables excluding non financial liabilities - Note 13 | **50,455** | **50,455** | **43,257** | **43,257** |
| Provisions under contract - Note 15 | **0** | **0** | **0** | **0** |
| Charitable Fund Financial Liabilities | **113** | **113** | **0** | **0** |
| **Total at 31 March 2026** | **74,169** | **74,169** | **115,601** | **115,601** |
| Borrowings excluding Finance lease liabilities - Note 14 | 11,029 | 11,029 | 11,029 | 11,029 |
| Obligations under finance leases - Note 14 | 14,689 | 14,689 | 47,851 | 47,851 |
| NHS Trade and other payables excluding non financial liabilities - Note 13 | 44,438 | 44,438 | 40,014 | 40,014 |
| Provisions under contract - Note 15 | 0 | 0 | 0 | 0 |
| Charitable Fund Financial Liabilities | 142 | 142 | 0 | 0 |
| **Total at 31 March 2025** | 70,298 | 70,298 | 98,894 | 98,894 |

**17.3 Liquidity Risk**

The Foundation Trust's net operating costs are incurred for the provision of services commissioned under the NHS standard contract with Integrated Care Boards and NHS England, which are financed from resources voted annually by Parliament. The Foundation Trust also finances its Capital expenditure from retained depreciation and accumulated surpluses. The Foundation Trust has a loan financed by the Independent Trust Financing Facility for £22m which partly funded the construction of the Emergency Care Centre. Deficit support loans totalling £12.235m were drawn in 2018/2019, these loans were converted to PDC in 2020/2021.

**17.4 Interest rate risk**

67% of the Foundation Trust's current financial assets consist of cash which carries a floating rate of interest.
Finance Lease arrangements are subject to a fixed rate of interest.
The current ITFF loan of £22m is subject to a fixed interest repayment rate of 3.78%

**17.5 Foreign currency risk**

The Trust has no foreign currency income or expenditure.

**17.6 Credit Risk**

Due to the continuing service provider relationship that the Trust has with local commissioning bodies and the way those bodies are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by other business entities. No collateral is held as security and there are no other credit enhancements.

The carrying value of financial instruments held by the Trust is equal to their fair value and as such this represents the maximum exposure to risk as at the operating date.

Financial assets held by the Trust are made up of cash and other cash equivalents and trade receivables. As the majority of these trade receivables are due from related parties (mainly commissioning bodies) the Trust expects that all non-impaired financial instruments are fully recoverable.

**Note 18. Carrying Values - Group and Foundation Trust**

The Trust considers book value (carrying value) to be a reasonable approximation of fair value

**Note 18.1 Carrying values of financial assets**

**Group**

| | **31 March 2026 Book Value £000** | **31 March 2026 Fair value £000** | 31 March 2025 Book Value £000 | 31 March 2025 Fair value £000 |
|---|---|---|---|---|
| Cash & cash equivalents | **31,933** | **31,933** | 26,960 | 26,960 |
| Current Receivables | **16,113** | **16,113** | 17,713 | 17,713 |
| Non Current Receivables | **314** | **314** | 1,008 | 1,008 |
| Charitable Fund Financial Assets | **1,331** | **1,331** | 1,371 | 1,371 |
| **Total** | **49,691** | **49,691** | 47,052 | 47,052 |

**Foundation Trust**

| | **31 March 2026 Book Value £000** | **31 March 2026 Fair value £000** | 31 March 2025 Book Value £000 | 31 March 2025 Fair value £000 |
|---|---|---|---|---|
| Cash & cash equivalents | **29,631** | **29,631** | 17,367 | 17,367 |
| Current Receivables | **14,018** | **14,018** | 16,956 | 16,956 |
| Non Current Receivables | **314** | **314** | 947 | 947 |
| Loan to Subsidiary | **0** | **0** | 2,988 | 2,988 |
| **Total** | **43,963** | **43,963** | 38,258 | 38,258 |

**Note 18.2 Carrying values of financial liabilities**

**Group**

| | **31 March 2026 Book Value £000** | **31 March 2026 Fair value £000** | 31 March 2025 Book Value £000 | 31 March 2025 Fair value £000 |
|---|---|---|---|---|
| Provisions under Contract | **0** | **0** | 0 | 0 |
| Obligations under finance leases - Note 14 | **13,474** | **13,474** | 14,689 | 14,689 |
| Trade & Other Payables | **50,455** | **50,455** | 44,438 | 44,438 |
| Loans | **10,127** | **10,127** | 11,029 | 11,029 |
| Charitable Fund Financial Liabilities | **113** | **113** | 142 | 142 |
| **Total** | **74,169** | **74,169** | 70,298 | 70,298 |

**Foundation Trust**

| | **31 March 2026 Book Value £000** | **31 March 2026 Fair value £000** | 31 March 2025 Book Value £000 | 31 March 2025 Fair value £000 |
|---|---|---|---|---|
| Provisions under Contract | **0** | **0** | 0 | 0 |
| Obligations under finance leases - Note 14 | **46,610** | **46,610** | 47,851 | 47,851 |
| Trade & Other Payables | **43,257** | **43,257** | 40,014 | 40,014 |
| Loans | **25,734** | **25,734** | 11,029 | 11,029 |
| **Total** | **115,601** | **115,601** | 98,894 | 98,894 |

Notes to the Accounts

**Note 18.3 Maturity of financial liabilities**

| | **Group 31 March 2026 £000** | **Trust 31 March 2026 £000** | Group 31 March 2025 £000 | Trust 31 March 2025 £000 |
|---|---|---|---|---|
| In one year or less | **54,841** | **62,055** | 41,051 | 43,274 |
| In more than one year but not more than five | **11,287** | **11,259** | 13,795 | 12,820 |
| In more than five years | **8,041** | **42,287** | 12,270 | 46,299 |
| **Total financial liabilities** | **74,169** | **115,601** | 67,116 | 102,393 |

**Note 19. Third party assets**

The Trust held £14,809.31 cash at bank and in hand at 31/03/26 (£9,077.70 at 31/03/25) which relates to monies held on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts as the Trust holds no beneficial interest.

**Note 20. Public dividend capital dividend**

The Foundation Trust is required to absorb the cost of capital at a rate of 3.5% of average relevant net assets. The resulting calculation of PDC (Public Dividend Capital) dividend, totalling £4,542,000 was calculated on the average relevant net assets of £129,778,000.

**Note 21. Losses and special payments - Group and Foundation Trust**

NHS Foundation Trusts are required to follow the guidance issued by the Department of Health and Social Care in accounting for losses and special payments:

- These are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation.
- By their nature they are items that ideally should not arise.
- They are divided into different categories, which govern the way each individual case is handled.

**The number and value of losses and special payment cases:**

| | | **1 April 2025 - 31 March 2026** | | 1 April 2024 - 31 March 2025 | |
|---|---|---|---|---|---|
| | | **Number of cases** | **Value of cases** | Number of cases | Value of cases |
| **Ref.** | **Category of loss / special payment** | | **£000** | | £000 |
| **Losses** | | | | | |
| 1a | Losses of cash due to theft, fraud etc. | **0** | **0** | 0 | 0 |
| 1b | Losses of cash due to overpayment of salaries etc. | **0** | **0** | 11 | 11 |
| 1c | Losses of cash due to other causes | **1** | **0** | 0 | 0 |
| 2 | Fruitless payments | **1** | **173** | 0 | 0 |
| 3a | Bad debts and claims abandoned – private patients | **0** | **0** | 19 | 5 |
| 3b | Bad debts and claims abandoned – overseas visitors | **0** | **0** | 8 | 19 |
| 3c | Bad debts and claims abandoned – other | **0** | **0** | 45 | 49 |
| 4a | Damage to buildings, loss of equipment and property due to theft, fraud etc. | **0** | **0** | 0 | 0 |
| 4b | Damage to buildings, loss of equipment and property due to other causes | **1** | **7** | 1 | 6 |
| 4c | Other | **0** | **0** | 0 | 0 |
| **Total Losses** | | **3** | **180** | 84 | 90 |
| **Special Payments** | | | | | |
| 5 | Compensation under legal obligation | **0** | **0** | 0 | 0 |
| 7a | Ex-gratia payments for loss of personal effects | **8** | **3** | 16 | 4 |
| 7b | Clinical Negligence with advice | **0** | **0** | 0 | 0 |
| 7c | Ex-gratia payments for personal injury with advice | **0** | **0** | 0 | 0 |
| 7d | Other negligence and injury | **1** | **1** | 0 | 0 |
| 7e | Other employment payments | **0** | **0** | 0 | 0 |
| 7f | Patient Referrals outside the UK and EEA Guidelines | **0** | **0** | 0 | 0 |
| 7g | Other | **0** | **0** | 0 | 0 |
| **Total Special Payments** | | **9** | **4** | 16 | 4 |
| **Total Losses and Special Payments** | | **12** | **184** | **100** | **94** |

The above values have been calculated on an accruals basis whereby expenditure is recognised in the period in which the associated liability was incurred.

Notes to the Accounts

**22 Charitable fund reserve**

The Trust is the corporate trustee to Gateshead Health NHS Foundation Trust Charitable Fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary in accordance with IFRS 10, because the Trust has the power to govern the financial and operating policies of the charitable fund so as to obtain benefits from its activities for itself, its patients or its staff. Prior to 2013/14 the Treasury had directed that IFRS 10 should not be applied to NHS Charities, and therefore the FT ARM did not require the Trust to consolidate the charitable fund.

The main financial statements disclose the Foundation Trust's financial position alongside that of the group (which comprises the Foundation Trust, subsidiary and charitable fund).

**Gateshead Health NHS Foundation Trust Charity - Summary Statement of financial activities;**

| | **Year ended 31 March 2026 £000** | Year ended 31 March 2025 £000 |
|---|---|---|
| Donated income | **182** | 181 |
| Income from legacies | **23** | 104 |
| Investment income | **85** | 101 |
| Grant Income | **0** | 0 |
| Total incoming resources | **290** | 386 |
| Patients' welfare and amenities | **118** | 192 |
| Staff welfare and amenities | **121** | 103 |
| Medical research | **0** | 0 |
| Contributions to the Foundation Trust | **92** | 183 |
| Governance costs | **6** | 7 |
| Total outgoing resources | **337** | 485 |
| Unrealised gain/(loss) on investments | **(88)** | (43) |
| Net incoming/(outgoing) resources | **(135)** | (142) |

**Gateshead Health NHS Foundation Trust Charity - Summary Statement of financial position;**

| | **Year ended 31 March 2026** | **Year ended 31 March 2025** |
|---|---|---|
| Investments | **1,315** | **1,362** |
| Receivables | **16** | **9** |
| Cash | **1,004** | **1,128** |
| Payables | **(113)** | **(142)** |
| Total net assets | **2,222** | **2,357** |
| Represented by: | | |
| Unrestricted funds | **2,076** | **2,189** |
| Restricted funds | **87** | **103** |
| Endowment funds | **59** | **65** |
| | **2,222** | **2,357** |

The total funds are represented in the Group accounts as Charitable Funds Reserve.

Restricted funds are funds donated for a specific purpose. Unrestricted funds may be designated for a particular area but are not restricted on the purpose of expenditure. Endowment funds relate to capital funds where the charity does not hold the power to convert capital into income. The capital must generally be held indefinitely; the income generated by the investment of the funds can be used for charitable purposes at the discretion of the Trustee.

# Glossary of terms

| Abbreviation | Meaning |
|---|---|
| **A&E** | Accident and Emergency |
| **AHPs** | Allied Health Professionals |
| **BAF** | Board Assurance Framework |
| **CCRA** | Climate Change Risk Assessment |
| **CDC** | Community Diagnostic Centre |
| **CDIs** | Clostridium difficile infections |
| **CIPD** | Chartered Institute of Personnel and Development |
| **CN** | Complete Nutrition |
| **CQC** | Care Quality Commission |
| **CRR** | Community Risk Register |
| **CYP** | Children and Young People |
| **DHSC** | Department of Health and Social Care |
| **DNA** | Did Not Attend |
| **EDI** | Equality, Diversity and Inclusion |
| **EAU** | Emergency Assessment Unit |
| **EPRR** | Emergency Preparedness, Resilience and Response |
| **ERIC** | Estates Return Information Collection |
| **FFT** | Friends and Family Test |
| **GAM** | Group Accounting Manual |
| **GEM** | Global Ethnic Majority |
| **GP** | General Practitioner |
| **HEF** | Home Enteral Feeding |
| **HFMA** | Healthcare Financial Management Association |
| **HM Treasury** | His Majesty's Treasury |
| **HSJ** | Health Service Journal |
| **HSRG** | Health Resilience Sub-Group |
| **IAS1** | International Accounting Standard 1 |
| **ICAEW** | Institute of Chartered Accountants in England and Wales |
| **ICB** | Integrated Care Board |
| **ICS** | Integrated Care System |
| **IFRS** | International Financial Reporting Standards |
| **IV** | Intravenous |
| **KPI** | Key Performance Indicator |
| **LCAT** | Local Climate Adaptation Tool |
| **LGBT+** | Lesbian, Gay, Bisexual and Transgender |
| **LHRP** | Local Health Resilience Partnership |
| **MECC** | Making Every Contact Count |
| **MRI** | Magnetic Resonance Imaging |
| **MRSA** | Methicillin-Resistant Staphylococcus Aureus |
| **N/a** | Not applicable |
| **NAP** | National Adaptation Programme |
| **NENC** | North East and North Cumbria |
| **NGOC** | Northern Gynaecological Oncology Centre |
| **NHS** | National Health Service |
| **NICE** | National Institute for Health and Care Excellence |
| **NLRF** | Northumbria Local Resilience Forum |
| **NRR** | National Risk Register |
| **NSRA** | National Security Risk Assessment |
| **ORR** | Organisational Risk Register |
| **PbR** | Payment by Results |
| **PHE** | Public Health England |
| **PSIRF** | Patient Safety Incident Response Framework |
| **PwC** | PricewaterhouseCoopers |
| **QEF** | QE Facilities Ltd |
| **RTT** | Referral to Treatment |
| **SDEC** | Same Day Emergency Care |
| **SHEQ** | Safety, Health, Environment and Quality |
| **SHMI** | Summary Hospital-level Mortality Indicator |
| **TCFD** | Taskforce on Climate-related Financial Disclosures |
| **TIA** | Transient Ischaemic Attack |
| **VONNE** | Voluntary Organisations' Network North East |
| **WCDS** | Women's Cancer Detection Society |

| | |
|---|---|
| **WDES** | Workforce Disability Equality Standard |
| **WNB** | Was Not Brought |
| **WRES** | Workforce Race Equality Standard |

# i - Review of the Year

## Presented by the Chief Executive

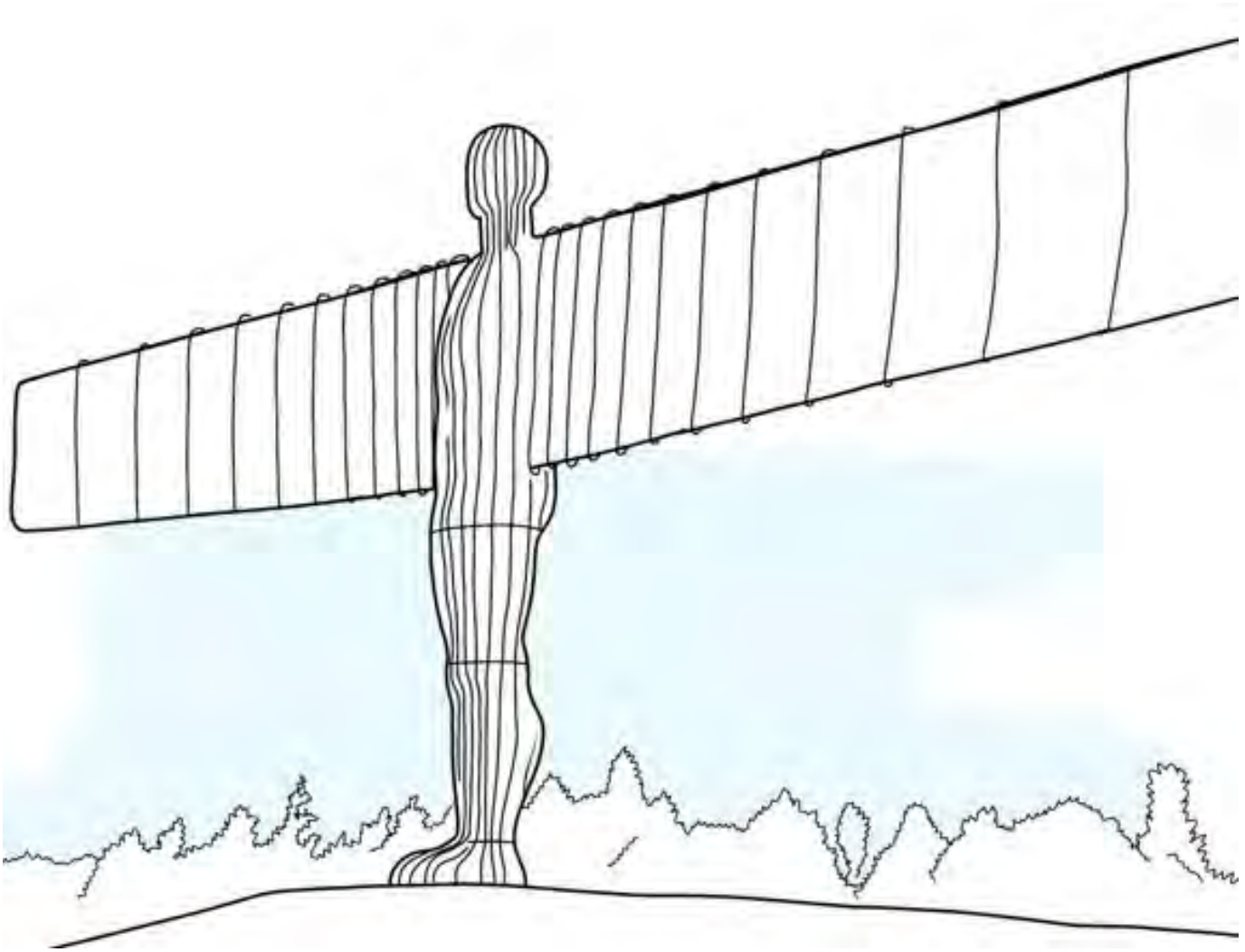
ii - Showcase Presentation - Gateshead Women's Health Hub

Presented by the Director of Strategy, Planning and Partnerships and former Strategy and Partnership Manager

# iii - Quality Accounts 2025/26

Presented by the Chief Nurse

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.

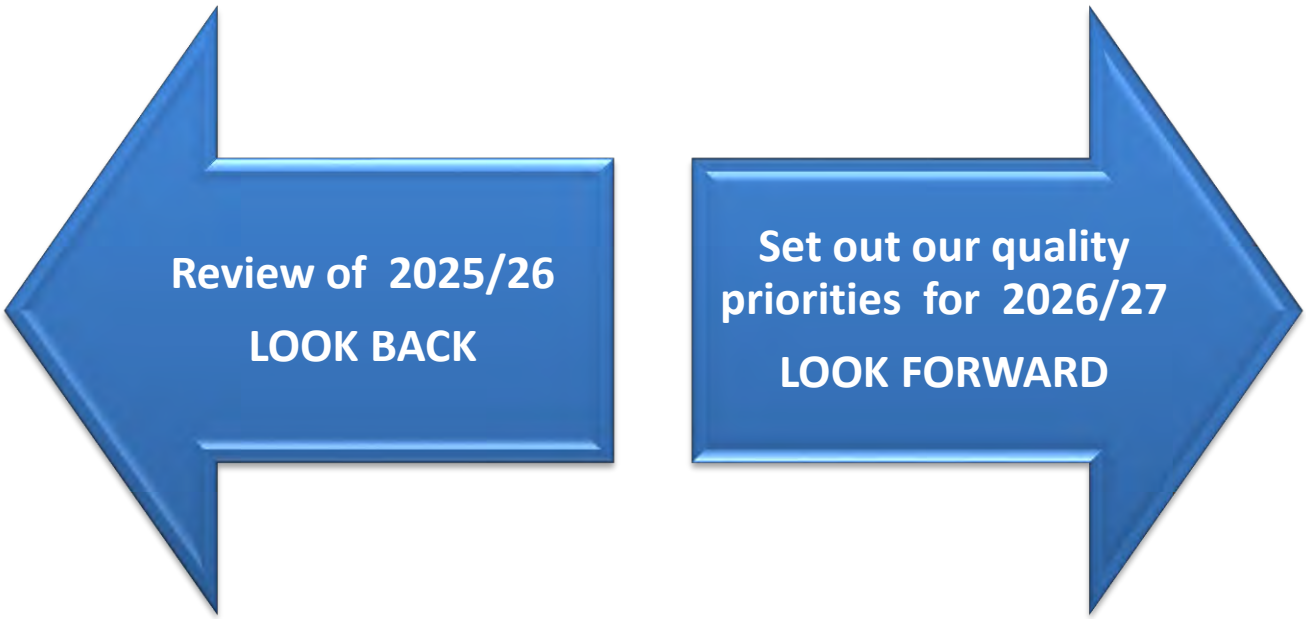
At Gateshead Health, we are proud of the care our teams deliver every day and equally proud of the culture of learning, honesty and continuous improvement that sits behind it. This report allows us to celebrate the achievements of our staff, recognise the experiences of our patients and communities, 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<br>HIP -237 Cases submitted<br>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<br>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.<br>• Additional Training has been offered to assist staff in completing paperwork |
| Nursing & Midwifery | Safeguarding Adults | Enhanced Care and DoLS compliance audit<br>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.<br>• 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.<br>• The audit was circulated, to feedback to ward teams.<br>• 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<br>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<br>• 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.<br>• Re circulate Employers procedure declarations.<br>• 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<br>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.<br>• 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<br>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.<br>• A formal guidance is needed to aid clinicians to accurately describe skin rashes, initiate investigations and managements when encountering acute dermatological conditions.<br>• 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<br>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.<br>• Gathering data on patients who vomit prep and require cancellation.<br>• Asking patients who have poor prep during procedure about diet and fluid intake.<br>• Extended bowel preparation policy in development.<br>• 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.<br>• Education sessions with preceptorship and Nursing students. |
| Surgery | Maternity | Newborn Apgar Score<br>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.<br>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<br>• Development of a regional "safety alert" to focus on correct scoring.<br>• 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<br>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.<br>• Discussed with CCD Clinical Lead.<br>• 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.<br>• 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% |

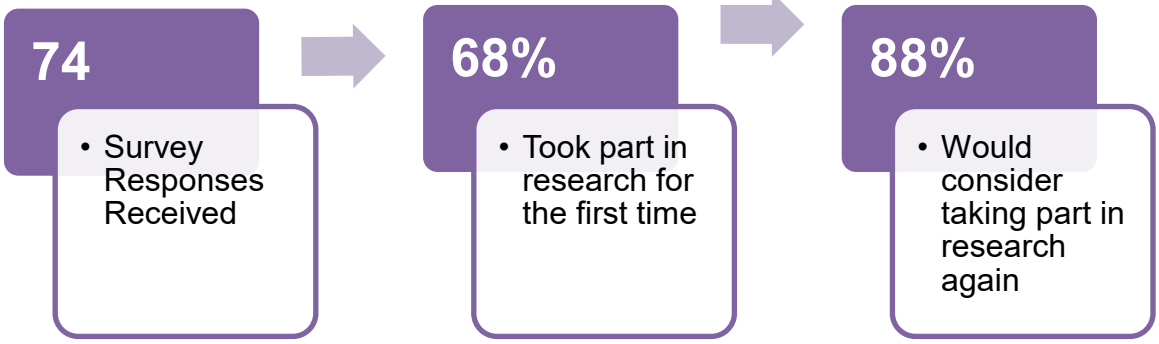
## Participation in clinical research

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.

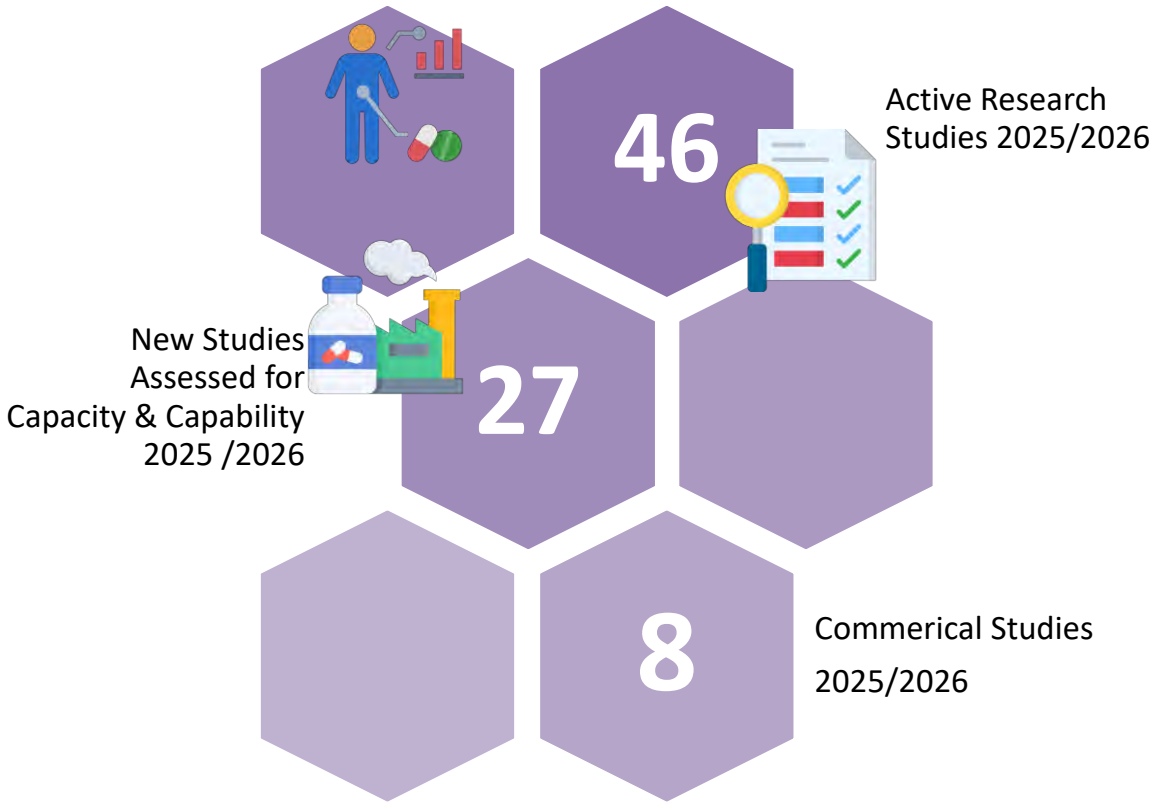
Many postmenopausal women without vaginal bleeding have internal scans for symptoms such as tummy pain or urinary problems. Some NHS hospitals offer a biopsy from the womb lining with or without a womb telescope test (hysteroscope) when the thickness is more than 4 mm while others use various thresholds 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.

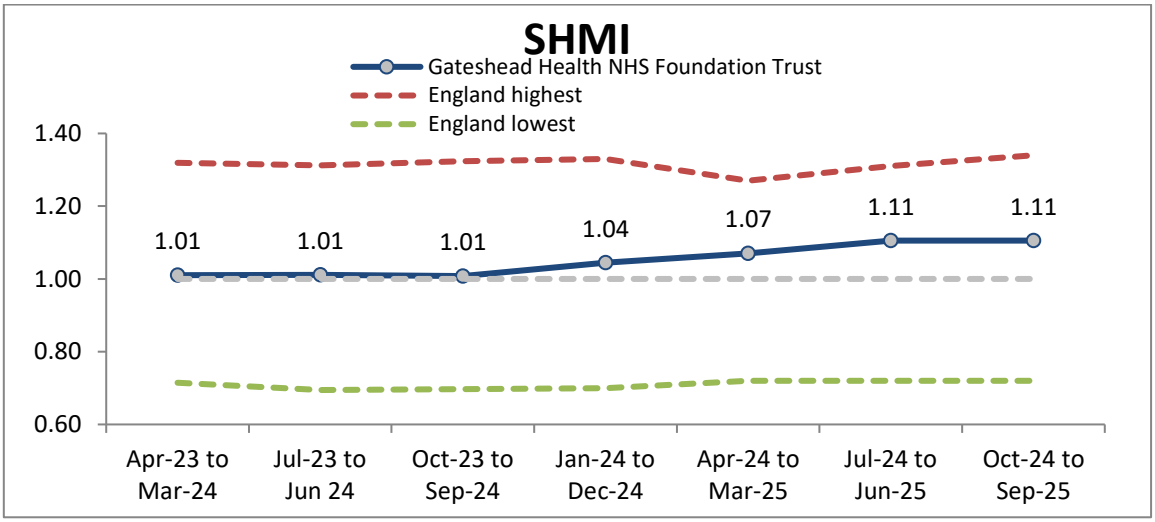
The Trust Board via the People and Organisational Development Committee receives an annual report from the Guardian of Safe Working which includes a consolidated report on rota gaps and actions taken by the Medical Workforce Group. This report is provided to the Local Negotiating Committee (LNC) by the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

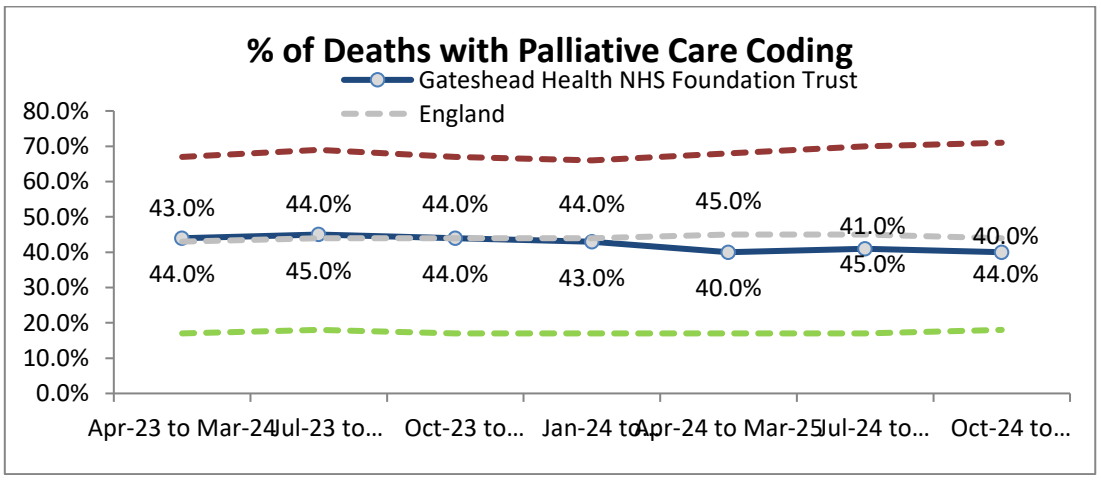
### (a) SHMI (Summary Hospital-level Mortality Indicator)

| 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.

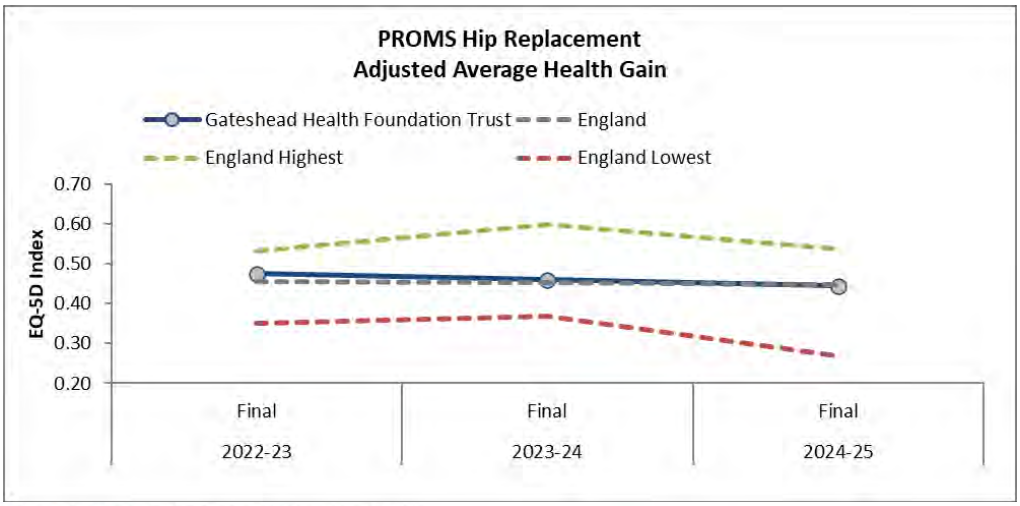
## PROMs (Patient Reported Outcome Measures) for Hip Replacement and Knee Replacement:

| Hip Replacement<br>Adjusted average health gain EQ-5D index | 2022-23<br>Final | 2023-24<br>Final | 2024-25<br>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<br>Adjusted average health gain EQ-5D index | 2022-23<br>Final | 2023-24<br>Final | 2024-25<br>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 |

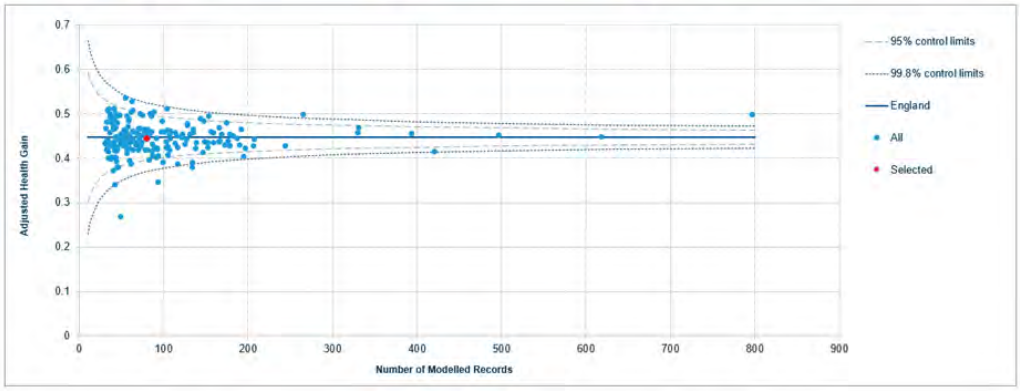
Source: https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms

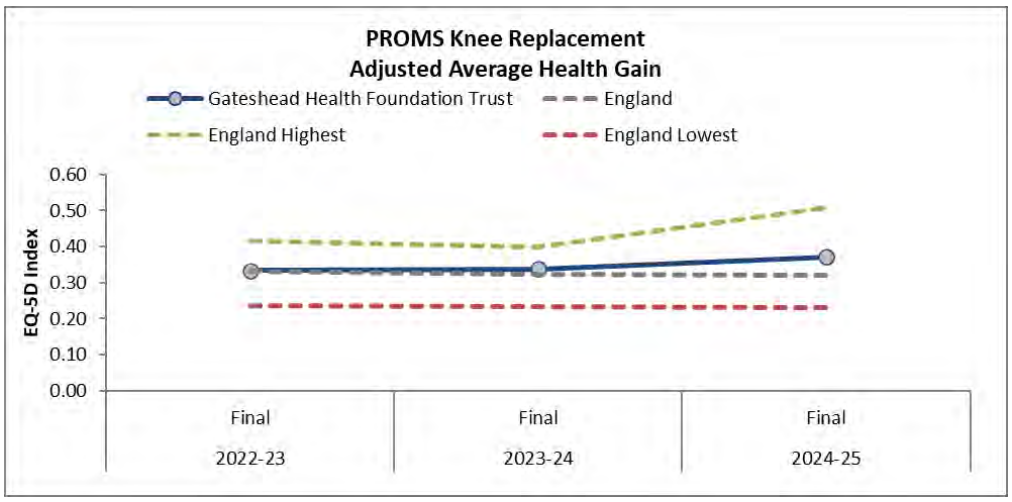



**Funnel Plot – casemix-adjusted average Health Gain**

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

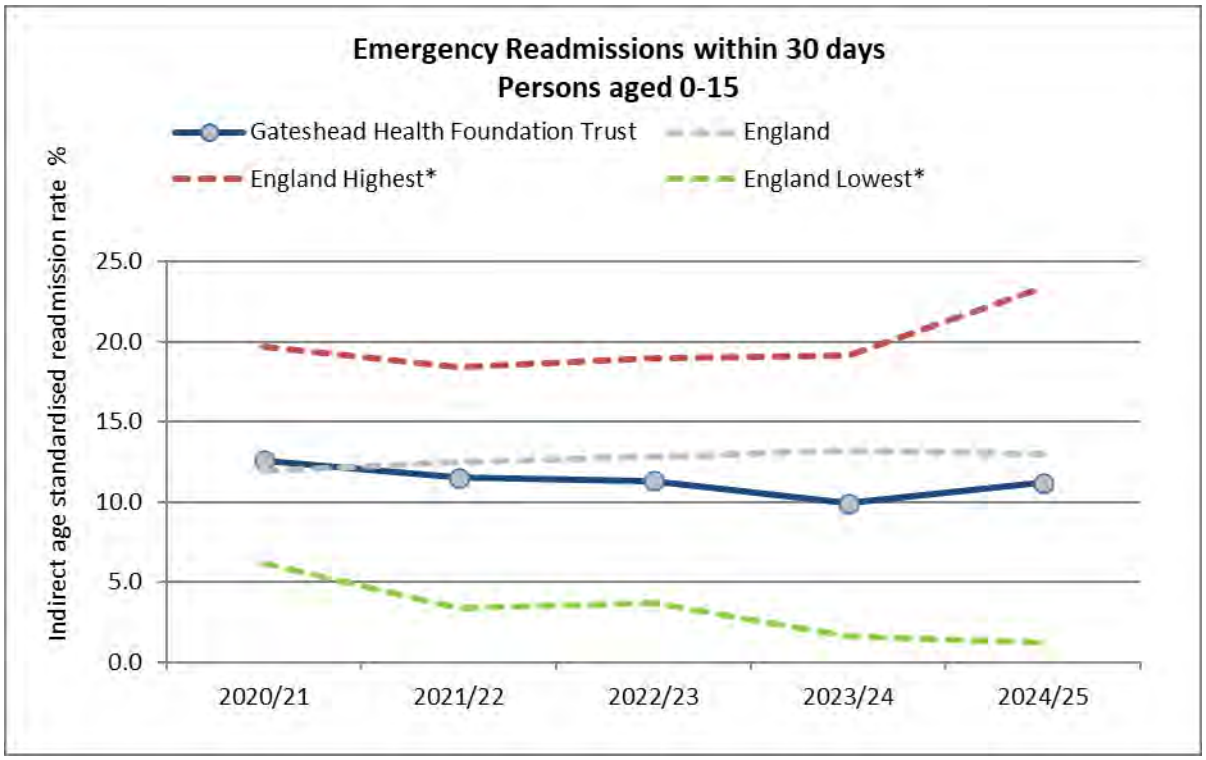
| Emergency readmissions within 30 days of discharge from hospital Persons aged 0-15 | 2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25 |
|---|---|---|---|---|---|
| Gateshead Health Foundation Trust | 12.6 | 11.5 | 11.3 | 9.9 | 11.2 |
| Banding | W | W | W | B1 | B5 |
| England | 11.9 | 12.5 | 12.8 | 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:**

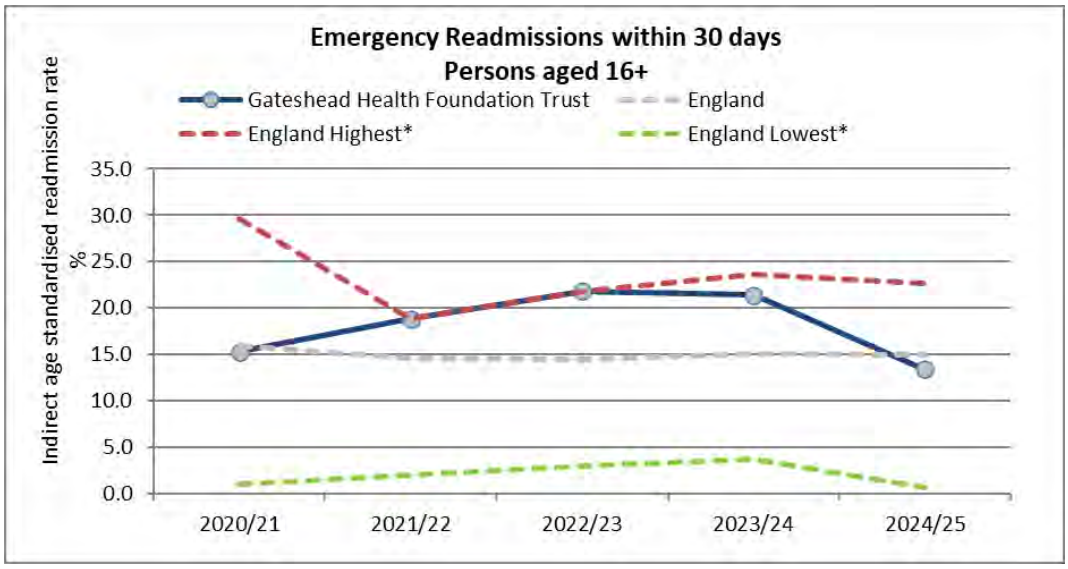
- The Trust will continue to monitor performance and undertake further investigations/actions should the rate increase.

## 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.

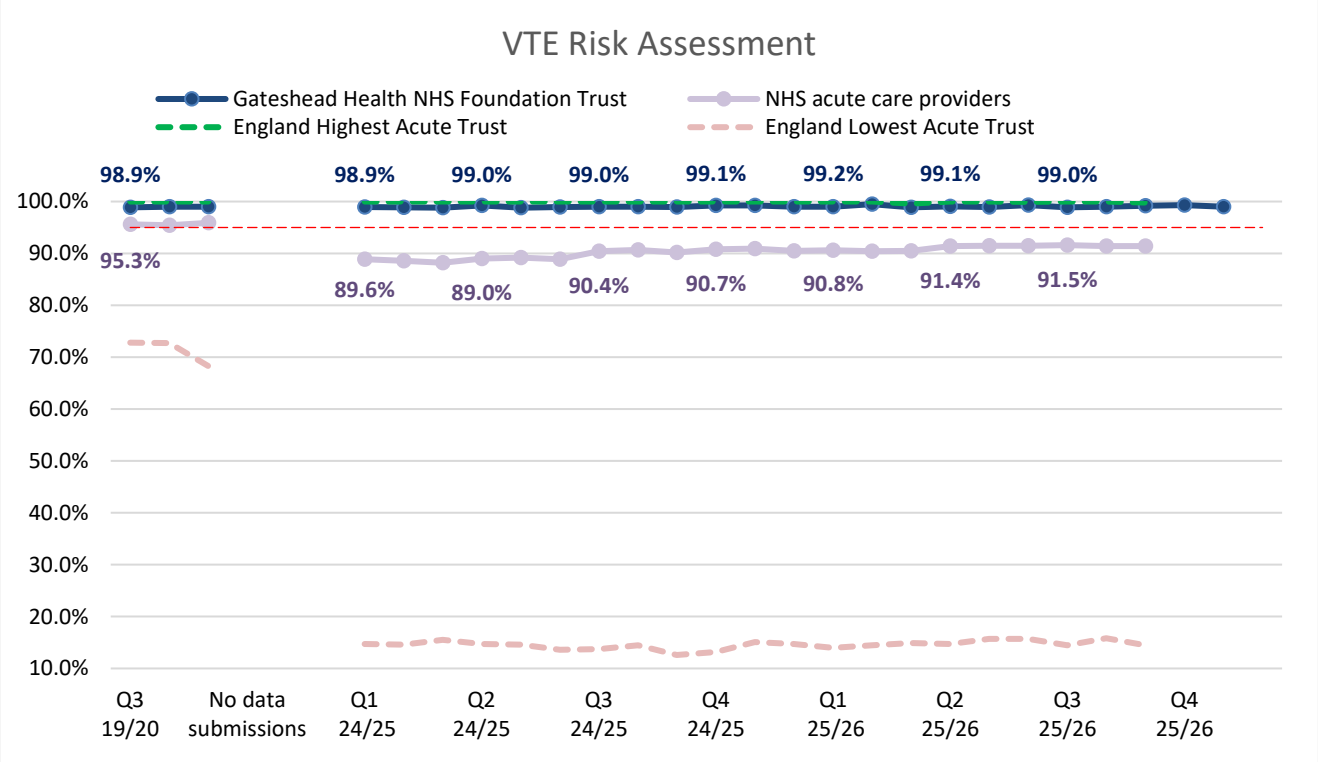
**Trust's responsiveness to the personal needs of its patients**

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.

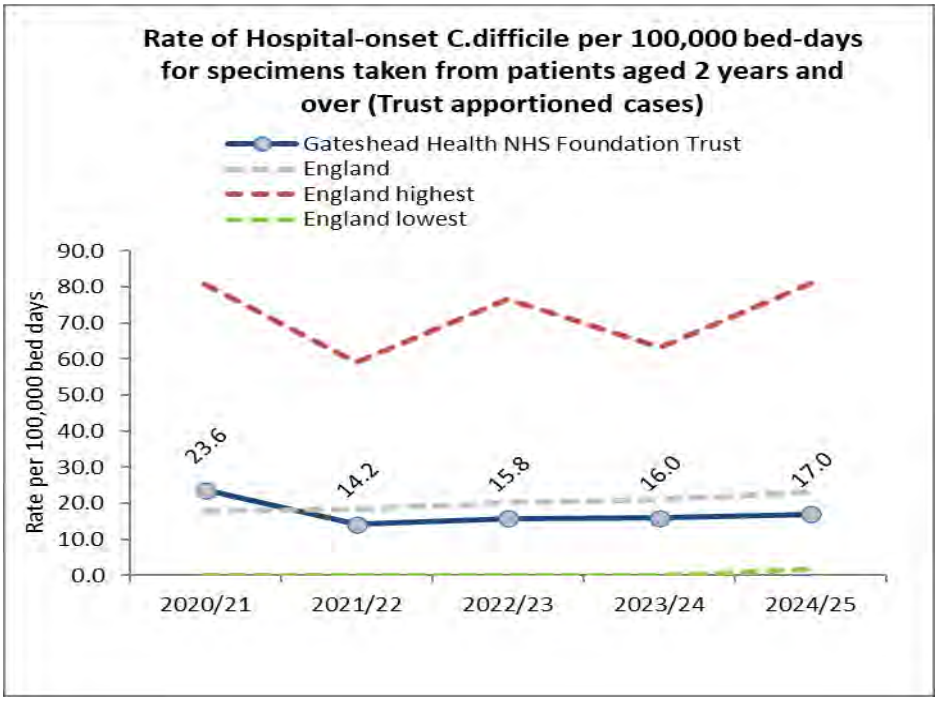
- VTE Risk assessment continued to be monitored by the Trust during the suspension of the national submission. Performance continues to exceed the 95% national objective.

**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:**

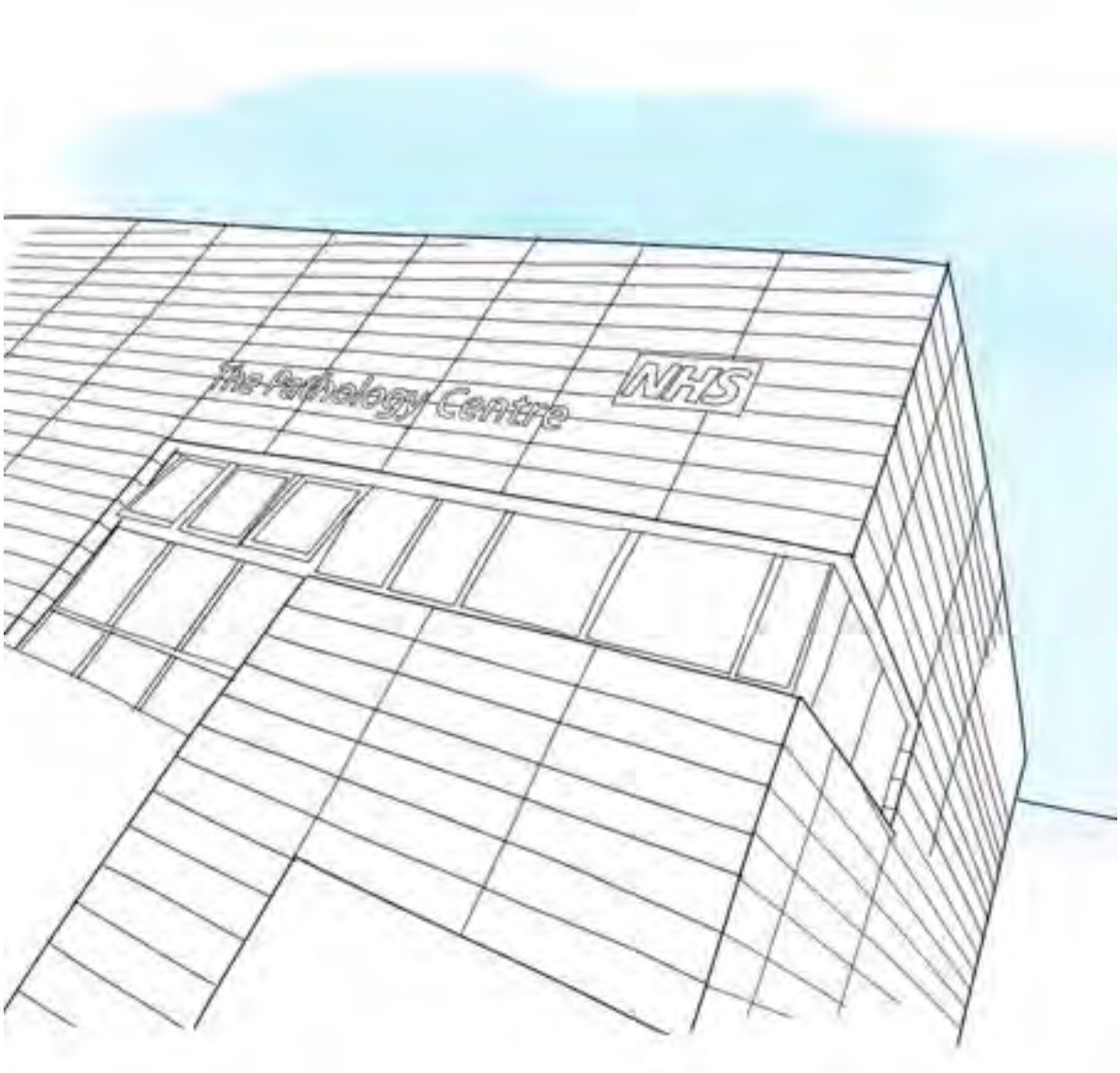
- An internal review is held for all healthcare associated CDI cases, supported by the PSIRF framework and internal safety triangulation review as necessary, where good practice and lessons learnt can be identified. The learning is then linked, if appropriate, to the key themes of sample submission, 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%<br>25 patients readmitted | 4.22%<br>14 patients readmitted | **6.05%**<br>15 patients readmitted | Improve Year on Year |
| Proportion of patients undergoing hip replacement who are readmitted within 30 days* | 9.03%<br>28 patients readmitted | 5.80%<br>17 patients readmitted | **6.22%**<br>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

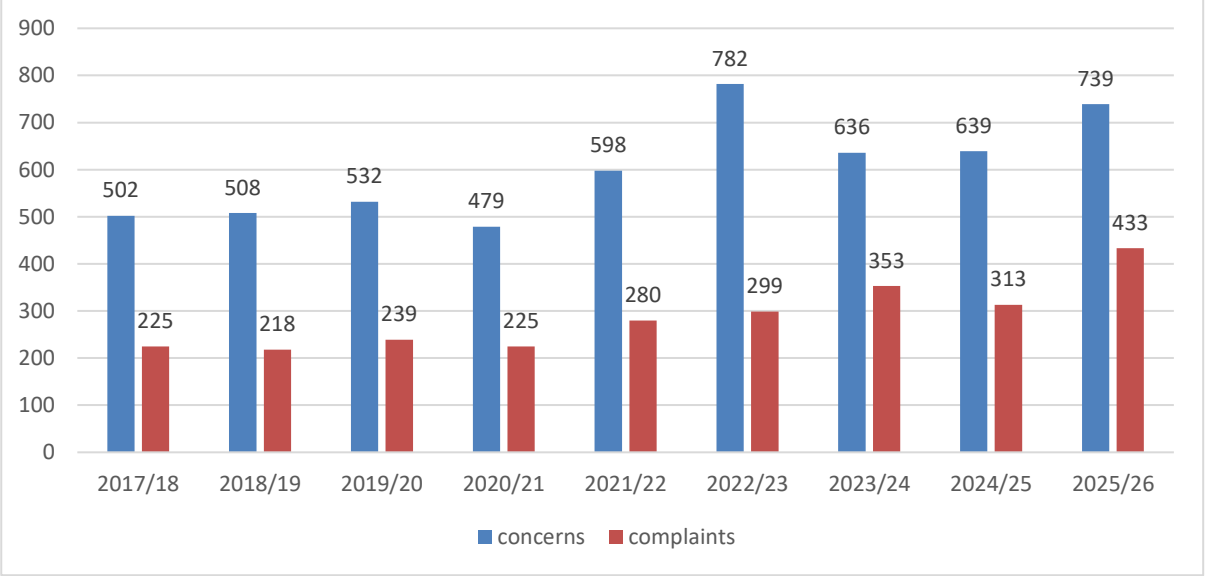
## 3.3 PATIENT EXPERIENCE

### 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.

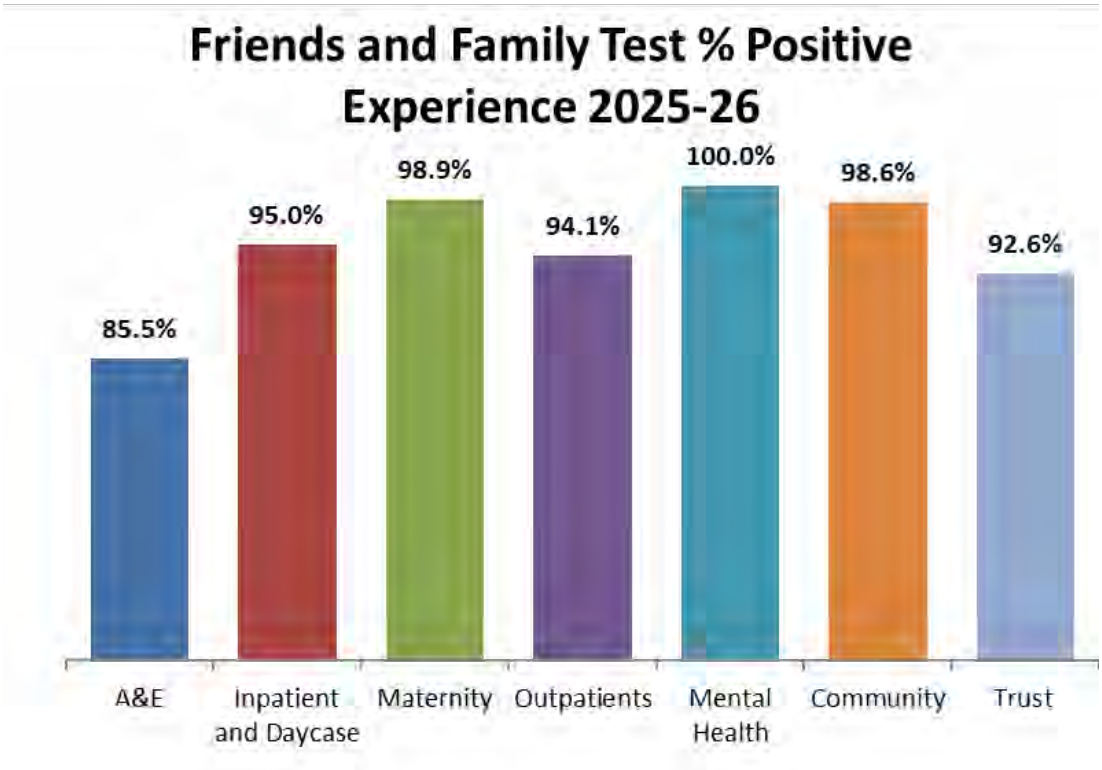
## Friends & Family Test

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.



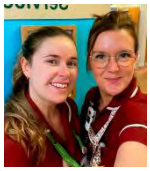
## 3.4 Good News Stories

# Year in Highlights

# Celebrating Achievement, Innovation and Impact

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

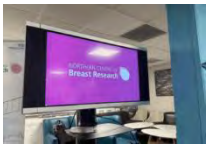
## 🏆 Recognition & Awards





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.

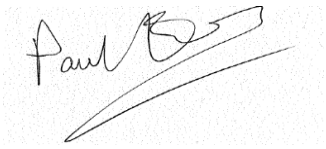
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- 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.

# iv - Financial Accounts 2025/06 and Audit Opinion

Presented by the Director of Finance

# Auditor’s Annual Report

# Gateshead Health NHS Foundation Trust

## Year ended 31 March 2026

25 June 2026

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# Contents

01

# Introduction

# Introduction

## Purpose of the Auditor's Annual Report

Our Auditor's Annual Report (AAR) summarises the work we have undertaken as the auditor for Gateshead Health NHS Foundation Trust ('the Trust') for the year ended 31 March 2026. Although this report is addressed to the Trust, it is designed to be read by a wider audience including members of the public and other external stakeholders.

Our responsibilities are defined by the National Health Service Act 2006 and the Code of Audit Practice ('the Code') issued by the National Audit Office ('the NAO'). The remaining sections of the AAR outline how we have discharged these responsibilities and the findings from our work. These are summarised below.

**Opinion on the financial statements**
We issued our audit report on 25 June 2026. Our opinion on the financial statements was unqualified.

**Reporting to the group auditor**
In line with group audit instructions issued by the NAO, on 25 June 2026 we reported that the Trust's consolidation schedules were not consistent with the audited financial statements.

**Value for Money arrangements**
In our audit report we reported that we were not satisfied arrangements were in place for the Trust to secure economy, efficiency and effectiveness in its use of resources, this is because we issued a recommendation in relation to a significant weakness in those arrangements. Section 3 provides our commentary on the Trust's arrangements and a summary of our recommendations and the weaknesses identified.

# 02

# Audit of the financial statements

# Audit of the financial statements

## Our audit of the financial statements

Our audit was conducted in accordance with the requirements of the Code, and International Standards on Auditing (ISAs). The purpose of our audit is to provide reasonable assurance to users that the financial statements are free from material error. We do this by expressing an opinion on whether the statements are prepared, in all material respects, in line with the financial reporting framework applicable to the Trust and whether they give a true and fair view of the Trust's financial position as at 31 March 2026 and of its financial performance for the year then ended. Our audit report, issued on 24 June 2026 gave an unqualified opinion on the financial statements for the year ended 31 March 2026.

A summary of the significant risks we identified when undertaking our audit of the financial statements and the conclusions we reached on each of these is outlined in Appendix A. In this appendix we also outline the uncorrected misstatements we identified and any internal control recommendations we made.

## Other reporting responsibilities

| Reporting responsibility | Outcome |
|---|---|
| **Annual Report** | We did not identify any material misstatements or significant inconsistencies between the content of the annual report, the financial statements and our knowledge of the Trust. |
| **Annual Governance Statement** | We did not identify any matters where, in our opinion, the Governance Statement did not comply with the NHS Foundation Trust Annual Reporting Manual 2025/26. We also did not identify any matters where, in our opinion, the Governance Statement is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements. |
| **Remuneration and Staff Report** | We report that the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the National Health Service Act 2006. |



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# 03

# Our work on Value for Money arrangements

# VFM arrangements

## Overall Summary

# VFM arrangements – Overall summary

## Approach to Value for Money arrangements work

We are required to consider whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The NAO issues guidance to auditors that underpins the work we are required to carry out and sets out the reporting criteria that we are required to consider. The reporting criteria are:

**Financial sustainability** - How the Trust plans and manages its resources to ensure it can continue to deliver its services.

**Governance** - How the Trust ensures that it makes informed decisions and properly manages its risks.

**Improving economy, efficiency and effectiveness** - How the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

Our work is carried out in three main phases.

## Phase 1 - Planning and risk assessment

At the planning stage of the audit, we undertake work so we can understand the arrangements that the Trust has in place under each of the reporting criteria; as part of this work we may identify risks of significant weaknesses in those arrangements.

We obtain our understanding or arrangements for each of the specified reporting criteria using a variety of information sources which may include:

- NAO guidance and supporting information
- Information from internal and external sources including regulators
- Knowledge from previous audits and other audit work undertaken in the year
- Interviews and discussions with staff and directors

Although we describe this work as planning work, we keep our understanding of arrangements under review and update our risk assessment throughout the audit to reflect emerging issues that may suggest there are further risks of significant weaknesses.

## Phase 2 - Additional risk-based procedures and evaluation

Where we identify risks of significant weaknesses in arrangements, we design a programme of work to enable us to decide whether there are actual significant weaknesses in arrangements. We use our professional judgement and have regard to guidance issued by the NAO in determining the extent to which an identified weakness is significant.

We outline the risks that we have identified and the work we have done to address those risks on page 13.



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# VFM arrangements – Overall summary

### Phase 3 - Reporting the outcomes of our work and our recommendations

We are required to provide a summary of the work we have undertaken and the judgments we have reached against each of the specified reporting criteria in this Auditor's Annual Report. We do this as part of our Commentary on VFM arrangements which we set out for each criteria later in this section.

We also make recommendations where we identify weaknesses in arrangements or other matters that require attention from the Trust. We refer to two distinct types of recommendation through the remainder of this report:

- **Recommendations arising from significant weaknesses in arrangements -** We make these recommendations for improvement where we have identified a significant weakness in the Trust arrangements for securing economy, efficiency and effectiveness in its use of resources. Where such significant weaknesses in arrangements are identified, we report these (and our associated recommendations) at any point during the course of the audit.
- **Other recommendations -** We make other recommendations when we identify areas for potential improvement or weaknesses in arrangements which we do not consider to be significant but which still require action to be taken.

The table on the following page summarises the outcomes of our work against each reporting criteria, including whether we have identified any significant weaknesses in arrangements or made other recommendations.

# VFM arrangements – Overall summary

## Overall summary by reporting criteria

| Reporting criteria | Commentary page reference | Identified risks of significant weakness? | Actual significant weaknesses identified? | Other recommendations made? |
|---|---|---|---|---|
| **Financial sustainability** | 12 | Yes – see risk on page 13 | Yes – see significant weakness identified on page 27 | No |
| **Governance** | 18 | No | No | Yes – see other recommendation on page 22 |
| **Improving economy, efficiency and effectiveness** | 24 | No | No | No |

# VFM arrangements

## Financial Sustainability

How the body plans and manages its resources to ensure it can continue to deliver its services

# VFM arrangements – Financial Sustainability

## Risks of significant weaknesses in arrangements in relation to Financial Sustainability

We have outlined below the risks of significant weaknesses in arrangements that we have identified as part of our continuous planning procedures, and the work undertaken to respond to each of those risks.

| Risk of significant weakness in arrangements | Work undertaken and the results of our work |
|---|---|
| 1 **Financial Sustainability**<br><br>In 2024/25 the Trust set a deficit financial plan of £12.4m. In the year the Trust received non-recurring deficit support funding of £10.2m which resulted in the planned deficit being adjusted to £2.4m. The Trust reported delivery of its plan as at 31 March 2025, which included the delivery of £22.8m through the Trust's Cost Reduction Programme (CRP). Although the Trust had achieved its CRP for the 2024/25 financial year, the level of recurring savings was lower than anticipated by £9.1m. The 2024/25 outturn has increased the underlying deficit in the year and this creates additional pressures in 2025/26, as the total unachieved target of £17.7m is carried forward to 2025/26 financial year.<br><br>Additionally, the Trust has set an overall deficit plan for 2025/26 of £8.6m which relies on receipt of non-recurrent deficit support funding of £14.3m and a CRP of £32.8m (7.1% of expenditure and higher than that achieved in 2024/25). Should the Trust deliver its 2025/26 plan, with no adjustments, it would have an underlying deficit of £26.8m.<br><br>In our view the increasing underlying deficit, underperformance in recurrent savings and continuous reliance on receipt of deficit support funding is evidence of a significant weakness in arrangements in the financial sustainability criteria - how the body plans to bridge its funding gaps and identifies achievable savings. Without an improvement in arrangements the Trust risks being unable to deliver services in an affordable way. | **Work undertaken**<br><br>We have:<br><br>•Reviewed the 2025/26 reported outturn;<br><br>•Reviewed the 2026/27 submitted plan;<br><br>•Reviewed minutes of meetings to monitor progress against the plan<br><br>•Considered other relevant information; and<br><br>•Met with officers of the Trust.<br><br>**Results of our work**<br><br>Based on the results of our work we have concluded a significant weakness in arrangements continues to exist. See page 23 for further detail. |

# VFM arrangements – Financial Sustainability

## Overall commentary on the Financial Sustainability reporting criteria

**Background to the NHS financing regime in 2025/26**

In 2025 the NHS 10-year plan was published, setting out a major reform programme to make the NHS sustainable by shifting care from hospitals into communities, from analogue to digital systems, and from treating illness to preventing it.

New NHS finance business rules will also be introduced for 2026/27 onwards, setting out that Integrated Care Boards (ICBs) and providers must achieve a breakeven position. Both ICBs and NHS trusts will be required to deliver a breakeven revenue position as individual bodies in future years, which reflects a change from the extant business rules where ICBs and NHS trusts were required to support the delivery of breakeven in aggregate across their system. To support that, NHS England (NHSE)set every ICB and provider a plan limit for each year. These replaced the plan limits that were previously issued at a system level.

ICBs and NHS trusts must continue to collaborate to support the delivery of locally agreed priorities. As part of this, ICBs and NHS trusts will be required to work together to agree plans that address the healthcare needs of the populations they serve, in accordance with national and local priorities, and ensure that resources are used effectively and efficiently in support of this. This includes each organisation taking proactive steps to ensure that plans are mutually aligned

Systems, including individual commissioners and providers, developed their financial plans for 2025/26 ahead of the financial plan submission, as set out in NHSE guidance. Gateshead Health NHS Foundation Trust submitted their financial plan for 2025/26 to NHSE in March 2025, which included a planned deficit position of £8.6m, as part of an overall balanced ICS position. The deficit plan for 2025/26 included receipt of £14.3m non-recurrent funding and a Cost Reduction Programme (CRP) balance of £32.8m, split £20.198m recurring (61%) and £12.674m non-recurring (39%). The planned CRP was 7.6% of planned expenditure and recognised by the Trust as challenging.

**Overall responsibilities for financial governance**

We have considered the Trust's governance framework, including review of Trust Board and Audit Committee minutes, the Annual Governance Statement, and Annual Report and Accounts to confirm the Trust has arrangements to meet its responsibility to make the best use of financial resources in delivering its services.

Gateshead Health NHS Foundation Trust introduced its new Corporate Strategy 2025–2030 in September 2025 which sets out a clear and ambitious vision for the future of healthcare in Gateshead. The Trust Strategy will be achieved by focussing on four key areas: - patients, people, sustainability and partners. The Trust Board approved the Corporate Objectives r in May 2025. One of the five strategic aims is: 'We will enhance our productivity and efficiency to make the best use of our resources'.

We confirmed with the Trust Director of Finance that the Trust Chief Operating Officer (COO) is responsible for the trust Transformation programme. The programme concentrates on productivity and efficiency. This is in recognition that Trust needs to achieve recurring efficiency savings if it is to deliver a sustainable financial position.

As in previous years, the Trust's Board has overall responsibility for financial supervision and control, and does this by formulating the financial strategy, and approving budgets. We confirmed through review of minutes that the Trust Board approved the 2025/26 and 2026/27 financial plans.

The Trust Constitution requires the establishment of an Audit Committee which has responsibility for oversight of the internal control framework. We confirmed through attendance of meetings that the Audit Committee met throughout the year. We have identified no matters that the financial governance arrangements have not functioned as expected during 2025/26.



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# VFM arrangements – Financial Sustainability

## Overall commentary on the Financial Sustainability reporting criteria

**The Trust's financial planning and monitoring arrangements**

The 2025/26 financial plan was approved in line with the local and national timescales, and we have confirmed through our review of reports and minutes that the Trust has monitored it's progress against the plan throughout the 2025/26 financial year. The Trust Board approved an £8.8m deficit plan which included the required national budget uplifts. The plan included a Cost Reduction Programme (CRP) target of £32.9m. In the year, the Trust received additional non-recurrent income of £3.276m and, as a result, the Trust's planned year end deficit was adjusted to £5.1m. The Trust has reported a year end deficit of £5.0m. Therefore, the Trust reported delivery against its revised plan, with a favourable variance of £0.057m.

Alongside this, the Trust has reported delivery of its CRP. Table 1 to the right details outturn efficiencies in 2023/24, 2024/25 and 2025/26 compared to plan, and table 2 details the recurrent efficiencies as a % of all efficiencies. Although the Trust has reported achievement of its 2025-26 cost reduction programme totalling £32.871m on a recurring basis the Trust achieved £12.696m, equivalent to 38.6%, with a total unachieved target of £18.115m to be carried forward to 2026-27.

The Trust's Statement of Financial Position has not significantly moved during 2025/26 when compared to the prior year, which can be demonstrated by total assets employed decreasing to £117.680m compared to a prior year position of £124.777m. The Group position has also slightly decreased to £156.147m as at 31 March 2026, compared to £158.854m at 31 March 2025. The Trust and Group's cash position has increased in year. The Trust position has increased from £17.367m to £29.575m and the Group £31.963m from £26.960m. This is mainly owing to the increase in trade payables and decrease in trade receivables. The Trust 2026/27 financial plan is forecasting the Group cash balances will reduce to £1.0m by March 2027. The Trust are expecting to require £5.1m of cash support in 2026/27 but recognises this is based on the delivery of the planned £0.384m deficit. Liabilities, current and non-current, increased by £15.8m for the Trust and increased by £3.6m for the Group at 31 March 2026. Alongside the Trust's 2026/27 plan, they have implemented a multi-year financial planning approach to allow them to better plan for the medium-term financial outlook they are facing.

Table 1: Total efficiencies

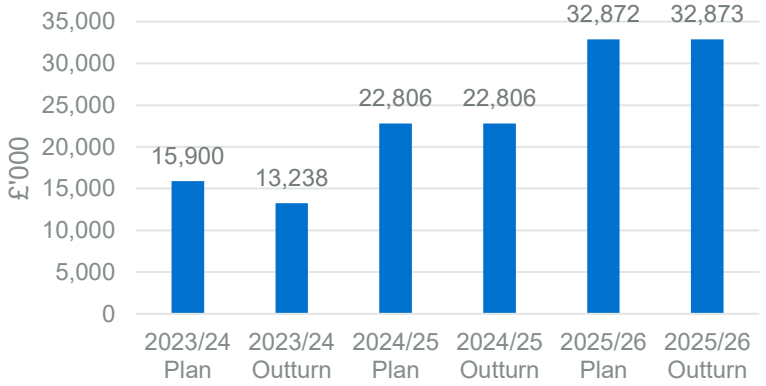
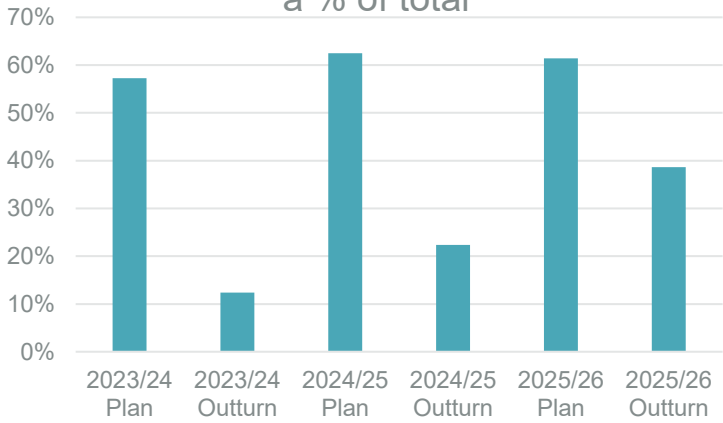



Table 2: Recurrent Efficiencies as a % of total

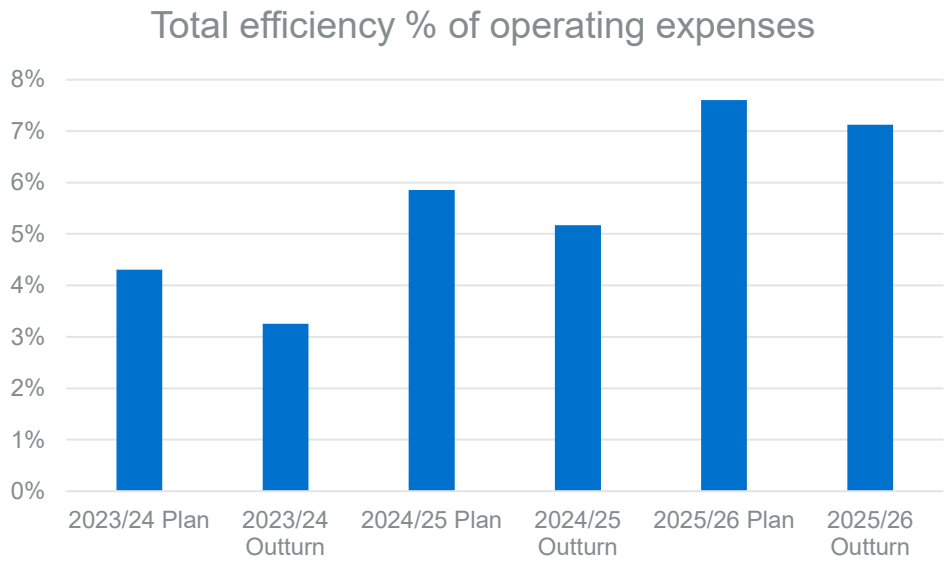


# VFM arrangements – Financial Sustainability

## Overall commentary on the Financial Sustainability reporting criteria

The Finance and Performance Committee, is sub-committee of the Trust Board with responsibility for monitoring financial performance and risks. We confirmed through review of minutes that the Committee continued to receive monthly finance updates throughout 2025/26. The Committee assists with the Trust's understanding of the financial information available and to inform decision making. The meetings in year were used to track financial performance for 2025/26 and assist with financial planning for the three-year period covering 2026/27 to 2028/29.

We have considered the Trust's 2026/27 planning through review of minutes, papers and discussions with management. The Trust developed its plan alongside ICS partners and submitted a final iteration in February 2026 in line with local and national timescales. The plan is based on breakeven delivery. The plan includes receipt of £16.9m non-recurrent funding and a CRP of £27.7m. The CRP is 6.3% of planned expenditure and is recognised by the Trust as challenging. The following graph illustrates the CRP as a percentage of planned expenditure:




At the time of submitting the plan £9.6m (35%) of the CRP was marked as 'unidentified'. Of the CRP included in the plan 75% was rated as 'high' risk, 15% as 'medium' and 10% as 'low'.

The Trust recognises several risks within the plan such as winter pressures, delivery of Elective Recovery Fund (ERF) targets and inflationary pressures. The Trust has confirmed these risk have been included in the 2026/27 risk register and will be reported and monitored by the Financial Sustainability Group. The Trust recognises continued reliance on non recurrent cost savings to deliver to plan is not sustainable and there needs to be a focus and drive to deliver recurrent savings.

Review of minutes and discussions with officers confirms the Trust is closely monitoring the progress against plan to date, is fully aware of where the gaps lie and continues to identify mitigating actions to bridge gaps. In 2024/25 we have raised a significant weakness which highlighted the challenging CRP and the risk to delivery of the Trust financial plans. Whilst we recognise the challenges faced by the Trust, and the actions taken in the year, the delivery of the CRP in 2025/26, alongside historic delivery, in our view is evidence that in 2025/26 there remained a weakness in the Trust arrangements. Consequently, on page 27 we are reporting the significant weakness and recommendations.

The Trust approved a revised capital programme for 2025/26 of £28.2m, comprising of £7.6m Capital Departmental Expenditure Limit (CDEL) limit and £20.5m of PDC awards relating to a number of capital schemes, including backlog maintenance, digital, and maternity. The Trust has reported capital spend of £27.5m comprising £7.6m CDEL spend, £19.8m PDC spend, and charitable funds spend of £0.1m. We confirmed through review of minutes that capital spend was reported throughout the year to the Board and sub-committees.

The Trust's approved CDEL totals £11.412m in 2026/27. As in the prior year the capital allocations have been delegated by the ICB to the Trust. As with any capital programme of this size, the Trust will need to ensure it has sufficient resources to project manage and achieve programme delivery, while mitigating inherent risks present in delivery of its programmed work.

# VFM arrangements – Financial Sustainability

## Overall commentary on the Financial Sustainability reporting criteria

**The Trust's arrangements for the identification, management and monitoring of funding gaps and savings**

Based on review of minutes and discussions with officers we are not aware of any significant issues that were included in the end of year position that had not already been highlighted to the Board through in-year reporting.

In previous years, the Trust was rated as being in segment 3 of the NHS England's Single Oversight Framework, largely owing to it's planned deficit. In 2025/26, a new NHS Oversight Framework was introduced. The NHS priorities and operational planning guidance 2025/26 made it clear that achieving a financial reset this year is a priority. As such, NHS England's approach to assessment under the new framework means that unless providers are delivering a surplus or breakeven position, their segmentation will be limited to no better than 3. The Trust acknowledged being placed in segment 3 as part of a statement published on their website in September 2025, noting that they have a 'commitment to restore financial balance while continuing to provide safe, high-quality care'. Through discussion with management, we confirmed the Trust has continued to work with the ICB and NHS England to address the Trust's financial position. Further commentary on the new NHS Oversight Framework is detailed in the following sections of our report.

Based on our audit work we have identified no evidence of unusual or inappropriate one-off accounting measures employed by the Trust to deliver financial performance in the short term.

The Trust has continued to develop its Transformation Programme recognising the need to focus and deliver on productivity and efficiency. Overall risk management arrangements have strengthened within 2025/26. The Trust has improved their CRP governance framework, with increased focus on divisional accountability and reporting. As well as increased scrutiny in the Finance and Performance Committee and Board meetings.

We confirmed through review of minutes that risk management arrangements include consideration of the Trust's finances. The Organisational Risk Register and Board Assurance Framework (BAF – see governance section below for further detail) were reported in year and include financial risks. The Organisational Risk Register (ORR), presented to Board in March 2026, included 3 Finance Risks, split under risk sub type of finance and business continuity:

Risk sub type - Finance:

- 4713 – Risk of not delivering our sustainable future CRP on a recurring basis.
- 4694 - Non-achievement of a 2025-26 revenue plan and likely deterioration from 2024-25 planned deficit of £12m

Risk sub type – Business Continuity:

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

Recognised actions include continued reporting on financial position, including continued divisional finance reporting as well as additional detail regarding non-recurrent spending and mitigations actions.

**Based on the above considerations, we have concluded a significant weakness in arrangements exists in the financial sustainability criteria. This is detailed on page 27.**

# VFM arrangements

## Governance

How the body ensures that it makes informed decisions and properly manages its risks

# VFM arrangements – Governance

## Overall commentary on Governance reporting criteria

**The Trust's risk management and monitoring arrangements**

The overall governance structure of the Trust is detailed in the Trust's Constitution. We confirmed that the Trust Constitution is in place and, along with other documents, details the governance structure of the Trust. A Corporate Governance Manual is in place which incorporates the Standing Orders of the Board of Directors, Standing Financial Instructions and Reservation and Delegation of Powers. We confirmed there are clear and defined decision making and internal controls within the Trust and its subsidiaries.

Review of minutes confirms the Council of Governors and the Trust Board of Directors met formally at regular intervals during the year to discharge their duties. The Trust has several subcommittees of the Board including the Group Audit Committee, Finance and Performance Committee, Quality Governance Committee and People and Organisational Development Committee. Terms of reference setting out their responsibilities and reporting channels continue to be in place, with a review of the terms of reference for both the Group Audit Committee and the Digital Committee most recently taking place in January 2026. Review of Board minutes confirms there has been regular reporting from Committees into the Trust Board during 2025/26.

The Group Audit Committee is attended, and chaired, by Non-Executive Directors. We attended Audit Committee meetings held in the year. The Committee terms of reference are reviewed and agreed annually, with the most recent review being carried out in January 2026. The functions of the Committee include seeking assurance in respect of risk management, control and governance systems and anti-fraud controls. The Group Audit Committees Annual Review of Effectiveness and Terms of Reference, which considers the responses to the Committee's effectiveness is presented to the Group Audit Committee on an annual basis, normally in September. The Group Audit Committee also consider the 'Audit Committee Annual Report' which is an extract included in the overall Annual Report prepared as part of the financial statements process, detailing the function of the Audit Committee in line with section D2.4 of the Code of Governance for NHS Providers.

The 'Audit Committee Annual Report' paper for 2024/25 was approved by Audit Committee in June 2025 and stated the following:

*The Group Audit Committee is a formal committee of the Board with delegated responsibility to conclude upon the adequacy and effective operation of the overall internal control system including an effective system of integrated governance and risk management. The Audit Committee is a Group Audit Committee, overseeing the controls, governance and risk environment of Gateshead Health NHS Foundation Trust and QE Facilities.*

The report sets out the actions carried out by the Committee during the year in relation to their roles and responsibilities and also details the attendance of members. We have identified no evidence in 2025/26 which would indicate significant changes in the role of the Committee, although confirmed from attendance that the Chair of the Group Committee changed from September 2025.

Through our attendance at the Committee meetings, we observed that the Committee received the internal and external audit work plans and reports, as well as the counter-fraud work plan, updates and reports. The Committee also routinely reviewed and approved the schedule of losses and special payments, as well as receiving updates on the work of the Group's Executive Risk Management Group.

**Board Assurance Framework**

The Trust has a Board Assurance Framework which sets out the key strategic objectives of the Trust and the risks identified against each objective. Each objective has an assigned Executive Lead and Board sub-committee, who provide quarterly reporting on changes to risks and mitigating actions through a formal assurance return. Each return is in-turn supported by management assessments, the work of internal audit (where applicable) and input from operational staff.

A paper showing the BAF process was presented at the March 2026 Audit Committee. The paper provided an overview of the development, review and monitoring of the BAF throughout 2025/26. In a typical year, the BAF is formally concluded early in Quarter 1, with a new BAF aligned to the new annual strategic objectives in place and running through the Board and its committees by the end of Quarter 1.

# VFM arrangements – Governance

## Overall commentary on Governance reporting criteria

However, in 2025/26, a significant piece of work was undertaken by the Trust to develop a new 5-year strategy to run from 2025-2030. The strategy was provisionally approved by the Board in June 2025 pending a review of this draft against the newly published NHS 10 Year Plan. The strategy was fully approved by the Board at its meeting in September 2025 and launched at the Annual General Meeting.

Prior to September 2025, with the Board's agreement, the 2024/25 objectives and BAF continued to flow through to the committees in the period between April and August 2025 to prevent a governance gap and ensure that controls and assurances continued to be assessed and triangulated.

Throughout August 2025, the Company Secretary and Executive Directors prepared draft summary risks and scores, and the Board established incremental target risk scores extending to 31 March 2027. The Board reviewed, debated, and amended risks and targets, with Executive Directors finalising the wording.

The first iteration of the Board Assurance Framework for 2025/26, mapped to the new 5-year strategy and strategic objectives, was presented to Board and formally approved at the Board meeting in September 2025 and is now used across all committees. Further work has been undertaken throughout 2025/26 to work with Executive Directors to populate controls and assurances.

The BAF has also been reviewed at each Board committee meeting as planned, although as noted above, the content and the format of the BAF changed from September 2025 in line with the new strategic objectives within the 5-year strategy. The Board agreed to retain the existing BAF format, aligning objectives with Directors and Committees.

The Group Audit Committee was asked in March 2026 to review the BAF process for assurance purposes. We are satisfied that the Trust ensured sufficient arrangements were in place throughout the year and as such have not deemed there to be a weakness in the Trust's arrangements.

### Operational Risk Register

The Trust continues to maintain an Operational Risk Register (ORR) which we confirmed is reported to the Board on a regular basis during the year. Reports highlight any new or re-rated risks. Each identified risk is given a current risk level, mitigating actions along with due dates and owners for each action, plus a progress rating. Through our attendance of Group Audit Committee throughout the year, we observed that risks are monitored and progress on the actions taken against each risk is reported regularly. Review of minutes confirmed the Executive Risk Management Group (ERMG) continued to meet in the year and reported to the Group Audit Committee. The ERMG responsibilities include monitoring the Organisational Risk Register.

Internal audit complete an annual review of risk management and the BAF. We note from the most recent Internal Audit progress report, shared at the March 2026 Group Audit Committee, the BAF review is currently in the review stage with the draft report in review by the Trust. The 2024/25 review of Trust's arrangements concluded that governance, risk management and control arrangements provide a 'good level of assurance' which was consistent with findings in the previous year.

To provide assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud, the Trust has appointed internal auditors and local counter fraud specialists. The Trust's internal auditor, Audit One, provide an opinion that the Trust's system of internal control, the governance and risk management are designed to meet the Trust's objectives, and that controls are being applied consistently.

We confirmed an Internal Audit Plan was developed and approved by the Group Audit Committee for the 2025/26 financial year. The Internal Audit Plan covers the Trust and QE Facilities, and is presented to, and agreed by, the Group Audit Committee on an annual basis, with the most recent plan for 2026/27 being presented at the March 2026 meeting.



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# VFM arrangements – Governance

## Overall commentary on Governance reporting criteria

As in previous years, through our attendance at Audit Committee meetings, we confirmed that progress against the Internal Audit Plan and detailed findings reports were regularly reported to the Committee. The progress reports include follow up reporting of recommendations not fully implemented by due dates. This allows the Committee to effectively hold management to account on behalf of the Board. We observed Committee members providing scrutiny and challenge on findings and recommendations

The Head of Internal Audit opinion for 2025/26 was presented to Group Audit committee in June 2026 and provides 'good assurance that there is a sound system of internal control, governance and risk management designed to meet the organisation's objectives and that controls are generally being applied consistently'. No matters noted to indicate a significant weakness in internal control environment. No matters noted to indicate a significant weakness in internal control environment

The Trust also employs a dedicated fraud team, who undertake and provide regular training and inductions to staff. We confirmed the team reports regularly to the Audit Committee. We confirmed reports were given appropriate attention at Audit Committee meetings and actions taken where deemed to be necessary. The Trust has a comprehensive fraud risk assessment that is continually reviewed and influences the annual fraud work plan. A comprehensive policy is in place to detail the Trust approach to fraud prevention.

No matters have been identified from our review of the above monitoring arrangements which suggest a significant weakness in arrangements.

**The Trust's arrangements for budget setting and budgetary control**

From our review of minutes, we have confirmed that the Trust carried out regular review and monitoring of the 2025/26 financial plan with revisions and updates to assumptions made as soon as the information became available. As detailed in the previous section the Trust has developed a detailed Financial Plan for 2026/27.The plan was approved by the Trust Board in February 2026 and then submitted as part of the local Integrated Care Systems (ICS) plan. We have observed evidence that the 2026/27 plan has been produced and submitted in line with NHSE requirements. This includes working with local partners to develop an overall ICS plan, and taking actively participating in system wide financial recovery discussions.

Through review of minutes and attendance at Group Audit Committee we confirmed that the budget setting and monitoring processes are reported frequently and in sufficient detail that allows for effective review and challenge at senior leadership and Board level. Based on discussion with officers and review of documentation the Trust is clear in the financial pressure it faces and the challenges in future financial years. Review of the Board Assurance Framework and Operational Risk Register (ORR) confirms the financial pressures are highlighted as a high risk to the Trust.

Strategic objectives are reflected in the Annual Plan and Budget with performance against budget monitored monthly through the centre and departmental structures. This information is consolidated and reported to Board with a monthly return submitted centrally to NHSE. Reporting includes the Trust's subsidiary company, QE Facilities Limited. This financial information supports the year end process with corrective action on performance escalated and approved by Board. Financial governance arrangements are managed within the corporate governance framework which includes Standing Orders, Standing Financial Instructions and a Scheme of Delegation.

Review of minutes confirms the Trust's performance continued to be monitored by the Finance and Performance Committee during the year. The Committee met regularly during the year and it reported into the Trust Board on a regular basis.

Draft accounts were received from the Trust on 27 April 2026, in line with the submission deadline, with working papers provided shortly after. Building on the prior year 'other recommendation' regarding delays in obtaining information, we have seen improved responsiveness from officers, alongside more efficient audit delivery supported by strengthened closedown planning and timetable discipline. While internal quality assurance processes have been enhanced prior to submission, with clearer accountability for key disclosures. Our initial review identified a number of consistency errors, particularly between the primary statements and disclosure notes. These issues delayed completion of audit procedures, including setting materiality.



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# VFM arrangements – Governance

Notably, several improvement areas were proactively raised by management, reflecting a more robust and transparent year-end process. However, given the issues identified, we have continued to raise an 'other recommendation'.

| Other Recommendation | |
|---|---|
| The audit team noted issues with the quality and consistency of information provided by officers, including the submission of multiple draft versions within a short period. This required additional review and clarification, impacting the efficiency of the audit process. | The Trust should review and improve closedown processes to ensure a smoother accounts production and audit process in future years. |

Operational performance data is included in Leading Indicators Report. These reports illustrate the pressures faced by the Trust in delivery of performance targets. The Trust is aware of its pressures and have plans to address. Reports were presented in a consistent manner and provided detail on the direction of travel and explanations for the reported position.

**The Trust's decision-making arrangements and control framework**

The Trust has an established governance structure, which was in place during 2025/26 as set out within its Annual Governance Statement. This is supported by the Trust's Constitution, which is available on the Trust's website. The Trust Constitution includes details of clearly defined delegation of powers and decision-making groups and individuals. Executive Directors have clear responsibilities linked to their roles and the Board sub-committee structure in place is designed to allow for effective oversight of the Trust's operations and activity.

The Trust structure includes committees and groups that undertake a governance and risk approach, such as Trust Board and the Group Audit Committee. We have reviewed the minutes of these meetings as part of our work and are satisfied that there is effective review and challenge of the Trust's activity. Furthermore, from our attendance at Group Audit Committee we have not identified evidence of a failure to challenge or hold officers to account.
The Trust has standards of business conduct process, reporting and governance in place to manage and gain assurance that the Trust meet regulatory requirements. Checks are taken to ensure the declarations are managed effectively, that Fit and Proper persons checks are carried out and reporting of such is made effectively to the Group Audit Committee. The Trust has a comprehensive policy in place to detail the Trust approach to Standards of Business Conduct. The Group Audit Committee receive regular updates from the Trust's Freedom to Speak Up (FTSU) Guardian, with the most recent report presented at the December 2025 meeting which provided assurance the FTSU process was in line with the FTSU Policy.

**Based on the above considerations, we are satisfied there is no evidence of a significant weakness in the Trust's arrangements in relation to governance. We have, however, raised an 'other recommendation'.**

# VFM arrangements

## Improving Economy, Efficiency and Effectiveness

How the body uses information about its costs and performance to improve the way it manages and delivers its services

# VFM arrangements – Improving Economy, Efficiency and Effectiveness

## Overall commentary on Improving Economy, Efficiency and Effectiveness

**The Trust's arrangements for assessing performance and evaluating service delivery**

There are two strands to the Trust's assessment of performance; operational and financial. Financial performance is monitored via monthly management accounts and reported quarterly to both the Finance and Performance Committee and the Board. Financial information is disaggregated in management information in the same manner as the financial statements (i.e. income is split between sources and expenditure is split between staff and other costs), with comparison at line level to budget for both actuals to date and full year forecasts and significant variances identified. Beneath the high-level reporting, both budgets and actual performance are split across the different departments of the Trust with individual budget holders responsible for ensuring each department delivers against its budget and providing accurate future forecasts. Staff costs are analysed between permanent staff, agency and bank staff with reasons for variations investigated.

Operational performance is reported via Strategic Objectives and Constitutional Standards Report which we confirmed were presented to the Trust Board on a regular basis throughout 2025/26. The reports presented data in a consistent manner. This allows for movements to be easily tracked and reasons for variances provided. The Trust monitors performance in four discreet categories, financial (considered above), operational (such as wait times), workforce (such as staff sickness and training) and quality (such as infections and complaints). Key performance measures are reported to Board and relevant sub committees with both current performance and trends reviewed and challenged. Reporting in the year details the Trust is continuing to struggle in some areas. The reports presented to Board detail actions being taken to address any under performance. We have identified no matters to indicate a significant weakness in arrangements based on our review of the reported performance data. The reporting processes within the Trust closely align the financial and operational planning processes.

The Trust has formal policies in place for both staff and patients to raise concerns over the quality of care, including protected means such as whistleblowing, and staff policies encourage people to come forward with concerns.

**NHS Oversight Framework**

In previous years, NHS England (NHSE) allocated trusts and ICBs to one of four 'segments' as part of their Single Oversight Framework. A segment indicated the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4).

Owing to the Trust's underlying deficit position, the Trust was previously placed in segment 3 and as a result the Trust was subject to higher level of scrutiny and support locally. Addressing the underlying deficit was, and remains, one of the Trusts objectives with many actions put in place to support delivery including the implementation of a new CRP Framework, Governance and PMO Team to support its delivery.

In 2025/26, a new NHS Oversight Framework was introduced. As part of the new framework, Trusts continue to be rated, however there are now five segments, and NHSE use the performance assessment process to measure delivery against an agreed set of metrics which determines the segment score for each provider and identify where improvement is required. NHSE's improvement response will be based on the segmentation score alongside consideration of the organisation's leadership and governance (provider capability) to ensure that it is tailored and nuanced, balancing performance improvement and management. The intention of the framework is to align the approach with that of Care Quality Commission (CQC). However, as noted in the financial sustainability section above, unless providers are delivering a surplus or breakeven position, their segmentation will be limited to no better than 3.

Our review of the NHS England oversight framework segmentation and performance dashboard shows that the Trust has an average metric score in each quarter of between 2.3 and 2.5, and if the segment rating was unadjusted would be rated in segment 2 in quarter 2 and segment 3 in quarters 1 and 3. However, because of the financial override, the Trust has been rated in segment 3 for every quarter of 2025/26 so far.

Per review of the individual metrics on the dashboard, the lower score is clearly attributable to the planned surplus/deficit metric which is consistent with expectations based on our knowledge of the Trust, and the significant weakness raised in both the current year and the prior year relating to financial sustainability. However, we note that one of the finance and productivity domain metrics confirms that the third metric shows that the planned deficit position is in line with the financial plan submitted, with there being a less than 0.5% variance to plan in Q1, and the Trust being on plan in Q2 and Q3. This supports the Trust's assertion that they are proactively monitoring and responding to their financial position.

We have reviewed the Trust's Annual Report and Annual Governance Statement and found them to be consistent with the performance reported during the financial year. The last Care Quality Commission (CQC) inspection of the Trust was in 2019. The report published in 2019, confirmed the overall rating of 'good'. Management have confirmed that there has been no further inspections during the current year.

# VFM arrangements – Improving Economy, Efficiency and Effectiveness

## Overall commentary on Improving Economy, Efficiency and Effectiveness

**The Trust's arrangements for effective partnership working**

Nine positions on the Council of Governors are allocated to partner organisations to ensure that partners are able to feed into the Trust's strategic and operational plans. A further 6 positions are allocated to staff representatives and other positions are elected by members (who may be staff, local residents or patients). Review of minutes confirms Governors receive regular financial and operational reporting and are able to challenge management, through the non-executive directors, on performance.

The Trust continues to have mechanisms for engagement with third party bodies at all levels across the organisation. We have confirmed through review of minutes that there has been regular engagement with partners during the year. As detailed in the previous sections the Trust has engaged with Integrated Care System (ICS) partners and in the North East and North Cumbria Provider Collaborative. The Trust has worked with its ICS partners in the financial planning submission. This required the Trust to work with ICS partners in developing a financial plan within the funding allocated to the ICS.

The Great North Healthcare Alliance is a partnership between the NHS Trusts in Gateshead, Newcastle, Northumbria and North Cumbria. The collaboration is intended to deliver better care for the local communities, as together they care for 1.3m patients over 4,600 square miles, employing 40,000 staff and an annual budget of around £3.4billion. By bringing together resources, expertise and skills, it can create a health system that delivers world-class healthcare. Relationships across the four organisations have continued to develop throughout the year to support joint working on Alliance priorities, and the Great North Healthcare Alliance leaders have continued to take steps to strengthen their collaborative working, the pace of this work, how it is governed, and what structures could support this. The Alliance Steering Group of the Chairs and CEOs from the four organisations meet monthly as Committees in Common. These arrangements have been strengthened through a Joint Committee and three sets of bilateral arrangements. We confirmed through review of minutes that regular updates were provided to Trust Board. In March 2025 it was announced that the three Trusts (excluding North Cumbria) would share a Chair. The appointment was formally announced in May 2025 with Sir Paul Ennals taking up the formal shared chair responsibilities for both Newcastle and Northumbria from the start of July 2025, followed by Gateshead at the end of September 2025.

From our review of minutes, and discussion of the Alliance with management, no matters have been noted to indicate a weakness in arrangements, and we will continue to monitor as the Alliance progresses in coming years.

Our review of Board reports confirms that the Board is regularly briefed on the Trust's engagement with system partners and any emerging issues. We have not identified any evidence of a significant weakness in the Trusts arrangements for working with partners.

**The Trust's arrangements for commissioning services**

Trust services are not typically outsourced, but where this is required, the procurement is usually managed by the Trust's subsidiary QE Facilities Limited (QEF) as part of the facilitated healthcare agreement between the two parties. We confirmed Group management receive regular reporting on the activities of QEF. This incudes updates from QEF management. The financial and operational performance of the Group includes performance of QEF. This was confirmed via review of Board minutes throughout the year. We have confirmed that QEF continue to follow the Group's Standing Orders (SOs) and Standing Financial Instructions (SFIs), including procurement processes. The SFIs includes a specific section on tendering and procurement procedures "21. Tendering and Contracting Procedure". As noted in the previous section QEF is covered by the Trust Internal Audit Plan and QEF specific reports are presented to the Group Audit Committee. There is a KPI report that is presented and monitored by the QEF Board. The Trust has representatives that sit on the QEF Board so have sight of QEF performance.

Trust employees are obliged to declare any actual or potential conflicts of interest with suppliers and this information is reviewed and published on an annual basis. We have confirmed this during our review of the related party disclosures in our audit opinion work. The Trust's policies are designed to meet the 'Managing Conflicts of Interest in the NHS' guidance.
We confirmed that Trust employees are obliged to declare any actual or potential conflicts of interest with suppliers. This information is reviewed and published on an annual basis. Our consideration of related party transactions confirmed this. The Trust's policies are designed to meet the Managing Conflicts of Interest in the NHS guidance. Registers of declared interests are available on the Trust website.

**Based on the above considerations, we are satisfied there is no evidence of a significant weakness in the Trust's arrangements in relation to improving economy, efficiency and effectiveness.**

# VFM arrangements

## Identified significant weaknesses in arrangements and our recommendations

# VFM arrangements – Prior year significant weaknesses and recommendations

## Progress against significant weaknesses and recommendations made in the prior year

As part of our audit work in previous years, we identified the following significant weakness, and made recommendations for improvement in the Trust's arrangements to secure economy, efficiency and effectiveness it its use of resources. These identified weaknesses have been outlined in the table below, along with our view on the Trust's progress against the recommendations made, including whether the significant weakness is still relevant in the 2025/26 year.

| Significant weakness in arrangements | Relevant Criteria | Work Undertaken and Conclusions Reached |
|---|---|---|
| **Significant weakness**<br>In 2024/25 the Trust set a deficit financial plan of £12.4m. In the year the Trust received non-recurring deficit support funding of £10.2m which resulted in the planned deficit being adjusted to £2.4m. The Trust reported delivery of its plan as at 31 March 2025, which included the delivery of £22.8m through the Trust's Cost Reduction Programme (CRP). Although the Trust had achieved its CRP for the 2024/25 financial year, the level of recurring savings was lower than anticipated by £9.1m. The 2024/25 outturn has increased the underlying deficit in the year and this creates additional pressures in 2025/26, as the total unachieved target of £17.7m is carried forward to 2025/26 financial year.<br><br>Additionally, the Trust has set an overall deficit plan for 2025/26 of £8.6m which relies on receipt of non-recurrent deficit support funding of £14.3m and a CRP of £32.8m (7.1% of expenditure and higher than that achieved in 2024/25). Should the Trust to deliver its 2025/26 plan, with no adjustments, it would have an underlying deficit of £26.8m.<br><br>In our view the increasing underlying deficit, underperformance in recurrent savings and continuous reliance on receipt of deficit support funding is evidence of a significant weakness in arrangements in the financial sustainability criteria - how the body plans to bridge its funding gaps and identifies achievable savings. Without an improvement in arrangements the Trust risks being unable to deliver services in an affordable way.<br><br>**Recommendation**<br>The Trust should continue to work with local ICS partners to develop a medium-term plan to address the underlying deficit position. | Financial Sustainability | **Progress against the recommendation**<br>In 2025/26 the Trust set a deficit financial plan of £8.621m. In the year the Trust received non-recurring deficit support funding of £3.663m which resulted in the planned deficit being adjusted to £4.958m.<br>The Trust reported delivery of its plan as at 31 March 2026, which included the delivery of £32.873m through the Trust's Cost Reduction Programme (CRP). Although the Trust had achieved its CRP for the 2025/26 financial year, the level of recurring savings was lower than anticipated by £6.046m. Although, the 2025/26 outturn has decreased the underlying deficit in the year and the achievement of the CRP creates additional pressures in 2026/27, as the total unachieved target of £18.115m is carried forward to 2026/27 financial year.<br><br>Additionally, the Trust has set an overall deficit plan for 2026/27 of £0.384m which relies on receipt of non-recurrent support funding of £16.909m and a CRP of £27.671m (6.3% of expenditure). Should the Trust to deliver its 2026/27 plan, with no adjustments, it would have an underlying deficit of £23.5m.<br><br>**Conclusions**<br>In our view the increasing underlying deficit, underperformance in recurrent savings and continuous reliance on receipt of deficit support funding is evidence of a significant weakness in arrangements in the financial sustainability criteria - how the body plans to bridge its funding gaps and identifies achievable savings. Without an improvement in arrangements the Trust risks being unable to deliver services in an affordable way.<br><br>The Trust should continue to work with local ICS partners to develop a medium-term plan to address the underlying deficit position. |

# VFM arrangements – Prior year significant weaknesses and recommendations

## Management response to significant weakness and recommendation

Management agree  that the report is a fair and balanced assessment of the challenges the Trust are facing.  Particularly in the context of prevailing NHS finance regime, system wide financial pressures and requirement to move to break even quickly.

Management acknowledges the conclusion that a significant weakness continues to exist, driven by:

- the level of underlying deficit;
- lower than planned recurrent efficiency delivery; and
- ongoing reliance on non-recurrent funding support.

They also recognise the specific references to:

- the scale and deliverability of the CRP;
- the level of recurrent savings achieved; and
- the carry-forward of unachieved savings into future years.

Management believe that The Trust Board has a clear and shared understanding of these challenges, and would collectively agree that:

- a structural gap remains between income and expenditure;
- delivery of recurrent efficiencies is critical to long-term sustainability; and
- reliance on non-recurrent funding is not a sustainable position

In response to the ‘other recommendation’, they acknowledge the feedback regarding the perceived quality and consistency of the draft accounts.  Noting, the improved efficiency of the audit process including the strengthened closedown planning and timetable discipline during the 2025/26 audit, as well as an enhanced internal quality assurance prior to submission, clear accountability and ownership for key disclosures.  Not withstanding that many of the observations made where the Trust could make improvements are aspects that we have raised with Forvis Mazars proactively – this in itself demonstrates the improved and strengthened approach to year end.

# 04

# Other reporting responsibilities

# Other reporting responsibilities

## Wider reporting responsibilities

**Public interest reports**
Auditors have the power to make a report if they consider a matter is sufficiently important to be brought to the audited body or the public as a matter of urgency, including matters which may already be known to the public, but where it is in the public interest for the auditor to publish their independent view.

We did not make a report in the public interest during 2025/26.

**Schedule 10 referrals**
Under Schedule 10 of the National Health Service Act 2006, auditors of a Foundation Trust have a duty to consider whether there are any issues arising during their work that indicate possible or actual unlawful expenditure or action leading to a possible or actual loss or deficiency that should be reported to the relevant NHS regulatory body.

We have not reported any such matters.

## Reporting to the group auditor

**Whole of Government Accounts (WGA)**
The Trust is consolidated into Consolidated NHS Provider Account which is then consolidated into the Department of Health and Social Care (DHSC) group. The National Audit Office (NAO), as group auditor, requires us to report to them whether consolidation data that the Trust has submitted is consistent with the audited financial statements. In addition, the NAO may also review our audit files in detail. For the 2025/26 year, The NAO did not include the Trust in its sample of component bodies for review for the purpose of its audit of the DHSC group.

We reported to the NAO that consolidation data was consistent with the audited financial statements. We also reported to the NAO in line with its group audit instructions.

Materiality for the Trust under WGA is distinct from the materiality thresholds set by us for reporting to the Audit Committee. Component materiality is determined by the NAO and is used by us for the purposes of reporting to the group auditor. For 2025/26, the component reporting threshold was £1m for financial statements and £300k threshold for parliamentary accountability disclosures and regularity requirements. These are also used as the maximum thresholds we can apply for our reporting to the Audit Committee.

# Appendices

A - Further information on our audit of the financial statements

# Appendix A: Further information on our audit of the financial statements

## Significant risks and audit findings

As part of our audit, we identified significant risks to our audit opinion during our risk assessment. The table below summarises these risks, how we responded and our findings.

| Risk | Our audit response and findings | Audit Conclusion |
|---|---|---|
| **Management override of controls (Group and Trust)**<br>In all entities, management at various levels within an organisation are in a unique position to perpetrate fraud because of their ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. Due to the unpredictable way in which such override could occur, we consider there to be a risk of material misstatement due to fraud and thus a significant risk on all audits. | **How we addressed this risk**<br><br>We addressed this risk by:<br>• making enquiries of senior management involved in the financial reporting process about inappropriate or unusual activity relating to the processing of journal entries and other adjustments;<br>• recording the Trust's financial reporting processes and controls over journal entries and other adjustments and performing a walkthrough of such controls;<br>• determining risk-based fraud characteristics for journals to test;<br>• testing journals made by the Trust in the preparation of the financial statements and post closing journals;<br>• critically reviewing accounting estimates and the judgements and decisions made by management in arriving at estimates to ensure there has been no manipulation of results;<br>• considering any significant transactions outside the normal course of business; and<br>• critically reviewing the selection and application of accounting policies. | We obtained the assurance sought, with no significant issues arising. |

# Appendix A: Further information on our audit of the financial statements

| Risk | Our audit response and findings | Audit Conclusion |
|---|---|---|
| **Risk of fraud in revenue recognition – Cut Off (Group & Trust)**<br>The risk of fraud in revenue recognition is presumed to be a significant risk because of the potential to inappropriately shift the timing and basis of revenue recognition as well as the potential to record fictitious revenues or fail to record actual revenues.<br><br>For the Trust we deem the risk to relate specifically to the timing of income recognition at the year end, in relation to judgements made by management as to when income has been earned, and the potential for year end income to be under or overstated. The pressure to manage income to deliver forecast performance in a challenging economic environment increases the risk of fraudulent financial reporting leading to material misstatement and means that we have not rebutted the presumption.<br><br>This does not imply that we suspect actual or intended manipulation but that we approach the audit with due professional scepticism. | **How we addressed this risk**<br><br>We addressed this risk by:<br>• evaluating the Trust's accounting policy in respect of revenue recognition to ensure that it is in line with the requirements of the Group Accounting Manual (GAM);<br>• testing a sample of year-end accruals by agreeing estimates made to appropriate source documentation and challenging the basis of estimates made by management; and<br>• cut-off testing of income at year end (checking income is recorded in the correct financial year).<br><br>Our testing was also informed by:<br>• considering information provided by the Department of Health and Social Care in respect of year end inter-NHS transactions. We reviewed any significant differences between the Trust's position and that of the counterparty and obtained assurance that the Trust's position was supported by appropriate evidence. | We obtained the assurance sought, with no significant issues arising. |
| **Risk of fraud in expenditure recognition – Cut Off (Group & Trust)**<br>The risk of fraud in expenditure recognition is not a presumed risk of fraud; however, underlying guidance highlights that recognition of expenditure is relevant to public sector bodies and that the risk should be considered.<br><br>We consider the risk to relate specifically to the timing of expenditure recognition at the year-end and the potential for year-end income to be under or overstated.<br><br>The pressure to manage expenditure to deliver forecast performance in a challenging economic environment increases the risk of fraudulent financial reporting leading to material misstatement. This does not imply that we suspect actual or intended manipulation but that we approach the audit with due professional scepticism. | **How we addressed this risk**<br><br>We addressed this risk by:<br>• evaluating the Trust's accounting policy in respect of expenditure recognition to ensure that it is in line with the requirements of the Group Accounting Manual (GAM);<br>• testing a sample of expenditure accruals at the year-end by agreeing estimates made to appropriate source documentation and challenging the basis of estimates made by management; and<br>• cut-off testing of expenditure at year end (checking expenditure is recorded in the correct financial year).<br><br>Our testing was also informed by:<br>• considering information provided by the Department of Health and Social Care in respect of year end inter-NHS transactions. We reviewed any significant differences between the Trust's position and that of the counterparty and obtained assurance that the Trust's position was supported by appropriate evidence. | We obtained the assurance sought, with no significant issues arising. |

# Appendix A: Further information on our audit of the financial statements

| Risk | Our audit response and findings | Audit Conclusion |
|---|---|---|
| **Valuation of land and buildings (forming part of the Property, Plant and Equipment and Right of Use Asset balances) (Group & Trust)**<br>Management engage Cushman and Wakefield, as an expert, to assist in determining the current values of land and buildings to be included in the financial statements. Changes in the values of land and buildings may impact on the Statement of Comprehensive Income depending on the circumstances and the specific accounting requirements of the Group Accounting Manual. | **How we addressed this risk**<br><br>We addressed this risk by:<br>• Obtaining an understanding of the skills, experience and qualifications of the valuer, and considering the appropriateness of the instructions to the valuer from the Trust;<br>• Obtaining an updated understanding of the basis of valuation applied by the valuer in the year. This will include understanding and challenging the methodology applied to estimate the gross replacement cost of the Trust's operational land and buildings on a modern equivalent asset basis;<br>• Sample testing the completeness and accuracy of the underlying data provided by the Trust and used by the valuer as part of their valuations;<br>• Testing the accuracy of how valuation movements are presented and disclosed in the financial statements; and<br>• Using relevant market and cost data to assess the reasonableness of the valuation as at 31 March 2026; including, where appropriate, the use of the NAO's commissioner valuer Montagu Evans report. | **Property valuations (part of the Property, Plant and Equipment balance**<br>2025/26 was an 'interim, 'desktop' valuation year. We critically reviewed the methodology adopted by the Valuer and sought assurance that there had been liaison between the Trust and the Valuer, to ensure any significant changes in the year had been taken into account. Our testing did not identify any significant issues.<br><br>**Right of Use Assets –** We have considered the Trust's right of use assets and we have not identified any risk of material misstatement.<br><br>We have completed our planned procedures and obtained the assurance sought, with no significant issues to report. |

# Appendix A: Further information on our audit of the financial statements

## Summary of unadjusted misstatements

Our overall materiality, performance materiality, and clearly trivial (reporting) threshold were reported in our Audit Summary Memorandum, issued on 9 Apil 2026. Any subsequent changes to those figures are set out in the *'Executive summary'* section of this report.

Management has assessed the misstatements in the table below as not being material, individually or in aggregate, to the financial statements and does not plan to adjust. We only report to you unadjusted misstatements that are either material by nature or which exceed our reporting threshold.

| Unadjusted misstatements | | SOCI | | SOFP | |
|---|---|---|---|---|---|
| **Description** | **Nature** | **Dr (£ '000)** | **Cr (£ '000)** | **Dr (£ '000)** | **Cr (£ '000)** |
| Dr: Provisions<br>Cr: Expenditure<br><br>As recorded in Section 04 of this document. The Trust continue to recognise provisions totalling £0.963m. This relates to a general creditor provision. In our view no obligations existed at 31 March 2026 and as such the provision is not appropriate per IAS 37 – Provisions, Contingent Liabilities and Contingent Assets.<br>(Group and Trust) | Judgemental | | 963 | 963 | |
| Dr: Revaluation Reserve<br>Cr: Property, Plant and Equipment (PPE)<br>The adjustment between Trust PPE and revaluation reserve is in relation to QE Hospital and Bensham Hospital land carrying revaluation values from 2024-25 accounts. The balances in the consolidated accounts are correct but there is an adjustment in Trust carrying note values that are incorrect between PPE and revaluation reserve. Although the figure for land now matches and is correct. It has caused an error, which the client accepts in the revaluation reserve of the Trust.<br>(Trust only) | Factual | | | 655 | 655 |
| **Aggregate effect of unadjusted misstatements** | | | **963** | **1,618** | **655** |

We will obtain written representations confirming that, after considering the unadjusted misstatements, both individually and in aggregate, in the context of the financial statements taken as a whole, no adjustments are required.

# Appendix A: Further information on our audit of the financial statements

## Other deficiencies in internal control

This Appendix sets out the internal control observations that we have identified as at the date of this report. These control observations are not, in our view, significant control deficiencies but have been reported to management directly and are included in this report for your information. In our view, there is a need to address the deficiencies in internal control set out in this section to strengthen internal control or enhance business efficiency. Our recommendations should be actioned by management in the near future.

| PPE – Decommissioned Assets (follow up from 2024/25) |
|---|
| **Description of deficiency**<br>As part of our PPE existence testing, it was discovered that two assets included in the sample related to decommissioned assets which not written out of the asset register, and were therefore still within the Asset Register with a net book value at 31st March 2025.<br>**2025/26 update** – Although our existence testing did not identify any decommissioned assets in 2025/26. As part of our wider PPE testing, we consider those assets with nil net book value within the accounts. Upon review, it was noted the Trust had not performed an evaluation of assets at 31 March 2026 which increased the risk that gross cost and gross depreciation reported in the disclosures to the accounts are overstated. Upon further testing performed, it was also noted the Trust was unable to determine the gross cost of these assets through the information held in the asset register.<br>Therefore, the recommendation remains outstanding. |
| **Potential effects**<br>Overstatement of assets |
| **Recommendation**<br>Perform a review of nil net book value assets as part of year end close down to ensure any assets no longer operational are removed from the asset register. The Trust should review assets with nil net book value held in the asset register and determine if they are still operational.<br>Ensure gross cost and gross historic depreciation is available information within the asset register. |
| **Management response**<br>Management accepts the recommendation |

| Payroll Contracts (follow up from 2024/25) |
|---|
| **Description of deficiency**<br>Our 2024/25 sample testing of employees to contracts has identified that personal files are not maintained for all employees. This meant the Trust found it difficult to provide details of contracts or letters of employment for individuals included in our sample. We note that records could only be provided for 27 of the 36 employees sampled.<br>2025/26 update - We have noted the same issue for 2025/26. Out of a sample of 36, only 26 contracts provided for those sampled.<br>Therefore, the recommendation remains outstanding. |
| **Potential effects**<br>The Trust is unable to confirm that employees are being paid in line with contracts. |
| **Recommendation**<br>Responsibility for maintaining staff records should be considered and allocated. |
| **Management response**<br>Management accepts the recommendation |

# Appendix A: Further information on our audit of the financial statements

| Lease Agreements (follow up from 2024/25) |
| --- |
| **Description of deficiency**<br>All leases recognised in the accounts should be supported by lease/tenancy agreements. Two of our samples per our lease testing had a tenancy at will document rather than a formal lease agreement.<br>From the sample of leases tested as part of our audit work in 2024/25, we noted that the only NHS property services lease we tested had no formal lease agreements, therefore the recommendation remains outstanding. Discussions with management of the Trust indicates that arrangements are being made to update all formal lease and other agreements in line with our previous recommendations.<br><br>**2025/26 update** – We tested one NHS property services leases and noted that the Trust had a tenancy at will agreement in place rather than a lease agreement. This is in line with our expectations of NHSPS<br><br>Therefore, the recommendation remains outstanding. |
| **Potential effects**<br>This makes valuation more subjective and increases the risk of differences of opinion with lessors regarding the terms of the lease including; lease term, frequency of rent reviews and rental increases. |
| **Recommendation**<br>The Trust should negotiate formal lease agreements for all the property leases that it holds and ensure that they are signed, with clear commencement and termination dates by 31 March 2027. |
| **Management response**<br>Management accepts the recommendation |

# Contact

## Forvis Mazars

**James Collins**
Director
Tel: +44 (0)191 383 6331
james.collins@mazars.com

# v - Looking Ahead

Presented by the Chief Executive

# 5. Questions and Answers

# Items for Information / Meeting

# Governance

## 6. Chair's Closing Remarks

Presented by the Chair of the Board of Directors and Council of Governors

## 7. Date and Time of Next Meeting

The next Annual General Meeting and Annual Members Meeting will be held in September 2027 (date to be communicated)