Board of Directors - Part 1

Schedule	Tuesday 29 September 2026, 9:30 — 12:30 BST
Venue	Room 3 / Teams
Organiser	Diane Waites

Agenda

AGENDA

NHS Gateshead Health NHS Foundation Trust

Board of Directors (Part 1 – Public)

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

AGENDA

No	Start time	Item	Purpose	Lead	Paper / Verbal
1. OPENING MATTERS					
a	09:30	Welcome and apologies for absence	Information	Chair	Verbal
b	09:32	Declarations of interest	Information	Chair	Verbal
c	09:33	Minutes of the last meeting held on 29 July 2026	Decision	Chair	Paper
d	09:34	Action log and matters arising	Assurance / decision	Chair	Paper
e	09:35	Top Organisational Risks	Information	Chair	Paper
f	09:37	Patient & Staff Story	Information	Chief Nurse	Presentation
2. GOVERNANCE					
a	09:52	Chair's Report	Assurance	Chair	Paper
b	09:57	Chief Executive's Report	Assurance	Chief Executive	Paper
c	10:10	Assurance from Board Committees:			
		i) Finance and Performance – August and September 2026	Assurance	Chair of the Committee	Paper
		ii) Quality Governance Committee – August 2026	Assurance	Chair of the Committee	Paper
		iii) People and Organisational Development Committee – September 2026	Assurance	Chair of the Committee	Paper
		iv) Group Audit Committee – September 2026	Assurance	Chair of the Committee	Paper
d	10.30	Board Committee Terms of Reference	Decision	Company Secretary	Paper
3. EXCELLENT PATIENT CARE					
a	10:35	Winter Plan	Decision	Chief Executive	Paper
b	10:45	EPRR Core Standards Self Assessment Report	Assurance	Medical Director	Paper
c	10:55	Responsible Officer Assurance Report	Assurance	Medical Director	Paper
d	11:05	Maternity Integrated Oversight Report	Assurance	Associate Director of Midwifery/SCBU	Paper
		i) Maternity Safety Champion Report	Assurance	Maternity Safety Champion	Paper
		ii) Maternity Staffing Report	Assurance	Associate Director of Midwifery/SCBU	Paper
e	11:20	Nurse Staff Exception Report	Assurance	Chief Nurse	Paper

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No	Start time	Item	Purpose	Lead	Paper / Verbal
4. GREAT PLACE TO WORK					
a	11:30	WRES and WDES Report	Assurance	Executive Director of People and Organisational Development	Paper
5. FIT FOR THE FUTURE					
a	11:40	Green Plan	Assurance	Medical Director	Paper
b	11:50	Governance Reports			
		i) Organisational Risk Register	Assurance	Chief Nurse	Paper
		ii) Board Assurance Framework	Assurance	Company Secretary	Paper
c	12:00	Finance Report	Assurance	Director of Finance	Paper
d	12:05	Strategic Objectives and Constitutional Standards Report	Assurance	Director of Finance	Paper
6. ITEMS FOR INFORMATION / MEETING GOVERNANCE					
a	12:10	Register of Official Seal	Information	Company Secretary	Paper
b	12:15	Cycle of Business 2026/27	Information	Company Secretary	Paper
c	12:17	Questions from Governors in Attendance	Discussion	Chair	Verbal
d	12:20	Any Other Business	Discussion	Chair	Verbal
e	12:22	Date and Time of Next Meeting – 9.30am on Wednesday 25th November 2026	Information	Chair	Verbal

Exclusion of the Press and Public
To resolve to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed

1. OPENING MATTERS

a - Welcome and Apologies for Absence
Presented by the Chair

b - Declarations of Interest

Presented by the Chair

c - Minutes of the Meeting Held on 29 July 2026

Presented by the Chair

Gateshead Health NHS Foundation Trust

Board of Directors (Part 1 – Public)

Minutes of a meeting of the Board of Directors (Part 1) held at 9.30am on Wednesday 29th July 2026 in Room 3, Education Centre, Queen Elizabeth Hospital and via MS Teams.

Name	Position
Members present	
Sir Paul Ennals	Chair
Andrew Besford	Non-Executive Director
Adam Crampsie	Non-Executive Director
Sean Fenwick	Chief Executive
Martin Hedley	Non-Executive Director
Carmen Howey	Medical Director
Robert Hughes	Non-Executive Director
Gill Hunter	Non-Executive Director
Kris Mackenzie	Director of Finance
Beth Swanson	Chief Nurse
Amanda Venner	Director of People & Organisational Development
Attendees present	
Jennifer Boyle	Company Secretary
Helen Fox	Head of Communications and Engagement
Tracy Healy	Freedom to Speak Up Guardian (26/07/4a)
Karen Parker	Associate Director of Midwifery/SCBU (26/07/3b)
Diane Waites	Corporate Services Assistant
Governors and Observers	
Helen Adams	Staff Governor
Paul Johnson	Public Governor – Central & Eastern Gateshead
Dr Lakkur Murthy	Public Governor – Western Gateshead
	One member of the public
Apologies	
David Elliott	Chief Digital Officer
Damon Kent	Managing Director, QE Facilities
Gerry Morrow	Vice Chair
Maggie Pavlou	Non-Executive Director / Senior Independent Director

Agenda Item No		Action Owner
Opening Matters		
26/07/1a	**Welcome and apologies for absence:** The meeting being quorate, Paul Ennals declared the meeting open at 9.30am. He welcomed Trust Governors, observers and members of the public. He made the Board aware of a recent incident within the Emergency Department and wished to thank the exemplary response of frontline staff in dealing with the situation.	

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Agenda Item No		Action Owner
	This is the first formal Board meeting for Gill Hunter as Non-Executive Director, and Sean Fenwick and Beth Swanson following their substantive appointments as Chief Executive and Chief Nurse. Sheena Fish has also been appointed as Chief Operating Officer and will take up her role in the coming months. There were no other advance items of business to be made aware of for consideration under the *Any Other Business* agenda item. Apologies were received from David Elliott, Damon Kent, Gerry Morrow and Maggie Pavlou.	
26/07/1b	**Declarations of Interest:** There were no declarations of interest.	
26/07/1c	**Minutes of the Previous Meeting:** The minutes of the meeting of the Board of Directors held on Wednesday 27th May 2026 were approved as a correct record.	
26/07/1d	**Action Log and Matters Arising from the Minutes:** The Board reviewed the action tracker as below: • Action 26/05/3a relating to sharing the Maternity Safety Champion Report with divisional teams has been agreed therefore the action was agreed for closure. • Action 26/05/3b relating to providing a thematic overview to the People and Organisational Development Committee in relation to red flag reporting and considering additional metrics following the recent NHS England visit. Beth Swanson reported that plans are in place to include this as an appendix to the next report to the Committee. Action agreed for closure. • Action 26/05/3b relating to triangulating C.difficile rates into the Nurse Staffing Exception Report in relation to escalation wards and beds per unit. Beth Swanson reported that this will be included in the triangulation section of the report going forward to provide clear correlation. Action agreed for closure. • Action 26/05/4a relating to bringing forward discussions on risk appetite and Board Assurance Framework functions within the Board Development plan. A meeting will take place with the Chair and Chief Executive to agree an approach. Action to remain open at present.	

Agenda Item No		Action Owner
	The Board reviewed the actions closed at the last meeting which ensures actions have been closed in line with expectations and the agreements made at the previous Board meeting. There were no further comments.	
26/07/1e	**Top Organisational Risks:** The top (composite) organisational risks were considered by the Executive Risk Management Group on 6 July 2026 and were agreed as follows: • Sustainability Risk – the Chief Executive will draft a new broader sustainability risk for agreement that incorporates financial sustainability and operational delivery. • 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 Paul Ennals reminded the Board to consider these during presentation of agenda items.	
26/07/1f	**Patient and Staff Story:** Beth Swanson shared a patient story with the permission from the family and the staff involved. The story demonstrates how compassionate, person-centred community nursing, supported by effective multidisciplinary working, enabled a patient with highly complex palliative care needs to remain and die in their preferred place of care. It also highlighted the impact on staff and the importance of supporting workforce wellbeing. Martin Hedley felt that this demonstrated strong community team support and effective working and Adam Crampsie commented that this links to the long-term ambitions for neighbourhood health and the shift in focus of community care therefore queried how this would be developed in the longer term. Beth Swanson explained that this would be reviewed as part of workforce plans to ensure the necessary resources, skills and knowledge were in place. Carmen Howey suggested that it would be useful to share this story with ward-based nursing staff to demonstrate how the community teams are delivering high intensity care to patients within their own home and Beth Swanson confirmed that this would be considered as part of rotational work to provide advanced practice skills. Paul Ennals emphasised the benefits of sharing this effective community working and using this as a trigger for future working. He thanked the teams involved on behalf of the Board.	

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Agenda Item No		Action Owner
Governance		
26/07/2a	**Chair's Report:** Paul Ennals gave an update to the Board on some current issues, events and engagement work taking place across the organisation. He began by highlighting the recent changes to the Non-Executive and Executive Director roles, including changes to Board committee composition and chairing arrangements. The Board will also have the opportunity to review team dynamics as part of the Board Development Plan. Engagement continues to take place with Governors to explore the concept of future engagement should the Health Bill be passed unamended and a first review of a set of draft principles for engagement has taken place via a recent Governor workshop. Paul Ennals highlighted that the session provoked some interesting discussions and suggestions and the Trust continues to be committed to ensuring that our decision-making is informed by the voices of our communities, patients and colleagues. After consideration, it was: **RESOLVED:** to receive the report for assurance.	
26/07/2b	**Chief Executive's Strategic Report:** Sean Fenwick gave an update to the Board on current issues which have been aligned to the Trust's strategic priorities. Sean Fenwick drew attention to the key areas in relation to national policy, context and operating models and highlighted that a letter has been received from the new Secretary of State for Health and Social Care which provides a focus on patient and social care. NHS England published minimum standards for planned patient care and discussions are taking place with Alliance Trusts to develop a set of principles. The new NHS College of Leadership and Management launched the NHS Leadership and Management Framework with the publication of new NHS staff standards which is on the agenda later in the meeting. Resident doctors have voted to accept an offer from the government, bringing an end to industrial action however consultant doctors have voted in favour of a mandate to take strike action in relation to pay and conditions. Carmen Howey highlighted that preparations are being made but no further information has been shared at present. Sean Fenwick drew attention to some of the national performance headlines and explained that the Trust continues to focus on finance and performance standards.	

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Agenda Item No		Action Owner
	In relation to the Trust's strategic priority for Excellent Patient Care, Sean Fenwick highlighted that pathology has been spotlighted by NICE (National Institute of Health and Care Excellence) as a leading example of early adoption of the faecal immunochemical test (FIT) and the Trust has launched an innovative virtual reality breast screening experience designed to promote early intervention screening. Teams across the organisation have also been promoting learning disability week using the theme of 'do you see me?', which focusses on people with learning disabilities being seen, heard and valued. Following a query from Gill Hunter around how this was being implemented, Beth Swanson explained that there was a national strategy and quality improvement is recognised across all patient experience programmes. In relation to Fit for the Future, the Trust's ranking in the acute sector NHS Oversight Framework (NOF) league table for Quarter 4 2025/26 dropped from 65th to 96th place out of a total of 134 trusts and the Trust remains in Segment 3 of 4. The key drivers behind the changed position relate to operational pressures and pressures on breast services which has been impacted by demand changes across the region. Sean Fenwick reported that a credible plan is in place to recover our position, and improvements are expected to be seen in future quarters. Adam Cramspie commented on the number of national reviews and queried whether all learnings were being consolidated for Board review. Paul Ennals explained that this could be discussed as part of the Board Development Plan to agree key areas and common themes. After further discussion, it was: **RESOLVED:** to receive the report for assurance.	PE/JB/SF
26/07/2c	**Assurance from Board Committees:** The Board reviewed the Committee escalation and assurance reports which identify areas of concern and ongoing monitoring of assurances. **Finance and Performance Committee:** Martin Hedley provided a brief verbal overview to accompany the narrative report from the June 2026 meeting. He reported that there were no alerts to highlight but drew attention to some advisory issues relating to the deterioration in financial and operational performance and plans were expected back at the Committee to provide further assurance. It was also noted that there were some gaps identified around the Operational Oversight Group Assurance Report which did not reflect the level of challenge in some areas or provide clear actions to be taken forward.	

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	In relation to the recent meeting which took place on 28th July 2026, Adam Crampsie reported that a written report will be provided following the meeting in future to ensure that the Board receives a full report. He reported that there were three alerts to highlight and drew attention to the reported deterioration in cancer performance for 28-day Faster Diagnosis and 62-day treatment, particularly in Breast and Urology and highlighted that a detailed update will come back to the Committee to provide further assurance on recovery trajectories, capacity required and timing of improvement. Assurance was provided to the Committee that the Trust was ranked first nationally for the 31-day cancer treatment standard in the most recent nationally benchmarked data. A cross-referral to the Quality Governance Committee was suggested to seek assurance on the quality and safety impact of cancer delays, particularly within Breast and Urology, including any actual or potential patient harm, the approach to harm reviews, patient tracking and the controls in place while recovery plans are delivered. Paul Ennals reminded the Board of previous discussions that improvements were expected to be seen by July 2026 and queried whether this was still anticipated. Sean Fenwick explained that discussions are taking place in relation to external support and service agreements however focus remains on patient quality and experience. Beth Swanson highlighted that there has been an increase in queries around waiting times, but no formal complaints have been received. Carmen Howey reported that cases continue to be reviewed via the Cancer Group and priorities are due to be discussed via the Alliance Clinical Framework Group this week. Paul Ennals reflected that good assurance has been provided to the Board that risks are being mitigated and improvement plans are in place which are being closely monitored. Adam Crampsie reported that another alert relates to internal audit actions particularly in relation to the overdue patient monies actions, including two high-priority actions and further assurance has been requested on interim controls, named owners, milestones and revised completion dates. Kris Mackenzie explained that a task and finish group has been established to review current processes, and target dates have been agreed which will be reported back via the Group Audit Committee. The final alert relates to financial performance with the cost reduction programme remaining significantly below plan. A division-by-division plan has been requested to set out immediate measures, recurrent schemes, named owners, delivery dates and a risk-adjusted assessment of delivery. Further discussion will take place around this in Part 2 of the Board.	

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Agenda Item No		Action Owner
	Quality Governance Committee: Adam Crampsie provided a brief verbal overview to accompany the narrative report following the June 2026 meeting and highlighted that Gerry Morrow has now taken over as Chair of the Committee. He reported that there was one alert to highlight relating to Healthcare-Associated Infection (HCAI) performance due to the Trust exceeding the trajectory in several infection indicators, including Clostridioides Difficile Infection (CDI) and bloodstream infections. It was recognised however that mitigations are in place and this is being monitored via the Safecare Group. Beth Swanson explained that a number of workstreams are taking place including deep cleans and reduction in escalation beds and a detailed report will come back to the Committee. Adam Crampsie drew attention to some of the advisory issues including the need for oversight of the use of digital systems for clinical decision making following the Badgernet issues and this was raised as a concern particularly around the development of Artificial Intelligence (AI). Andrew Besford highlighted that this has been discussed at the Digital Committee and assurance has been provided in relation to Badgernet but wider discussions are required around AI programmes. **Group Remuneration Committee:** Martin Hedley provided a brief verbal overview to accompany the narrative reports following the June and July 2026 meetings. He reported that there were no alerts or advisory issues to highlight but provided assurance that the Committee formally approved the appointments for the substantive Chief Executive, Chief Nurse and Chief Operating Officer. **People and Organisational Development Committee:** Adam Crampsie provided a brief verbal overview to accompany the narrative report following the July 2026 meeting. He reported that there were three alerts to highlight, one relating to violence and aggression which indicates a potential increase in organisational risk due to the lack of improvement in the overall violence and aggression score and a number of actions remaining overdue. It has been recognised that work is underway to strengthen oversight, action tracking and triangulation of information across Committees and an updated position is expected at the next meeting. Another alert relates to the delivery of the current Equality, Diversity, and Inclusion (EDI) programme and Amanda Venner highlighted that work is taking place to consolidate key actions and recommendations and will be reported back to the Committee in September 2026. The final alert relates to Healthcare Support Worker (HCA) vacancies with levels remaining a workforce risk within a number of services. The	QGC cycle of business PODC cycle of business

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	Committee acknowledged that levels were being closely monitored and current recruitment pipeline and apprenticeship opportunities are expected to improve the position by September 2026. Following a query from Gill Hunter around longer term plans, Amanda Venner highlighted that the Trust is working closely with Gateshead College and Derwentside College around future vocational studies and Paul Ennals reported that discussions have been taking place with Alliance Trusts to develop proposals. **Digital Committee:** Andrew Besford provided a brief verbal overview to accompany the narrative report following the July 2026 meeting. Andrew Besford reported that that there was one alert to highlight relating to cyber. He highlighted that standards have been met but NHS England have requested that Boards provide assurance. It was agreed that opportunities would be explored through Board development regarding Board-level training and risk appetite discussions. Andrew Besford drew attention to some advisory issues relating to the non-elective electronic patient record business case and concerns raised in relation to having achievable plans in place to allow the Board to received costed plans. Kris Mackenzie explained that this is being worked through and the business case will need to be considered by the Executive Committee and Finance and Performance Committee prior to Board review. Sean Fenwick felt that it was important to ensure that a clinically led service specification was in place and Paul O'Loughlin has been leading on this. Paul Ennals suggested that it would be useful to have some further discussion around this prior to the business case being presented and this will be considered as part of the Board Development Plan. **Group Audit Committee:** Rob Hughes provided a brief verbal overview to accompany the narrative report following the June 2026 meeting which has been previously shared with the Board at the Extraordinary meeting on 24 June 2026. He reported that there was one alert to highlight relating to value for money arrangements which has been raised by the External Auditors as a significant weakness in relation to financial sustainability criteria. Kris Mackenzie highlighted that this has been raised previously due to the reported deficit and a management response has been provided setting out actions being taken but a longer term risk has been acknowledged. Rob Hughes drew attention to some advisory issues relating to the Patient Monies and Property and Do Not Attempt Cardio Pulmonary Resuscitation (DNA CPR) follow up audits and the Committee received a comprehensive report which provided assurance over the actions taken since the re-audit. The Committee received the Annual Report and	PE/SF/JB PE/JB/SF

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	Accounts which were submitted in line with the NHS England requirements. Paul Ennals thanked the Committee Chairs for their reports which provides good assurance that processes are in place to address alerts and advisory issues raised. After consideration, it was: **RESOLVED**: to receive the reports for assurance	
26/07/2d	**Board Committee Terms of Reference:** Jennifer Boyle presented the terms of reference for the Finance and Performance Committee and the Quality Governance Committee. She reported that both committees have reviewed and approved their terms of reference as part of their annual effectiveness reviews and copies of the reviews of effectiveness are available in the supplementary information pack which accompanied the Board papers. Adjustments have been made to membership and attendees to reflect additional changes following the Chair's review of Non-Executive Director committee membership and Non-Executive Director (NED) membership has been increased to ensure that at least two NEDs are present for quoracy purposes which will be standardised across all Board Committee. Carmen Howey suggested a minor amendment to change the wording relating to reviewing quality / medical–related risks on the Organisational Risk Register to clinical related risks within the Quality Governance Committee terms of reference. After consideration, it was: **RESOLVED**: to ratify the Finance and Performance Committee and the Quality Governance Committee terms of reference following recommendation from the respective Committees, subject to the above amendments.	JB JB
Excellent Patient Care		
26/07/3a	**Learning from Deaths Quarterly Report:** Carmen Howey presented the Learning from Deaths report for Quarter 4 2025/26 which outlines the process for review of deaths within the organisation and the way in which those review processes enable learning from good practice and learning where there is evidence that care could be improved. She reported that the SHMI (Summary Hospital-level Mortality Indicator) has shown signs of stabilising in recent months and has fallen slightly,	

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	remaining within the expected range. This is due the number of expected deaths stabilising as Same Day Emergency Care activity has been fully removed from the SHMI for the last three periods. There were two SHMI Mortality Alerts from Healthcare Evaluation Data (HED) for specific diagnosis groups relating to peripheral and visceral atherosclerosis and acute and unspecified renal failure which have undergone internal scrutiny and no concerns regarding the management of renal failure were found. A coding issue regarding acute kidney injury was identified and learning identified is going to be shared with the coding and clinical teams. Carmen Howey highlighted that three extraordinary Mortality Council meetings took place during the quarter to address the backlog of cases awaiting review which has now reduced to 50. Considerable progress has also been made in the review of the deaths of patients with a learning disability with 4 cases outstanding for review and the number of deaths of patients with a serious mental illness has reduced to 16. The Board acknowledged the significant progress made in the review of deaths and thanked the team for their hard work. Carmen Howey explained that revised timelines have been agreed to ensure that cases are reviewed within a 12 week period therefore the 16 outstanding cases represent cases beyond this point and will be reported on in future reports. It is expected that full assurance can be provided to the Board that all cases have been reviewed in line with the timeframe in Quarter 2 2026/27. After further discussion, it was: **RESOLVED:** to receive the report for assurance noting partial assurance due to the outstanding cases awaiting review.	
26/07/3b	**Maternity Integrated Oversight Report:** Karen Parker presented an overview of maternity and neonatal metrics for June 2026. She reported that there were no new alerts to highlight but drew attention to some of the advisory issues including the publication of the Ockenden Nottingham Maternity Report and National Maternity and Neonatal Review (Amos) and it is expected that national recommendations will be received in December 2026. Focus remains on the 10 point plan which sets out urgent actions to support and report into the National Maternity and Neonatal Taskforce. An interim assurance visit for Safety Action D relating to service user engagement and equity of the Maternity Incentive Scheme is planned to take place in August 2026 and Karen Parker explained that the Trust continues to support community family hubs and works closely with the Maternity and Neonatal Voices Partnership.	

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	Assurance was provided to Board that there has been a reduction in the regional heatmap score following resolved stakeholder concerns and the Trust continues to work with specialised commissioning teams to ensure actions are in place in relation to medical staffing levels. Following a query from Paul Ennals in relation to staff morale and public perception, Karen Parker highlighted that demand for services remains high and staff remain committed and appreciated. Adam Crampsie felt that it was important to celebrate the success of the service and Helen Fox highlighted that information continues to be shared on the website outlining good patient experience. **Maternity Incentive Scheme:** Karen Parker presented the report which outlines an initial gap analysis of compliance with Year 8 of the Maternity Incentive Scheme. She explained that full compliance is required with each part of the six actions for eligibility for the Clinical Negligence Scheme for Trusts (CNST) payment however there is currently one action that the service feels may present a potential risk to compliance and leads are being identified to ensure plans are in place to meet this action. **Maternity Safety Champion Report:** Paul Ennals presented the report on behalf of Gerry Morrow which provides additional assurance to support the Maternity Integrated Oversight Report based on regular discussion with our people, patients and maternal and neonatal voices partnership (MNVP) service users. He drew attention to some of the key issues and highlighted the recognition of the burden on several ongoing regulatory reporting processes despite assurances from NHS England that this would be reduced. Karen Parker explained that this remains challenging and produces increased pressures on workloads, but work continues to ensure that the requested actions plans are developed and progressed. **Mortuary Oversight Board Assurance Statement:** Beth Swanson presented the Trust's Board Assurance Statement for submission to NHS England in response to the national requirements following the Fuller Inquiry and subsequent Ockenden report and NHS England guidance. Beth Swanson explained that a comprehensive self-assessment against the NHS-relevant Fuller Inquiry recommendations has been completed which concludes that assurance across the required domains is provided but further work is required around some of the actions and defined owners have been identified with completion dates and will be reported back to the Board in September 2026. Adam Cramspie highlighted that there is a requirement to submit an assurance statement from the Board by 31st July 2026 and it was felt that	Cycle of business

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	further discussion should take place in Part 2 of the Board to allow further scrutiny to take place. After consideration, it was: **RESOLVED:** to receive the reports for assurance. Karen Parker left the meeting.	
26/07/3c	**Nurse Staffing Exception Report:** Beth Swanson presented the report for April and May 2026 which provides assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis to provide adequate staffing levels. Beth Swanson highlighted that sustained workforce pressures continue across inpatient areas, most notably within the Healthcare Support Worker (HCSW) workforce. Registered nurse vacancy rates remain low, but HCSW vacancies remain high which is impacting the Trust's ability to consistently achieve planned staffing levels with difficulties filling HCSW bank shifts and reliance on agency usage. She highlighted that red flag reporting reduced from March and remained stable across April and May, and compliance with review and closure processes requires continued strengthening. Targeted recruitment continues, including localised recruitment approaches, bank recruitment campaigns and the Band 2 and Band 3 apprenticeship pathway has been approved and is progressing to support sustainable pipeline development. Partnership working is also in place with Derwentside College with new starters expected into the Trust in August 2026. The Board noted the positive recruitment and apprenticeship pathways and Adam Crampsie felt that it was important to do some further work around turnover rates and bank and agency usage to provide clarification around potential additional spend. Following discussion, it was: **RESOLVED:** to receive the report for information and assurance.	
Great Place to Work		
26/07/4a	**Freedom To Speak Up Guardian Report:** Tracy Healy presented the report which provides the Board with a summary of Freedom to Speak Up (FTSU) activity between January - June 2026.	

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	She reported that analysis continues to identify concerns relating predominantly to behaviours, culture, and civility across the organisation and aligns with findings from staff survey results and wider workforce intelligence. Cases continue to be raised by staff with a protected characteristic and arrangements have been strengthened with the Staff Experience and Inclusion Oversight Group being established to improve intelligence sharing, identify emerging themes, and support targeted improvement activity. There are also plans for patient safety team representation to be co-opted into the meetings to broaden representation and triangulation of data sets. Amanda Venner highlighted the work taking place to support staff with disabilities and neurodiverse conditions with manager resources in place to provide increased levels of support and potential reasonable adjustments in the workplace. Tracy Healy drew attention to the FTSU dashboard and key changes to FTSU functions following the closure of the National Guardian's Office (NGO) on 30 June 2026 with responsibility transferring to NHS England, and providers, commissioners and Integrated Care Boards taking on greater local accountability. Following a query from Gill Hunter on initiatives taking place and whether additional support from the Board was required, Tracy Healy explained that national schemes are in place and continued support to service provision within the Trust was beneficial with monthly meetings continuing to take place with key Executives. Paul Ennals reaffirmed the Board's commitment to the service and was assured that methods of escalation were in place to address concerns raised. After discussion, it was: **RESOLVED:** to receive the report for information and assurance. Tracy Healy left the meeting.	
26/07/4b	**Staff Standards and Leadership and Management Framework:** Amanda Venner informed the Board of the introduction of the NHS Staff Standards and the NHS Leadership and Management Framework and presented the report which provides a single integrated update focused on organisational culture, staff experience, leadership capability and Board assurance. She explained that many of the requirements align with existing Trust priorities and activity including leadership development, staff engagement, flexible working, health and wellbeing, violence reduction,	

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	equality, diversity and inclusion, staff survey improvement and organisational culture programmes. The staff standards will form part of the NHS Oversight Framework (NOF) rating, measured through staff survey indicators as well as forming part of the Provider Capability Assessment. An initial gap analysis has been completed which has confirmed that the Trust is in a strong position, but some gaps have been identified in relation to training relating to digital skills, research and innovation and embedding consistent and wider ranging approaches to flexible working. Amanda Venner highlighted that there are two associated initial risks – the first relating to not undertaking meaningful implementation and adoption of the standards and not using these as an opportunity to truly improve staff experience. The other risk relates to the Trust's NHS Oversight Framework rating which will include staff survey scores relevant to the staff standards. In addition the provider capability assessment will include staff experience and engagement measures which these scores currently require improvement and could further deteriorate the Trust's rating. Gill Hunter felt that it was important to ensure that the Trust's approach creates measurable positive outcomes and Adam Crampsie commented that a greater focus on revised reporting metrics needs to be considered. Amanda Venner highlighted that this will be reported via the People and Organisational Development Committee. Following a query from Andrew Besford in relation to digital training, Amanda Venner explained that further details are required however this will be available across all staff cohorts to ensure that skills can be developed. After further discussion, it was: **RESOLVED:** to receive the report for information and assurance.	
Fit for the Future		
26/07/5a	**Governance Reports:** **Organisational Risk Register (ORR):** Beth Swanson presented the updated ORR to the Board which shows the risk profile of the ORR, details of risk movements over the previous 12-month period, review compliance, and top composite organisational risks. This report covers the period 17th May 2026 to 17th July 2026. She reported that there are currently 18 risks on the ORR. Following the Executive Risk Management Group meetings in June and July 2026, there have been 8 risks added to the ORR including 2 digital risks to adopt a thematic risk approach, and 6 new financial risks in period, articulating the separation between in-year delivery versus the sustainability position. There were no escalations or reductions and 6 closures. Compliance with reviews in period remains consistent with the previous data set at 94% for risks and 91% for associated actions.	

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	Following a query from Adam Crampsie in relation to some of the risk scores being reflective of current high priority areas, in particular the risks relating to breast pathways, violence and aggression incidents, and non-compliance of fire safety standards, Sean Fenwick explained that the review of risks continues to be developed via the Executive Risk Management Group and will be discussed further. Following consideration, it was: **RESOLVED:** to receive the report for assurance.	
26/07/5b	**Finance Report:** Kris Mackenzie provided the Board with assurance against delivery of the approved 2026/27 revenue and capital plan as at 30th June 2026 (Month 3). She reported that the position does not include the Deficit Support Funding as this is being held due to the year-to-date performance being behind plan. The Trust has reported an actual deficit of £2.557m which is an adverse variance of £1.819m which is mainly due to the under achievement against the Cost Reduction Programme. Discussion will take place with the Board in Part 2 of the meeting in relation to potential further financial controls following Executive Committee and Finance and Performance Committee discussions. After consideration, it was: **RESOLVED:** to receive the Month 3 financial position and note partial assurance for the achievement of the 2026/27 planned financial targets.	
26/07/5c	**Strategic Objectives and Constitutional Standards Report:** Kris Mackenzie presented the report which provides the Board with oversight and assurance of the key performance metrics which underpin the delivery of the Trust strategy for Month 3 2026/27. She drew attention to some of the key headlines which have mainly been addressed during discussion throughout the meeting and highlighted that the main issues remain the underperformance against cancer standards and deteriorating financial position. There is evidence that improving flow and recovery interventions are beginning to generate measurable improvements across urgent care, elective recovery and length of stay. Quality indicators also remain broadly stable, with improving estates assurance.	

Gateshead Health NHS Foundation Trust

Agenda Item No		Action Owner
	Following a query from Adam Crampsie in relation to continued focus on patient flow particularly around winter plans Beth Swanson highlighted that a report will be provided to the Quality Governance Committee in relation to improvement work undertaken by the operational teams. Following consideration, it was: **RESOLVED:** to receive the report for assurance and note the key areas of improvement and challenge.	QGC cycle of business
Items for Information / Meeting Governance		
26/07/6a	**Cycle of Business 2026/27:** Jennifer Boyle presented the cycle of business for 2026/27 which outlines forthcoming items for consideration by the Board. It provides advanced notice and greater visibility in relation to forward planning, and Board members are asked to provide any feedback to ensure this is reflective of the required Board business. After consideration, it was: **RESOLVED:** to review the cycle of business for 2026/27.	
26/07/6b	**Questions from Governors in Attendance:** Paul Johnson noted the discussions around cyber security and Andrew Besford highlighted that clear government guidance was in place and Sean Fenwick explained that consideration will take place around national direction.	
26/07/6c	**Any Other Business:** There was no other business raised.	
26/07/6d	**Date and Time of Next Meeting:** The next meeting of the Board of Directors will be held at 9.30am on Tuesday 29th September 2026.	
Exclusion of the Press and Public: Resolved to exclude the press and public from the remainder of the meeting, due to the confidential nature of the business to be discussed.		

d - Action Log and Matters Arising
Presented by the Chair

Gateshead Health NHS Foundation Trust

PUBLIC BOARD ACTION TRACKER

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

Agenda Item Number	Date of Meeting	Agenda Item Name	Action	Deadline	Lead	Progress	RAG-rating
26/05/4a	27/05/2026	Organisational Risk Register and Board Assurance Framework	To bring forward discussions on risk appetite and BAF functions within the Board Development plan	29/07/2026	JB	July 26 – approach to be agreed with CEO and Chair. Action to remain open. Sept 26 – meeting arranged for 28 September – verbal update to be provided.	
26/07/2b	29/07/2026	Chief Executive's Strategic Report	To consider discussion around national reviews and key areas of learning / common themes as part of the Board Development Plan	29/09/2026	PE/JB/SF	Part of discussions as above. Sept 26 – meeting arranged for 28 September – verbal update to be provided.	
26/07/2c	29/07/2026	Digital Committee Assurance Report	To consider discussion around cyber training, risk appetite and the EPR business case as part of the Board Development Plan.	29/09/2026	PE/JB/SF	Part of discussions as above. Sept 26 – meeting arranged for 28 September – verbal update to be provided.	
26/07/2d	29/07/2026	Board Committee Terms of Reference	Increase of Non-Executive Director (NED) membership (at least two NEDs) to be standardised across all Board Committee to provide further resilience.	29/09/2026	JB	Sept 26 – terms of reference updated, as agreed by Board. Action recommended for closure.	
			Minor amendment to be made to QGC terms of reference	29/09/2026	JB	Sept 26 – wording adjustment from medical / nursing risks to clinical risks as agreed. Action recommended for closure.	

Closed Actions from last meeting

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

e - Top Organisational Risks

Gateshead Health NHS Foundation Trust

Top Organisational Risks – September 2026

The top (composite) risks were confirmed by the ERMG on 4th August 2026 as remaining the same. These are as follows:

1. **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

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

3. **Sustainability** - Risk to delivery of all key metrics included in the National Oversight Framework impacting on our strategic aims of Excellent Patient Care, Great Place to Work, Working Together for Healthier Communities and Fit for the Future.

f - Patient and Staff Story

Gateshead Health NHS Foundation Trust

Patient Story - Maternity

Gateshead Health NHS Foundation Trust

Ebere's story

- Ebere had previously experienced 2 stillbirths in her birth country of Nigeria, and one neonatal death since arriving in the UK in 2022, she has 2 living children.
- Ebere booked with her Gateshead community midwife, Joy, when she was 9 weeks pregnant.
- At booking she was very sceptical about pregnancy, and she was very closed down from her past experiences.
- Joy referred her to the obstetric team at booking, and they made a personalised and comprehensive plan of care. This offered hope and reassurance throughout Ebere's pregnancy journey.
- Ebere gave birth to a healthy baby girl at the QE in August 2026.

Gateshead Health NHS Foundation Trust

Joy's experience (community midwife)

- During her last postnatal contact, she spoke in detail about all aspects of her care and how individuals had made her feel. She cried happy tears as she expressed her gratitude. She even spoke about her previous babies, which is something she had struggled with before.

- I left feeling so proud to be part of such an amazing team and I want all of our team to know of the difference they made to this lady and her family.

- The thing that stood out the most to me, was that Ebere felt that the outcome of her pregnancy mattered as much to our team as it did to her.

- Ebere wanted a way to report her feelings. I have said I will pass this on.

Ebere's words of gratitude

Gateshead Health NHS Foundation Trust

Hello Joy,

Thanks for reaching out to me and giving me this medium to express my heartfelt gratitude to Queen Elizabeth Maternity teams for the good works they put in place to carter for people like me who was struggling at that moment to find every reason to keep fighting throughout my pregnancy.

I want to specially thank my amiable midwife Joy for her words of encouragement, Empathy, good follow up to see that I gave birth to a healthy baby without fear or doubts, the doctors I was referred to were amazing profiling different solution and procedures so I can't have a stillbirth child am really grateful you guys were part of my journey. The amazing surgical teams that took care of me, did the surgery with good and chatting environment with laughter that made every procedure successful.

I want to thank the postnatal teams especially the night staff were around the first night came in, they took care of me and made my recovery process mentally sane, taking care of my baby overnight while I have a little sleep, thanks to Maternity support workers and students nurses that help me through the process and my personal needs. My heart is full of gratitude, may you guys continue your good works in saving humanity with Empathy and compassion.

Ebere was cared for by well over 50 different members of the Gateshead team during her pregnancy, delivery and afterwards.

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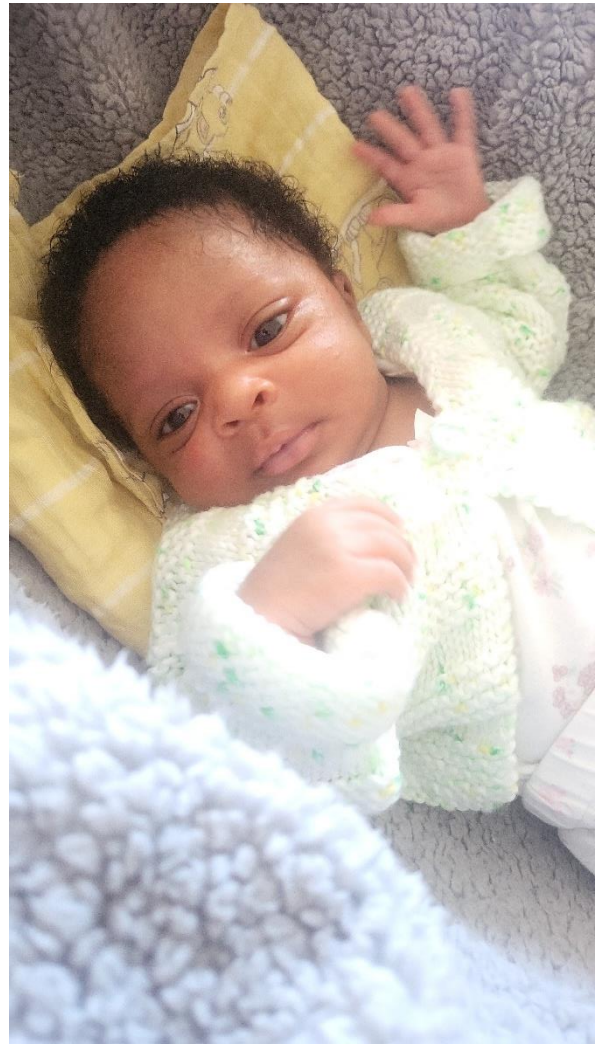
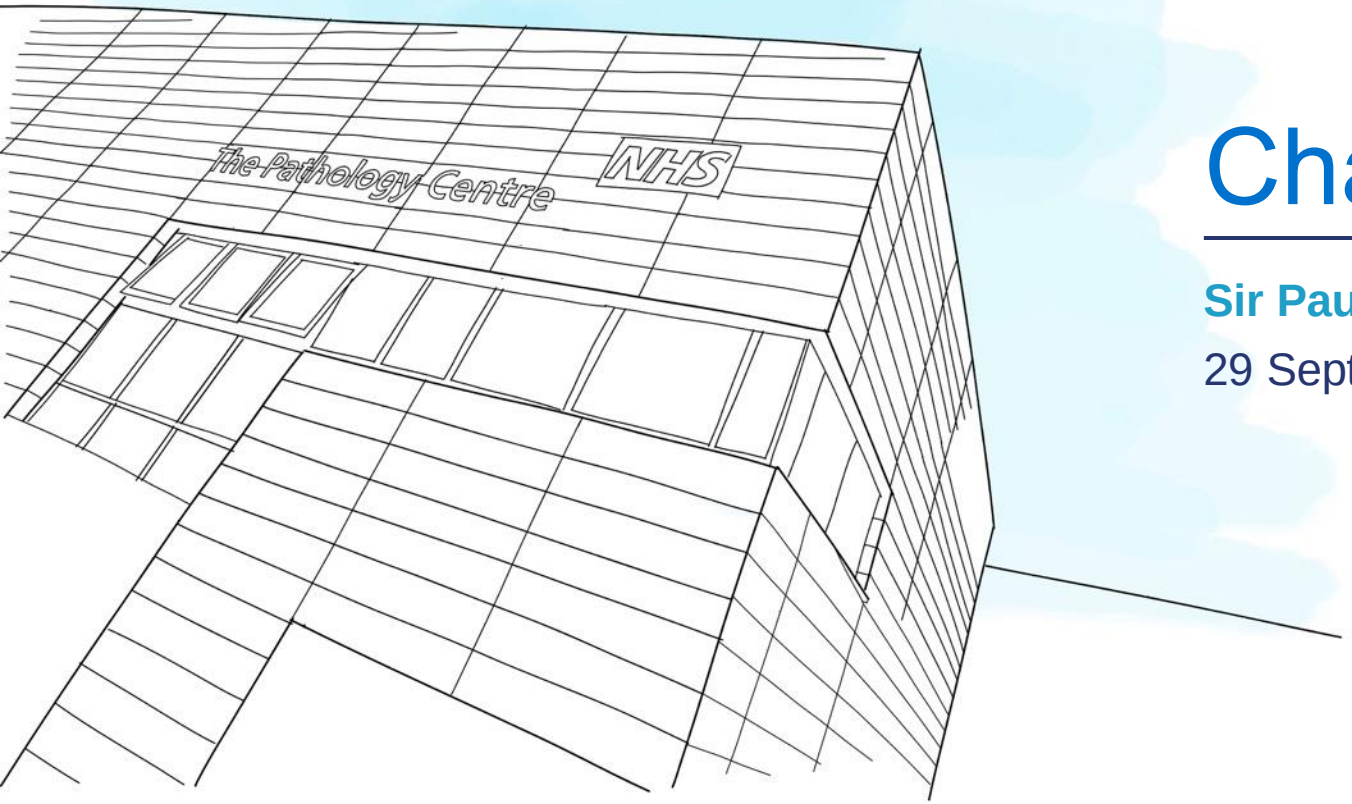


2. GOVERNANCE

a - Chair's Report

Presented by the Chair

Gateshead Health NHS Foundation Trust



Chair's Report

Sir Paul Ennals, Chair of the Board of Directors

29 September 2026

Board Updates

Non-Executive Directors

- This will be Martin Hedley's last Board meeting before he leaves the Trust to relocate to the USA. Martin has been a Non-Executive Director for just over three years. During this time he has shown great commitment to the Board including as Senior Independent Director, Chair of the Group Remuneration Committee and Chair of the Finance and Performance Committee. On behalf of the Board I wish to formally thank Martin and wish him well for his new life in the USA.
- In early September the Council of Governors appointed Debbie Francis to the role of Finance Non-Executive Director. Debbie is a qualified accountant who brings a wealth of financial and commercial experience from the rail industry, as well as Non-Executive Director experience from the NHS, education and voluntary sectors. Debbie will join the Board in October and we look forward to welcoming her to the next Board Meeting, along with Sheena Fish, the new Chief Operating Officer (as announced at the last Board meeting).

Governor Updates

Gateshead Health NHS Foundation Trust

- Since the last Board the Vice Chair and I have had several opportunities to engage with members of our Council of Governors, including monthly meetings with the Lead and Deputy Lead Governors.
- Members of the Governor Remuneration Committee have been busy over the summer months leading the recruitment of the Finance Non-Executive Director with a successful outcome.
- We continue to work proactively with the Council of Governors to explore the concept of future engagement models should the Health Bill be passed unamended in respect of Governors and members.
- I attended a recent NHS Alliance workshop for Chairs to discuss what effective local engagement and accountability might look like. The Company Secretary, Lead Governor and Deputy Lead Governor also attended similar NHS Alliance sessions with their peers. We look forward to the publication of the findings from the sessions in the autumn, but we are clear that we are proceeding with designing our own model in the interim.
- A Board workshop was held in August on the topic of future engagement. We are committed to developing a model for engagement that strengthens our patient and public involvement and supports us to improve our services for the benefit of our patients and people, whilst also maintaining the accountability that has underpinned the Foundation Trust concept.
- Company Secretaries and other colleagues across the Alliance are working together to refine a draft set of common principles and enablers, whilst also considering whether there are opportunities for aspects of the engagement models to span across several organisations in order to reflect patient pathways.
- A key aim is to develop a model which could be trialled in shadow format from early 2027 and we look forward to continuing to work collaboratively with Governor colleagues on this.

Gateshead Health NHS Foundation Trust

Other key activities

- Since the last Board meeting in July I have:
  - Met with Cllr Rachel Cabral, Appointed Governor for Gateshead Council, to welcome her as part of the induction;
  - Met with Maggie Pavlou as she takes over the role of Senior Independent Director;
  - Alongside Sean Fenwick I met with the new Leader and Deputy Leader of Gateshead Council;
  - Engaged in a collective meeting with the Vice Chairs from the three east coast Alliance trusts;
  - Chaired the August Alliance Steering Group, with key updates from the new Clinical Framework Group;
  - Worked alongside Governors to advise in a non-voting capacity on the Finance Non-Executive Director recruitment; and
  - Chaired the August Board Development session with a focus on the draft Provider Capability Assessment and future engagement models.

b - Chief Executive's Report

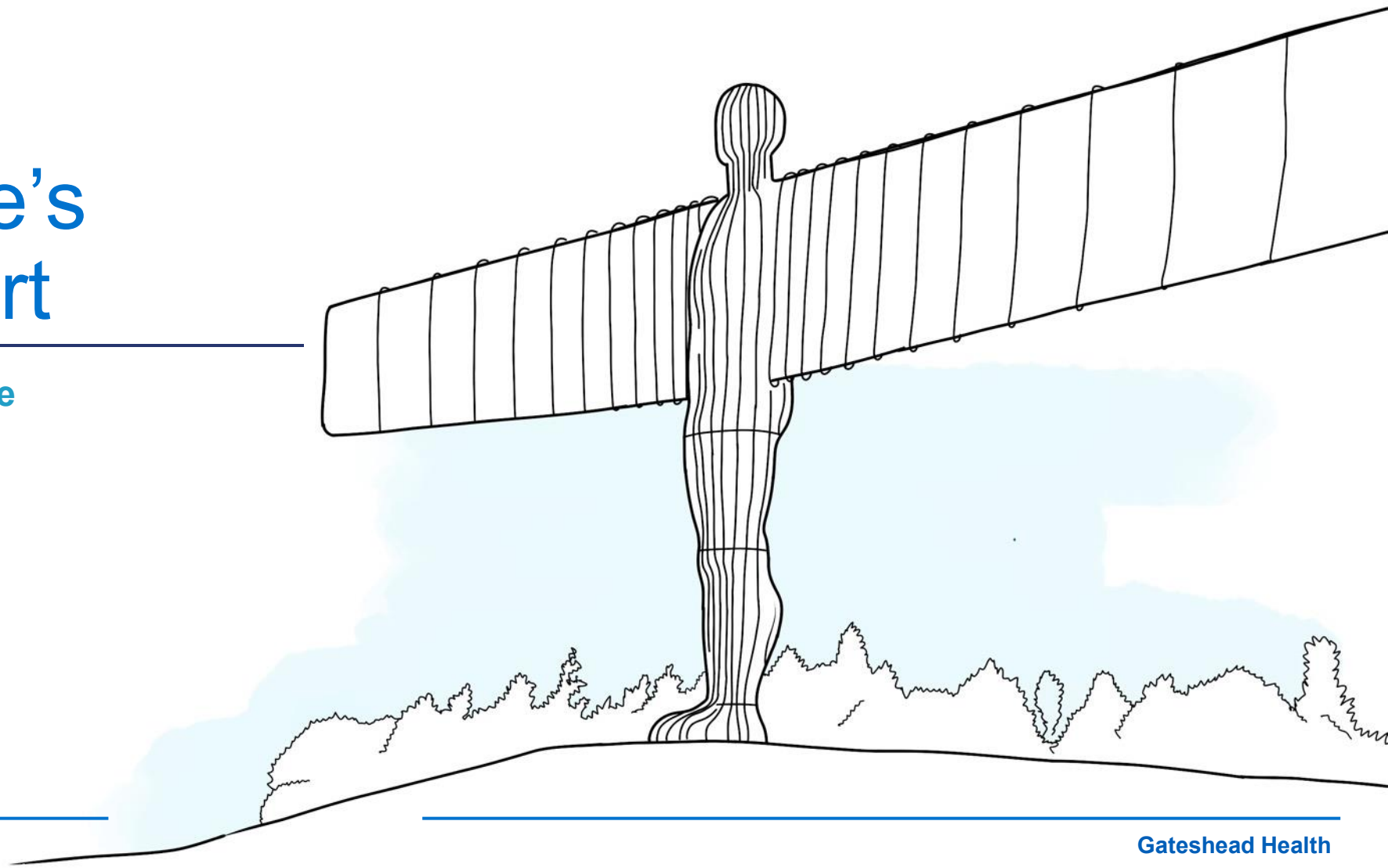
Presented by the Chief Executive

Gateshead Health
NHS Foundation Trust

Chief Executive's Strategic Report

Dr Sean Fenwick, Chief Executive

29th September 2026



Gateshead Health NHS Foundation Trust

National statistics and context

National policy, context and operating models

NHS England outlined the Maternity and Neonatal 10 Point Plan assurance process for trusts. Trusts were required to complete a baseline assessment by 25 September to support and evidence progress against the plan.

The Health Bill has recommenced its progress through Parliament following recess. Several government new clauses have been added to the Bill, including ones to restore local authority representation on Integrated Care Boards.

NHS England North East and Yorkshire is currently consulting on its regional operating framework. This is expected to be finalised in the autumn.

As part of the government's Rewiring the State announcement it was announced that Integrated Care Boards will align with the boundaries of elected mayors and combined authorities by the end of Parliament. The North East and North Cumbria ICB is working with partners to understand the national requirements and implications.

The government announced new capital funding to support a range of mental health initiatives, including increasing the number of 'mental health A&Es' and neighbourhood mental health centres.

NHS England reported that the NHS had experienced its busiest ever summer, but also that more patients than ever were seen within 4 hours in A&E.

Excellent patient care

Gateshead Health NHS Foundation Trust

- The **Thirlwall Enquiry** report has now been published. We are committed to reviewing this important report in detail and ensuring that we address relevant recommendations and learnings to support our patients, families and colleagues. The Board will be appraised of this work as it progresses. Assurance is provided to the Board that the Sudden and Unexpected Death in Children (SUDIC) protocol applies to every death (or collapse leading to death) of an infant or child under the age of 18 which would not have been reasonably expected to occur 24 hours previously and in whom no pre-existing medical cause of death is apparent, irrespective of the place of death. This includes sudden and unexpected deaths within the neonatal unit.
- Our patients rated their experience of care at Gateshead highly in the **national inpatient survey** with the Trust receiving its best ever results. Ten areas improved significantly compared with the previous year, with no areas showing a significant decline. Gateshead scored significantly better than the survey average in 34 of the 47 areas assessed, with no areas where it scored significantly worse.
    - 91% of patients surveyed rated their overall experience of care as seven out of ten or higher, up from 85% in the previous year.
    - 100% said they were treated with kindness and compassion
    - 100% said they were treated with respect and dignity
    - 99% had confidence and trust in the doctors treating them
    - 99% had confidence and trust in nurses.
    - 80% of patients said they did not have to wait too long to get to a ward bed, up from 71% in 2024.
    - 89% felt they received the right amount of information about their condition or treatment, up from 82% in 2024.

- We also performed well in the latest **National Cancer Patient Experience Survey**, with respondents rating their overall care as 9.2 out of 10. 100% of respondents confirmed their care team regularly reviewed care plan with them and 97% found the advice from their main contact person exceptionally helpful.
- Our **Special Care Baby Unit** (SCBU) has achieved Stage 1 accreditation from the prestigious UNICEF UK Baby Friendly Initiative. The SCBU team has successfully established the foundational policies, guidelines, and training frameworks necessary to ensure parents are supported to be active partners in their baby's hospital care journey, then continue to develop strong bonds with their child.
- Well done to Wendy Turnbull, Maternity Support Worker, whose vigilance and instinct when providing routine breastfeeding support identified an unwell mother who needed further assessment. Following referral to the Patient Assessment Unit (PAU) the patient was identified as having sepsis. The PAU manager contacted the Maternity team to pass on her thanks to Wendy for the excellent assessment and timely action – a reminder that our Maternity Support Workers are often the extra set of eyes that make a huge difference to the safety and wellbeing of our patients.

Great place to work

- We have strengthened their commitment to developing the NHS workforce of the future through the signing of a Memorandum of Understanding with **Derwentside College**. This formalises a successful partnership focused on creating career opportunities for local people while addressing workforce needs across the health and care sector. The collaboration has already delivered key initiatives such as the apprenticeship pathway for Healthcare Assistants.
- We are delighted that **QE Facilities** has been shortlisted in three categories at the Healthcare Estates IHEEM (Institute of Healthcare Engineering and Estates Management) Awards 2026: Porter Mark Dykes has been nominated for the Champion of Champions Award; the refurbishment of the Northern Gynaecological Oncology Centre (NGOC), Colposcopy, and Children and Young People's Departments has been shortlisted for Refurbishment Project of the Year; and the whole QE Facilities team has been shortlisted for the Estates and Facilities Team of the Year.
- Our **Decontamination team** received excellent results in two key audits, including receiving the highest level of assurance in the annual IHEEM review. This evidences the team's ongoing commitment to maintaining the highest standards of quality and compliance.
- Board Members undertook a number of visits to clinical and non-clinical areas as part of our **Walkabout Wednesdays** programme. This provides an excellent opportunity to talk informally to colleagues and receive key insights into what is working well and where we can make improvements. In July and August Board Members visited the Emergency Preparedness, Resilience and Response (EPRR) team, the complaints and PALS teams, pharmacy, digital nursing team, legal team, Ward 2 (Emergency Assessment Unit) and infection prevention and control (IPC).
- Colleagues were consistently described by the Board Members as engaged, proud and committed to patient care, and colleagues assured that they felt safe to raise concerns. Strong local leadership, teamwork and expanding professional roles were recurring positive themes.
- Key areas for follow-up include some concerns that were raised around culture in a specific area, capacity / recognition in another area, complaints accountability and timescales, better ward-level resolution for patient concerns, improved IPC data access, and continued support for digital innovation. This is really valuable feedback which we will use to drive improvements and enhancements for our patients and colleagues.

Working together for healthier communities

Gateshead Health NHS Foundation Trust

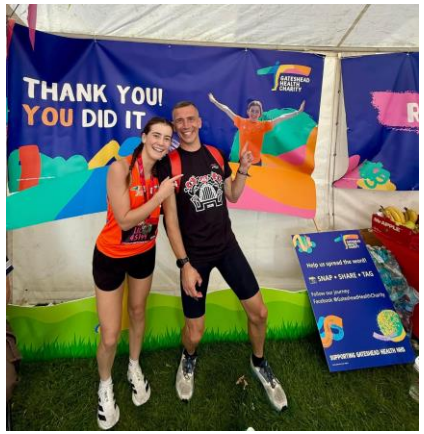
- On 22 August we hosted a **pop-up women's health hub** as part of the Beacon Lough and Wrekenton Pride in Place event. Teams offered advice, support and signposting to local services. Our QE Facilities colleagues also provided a free shuttle bus from the Beacon Lough East shops to the venue to support local people to be able to attend.
- Plans for **MetroGreen** will create a major new community around the Metrocentre, with around 1,000 new homes planned in the first phase and a much wider development expected over time. As a major local healthcare provider we are seeking involvement as a key stakeholder to be able to shape how the health needs of the new community, access to services and wider health and wellbeing are considered from the outset.
- We have reviewed how our **speech and language therapy support services** are provided to patients with Parkinson's and other conditions which may impact upon swallowing and communications. The review has helped shape changes to how support is provided in hospital and in the community, incorporating learnings from the recent pilot project. The service has already changed how referrals are triaged and how roles are organised within the team, which has helped increase capacity and reduce waiting times. The most urgent community referrals are now being seen within 10 days. As part of this work, the speech and language therapy service is developing its role in supporting swallow screening across community services in Gateshead. This will help patients with swallowing difficulties to be identified earlier and referred for assessment when needed.

Fit for the future

Gateshead Health NHS Foundation Trust

- We are delighted to have secured **£12 million** from the national Strategic Estates Safety Funding programme to modernise our **maternity and neonatal facilities**, including a new modular maternity theatre, improved infrastructure and a direct link into the main hospital. Led by QE Facilities and expected to complete in 2027, the programme will improve safety, privacy, dignity and service flow for women and families, while providing a better working environment for our people.
- Our ranking in the acute sector **NHS Oversight Framework (NOF)** league table for Quarter 1 2026/27 improved from 96th to 90th place out of a total of 134 trusts. We remain in Segment 3 of 4. The improvement in the ranking is positive but there is more to do. Our focus remains on improving our operational performance and financial position whilst continuing to provide safe, high-quality services for all.
- At Gateshead and across the NHS we are planning for **winter**. We have met with the Integrated Care Board to provide assurance over our plans and we are engaged in regional planning. The winter plan is presented for Board approval as part of today's Board meeting.
- Waiting times within **breast services** continue to improve, although work remains to reduce waits further and make sure that patients referred to the service receive assessment and treatment as quickly as possible.
- On 14 August we experienced a power outage across the QE site caused by a fault on high-voltage underground cables. Teams across the Trust and QE Facilities worked exceptionally hard to maintain high standards of patient care and support one another during the incident, which happened on one of the hottest days of the year. On behalf of the Board we thank all colleagues for their dedication, patience and professionalism during this difficult incident.

Gateshead Health Charity – Great North Run 2026



99 runners for Gateshead Health Charity raised more than £36,000 by completing the Great North Run, Junior and Mini Great North Runs. Congratulations and thank you!

c - Assurance from Board Committees

i) Finance and Performance Committee - August and September 2026 - presented by the Chair of the Committee

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

iii) People and Organisational Development Committee - September 2026 - presented by the Chair of the Committee

iv) Group Audit Committee - September 2026 - presented by the Audit Committee Chair

Gateshead Health NHS Foundation Trust

3A Escalation and Assurance Report

Name of Committee / Group:	*Finance and Performance Committee*
Date of Committee / Group:	*25 August 2026*
Chair of Committee / Group:	*Adam Crampsie*

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

- **CRP:** The committee remains concerned about the gap in relation to CRP delivery. There is a mitigation plan for the current year, but this will not mitigate the underlying position.

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

The following advisory items were identified:

- **Breast/Cancer Recovery:** A detailed update was received by the Committee and assurance provided that a recovery plan is in place.
- **QEF financial Recovery Plan:** The committee received a report on the recovery plan with information provided on plans to address the gap in CRP. The scheduled QEF finance report is due to be reported to the September meeting.
- **Procurement Processes in High Spend Areas:** A more detailed report was provided to follow the report received at the last meeting. The Committee received good assurance that procurement processes are compliant but identified a need for a wider discussion around risks and value for money.
- **CDC Phase 2:** There are delays in the project, but some expected asks will be coming through to the Board in September.
- **Flow and Discharge:** Plans are in place to improve flow and discharge but there is a need to see positive improvements coming through.
- **Finance Controls:** Weekly reporting is taking place, and this information is helpful.
- **Capital programme:** The Trust is still awaiting confirmation from NHSE on a number of externally funded schemes.

Gateshead Health NHS Foundation Trust

- **Productivity:** The Committee welcomed the new standing report on Productivity as a useful paper with a need to consider how this can be developed to provide assurance in relation to CRP, productivity and opportunities for the future.

- **AuditOne Reports –** partial assurance received on the Trust Cost Improvement Governance Process audit.

Assure
(key assurances received and any highlights of note)

The Committee received the following assurances:

- AuditOne Reports
- Premises Assurance Model Return
- Performance:
  - Cancer performance 31-day position ranked between 1 and 50 in national benchmarked data.
  - RTT Position
  - Diagnostics DM01

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

- No new risks were identified.

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

- No Cross Referrals

Gateshead Health NHS Foundation Trust

Committee Escalation and Assurance Report

Name of Board Committee	Quality Governance Committee
Date of Board Committee:	12 August 2026
Chair of Board Committee:	Gerry Morrow

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

- **Healthcare-associated infection (HCAI) Performance -** To remain as an alert as no improvement has yet been reported and some gaps in assurance were identified, although progress has been reported on actions to improve processes.

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

- **Maternity -** ANNP recruitment remains an issue.
- **Martha's Rule** – an update to be provided to the next meeting. Progress is continuing but reporting has been delayed due to staff sickness. Some concern raised about single point of failure issues.
- **Cross Referral – Breast and Urology performance -** A cross referral had been received from the Finance and Performance Committee in relation to cancer performance and harm. The Committee has requested a report to the next meeting on the process for assessing harm for both breast and urology services.
- **Complaints** – concern that issues continue in relation to the timeliness of complaint responses and outstanding complaints with a need to review the policy and compliance with the policy.

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

Positive assurances were agreed in relation to:

- Discharge and Flow
- EQIA flow chart
- Health Inequalities
- EPRR Core Standards
- Parkinson's Service Evaluation Report
- QEF Health and Safety reports
- Patient Experience – strong position from recent surveys

Risks (any new risks / proposed changes to risk scores)
• There were no new risks identified.
Cross-referrals (by exception only)
• There were no cross referrals

3A Escalation and Assurance Report

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

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

No alert items identified

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

1. **Guardian of Safe Working** – Recruitment is taking place for a Guardian of Safe Working along with a Resident Doctor Peer Lead. The findings of the most recent report of the Guardian of Safe Working needs further review – the report offers valuable insight but not all of the recommendations will be suitable for adoption. The quarter 2 report will incorporate quarter 1 data to enable trend analysis and provide further insight into staff experience and the reasons behind exception reporting.

2. **Staff Survey** – There is a need to strengthen local ownership and accountability for staff survey outcomes at all levels of the organisation, ensuring that actions are led and delivered within services as well as through corporate programmes.

3. **EDI Update** – Four strategic priorities identified for 2026-27 to allow a more focussed approach to EDI, setting a clear direction of travel. The paper was well received but focused work is now needed on these priorities to be able to see and feel the impact of the actions taken.

4. **Midwifery, Maternity and Neonatal Workforce Report** - To note the alert in relation to neonatal nursing workforce fragility, acknowledging work already underway to address.

5. **Violence and Aggression** – highlighted as an alert at the last meeting. Verbal update provided on actions being taken forward and a more robust update will be brought to the next Committee.

6. **Overpayments** – Highlighted as an advisory item by the POD Steering Group. The Group expressed concern regarding both the financial implications for the Trust and the potential adverse impact on employees' financial wellbeing and experience. Whilst recognising that overpayments cannot be entirely eradicated

the need to implement and maintain robust controls remain a priority area for improvement and assurance.

7. **Governance Alignment** – Discussed the need for ensuring clear alignment and connectivity of issues across the Triple A reports from the Committee and the POD Steering Group to strengthen organisational oversight and assurance arrangements. Proposal to ensure that any 'Alert' items should be on the POD Steering Group Agenda in future as well as a review of the advisory items to assess if they also need to be included. This is something that may need to be considered across all Committees.

8. **Communication/engagement** – issues in relation to communications have been raised across a number of areas, not just POD Committee. This will be considered via the Executive Committee.

Assure
(key assurances received and any highlights of note)

9. **People Chapter of the Corporate Strategy** – Progress made against strategy over the past 6 months noted. Agreement for future reporting to incorporate clearer milestones and trajectories to strengthen oversight of delivery, demonstrate the progress being made and support RAG-rated performance monitoring.

10. **NHS England Workforce Training and Education Annual Quality Report** – A positive report received showing Gateshead as a training provider of choice. This is the formal outcome that follows on from previous discussions and feedback on the work undertaken.

11. **WRES and WDES** – Annual reports and action plans approved for publication.

12. **Nursing and Midwifery Job Profiles** – Delivery plan submitted to NHS England in line with national requirements, demonstrating progress made to date.

13. **Nuse Staffing Report** – staffing establishments are being monitored, and mitigations are in place and action to address HCA vacancies is progressing. Although gaps remain in the HCA workforce, these have been reducing month on month for the past 3 months.

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

No new risks to add.

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

No cross referrals

Gateshead Health NHS Foundation Trust

Committee Escalation and Assurance Report

Name of Board Committee	Group Audit Committee
Date of Board Committee:	1 September 2026
Chair of Board Committee:	Rob Hughes

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

- **Internal Audit Actions** – The Committee expressed concerns around general KPIs and the high number of overdue actions outlined in the report. It was acknowledged that an Internal Audit Control Environment/process document had been presented to the Committee and endorsed, but assurance on the sustained impact of this is needed.

- **Do Not Attempt Cardio Pulmonary Resuscitation (DNA CPR) Actions Update** – a report was not made available to the Committee at this meeting so the Committee could not be assured that actions are complete.

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

- **Internal Audit Progress Report** – The report included four final reports with a reasonable assurance rating. The Committee noted a level of concern regarding the Pathology IT audit and was assured that the detailed findings and recommendations would be reviewed and monitored by the Digital Committee. The proposed changes to the Audit Plan were approved.

- **Executive Risk Management Group (ERMG) –** The Committee received assurance on the work of the ERMG and noted the improved position in relation to risk review and action compliance which were all at 100% for July and August. There is further work needed to review the organisational risk appetite.

- **Board Assurance Framework (BAF)** – it is recognised that ongoing work is in progress to improve the effectiveness of the BAF.

- **Failure to Prevent Fraud Self-Assessment Action Plan** – The Committee noted the proposed strategic workstream approach but requested clearer information on what good would look like. There is also a need to extend this work to cover the new

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corporate criminal offence outlined in the Crime and Policing Act 2026. It was agreed that an update would be provided to the next meeting in December.

- **2025-26 National Cost Collection Assurance Report** – The Committee received assurance of compliance with the 2025-26 approved costing guidance. There is increasing visibility of cost information across the Trust. The report set out some areas of non-compliance with the healthcare costing standards particularly in relation to governance and usage.

- **Counter Fraud Investigation Conclusion** – report to be submitted to Board for information.

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

- **Internal Audit Control Environment –** The Committee endorsed the Audit and Counter Fraud Management Framework and will keep a watching brief as this is implemented (linked to the alert regarding Internal Audit actions).

- **Internal Audit, Counter Fraud, External Audit and Audit Committee Effectiveness Reviews** – positive assurance was provided by these reviews. The Audit Committee approved minor amendments to the terms of reference, which are recommended to Board for ratification.

- **Schedule of Losses and Special Payments** – these were approved.

- **Appointment of External Auditors** – a verbal update on the process was provided for assurance.

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

There were no new risks.

Cross-referrals to Tier 1 Board Committees

There were no cross referrals

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

NHS Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 2d

Report Title:	**Board Committee Terms of Reference**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29 September 2026			
Author:	Jennifer Boyle, Company Secretary			
Sponsor:	Chairs and Executive Leads for the Board Committees			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☐	**Information:** ☐
	To ratify the terms of reference for the Joint Audit Committee			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Group / Joint Audit Committee – September 2026			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	The Audit Committee reviewed and approved its terms of reference as part of the annual effectiveness review. A copy of the review of effectiveness is available in the supplementary information pack accompanying the Board papers. A copy of the proposed terms of reference is appended to this paper with the changes highlighted. Key updates to terms of reference include: • Adjustments to membership and attendees – for example to include the Deputy Director of Finance as an attendee; • The Trust and QE Facilities are moving to the use of the word 'joint' rather than 'group' to denote meetings or arrangements which involve both organisations – it is therefore proposed to amend			

Gateshead Health NHS Foundation Trust

	the title of the committee from Group Audit Committee to Joint Audit Committee; and
	• Minor updates to wording and terminology – not considered to be material.
	
	<u>Updates to other terms of reference</u>
	
	• As outlined at the July Board meeting the Chair has reviewed and revised the Non-Executive Director (NED) membership of committees.
	• For some committees this has increased the number of NED members overall.
	• The Board ratified the full terms of reference for the Finance and Performance Committee and Quality Governance Committee at its meeting in July (with the timing of this meaning that changes in NED numbers were reflected in these versions).
	• Other changes in NED members were as follows:
	  • Digital Committee – an increase from 2 to 3
	  • People and OD – an increase from 2 to 4
	• To be pragmatic it is requested that the Board provides approval to reflect these changes in the terms of reference (rather than presenting the full terms of reference back to the Board for this purpose).

Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Group / Joint Audit Committee recommends the appended terms of reference for ratification by the Board. The Board is requested to provide the Company Secretary with delegated authority to make the required adjustments to the membership sections of the Digital Committee and People and OD Committee terms of reference to reflect the outcome of the Chair's committee membership review.
Trust strategic priorities that the report relates to:	☒ Excellent patient care ☒ Great place to work ☒ Working together for healthier communities ☒ Fit for the future
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	Collectively the Board Committees (Tier 1) support the Board in ensuring that there is effective assurance, accountability, risk management and decision-making in

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	place. Well-governed Board committees ultimately support the achievement of the strategic objectives.				
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	-				
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

NHS Gateshead Health NHS Foundation Trust

Committee

Terms of Reference

NHS Gateshead Health NHS Foundation Trust

QE Facilities Professional, Proud and Passionate

Joint Audit Committee

Constitution and Purpose – The Joint Audit Committee (thereafter referred to as the Audit Committee) is a formal committee of the Board with delegated responsibility to conclude upon the adequacy and effective operation of the organisation's overall internal control system including an effective system of integrated governance and risk management.

It provides a form of independent check upon the executive arm of the Board. The Audit Committee is a Joint Audit Committee, overseeing the controls, governance and risk environment of Gateshead Health NHS Foundation Trust and QE Facilities.

In this document the use of the term 'joint' shall mean Gateshead Health NHS Foundation Trust and QE Facilities.

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

Date Adopted / Reviewed	September 2026
Review Frequency	Annually
Review and approval	Group Audit Committee – September 2026
Adoption and ratification	Gateshead Health NHS Foundation Trust Board – September 2026 (TBC)

Membership	The Committee shall be appointed by the Trust Board and shall consist of: • 4 Non-Executive Directors

	At least one Audit Committee member should have recent and relevant financial experience and this person should chair the Committee. A Non-Executive Director shall be nominated as Vice Chair for a specific Committee meeting should the Chair be absent.
Attendance	The following are also invited and expected to attend all Audit Committee meetings: • Group Director of Finance and Digital • QEF Director of Finance • Chief Nurse • Company Secretary • ~~Assistant Director of Finance~~ Deputy Director of Finance • A representative of Internal Audit • A representative of External Audit • A representative of the Counter Fraud The Chair of the Trust shall not chair or be a member of the Committee, but can be invited to attend the Committee as required. The Accounting Officer (Chief Executive) should be invited to attend the meeting that considers the draft Annual Governance Statement and the Annual Report and Accounts and should discuss the process for assurance that supports the Governance Statement. All invited attendees, if they cannot attend, should ensure a deputy attends in their absence. Other Executive Directors and Senior Managers may be invited to attend meetings depending upon the issues under discussion.
Meeting frequency and quorum	Meetings shall be held **no less than five times per year** (including the meeting held to review and make recommendations relating to the Annual Report & Accounts) and as required by the national regulatory timetable. Meetings shall be held at such a time that supports the timely flow of assurance and items for escalation to the Gateshead Health NHS Foundation Board of Directors. To be quorate there should be at **least 2 Non-Executive Directors** present. The Committee reserves the right to pragmatically invite

	other Non-Executive Directors (excluding the Chair) to attend for a single meeting in order to achieve quoracy if the lack of quoracy is short term / short notice. The external and internal auditors shall be afforded the opportunity at least once per year to meet with the Audit Committee without Executive Directors present. Members of the Audit Committee shall meet at least once a year without Executive Directors present. Members of the Audit Committee will meet with the Chief Executive at least once a year.
Meeting organisation	The Committee shall be supported administratively by the Corporate Management Team secretarial body. In accordance with the Trust's Standing Orders, **papers will be circulated to members and attendees six days before the meeting.** Minutes of the Committee's meetings are held by the Corporate Management Team secretarial body and are circulated (alongside the agenda for the following meeting), to members and attendees.

Committee duties and responsibilities	
Internal control and risk management	To ensure the provision and maintenance of an effective system of **financial risk identification and associated controls, reporting and governance**. To maintain an **oversight of the general risk management structures, processes and responsibilities**, including the production and issue of any risk and control-related disclosure statements. The Executive Risk Management Group will support the flow of risk management assurance to the Joint Audit Committee. To **review processes to ensure appropriate information flows to the Joint Audit Committee** from executive management, the Executive Risk Management Group and other board committees in

	relation to the trust's overall internal control and risk management position. To **review the adequacy of the policies and procedures in respect of all counter-fraud work**. The Committee must satisfy itself that adequate arrangements are in place to counter fraud and consider and agree the Annual Counter Fraud Plan and the results of counter fraud work. To review the **adequacy of the arrangements by which staff may, in confidence, raise concerns** about possible improprieties in matters of financial reporting and control or any other matters of concern. To review the **adequacy of underlying assurance processes indicating the degree of achievement of corporate objectives** and the effectiveness of the management of principal risks via the Board Assurance Framework. To review the **adequacy of policies and procedures** for ensuring **compliance with relevant regulatory, legal and conduct requirements**.
Financial reporting	The Committee shall **review the Annual Report and Financial Statements** before submission to the Board in order to determine their completeness, objectivity, integrity and accuracy. The review should particularly focus on: • The contents of the Annual Report and Accounts and **Annual Governance Statement** and other year-end disclosures / reporting including the Corporate Governance Statement and self-certifications. • Changes in, and compliance with, the accounting policies and practices and estimation techniques. • Unadjusted mis-statements in the financial statements. • Major judgemental areas. • Significant adjustments resulting from the audit. • Letters of representation. • Explanations for any significant year on year movements. The Committee shall also ensure that the **systems and processes for financial reporting** to the Board, including those of budgetary

Gateshead Health NHS Foundation Trust

	control, are subject to review as to **completeness and accuracy** of the information provided to the Board. This includes seeking assurance that controls and processes are in place to enable the Trust to utilise the outputs of the annual reference cost exercise to identify efficiencies and promote value for money. The Committee shall review the **QE Facilities year-end accounts** in conjunction with the work and opinion of external audit. The Committee shall review the **Charitable Funds accounts** in conjunction with the work and opinion of external audit.
Internal Audit	To **review and approve the approach adopted by Internal Audit and the Internal Audit annual plan**, ensuring that it is consistent with the needs of the organisation. To oversee on an on-going basis the **effective operation of Internal Audit** in respect of: • Adequate resourcing and has appropriate standing within the Trust; • Its co-ordination with External Audit to optimise the use of audit resources; • Meeting relevant internal audit standards; • Providing adequate independence assurances; • Meeting the Public Sector Internal Audit Standards 2017; and • Meeting the internal audit needs of the Trust. To **consider the major findings of internal audits undertaken** and management's response and their implications and monitor progress of the implementation of agreed recommendations. To consider the **provision of the Internal Audit service and the cost** of the service. To conduct an **annual review** of the Internal Audit function, seeking feedback from Committee members / attendees, Internal Audit and other Trust personnel involved in audits during the year
External Audit	The Committee will **agree with the Council of Governors the criteria for appointing, reappointing and removing auditors**. The Audit Committee should make recommendations to the Council of

Governors in relation to the appointment, re-appointment and removal of the External Auditor alongside the remuneration and terms of engagement.

The Committee shall review and monitor the external auditors' **independence and objectivity and the effectiveness** of the audit process.

The Committee shall **review the work and findings of the External Auditor** appointed by the Governors and consider the implications and management's responses to their work and monitor progress of the implementation of agreed recommendations.

Consider the performance of the External Auditor and **report at least annually to the Council of Governors on the continued adequacy or otherwise of the appointed auditors**, including recommendations for the tendering of External Audit services. A review of effectiveness will include seeking feedback from Committee members / attendees, External Audit and other Trust personnel involved in the audit during the year.

The Audit Committee will **discuss and agree** with the External Auditor, before the audit commences, of **the nature and scope of the audit** as set out in their Annual Plan, and ensuring co-ordination, as appropriate, with other External Auditors in the local health economy.

Discuss with the External Auditors of their **evaluation of audit risks** and assessment of the Trust in line with the tendered audit fee and agreement of any additional work and fees.

Review all External Audit reports, including agreement of the annual audit letter before submission to the Gateshead Health NHS Foundation Trust Board or QE Facilities Board (as appropriate) any work undertaken outside of the annual audit plan, together with the appropriateness of the management responses.

Develop and implement a policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance and National Audit Office requirements regarding the provision of non-audit services by the external audit firm (noting that assurance work on the Quality Report is classified

	as a non-audit service but excluded from non-audit service cap threshold set by the National Audit Office).
Counter Fraud (CF)	The Committee shall ensure that there is an **effective Counter Fraud function** established by management, which meets the standards of NHS Counter Fraud Authority. This will be achieved by: • The provision of the CF function. • Review and approval of the CF Annual Plan. • Consideration of the major findings of CF work and fraud investigations, management's response and progress of the implementation of agreed recommendations. • Ensuring that the CF function is adequately resourced. • Receiving a copy of the completed Counter Fraud Functional Standard Return (CFFSR) for awareness and to demonstrate consistency with counter fraud updates from throughout the year. • Annual review of the effectiveness of the CF function.
Regulatory and governance	Review on behalf of the Foundation Trust Board of Directors the operation of, and proposed changes to, the **Standing Orders** and **Standing Financial Instructions**, the **Constitution** and the **Scheme of Delegation**. The Committee will make recommendations to the Foundation Trust Board regarding the adoption of proposed amendments. To review reports outlining identified instances of non-compliance with these core documents, providing assurance over any corrective actions taken. To **review the findings of other significant assurance functions**, both internal and external to the organisation and consider the implications to the governance of the organisation, where the review is not covered by another Board Committee. The Committee shall receive and review the **schedules of losses and special payments** and authorise the Chief Executive and Group Director of Finance to approve any write-offs / special payments.

	On an annual basis the Committee shall receive and review a comprehensive **litigation register**, detailing cases and claims from across all subject areas (including for example patient / quality, people and health and safety). The Committee will seek to **satisfy itself that the Tier 1 Board Committees are operating effectively**, seeking and obtaining appropriate levels of assurance and identifying emerging risks from the business transacted. Assurance will be obtained via: • Review of the **Board Assurance Framework** on a bi-annual basis as part of the wider risk management reporting; • Review of the controls and processes for the development and delivery of the **clinical audit programme** (whose content and outputs are monitored by Quality Governance Committee); and • Access to the **Tier 1 Board committee effectiveness reviews** conducted annually, for information and assurance only (noting that they are also presented to the Board of Directors).

Reporting and monitoring	
Sub-groups	The following sub-groups report into the Committee: • Executive Risk Management Group (via the Executive Committee) The summary of assurances and escalations document are received by the Committee as part of the flow of assurance through the Trust's governance structure.
Board reporting	An assurance report from the Committee will be presented by the Chair to the next meeting of the Foundation Trust Board of Directors. Where items considered at the Committee pertain to QE Facilities and require further action, a separate cross-referral will be

	submitted to the QE Facilities Board of Directors for consideration (~~with the Non-Executive Director holding a dual role on Group Audit Committee and QE Facilities Board able to facilitate this~~).
Monitoring	Compliance with the terms of reference will be reviewed via an annual self-assessment. This will inform any proposed revisions to the terms of reference and the cycle of business. The outcome of the effectiveness and terms of reference review is presented to the Foundation Trust Board of Directors following considered by the Committee. This will also be shared with the QE Facilities Board of Directors. The Gateshead Health NHS Foundation Trust Annual Report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee considered in relation to the financial statements and how they were addressed.

3. EXCELLENT PATIENT CARE

a - Winter Plan

presented by the Chief Executive

NHS Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 3a

Report Title:	**Winter Plan 2026/27**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29 September 2026			
Author:	Joanna Clark, Director of Operations Mark Dale, Assistant to the COO			
Executive Sponsor:	Carmen Howey – Medical Director			
Report presented by:	Joanna Clark – Director of Operations			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☐
	This report provides the overview of the winter plan for 2026-27 and seeks to obtain endorsement of the Board Assurance Statement.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by:	Internal Winter Oversight Group members (September 2026) External System Resilience Group members (September 2026) Executive Committee (September 2026)			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	As a reminder, Gateshead Health expects **significant winter pressures** due to: • Increased patient demand with an inability to match capacity without additional actions • Infectious disease outbreaks which reduce patient flow and increase length of stay • A need to maintain elective care • Financial constraints • Increased focus on patient safety and use of temporary escalation spaces **Overview of winter planning approach** Our winter plan approach 2026-27 at Gateshead Health aims to ensure timely access to appropriate care and treatment for all our patients and carers. The planning has been developed with the oversight of the national and local context that has been factored into our approach, with engagement from system partners.			

The Group Medical Director is the identified **Executive accountable for the winter period** who has ensured mechanisms are in place to keep the Board informed on the response to pressures. The **strategic winter lead** is the Director of Operations for Medicine and Community supported by the Assistant to the COO.

The requirements for meeting the challenges of winter are dynamic and iterative. To complement the Strategic Winter overview, an **internal Winter Tactical Plan** has been developed for 2026-27 that sets out the framework within which operational principles and processes will be implemented, and how any surge or extreme activity is effectively managed.

The internal Winter Tactical Plan is a key part of our planning to meet the challenges that the winter months bring. Working in conjunction with Gateshead Place, we are seeking to ensure that our operational teams are prepared for the challenges of winter 2026 - 27 and have a menu of tactical options that include:

- **Occupancy and Discharge:** Joint plans with system partners to support discharge seven days a week, admission avoidance through SDEC, Virtual Wards and Frailty Services, and the management of activity during Bank Holidays.
- **Capacity:** Rotas have been reviewed to ensure the appropriate skill mix is available to meet demand. This will support the delivery of care within four and 12 hours, the maintenance of RTT performance and the provision of an Urgent Community Response.
- **Flow and Ambulance Handovers:** The Trust has detailed SOPs, supported by appropriate staffing and operational management arrangements, are in place to ensure this is sustained.
- **Infection Prevention and Control (IPC):** Appropriate plans are in place to manage infection risks, with these plans approved by the DIPC.
- **Leadership and Grip:** Appropriate on-call arrangements, OPEL levels and mutual aid arrangements are in place and have been reviewed to ensure they remain appropriate throughout the winter period.
- **A winter testing plan** to identify respiratory viruses**,** a **clinical risk assessment** template to assess and isolate any infectious patients, an **isolation hierarchy** to prevent unnecessary spread of infection and a robust and a clear **cleaning methodology**.

- A **vaccination campaign** that will focus on providing flu vaccinations across the workforce with a key focus on improving uptake rates. Robust clinical led focus on vaccination delivery across all staff will be offered with a regionally wide communications campaign and an oversight of uptake data scrutinised to monitor uptake and improvement.

- An **internal and external exercising and testing schedule** is in progress to stress test plans, and a regionally led winter testing exercise was held in September 2025.

- The **internal Winter Oversight Group**, chaired by the Director of Operations for Medicine and Community, will oversee all key influencing factors and activity levels to ensure actions and resources are optimised and patient safety is maintained throughout the winter period.

- A **winter communication plan** with a clear internal focus on productive messaging supporting the regional campaign and alignment with partners within the Great North Healthcare Alliance to align messaging.

- **Workforce planning** is ongoing to review staffing rosters (medical, nursing and allied health professionals) across the winter period and in the event of a surge ward area being required. This will be informed by predicted surge and extremis planning in the first instance and planning for bank holiday periods.

System collaboration and governance
The requirement for system collaboration & governance is a key component of our winter planning and will be monitored through a number of governance channels:

- the regional NENC ICB winter assurance and delivery group chaired by the Medical Director for the NENC ICB
- the Great North Healthcare Alliance LADB (formerly North LADB) chaired by the Group Chief Operating Officer, Gateshead Health
- the Gateshead Winter System Resilience Group chaired by the Director of Operations, Medicine and Community, Gateshead Health

Board assurance & national requirements
There were a number of actions required by the Trust

- Submit a draft winter plan to the NENC ICB by 30th September
- Participate in an NHS England-hosted stress test in September 2026 based on the draft plans (**due 17th September)**

	• Mature and finalise the Gateshead Winter Plan for presentation at the September 2026 Trust Board – **completed, overview provided within this report** • Ensure staff vaccination programmes and preparatory actions are underway – **planned and in progress** • Submit a Board Assurance Statement signed by the CEO and Chair by 30 September 2026 following Board review of the final winter plan – **attached as appendix 1.** Note that the Equality and Quality Impact Assessment (EQIA) referenced in the Board Assurance Statement is available as part of the supplementary information pack accompanying the Board papers.
Recommended actions for this meeting:	The Trust Board is requested to review the approach to winter planning, confirm that it offers the necessary assurance and endorse the Board Assurance Statement (BAS)

Trust strategic priorities that the report relates to:	☒	Excellent patient care
	☐	Great place to work
	☒	Working together for healthier communities
	☒	Fit for the future

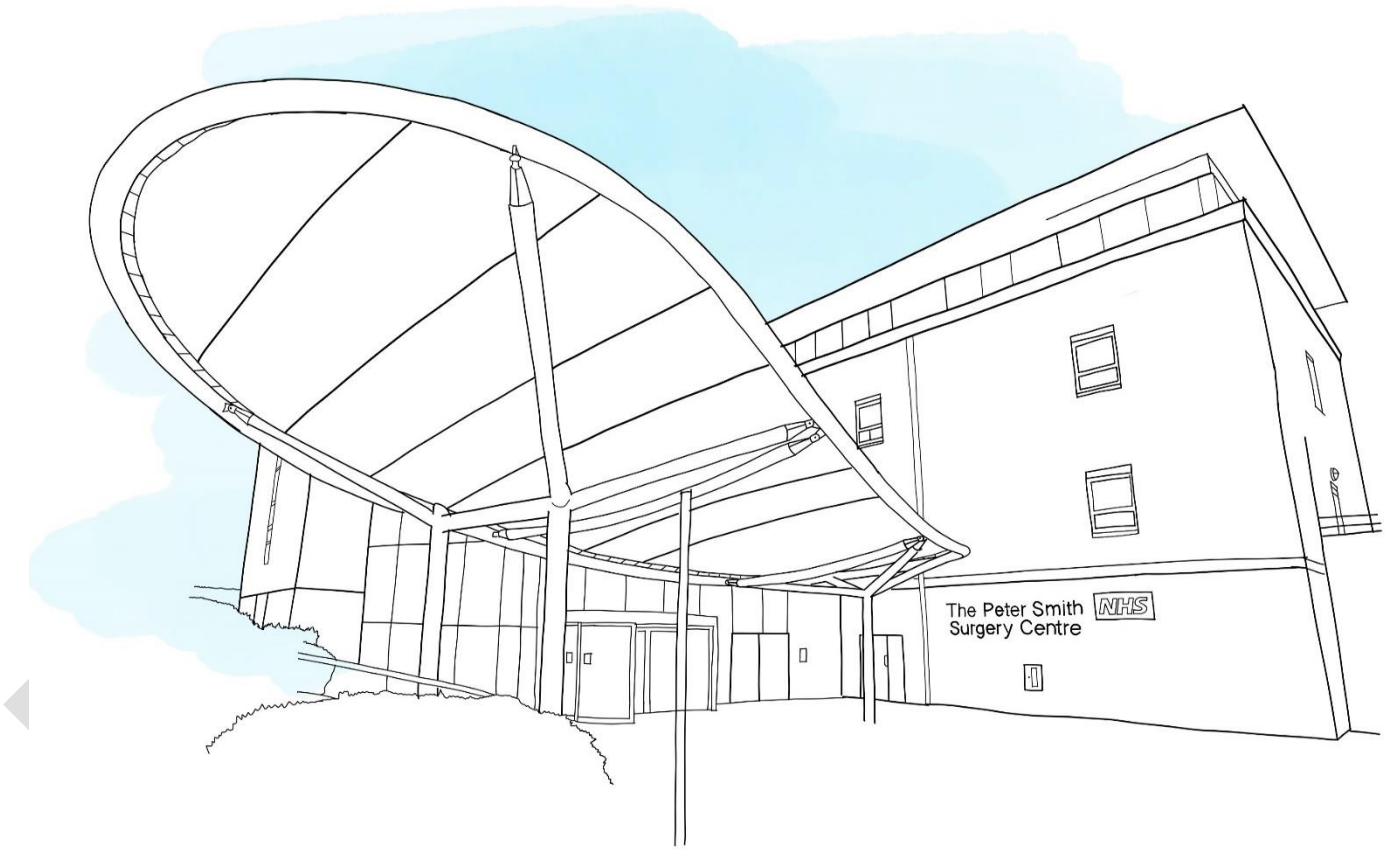
Trust strategic objectives that the report relates to:					
Links to CQC KLOE	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒

Risks / implications from this report (positive or negative):			
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	There is an organisational risk (ref 4768) which is currently at 16. There are several risks that are factors to the successful delivery of the winter plans that may impact the trust concurrently. This will be linked to the overarching risk and will influence the summary risk score accordingly.		
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☒	**No** ☐	**Not applicable** ☒

Gateshead Health
NHS Foundation Trust

Winter Tactical Plan 2026-27

September 2026



Version 1.0
Gateshead Health Internal Winter Oversight Group
Published: XXXX
Review on a monthly basis

Table of Contents

Version Control

Version	Release	Author/ Reviewer	Ratified by/Authorised by	Date	Changes (Please identify page no.)
1.0	5 August 2026	Internal winter oversight group	Internal winter oversight group	5 August 2026	First draft of plan
2.0	6 September 2026	Director of Ops Medicine, Assistant to COO, Chief Pharmacist, Pathology Service Manager, IPC Manager	Informal Execs	6 September	Updated full plan with all relevant updates included.
3.9	16 September	Internal Winter Oversight Group	IWOG	16 September	
3.0	17 September 2026	Executive Committee	Executive Committee	17 September 2026	Updated full plan for ratification
4.0					

1. Approach to Winter 2026 - 27

The Internal Winter Tactical Plan forms a key part of Gateshead Health's planning to meet the challenges presented by the winter months. Working collaboratively with partners across Gateshead and the wider system, the Trust will ensure that its operational teams are prepared to respond effectively to periods of pressure, surge and extremis.

Throughout the winter period, prediction information and available data will be regularly reviewed and modelled to support the identification of emerging risks and inform the appropriate operational response.

1.1 National Context

A number of supporting documents have been produced during 2026 to assist organisations in managing the challenges of Winter 2026/27. These identify three key pillars for the coming winter:

1. Implementation of the Model Emergency Department requirements
2. Implementation of the Model Acute Pathway and
3. Implementation of the Model discharge pathway requirements ahead of winter,

NHS England (NHSE) has also issued further expectations for Trusts, alongside a requirement for assurance that appropriate actions are being taken. At Gateshead Health, this directs our focus towards the following key areas:

- **Prevention:** The Trust has robust plans to increase vaccination uptake among frontline staff and vulnerable groups.
- **Occupancy and Discharge:** The Trust has jointly planned with system partners to support discharge seven days a week, admission avoidance through SDEC, Virtual Wards and Frailty Services, and the management of activity during Bank Holidays.
- **Capacity:** Rotas have been reviewed to ensure the appropriate skill mix is available to meet demand. This will support the delivery of care within four and 12 hours, the maintenance of RTT performance and the provision of an Urgent Community Response.
- **Flow and Ambulance Handovers:** The Trust will continue to maintain good ambulance handover performance. Detailed SOPs, supported by appropriate staffing and operational management arrangements, are in place to ensure this is sustained.
- **Infection Prevention and Control (IPC):** Appropriate plans are in place to manage infection risks, with these plans approved by the DIPC.
- **Leadership and Grip:** Appropriate on-call arrangements, OPEL levels and mutual aid arrangements are in place and have been reviewed to ensure they remain appropriate throughout the winter period.
- **Specific Actions for Mental Health Trusts:** Patients who frequently access services will have tailored crisis and relapse plans. This applies to OPMH, where plans are in place. Further requirements relating to Section 136 arrangements apply to CNTW.

The Trust has been asked to ensure that its plans are sufficiently robust and have been stress tested to ensure that we can:

- Improve vaccination uptake.
- Manage infection prevention and control effectively.
- Eliminate corridor care.
- Increase the level of care provided in primary, community and mental health settings.
- Meet the 45-minute ambulance handover standard.
- Improve patient flow through hospitals.
- Eliminate discharge delays.

1.2 Local Context

Within the Urgent and Emergency Care Network (UEC), three winter priorities have been agreed across the North East and North Cumbria Integrated Care Board (ICB) area under Delivering Safer Urgent and Emergency Care – Right Place, First Time:

- Enhance the respiratory pathway.
- Maximise preventative and home-facing provision.
- Improve in-hospital flow and discharge.

The national and local context has been incorporated into the Trust's operational planning approach. The plan has been developed with appropriate input from, and engagement with, system partners.

The Chief Operating Officer is the identified Executive accountable for the winter period and will ensure that appropriate mechanisms are in place to keep the Board informed of the Trust's response to operational pressures.

The identified strategic lead is the Director of Operations for Medicine and Community, supported by the Head of Emergency Planning, Resilience and Response and the Assistant to the Chief Operating Officer.

The Director of Operations for Medicine and Community is the Trust's Winter Lead.

2. Aim, principles and purpose

Taking into account the learning from Winter 2025/26, this Internal Winter Tactical Plan for 2026/27 sets out the framework within which operational processes will be implemented and provides a structure for the effective management of periods of surge or extremis.

The plan does not contain detailed daily operational patient flow management arrangements, contingency plans or associated procedures for managing routine business-as-usual escalation. These existing plans will continue to support and complement the winter arrangements, with the appropriate differential response applied according to the level of site escalation.

This document applies across the whole of Gateshead Health NHS Foundation Trust and forms part of the Gateshead Place and regional NENC ICB whole-health-economy winter plan. It will be submitted to the Executive Committee for approval and assurance.

Our winter plan at Gateshead Health aims to ensure timely access to appropriate care and treatment for all our patients and carers.

The following principles have been informed by learning from the Winter 2025/26 debrief and associated multidisciplinary planning and will support delivery of this overall aim:

- We will focus on delivering safe, high-quality care and improving health outcomes for our patients throughout the winter period.
- We will embed organisational learning from previous winter periods.
- We will maintain patient flow and minimise the impact on delivery of the elective programme. Additional beds and escalation areas will only be opened where necessary and will be introduced in a planned manner, informed by learning from previous winter pressures.
- We will identify and manage risks while maintaining patient safety and experience.
- We will maintain the highest standards of patient safety, quality of care and patient experience.
- We will achieve high levels of immunity among staff against vaccine-preventable diseases.
- We will provide appropriate staffing and resources within the existing budget.
- We will provide effective leadership and accountability across all areas of Gateshead Health.
- We will maintain robust governance and escalation processes with system partner organisations across the Gateshead Place Based System.
- We will seek to eliminate corridor care within the Trust.
- We will use national direction, guidance and best practice to inform our winter planning.

For operational purposes, Winter 2026/27 will cover the period from Monday 9 November 2026 to Friday 9 April 2027, following the Easter Bank Holiday period.

3. Governance

Gateshead Health has worked collaboratively with system partners throughout its winter planning arrangements. This includes engagement through the Regional Chief Operating Officer Group (COO Group), Urgent and Emergency Care (UEC) Network, Integrated Care System (ICS), Local A&E Delivery Boards (LAEDB) and Integrated Care Board (ICB).

To support the management of winter pressures, the Trust works with health and care partners across Gateshead through the Gateshead Winter System Resilience Group (SRG).

Internally, the Gateshead Health Internal Winter Oversight Group provides tactical and operational oversight of the monitoring, management and delivery of the Trust's winter plan.

3.1 Gateshead Health Internal Winter Oversight Group

The Internal Winter Oversight Group will oversee the key factors influencing winter pressures and activity levels. It will work collectively to ensure that actions and resources are appropriately coordinated, while maintaining patient safety and quality of care.

3.2 Responsibilities

The group will bring together leaders from across the Trust to monitor key indicators and respond to emerging pressures throughout the winter period. Members will take collective ownership for the delivery of the agreed winter framework.

The purpose of the Internal Winter Oversight Group is to take tactical responsibility for monitoring and responding to the combined impact of winter schemes and to seek resolution of issues as they arise.

The group will work in alignment with the Gateshead Winter System Resilience Group, identifying and escalating issues that require wider system support or intervention.

The group will be responsible for all aspects of winter delivery, including:

- Measurement and monitoring.
- Working collectively to ensure quality is maintained and risks are understood.
- Escalation in accordance with agreed frameworks.
- Assurance and oversight of external reporting requirements.

3.3 Values and Principles

The group will work within the Trust's iCore values, using these principles to support collegiate and collective delivery of the winter plan.

3.4 Governance, Membership and Reporting

The Gateshead Health Internal Winter Oversight Group will be chaired by the Director of Operations for Medicine and Community within Gateshead Health NHS Foundation Trust.

The group will report to the Operations Oversight Group using the Trust's AAA reporting format.

All members are required to attend as decision-makers for their respective divisions, subject areas and services. Members will:

- Provide expert knowledge and advice from their area of responsibility.
- Actively participate in organisational risk assessments and mitigations.
- Support the authorisation of winter activities where required.

- Communicate relevant information into the group and cascade agreed information to their respective divisions, subject areas and services.
- Escalate and report issues to the group in accordance with the agreed terms of reference.

3.5 Access to Planning Arrangements

All winter planning arrangements for 2026/27 will be available through the EPRR Winter Planning SharePoint area within the Staff Zone.
Winter planning: Winter planning SharePoint area

4. Methodology

To anticipate the potential challenges presented by Winter 2026/27, the Trust has undertaken an analysis of learning from the previous winter, assessed current organisational risks and undertaken horizon scanning to identify significant pressures that may arise.

This work has focused specifically on winter pressures. Existing business-as-usual activities outlined within site management procedures are referenced within the winter planning arrangements, as these will form part of the Trust's winter response. The level and nature of the response will vary according to the level of site escalation.

The key areas of focus have been:

- **Winter 2025/26:** feedback and lessons learned.
- **Horizon scanning:** including seasonal viruses, adverse weather, changes in Government policy and demographic changes.
- **Testing our ability to respond:** including periods of increased demand and surge.
- **Demand prediction:** assessing our ability to anticipate demand for operational services.

5. Role and Responsibilties

Roles and responsibilities across the Trust will be determined according to the level of escalation.

The responsibilities of staff at each level are set out within the **OPEL Policy** and **GEL Frameworks**.

6. Operational winter planning for 2026 - 27

A number of principles have been developed to support core operational winter service delivery, including preparedness for seasonal infection and workforce sickness.

6.1 Operating Principles

The Trust will:

- Ensure that an effective vaccination programme is in place for staff and patients.
- Maximise alternatives to Emergency Department attendance and/or hospital admission.
- Optimise the use of inpatient beds by reducing length of stay and ensuring timely discharge.
- Maintain appropriate patient support within the community.
- Support our staff to remain healthy and well throughout the winter period.
- Maintain performance and patient safety across the hospital.
- Use existing plans and frameworks to manage or escalate emerging issues including staffing and rotas
- Avoid opening additional beds or escalation areas unless this is necessary.
- Ensure that IPC plans are in place and are enacted effectively
- Provide consistent, clear operational leadership at times of surge and throughout the winter.

Delivering Our Principles

To support these principles, we will:

6.2 Maximise Preventative measures

The Trust has robust plans to increase vaccination uptake among frontline staff and vulnerable groups.

The vaccination plans will commence with a Jab-a-thon in early October, with peer vaccinators on wards and a clear communication plan to encourage staff to become immunised.

The well established plans with the Community nursing teams to offer vaccinations to the housebound and those in Care Homes will continue, also commencing in October.

The 2026 vaccination campaign will focus on increasing influenza vaccination uptake across the workforce, with particular emphasis on clinical and frontline staff.

The Deputy Chief Nurse will provide strategic leadership for this focused workstream in collaboration with the Director of People and OD and the Group Chief Operating Officer. The campaign will place particular emphasis on improving communication, providing clear information and making vaccination readily accessible to staff.

A region-wide communications campaign will be developed in accordance with national direction.

Vaccination delivery will be clinically led and accessible to all staff groups. A range of approaches will be used to maximise accessibility, both within and outside usual work areas. This will include ward-based vaccination and opportunities to receive vaccination in locations such as the staff restaurant.

Addressing vaccination fatigue and removing barriers to access will be key priorities.

In line with the national expectation to increase vaccination uptake by at least two percentage points compared with the previous year, Gateshead Health will aim to achieve a minimum influenza vaccination uptake of **60% among frontline staff**, compared with 58% in 2025/26.

The campaign will continue to promote vaccination across all workforce groups, with a particular focus on ensuring staff working in clinical areas are vaccinated in a timely manner.

Vaccination data will be subject to strengthened oversight and scrutiny through the **Internal Winter Oversight Group** and **Gateshead Health Leadership Group**.

The POD Steering Group will retain overall oversight of the influenza vaccination.

6.3 Focus on Occupancy and Discharge

The Trust will continue to maximise alternatives to hospital admission through:

- Frailty and Respiratory Virtual Wards.
- Community Services UCR.
- Admission criteria and new RAT pathways.
- SDEC pathways are maximised through an ongoing improvement programme which has demonstrated a significant increase in patients being managed via SDEC pathways.
- Effective streaming at the Front door
- Working with GPs, Adult Social Care, the Mental Health Trust and the Voluntary Sector to ensure that patients who are not for acute hospital care are transferred to the most appropriate place for their care.

Community capacity will be prioritised for the most unwell patients through appropriate clinical triage.

The Gateshead Winter System meetings are in place and partners in Primary Care have indicated that they have identified high risk patients and put in place review arrangements to optimise their health prior to winter.

6.4 Patient Flow

The **Patient Flow Meetings**, held several times each day, will provide hands-on operational oversight of day-to-day site management. These meetings will incorporate escalation plans, national OPEL levels, internal GEL levels and the relevant action cards for each role.

There are a number of patients within our bed base who no longer meet the criteria to reside, including reducing the number of patients remaining in hospital at 7, 14 and 21 days.

While this number has reduced over consecutive years, it remains a key challenge and a number of measures are in place to support patient flow. These include:

- A 10.30 a.m. huddle attended by system partners including Adult Social Care
- A well established board and ward round process on all wards.

- A weekly discharge meeting to identify any barriers to patient discharge that have not been resolved by daily meetings
- A weekly review led by the Associate Medical Director for Medicine and Community to review the reasons for patients over 21 days remaining in the bed base.
- Escalation routes directly to senior staff across the system to support flow
- Close working with ASC colleagues to ensure that appropriate out-of-hospital provision is fully utilised including intermediate care capacity.

Patient Flow Action Cards and agreed triggers are used to initiate appropriate actions in a timely and effective manner.

This will enable the Trust to maintain 4 and 12 hour trajectories and mitigate the risks posed by winter pressures.

6.5 Capacity

The Trust has plans in place to ensure that all capacity is effectively used including a plan for further Winter beds in times of surge. There is a specific focus on ensuring that the four hour target within ED is supported and that patients do not remain within the Department over 12 hours due to the increasing level of clinical risk. This includes plans to mitigate the issues if the Department becomes over crowded.

- There are staff deployed to ED in order to support timely ambulance handover.
- There is an identified area within the Trust which will form the winter ward to support with de-escalation of the site.
- The primary way of maintaining capacity is to ensure good patient flow, a clear focus on reducing avoidable admissions through the expansion of the Rapid Access and Treatment model will be in place in ED during peak periods this winter. There will also be additional support for weekend discharges to ensure these take place over seven days.
- There is a SOP to de-escalate the ED when required if ongoing pressure does not abate.

As part of ensuring sufficient capacity, there are holiday period occupancy reduction plans in place.

6.6 Corridor Care and the use of temporary escalation spaces (TES)

NHSE provides a clear definition of patients for whom corridor care has been provided along with a commitment to eradicating this within the NHS.

These are patients who remain outside a bedded space for more than 45 minutes and do not have access to bed head services such as oxygen or call bells, for whom privacy and dignity cannot be maintained and where lights cannot be turned off to allow for sleep.

Temporary Escalation Spaces apply to beds in areas which would not normally be used for patient care.

Good patient flow reduces corridor care and the measures to ensure this is effective are in place. Where a patient does need to be cared for in a corridor for more than 45 minutes, this is escalated appropriately and governed by detailed SOPs to ensure that patients are appropriately cared for and that the use of corridor care is minimised.

6.7 Leadership and staffing

The Trust's business-as-usual out-of-hours on-call arrangements are aligned with the NHSE EPRR Core Standards and the Trust On-Call Framework.
These arrangements ensure that the required **Command, Control, Coordination and Communication (C4)** structures can be implemented when necessary.

The escalation model brings together the appropriate operational, tactical and strategic levels of leadership to manage periods of surge and provide clear direction across the Trust. This includes:

- Operational on-site teams.
- Tactical senior management on-call.
- Strategic Executive Director and Deputy on-call arrangements.

Workforce planning will continue throughout the winter period to review staffing rosters across medical, nursing and allied health professional groups.
This planning will also consider the staffing requirements associated with any escalation or surge areas that may need to be established.

Nursing Cover

All areas will continue to operate in accordance with their established **365-day operational plans**, including contingency arrangements for Bank Holidays.

Medical Cover

To maintain the delivery of safe, high-quality care rotas have been reviewed to ensure consistent clinical decision making across all seven days. At times of peak pressure additional medical staff, including senior and resident doctors, may be redeployed where possible to support escalation areas when required.

Where additional medical resource is identified as necessary, the Trust's established escalation and approval process will be followed.

6.8 Infection, Prevention and Control (IPC)

Winter months are associated with an increase in seasonal infectious diseases, including respiratory viruses and Norovirus. These infections can spread readily within the hospital environment, particularly when bed occupancy is high and there is increased movement of patients and staff across the organisation.

Seasonal infections can contribute to increased morbidity and mortality, as well as longer patient lengths of stay, creating additional pressure on hospital capacity and patient flow. Primary care services are continuing to develop approaches to assess and treat patients with known or suspected respiratory conditions in the community. This includes the use of Acute Respiratory Infection (ARI) hubs and vaccination programmes to reduce avoidable attendances and admissions.

It is therefore essential that infectious patients are identified promptly and isolated appropriately following clinical risk assessment using the **IPC Risk Assessment Questionnaire**.
IPC Risk Assessment Questionnaire 2025

Transmission of infection is more likely when patients are nursed in close proximity, for example in Emergency Department corridors or larger bays. Every effort should therefore be made to avoid these circumstances wherever possible.

Patient movement between beds and wards should also be minimised to reduce the risk of unnecessary transmission between clinical areas. These requirements are reflected within the Trust's operational planning guidance:
Gateshead NHSFT Isolation Hierarchy

Advice and Guidance

The IPC Team provides expert advice in accordance with the most up-to-date national guidance and available evidence.

Operational teams can access advice and guidance from the IPC Team and Consultant Microbiologists between 08:00 and 17:00, Monday to Friday. An on-call system is also available outside these hours and at weekends for microbiology advice.

Throughout the winter period, Microbiologists across the South of Tyne area will continue to provide a 24-hour emergency on-call service. During working hours, they can be contacted via Vocera and, outside working hours, via the switchboard.

Daily Reporting

The IPC Team will provide a daily SitRep to the Patient Flow Team. This will include an overview of:

- Beds closed for IPC reasons.
- Patients with infectious conditions.
- Declared outbreaks.

This information will support organisational dynamic risk assessments and inform decisions relating to the maintenance of safe hospital flow.

Where there is an increase in infectious disease incidents or outbreaks that affect bed occupancy and patient flow, the **IPC Outbreak Policy** will be followed.

IPC, working jointly with Patient Flow, will undertake dynamic risk assessments and provide advice on the safe isolation and cohorting of patients.

Winter Testing Plan

The Winter Testing Plan has been agreed through the Clinical Strategy Group.
Patients being admitted with an acute history of respiratory viral symptoms of less than 72 hours should have a respiratory screen taken as soon as the decision to admit has been made. This will usually take place in the Emergency Department.

Testing for Influenza A/B and COVID-19 will take place from **mid-October 2026 until the end of March 2027**.

The laboratory will undertake two testing runs each day. Where patients are swabbed early during their Emergency Department attendance, a result is therefore expected to be available in most cases by the time a bed is allocated.

Urgent or point-of-care testing will **not** be available during Winter 2026/27. The approach will instead be clinically led and informed by learning and experience from previous years.

Patients **must not be held in ED, SDEC or EAU pending test results**. Testing must not be used as a reason to delay patient flow through the Emergency Department or admissions pathways.

Patients with confirmed Influenza A/B and/or COVID-19 who also have an acute infectious history should be isolated for **five days from the onset of symptoms**.

Asymptomatic testing is no longer recommended in accordance with national guidance. Testing patients whose symptoms have been present for more than 72 hours is also not advised, as PCR tests may remain positive beyond the infectious period.

Patients presenting with loose stools or vomiting where Norovirus is suspected must be isolated immediately. The IPCN Team should be informed and will provide advice regarding testing.

Prophylactic IPC Measures

For Winter 2026/27, proactive IPC measures will be essential in reducing the risk of infectious disease transmission. These include:

- Maintaining an up-to-date vaccination programme for staff and long-stay patients.
- Ensuring patients with acute respiratory symptoms are isolated wherever possible. Where isolation is not possible, patients should be nursed in a bay with curtains drawn to provide a physical barrier and should wear a mask where tolerated.
- Ensuring staff use appropriate PPE when caring for patients with suspected or confirmed respiratory infections, in accordance with the National Infection Prevention and Control Manual for England (NIPCM).

- Isolating patients with suspected infections, including suspected Norovirus, on admission and obtaining appropriate samples as soon as possible.
- Maintaining a back-to-basics approach to IPC, ensuring that good infection prevention practices are consistently applied and sustained.
- Maintaining and promoting excellent hand hygiene, particularly during periods of high Norovirus prevalence.
- Regularly monitoring general cleanliness, including the clinical environment and equipment used to deliver care.
- Avoiding escalation of beds and temporary escalation spaces, particularly within bays, wherever possible, as these arrangements can increase the risk of healthcare-associated infection.
- Avoiding overcrowding and the use of corridors to accommodate patients within the ED or temporary escalation areas wherever possible.

The IPC/Microbiology Team will work to minimise unnecessary bed closures for IPC reasons. However, there may be circumstances where bed closure is necessary to control an outbreak, particularly in cases of Norovirus.

During periods of heightened respiratory infection risk, **universal mask wearing and restrictions on visiting may be introduced**. These measures are intended to reduce transmission between patients, staff, carers and visitors.

Fit testing: There is ongoing IPC-led fit-testing provision, with additional capacity to support increased winter demand and priority clinical areas. Compliance is monitored through ESR/monthly reporting, with targeted sessions arranged where gaps are identified.

PPE: Staff who may be required to use tight-fitting RPE must have a current successful fit test for the specific make/model of respirator being worn. Availability and appropriate use of RPE will form part of winter preparedness. Appropriate PPE will continue to be available in clinical areas in line with the National Infection Prevention and Control Manual and transmission-based precautions, with requirements determined by the suspected/confirmed infection and anticipated exposure.

Any decision to introduce these measures will be made in conjunction with the DIPC and Group Chief Operating Officer, with implementation coordinated through the Internal Winter Oversight Group.

Further Information and Guidance

National IPC guidance is available through the National Infection Prevention and Control Manual for England:
NHS England – National Infection Prevention and Control Manual

Additional internal IPC policies and guidance are available through the Staff Zone:
Infection Prevention and Control – Staff Zone

6.9 Elective and Cancer Delivery Plans

We will continue to maintain the elective surgical programme throughout the winter period wherever possible. This is supported by surge capacity for Medicine and dedicated ward availability for T&O.

There are challenges in our cancer delivery pathways however, these are not related to winter pressures and are not referenced in this plan.

6.10 Industrial Action

The Trust has a robust response mechanism should Industrial Action be called during the Winter period managed via the Medical Director and EPRR. This has been well tested in recent years.

6.11 Staff Support

Staff support is available throughout the year. This should be accessed through normal line management arrangements who can make the relevant referrals for onward support. At periods of high demand, leadership will be visible and communications increased to ensure that teams are aware of available support.

6.12 Response from Older Persons Mental Health Directorate

Across Older Persons Mental Health (OPMH) services, patients who frequently access services, experience recurrent relapse, or are at increased risk of mental health crisis receive personalised risk assessments and crisis and where required personalised safety plans to manage risks related to self harm and suicide.

These plans are developed collaboratively with the patient, carers and multidisciplinary team, identifying early warning signs, known triggers, agreed coping strategies, medication and treatment plans, and clear escalation routes. Plans are documented within the clinical record, reviewed regularly, and used across community, memory, inpatient and liaison pathways to support early intervention, reduce avoidable deterioration, and promote continuity of care

7. Supporting Winter Plans

A number of focused areas have dedicated winter plans to support delivery of operational services and the overall winter principles. These include:

- Pharmacy, including the oxygen cylinder escalation plan.
- Excess deaths and mortuary management.
- Adverse weather plan.

7.1 Pharmacy Cover

The Pharmacy Department currently provides an established seven-day service, offering comprehensive operational and clinical pharmacy support, medicine supply and pharmacy on-call services.

Opening times are:

- Monday to Friday: 08:30–19:00
- Saturday and Sunday: 09:00–17:00
- Bank Holidays: 09:00–16:30
- Christmas Day: Dispensary open for two hours.

An emergency duty pharmacist is available outside of these core hours.
The pharmacy winter cover arrangements provide enhanced pharmacist independent prescriber provision, clinical pharmacy technician support to the discharge lounge and weekend pharmacy support to the admissions pathway.

Community Services also have access to a Macmillan pharmacist to provide advice and support for palliative and End of Life (EOL) patients within the community and on St Bede's.

See Appendix 1 for Pharmacy Winter Cover

7.2 Excess Death Management

Gateshead Health manages mortuary services across Gateshead, South Tyneside and Sunderland Hospitals. Existing agreements between the Coroners provide additional resilience across the system. Where one site reaches capacity, the deceased can be transported and accommodated across the three mortuary facilities.

Mortuary capacity can come under increased pressure during the winter months due to a rise in both hospital and community deaths. The capacity of local funeral directors can also affect the length of time deceased patients remain within the mortuary facilities.

Where required, Trusts can escalate to the temporary mortuary facilities established for Winter 2026/27. These facilities are located adjacent to the main mortuary facilities on the QEH site. During the winter period, mortuary capacity will be reviewed daily and reported through the Patient Flow Meetings prior to any external submission.

7.3 North East Mortuary Activation (NEMA)

County Durham and Darlington NHS Foundation Trust hosts the North East Mortuary Activation (NEMA) facility at Darlington Memorial Hospital, Hollyhurst Road, Darlington, DL3 6HX.

The facility comprises four units, providing additional storage capacity for up to 80 deceased people. It is held on behalf of the three Local Resilience Forums (LRFs).

Where mobilisation is required, the agreed activation protocol should be followed:

NEMA Activation Protocol

7.4 Ageing Well

The Ageing Well in Gateshead guide provides information about the support available across Gateshead to help people age well and remain healthy and independent for longer.
The advice is aimed at people aged 65 years and over, as well as anyone who supports them, including family members, friends and carers.

The guide will be promoted throughout the winter period through Gateshead system partners to provide advice, information and guidance to the local population.
Ageing Well in Gateshead: Ageing Well in Gateshead guide

8. Response to Adverse Weather

The Trust will manage periods of adverse weather in accordance with the **Winter Maintenance Plan/Adverse Weather Plan**.

Depending on prevailing weather conditions, the Estates Team will deploy resources in accordance with the priorities and arrangements set out within the plan.

8.1 Adverse Weather Plan:

Adverse Weather Plan

Weather Warnings

The Trust EPRR Team and QE Facilities Estates and Facilities Teams receive Met Office Civil Contingency Advisor weather forecasts directly and have access to relevant weather warnings and alerts.

These teams will initiate the appropriate Trust response when required.

To support this response, QE Facilities has a dedicated gritting and snow-plough plan incorporated within the Adverse Weather Plan.

9. Managing Surge

As part of the winter planning process, arrangements have been developed to enable the Trust to respond effectively to periods of surge and extremis. These arrangements include indicative triggers to support timely escalation and action.

9.1 Existing Policies, Frameworks and Plans

Existing Trust policies, frameworks and protocols will support the management of periods of surge or extremis. These arrangements provide the operational framework for managing capacity and demand.

Further information is available through the Trust's Site Management arrangements which incorporate information from the Model ED and Model Discharge pathways where appropriate:

Site Management

10. System Coordination

The tactical winter plan is supported by the **North East and North Cumbria ICS System Resilience Framework**.

The framework sets out how operational pressures will be identified and managed across the North East and North Cumbria Integrated Care System. It also describes the high-level, multi-agency approach to ensuring that surges in demand, system escalation and outbreaks of communicable disease are recognised and managed rapidly and effectively.
The framework includes:
System coordination and escalation management, including the North East and North Cumbria System Coordination Centre (SCC).

- System teleconferences.
- Communication with local partners, patients and the public.
- System resilience core principles.
- Use of SBAR for external reporting and communication.
- Ambulance handover arrangements, including diverts and deflections.
- Referral and repatriation of patients.
- Mutual Aid Checklist.
- Consideration or declaration of a Critical Incident and/or Major Incident.
- Recovery arrangements.

Internal governance arrangements are in place to ensure that the appropriate decision-makers and Trust representatives can engage with system partners when required.

Acute Respiratory Infection (ARI) Hubs
GPs will provide additional capacity to manage the majority of patients presenting with respiratory illness outside the hospital setting.
Connectivity with NHS 111 will enable patients to be booked directly into appropriate appointments, providing an alternative to attendance at the Emergency Department or Urgent Treatment Centre.
Further details of the programme are yet to be confirmed.

11. Escalation

Where escalation is required, the **Incident Response Coordination Framework** should be activated.

The framework provides a structured approach for the Trust to respond effectively, efficiently and proportionately to a range of incidents, including business continuity incidents, critical incidents, major incidents and other emergencies that impact, or have the potential to impact, patients, staff, services or service provision.

Incident Response Coordination Framework v3 June 2025

Any declaration of an incident should be supported by a clear rationale, demonstrating why escalation is required and confirming that all appropriate actions have been undertaken.

An incident declaration should be considered a **last resort** following the completion of the relevant escalation actions.

Any declaration must be discussed and agreed with the Group Chief Operating Officer during working hours, or with the Strategic On-Call lead outside working hours, before contact is made with the ICB.

Where escalation occurs, an additional command structure may be required to support coordination and management of the response.

12. Risk Management

Winter 2026/27 will require Gateshead Health to operate against a backdrop of existing operational pressures and associated organisational risks.

A number of risks may be exacerbated during the winter period and could affect the Trust concurrently. Effective identification, monitoring and mitigation of these risks will therefore be central to the successful delivery of the winter plan.

12.1 Winter Risks 2026/27

An overarching winter risk has been added to the current Trust risk register relating to the **risk of demand overwhelming organisational capacity during Winter 2026/27**.

12.2 Risk Description

This risk is associated with the potential for demand to exceed organisational capacity during Winter 2026/27 as a result of increased respiratory illness, other infections, injury and changes in service availability caused by limitations in staffing or other resources.

If demand exceeds available capacity, this could increase the risk of clinical harm, adversely affect patient outcomes and result in poorer experiences for patients, carers and staff.

The likelihood and consequence of these impacts will be reviewed dynamically. Changes will be captured through the overarching winter risk and the winter planning risk register.

These risks will be continually monitored through the **Gateshead Health Internal Winter Oversight Group**.

The winter plan has considered the key risks to quality and provides assurance that appropriate mitigations are in place across base, moderate and extreme levels of winter escalation.

13. Financial Plan

The financial model for Winter 2026/27 will be managed within the organisation's overall financial framework.
The Trust's financial position and available resources will be considered as part of the operational response to winter pressures, ensuring that winter arrangements appropriately balance financial sustainability with operational performance and the delivery of safe, high-quality patient care

14. Communications

Gateshead Health will continue to support regional and national winter communications campaigns. These campaigns will provide practical and consistent messages to help people stay well, access services appropriately and support one another throughout the winter period.

The approach will include shared content, media campaigns and coordinated advertising activity.

During Winter 2026/27, Gateshead Health will build on this approach by using available data to anticipate periods of increased demand and, where possible, schedule communications in advance. This will reduce the need for reactive communications during periods of pressure.

A dedicated **Winter Communications Plan** has been developed to support the Trust's operational winter planning. It sets out internal and external communication priorities, escalation processes and arrangements for using and tailoring regional and national communications for Gateshead audiences.

Gateshead Health Winter Communications Plan – August 2026

Internally, a dedicated winter section within the staff newsletter will provide regular updates, supported by the intranet and screensavers. Content will be informed by the Internal Winter Oversight Group.

Any urgent internal communications will be subject to appropriate executive oversight and approval before being cascaded by email where required.

Gateshead Health will also work closely with partners across the **Great North Healthcare Alliance** to align winter messaging and ensure consistency across the system.

Vaccination messages will be delivered through the existing vaccination campaign and incorporated into wider winter communications.

15. Quality, equality impact assessment

A robust **Quality and Equality Impact Assessment (QEIA)** has been developed to support the Winter Tactical Plan.

The QEIA provides assurance that the potential impact of the winter arrangements on quality, equality and patient experience has been considered as part of the planning process.

16. Plan exercising schedule

An internal and external exercising and testing programme has informed the development of the Winter Tactical Plan.

This includes a regionally led winter exercise, together with a review of exercise outcomes and incorporation of lessons identified into the winter planning arrangements.

All areas have Business Continuity plans and the Trust has been involved in a series of exercises locally and at regional level during 2026 which have enabled testing to occur.

Winter Testing Schedule 2026/27:

Winter Testing Schedule 2026/27

17. Debriefing

A formal evaluation of the winter period will take place in **April 2027**. Learning from the evaluation will be shared with the relevant areas of the organisation and system to inform future planning, service developments and delivery.
The EPRR Team will ensure that staff involved in winter planning and response have appropriate opportunities to review and reflect on their experience.
A structured debrief will take place following significant incidents and, where appropriate, shortly after the event. This will provide staff with an opportunity to:

- Share their views and experiences.
- Reflect on their individual and team roles.
- Identify what worked well.
- Identify areas for improvement.
- Consider changes that could strengthen future winter planning and response.

Depending on emerging issues, incidents or operational pressures, an interim review may also be required to ensure that important learning is identified and shared promptly.
The Trust EPRR Team has trained debrief facilitators and will use the Trust's established Debrief Protocol.
Debriefing Incidents, Events and Exercises Protocol

18. Conclusion

Winter 2026/27 is expected to present significant operational challenges for Gateshead Health, with the potential for increased and sustained demand across services.

The Internal Winter Tactical Plan provides a framework for the Trust to anticipate and respond to these pressures while maintaining patient safety, quality of care and service resilience.

The planning process has enabled the Trust to identify potential pressures, develop appropriate mitigations and establish governance arrangements to support effective decision-making throughout the winter period.

A strong governance framework is in place at Trust, local and system level, enabling Gateshead Health to work collaboratively with partners across multiple providers and sectors to manage the impact of winter pressures.

The plan will remain dynamic and will be reviewed in response to changes in organisational and clinical risk, emerging pressures and learning throughout the winter period.

Formal evaluation following Winter 2026/27 will inform organisational and system planning, ensuring that learning is incorporated into future winter plans and associated service developments.

Appendix 1 - Pharmacy Winter Cover

Scheme	Dates	Actions	Implications
7-day Pharmacy Services: Operational, dispensary and discharge support	Continuous	In-Patient Pharmacy Weekend Opening Times: Monday to Friday: 08:30 - 19:00 Saturday: 09:00 – 17:00 Sunday: 09:00 – 17:00 *On call pharmacist available out of hours* Bank holiday: Usually 09:00 – 16:30 (Dispensary will be open for part of the day on Christmas Day) Weekend Clinical Pharmacy Weekend BD® Automated Drug Cabinet refills and ward top ups	Access to medicines from Pharmacy, and the availability of dispensing of discharges over a longer timescale at weekends. Quick and accurate medicines reconciliation and support with prescribing. Clinical Pharmacy support beyond EAU. The ability to refill Omnicell® Automated Drug Cabinets in high use areas across the weekend, where appropriate.
Clinical Pharmacy Weekend Support	Continuous	Clinical Technician and Pharmacist Independent Prescribers at Weekends with Medicines Reconciliation – Sat and Sun.	Maximise Medicines Reconciliation Rate GIRFT NB: This will be to undertake Med Rec on EAU Only.
Weekday Late Shift Flexibility	January and February 2027	Increase dispensary staff capacity to manage peaks in activity	To help manage surges in discharge prescriptions
Medical Gases	Escalation periods	Engagement and planning with medical gases suppliers, including BOC to ensure supply chain of critical medical gases over winter escalation period	To ensure robust supply chain of medical gases

Winter Planning 26/27
Board Assurance Statement (BAS)

1. Purpose
The purpose of the Board Assurance Statement is to ensure the Trust Boards has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement
Please include the Trust / Provider name at the top of the tab.
This section gives Trust the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist
This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to
the national UEC team via england.eecpmo@nhs.net by **30 September 2026.**

Winter Planning 26/27
Section A: Board Assurance Statement (BAS)

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Provider/Trust Name (drop down):	Gateshead Health Foundation Trust
If Other, write Provider/Trust Name:	
Contact details (email, phone number):	Joanna Clark joanna.clark10@nhs.net
Date:	07/09/2026

Please complete these sections

Assurance statement			Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Governance and executive leadership					
1	1.1	The Board has assured the Trust Winter Plan for 2026/27.	Yes	The plan will go to Board on 29th September	
	1.2	The Board is assured that a robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	Attached	
	1.3	The Board is assured that the Trust's plan was developed with appropriate input from and engagement with all system partners, including primary care and social care.	Yes	The system planning event took place on 27 July 2026 with monthly follow up meetings.	
	1.4	The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	York 17th September regional event attended by Trust representatives	
	1.5	The Board has identified a named Executive Winter Sponsor with accountability for winter preparedness (including vaccinations), escalation and operational delivery.	Yes	Carmen Howey, Group Medical Director (pending new COO)	
	1.6	The Board is assured that clear governance arrangements, escalation processes and operational leadership arrangements are in place throughout the winter period.	Yes	Trust Management Framework in place	

Winter Planning 26/27
Section B: 26/27 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 26/27 Winter plans.
Board Assurance Statements should not be submitted until they have been tested during a regionally-led winter exercise programme.

Please complete these sections

		Section B: 26/27 Winter Plan checklist	Confirm (Y/N)	Additional comments or qualifications (optional)	Blockers/Support requirements (optional)
Prevention					
1	1.1	The Board is assured there are plans in place to deliver a frontline healthcare worker (FHCW) flu vaccination programme that achieves the trust level uptake ambitions and demonstrates: •the offer is accessible to all frontline staff between 1 October – 31 March with the majority of vaccinations completed by 30 November; •that both walk-in and bookable appointments are available; •that all FHCW vaccination activity will be recorded on Record a Vaccination Service (RAVS); and •the FHCW flag has been applied to the ESR records of all clinical and non-clinical staff who are in direct contact with patients to ensure accurate reporting on FDP.	Yes	See section 6.2 Winter plan - Operational Winter planning - Maximise preventative measures.	
	1.2	The Board is assured that frontline staff vaccination, respiratory virus prevention, and staff health measures are supported by targeted operational plans.	Yes	See section 6.2 Winter plan - Operational Winter planning - Maximise preventative measures.	
	1.3	The Board is assured that plans are in place to offer vaccinations (flu and COVID-19) to long stay inpatients (21 days and above) and inpatients who are being discharged into a care home.	Yes	section 6.2	
	1.4	The Board is assured that population health intelligence and risk stratification information are used in partnership with system colleagues to identify and support vulnerable patients and high-risk cohorts ahead of and during periods of winter pressure.	Yes	Section 6.2 and system planning for Gateshead Primary Care	
Occupancy and discharge					
2	2.1	The Board is assured that a review of discharges across each pathway required to manage bed demand and occupancy has taken place ahead of winter with system partners. These have been developed jointly with local authority, Community Health Service Providers and system partners, including holiday-period arrangements.	Yes	Section 6.4	
	2.2	The Board is assured that model discharge pathway requirements are in place to optimise discharge seven days a week across acute, community and social care services. This should include: • coordinated escalation, surge and extreme surge response arrangements, including bed escalation capacity, which have been tested and capable of safe activation to maintain patient flow, create additional capacity and support operational resilience during periods of increased demand. •executive-led governance arrangements to provide oversight of occupancy, the number of discharges required and delivered each day to support safe bed availability and flow, along with the number of patients who are NCTR by pathways 1 to 3 with monitoring of patients with long discharge delays. •targeted operational actions to reduce long discharge delays. •Discharge to Assess pathways that operate effectively with home first as the default and assessment taking place outside hospital wherever possible. These should be supported by integrated escalation arrangements with community and social care partners to maintain patient flow.	Yes	Section 6.4	
	2.3	The Board is assured that pre-Christmas and holiday-period occupancy reduction plans will be implemented.	Yes	Section 6.5	
	2.4	The Board is assured that Same Day Emergency Care (SDEC) and ambulatory emergency care pathways have been optimised to support admission avoidance.	Yes	Section 6.5	
	2.5	The Board is assured that frailty pathways have been reviewed and are operating effectively to support avoidance of unnecessary admission.	Yes	Section 6.3	
Capacity					
3	3.1	The Board is assured that workforce resilience assumptions are evidenced and include safe staffing levels, appropriate skill mix, redeployment models and staff wellbeing support, with clear mitigations in place for sustained periods of increased demand.	Yes	Section 6.7	
	3.2	The Board is assured that rotas have been reviewed to ensure consistent senior clinical decision-making capacity at times of peak pressure, including weekends, supported by clear escalation and supervision arrangements.	Yes	Section 6.7	
	3.3	The Board is assured that elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Yes	Section 6.9	
	3.4	The Board has reviewed its 4-hour and 12-hour, and RTT trajectories, and is assured that the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off for 2026/27.	No	The Winter plan will mitigate most of the issues raised but the trajectories signed off are currently unachieved for 4 hour performance	
	3.5	The Board is assured that there are effective operational actions in place to ensure urgent community capacity is prioritised for the sickest patients.	Yes	Section 6.3	
Flow					
4	4.1	The Board is assured that emergency department crowding mitigations have been reviewed and implemented to actively eliminate corridor care as a patient safety priority. This should include implementation of relevant GIRFT recommendations, and with defined safety thresholds, clear escalation triggers, and routine Board level oversight of associated risks, including dignity, privacy and clinical harm.	Yes	Section 6.5	
	4.2	The Board is assured that ambulance handover plans are deliverable and supported by appropriate operational arrangements and escalation processes.	Yes	Sectoin 6.5	
	4.3	The Board is assured that escalation arrangements with system partners support timely transfer of care and patient flow.	Yes	Section 10	
	4.4	The Board is assured that plans are in place to implement the Model ED and Model Discharge requirements ahead of winter.	Yes	Section 9	
Infection Prevention and Control (IPC)					
5	5.1	The Board is assured that plans, infrastructure, estates arrangements, IPC governance and operational capability are in place to enable the safe rapid reconfiguration of physical space, creation of additional clinical capacity and implementation of patient cohorting arrangements during periods of increased demand or infectious disease transmission, supported by appropriate environmental risk assessments and compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.	Yes	Sectoin 6.8	
	5.2	The Board is assured that IPC colleagues, including the Director of Infection Prevention and Control or nominated IPC Lead, have been engaged in the development of the winter plan, and are confident in the planned mitigations and actions.	Yes	Section 6.8	
	5.3	The Board is assured that fit testing arrangements are in place for relevant staff, are appropriately recorded and monitored, and can be rapidly expanded during periods of increased respiratory disease and gastrointestinal viral transmission. Appropriate PPE supply, stock management and escalation arrangements are in place to support periods of increased demand.	Yes	Section 6.8	
	5.4	The Board is assured, as encompassed by criterion 5 of the Health and Social Care Act 2008: code of practice on the prevention and control of infections, that a patient cohorting plan, including risk-based escalation, is in place that is understood by all staff and is ready to be activated by site management teams.	Yes	Section 6.8	
Leadership and operational grip					
6	6.1	The Board is assured that on-call arrangements are in place and have been tested, and those on-call have access to medical and nursing leaders for urgent advice, and effective operational oversight to ensure urgent community capacity is prioritised for the sickest patients, where needed.	Yes	Section 9	
	6.2	The Board is assured that plans are in place to monitor and report real-time pressures utilising the OPEL framework, with clear triggers for escalation and timely operational response.	Yes	Section 9	
	6.3	The Board is assured that mutual aid arrangements have been reviewed and are capable of activation, if required.	Yes	Section 10	
	6.4	The Board is assured that business continuity plans have been reviewed and tested where appropriate.	Yes	Section 11	
	6.5	The Board is assured that severe weather and infrastructure disruption contingencies have been reviewed.	Yes	Section 8	
	6.6	The Board is assured that industrial action contingencies have been reviewed where relevant.	Yes	Section 6.10	
	6.7	The Board is assured that plans are in place to support staff welfare through periods of high demand.	Yes	Section 6.11	
Specific actions for Mental Health Trusts					
7	7.1	The Board is assured that a plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via NHS 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.		This is for CNTW	
	7.2	The Board is assured that any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	Yes	To be added.	
	7.3	The Board is assured that liaison psychiatry pathways and Section 136 arrangements remain resilient during periods of peak demand.		This is for CNTW	

Executive Approval

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

Trust / Provider Name:	Gateshead Health
Provider CEO name:	Dr Sean Fenwick
Date reviewed:	18/09/2026
Provider Chair name:	Sir Paul Ennals
Date reviewed:	18/09/2026

Please update following completion of the BAS template

Please provide name and contact details of designated Senior Responsible Officer (Executive Level)
Carmen Howey, Group Medical Director

Please provide confirmation that the SRO has reviewed and approved the responses within this document, confirming they are correct and complete.
This has been confirmed

Please confirm date reviewed
18/09/2026

BAS Self-Assessment Dashboard

Trust

Overall Assessment Rating: 5 - Full assurance

		Rating
Section B	Prevention	**5 - Full assurance**
	Flow, occupancy and discharge	**5 - Full assurance**
	Capacity and community	4 - Substantial assurance
	UEC Flow	**5 - Full assurance**
	Infection Prevention and Control (IPC)	**5 - Full assurance**
	Leadership and operational grip	**5 - Full assurance**
	Specific actions for Mental Health Trusts	Awaiting assessment

b - EPRR Core Standards Self Assessment Report presented by the Medical Director

NHS Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 3b

Report Title:	**NHS EPRR Core Standards self-assessment 2026-27**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29 September 2026			
Author:	Graeme Murray – Head of Emergency Preparedness, Resilience and Response (EPRR)			
Executive Sponsor:	Carmen Howey – Group Medical Director / Accountable Emergency Officer (AEO)			
Report presented by:	Carmen Howey – Group Medical Director / AEO			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☒	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	The purpose of this report is to provide an overview of the NHS EPRR Core Standards assurance process and timelines for 2026-27			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	N/A			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• It is a requirement that NHS providers submit an annual self-assessment statement of assurance against the EPRR core standards to their board • The EPRR Annual Assurance Process letter for 2026-27 was received by the Trust on 3 July 2026 from NHS England (appendix 1) • There are no significant changes to the standards, and the Trust will not undergo a deep dive, which was removed in the 2025 – 2026 process • The final external submission date for the self-assessment is 30 October 2026 • A previous self-assessment rating of substantial compliance was submitted in October 2025. Our strategic intention is to sustain a substantial compliance rating and strengthen the quality of evidence for the 2026 self-assessment submission.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	Board of Directors are asked to note the assurance provided within this report, agree the process of self-assessment and governance and to receive the final core standards submission and annual report in January 2027.			

Gateshead Health NHS Foundation Trust

Trust strategic priorities that the report relates to:	☒	Excellent patient care
	☐	Great place to work
	☒	Working together for healthier communities
	☒	Fit for the future
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	• We will continually improve our services creating a restorative culture where learning, innovation and research can flourish • We will collaborate with system partners with an emphasis on maximising efficient use of collective resources across health and care services • We will ensure effective and efficient use of our resources identifying opportunities to improve productivity and ensure the best use of public money	

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

Gateshead Health
NHS Foundation Trust

NHS EPRR Core Standards Self-Assessment 2026-2027

1. Executive Summary

On 3 July 2026, the Trust received notification from NHS England regarding the annual Emergency Preparedness, Resilience and Response (EPRR) Core Standards Assurance Process for 2026/27 (appendix 1). The Core Standards provide the national framework through which NHS organisations demonstrate compliance with statutory EPRR requirements and organisational resilience arrangements.

A comprehensive governance and assurance process will be established to support the Trust's 2026 submission. This will incorporate internal challenge, executive oversight and external scrutiny to ensure the accuracy and robustness of the self-assessment and supporting evidence. The assurance process will align with regional requirements and key milestones set by the North East and North Cumbria Integrated Care Board (NENC ICB).

The Trust's most recent submission, completed in October 2025, achieved an overall rating of Substantial Compliance, consistent with the previous year's assessment. The 2025 submission was subject to a rigorous assurance process, including external peer review and scrutiny through the NENC ICB, Local Health Resilience Partnership (LHRP) and Regional Health Resilience Partnership (RHRP), providing assurance regarding the quality of the evidence submitted and the maturity of the Trust's EPRR arrangements.

The strategic objective for the 2026 submission is to maintain the Trust's Substantial Compliance rating (fully compliant against 60 and partially compliant against 2 standards) whilst continuing to strengthen the quality, consistency and maturity of supporting evidence, demonstrating ongoing improvement in organisational preparedness, resilience and response capabilities.

Board are asked to support the process of self-assessment submission and agree that the initial submission can be made to the NENC ICB on 08/10/26 and final submission following ICB Check and Challenge on 30/10/26. Board are asked to agree that the authority to make the final submission can be delegated to Executive Committee through the Accountable Emergency Officer.

Board are asked to note that the final annual report regarding regarding our compliance for this year will be available in January 2027.

2. Introduction

The Civil Contingencies Act (CCA) 2004 imposes a statutory duty on the Trust to have in place arrangements to respond to incidents and emergencies. Under the terms of the CCA the Trust is a Category 1 Responder, meaning that the Trust must be able to respond to internal or external disruptive events that might impact on the Trust's ability to deliver its services.

The Civil Contingencies Act also places other duties on Category 1 responders, including the requirement to:

- Assess local risks and use this to inform emergency planning
- Put in place emergency plans
- Put in place Business Continuity Management arrangements
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- Share information with other local responders to enhance co-ordination
- Co-operate with other local responders to enhance co-ordination and efficiency.

The NHS England EPRR Framework (2022) requires all NHS organisations to plan for and respond to incidents in a manner which is relevant, necessary, and proportionate to the size and services provided.

3. Self-assessment

The EPRR assurance process is based on the 62 NHS England (NHSE) Core Standards for EPRR which cover ten core domains

1. Governance
2. Duty to risk assess
3. Duty to maintain plan
4. Command and Control
5. Training and Exercising
6. Response
7. Warning and informing
8. Co-operating
9. Business Continuity
10. Chemical biological radiological nuclear (CBRN) and Hazardous material (HAZMAT)

As per our January 2026 Board report our rating is one of Substantial Compliance (fully compliant against 60 and partially compliant against 2 standards) and our priority areas for 2026 included:

- 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 our EPRR capabilities and capacity, strengthening our 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 our arrangements
- An embedding of identified organisational learning
- Use of the self-assessment as a benchmark for prioritisation of the trust EPRR development work-plan for 2026
- A trajectory to continue to work collaboratively with the NENC ICB and other health providers to identify best practice and enhance threshold of evidence

As the Trust enters the 2026/27 EPRR Core Standards assurance cycle, the assessment process will be used as an opportunity to undertake a review not only of the Core Standards but also the EPRR function, our progress against those agreed priorities and wider organisational resilience arrangements.

3.1 Self-Assessment RAG Criteria

The self-assessment RAG criteria set out by NHS England for each individual EPRR Core Standard are :

Red (not compliant)	Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months.
Amber (partially compliant)	Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.
Green (fully compliant)	Fully compliant with core standard.

Gateshead Health NHS Foundation Trust

3.2 Compliance Criteria

Overall, there are four levels of compliance criteria for the EPRR Core Standards. This is calculated based upon the percentage of the 62 standards where there is evidence to support full compliance with no credit given for Amber (partially compliant) or Red (non-compliant). Last year's position gave us compliance against 97% of the core standards, hence substantial compliance.

Organisational rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial	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

The Trust will also undergo several reviews against Trust evidence and submission details which will follow the same process as 2025 as mentioned in the executive summary, including internal governance and oversight.

4 Governance Process

Alternative Trust Peer Review – North Tees NHS Foundation Trust

- 8th September 2026
- A review of all core standards with actions & recommendations to enhance our evidence or to carry forward into the 2027 workplan. The review was based upon similar evidence base against the national standard which ensures alignment against the audit framework.

Gateshead NHSFT Executive Committee

- 1st October 2026
- To review the initial self-assessment ahead of submission to the ICB

NENC ICB Review

- 8th October 2026
- To review, check and challenge the Trust against the core standard submission.

Gateshead NHSFT Executive Committee

- 29th October 2026
- To review the self-assessment following ICB check and challenge ahead of final submission.

LHRP Review – NHSE, ICB & all Acute Trusts

- 3rd December 2026.
- – 3rd December 2026.
- This meeting is the last check and challenge meeting for the Trust and allows those that have not been involved in the process so far (NHSE), to check and challenge the assurance level the Trust is providing.

RHRP Review

- 4th December 2026.
- Regional confirm and challenge session to take place prior to submission of the RHRP Paper to the Regional Management Executive.

Gateshead Health Board of Directors

- January 2027.
- A full EPRR Assurance Report highlighting the Trusts final submission position, with accompanying statement of compliance to be dated

5. Recommendations

- Board are asked to support the process of self-assessment submission and agree that the initial submission can be made to the NENC ICB on 08/10/26 and final submission following ICB Check and Challenge.
- Board are asked to agree that the initial submission will be made by the Accountable Emergency Officer following presentation of the submission in Executive Committee with final submission made via the same route following Executive Committee review of ICB feedback.
- Board are asked to note that the final annual report regarding our compliance for this year will be available in January 2027.

Gateshead Health NHS Foundation Trust

Appendix 1 – EPRR Core Standards Assurance Process (NHS England Letter Inc. Submission Timeline)

Classification: Official-Sensitive

NHS England North East and Yorkshire

To: • North East & Yorkshire ICB AEO's

cc. • North East & Yorkshire ICB EPRR leads

NHS England
7- 8 Wellington Place
Leeds
LS1 4AW

1 July 2026

2026-2027 EPRR Core Standards Assurance Process

Dear Colleagues,

We have now received confirmation from NHS Resilience as to the expectations for this years assurance process for the EPRR Core Standards, and I am writing to confirm the timescales and arrangements for the NEY regional process.

Assurance Expectations

Under the NHS Act 2006, NHS England is required to take such steps as it considers appropriate for securing that each Integrated Care Board (ICB) and Service Provider is properly prepared for dealing with an emergency. ICBs have a statutory responsibility to ensure that they are properly prepared for dealing with an emergency, and are responsible for agreeing the process by which they will seek local assurance.

In 2023 the North East & Yorkshire Assurance process included an in-depth review of both provider and ICB level compliance against the core standards. Organisations undertook a self-assessment, followed by submission of supporting evidence to provide a more rigorous review of our collective resilience within the region and in order to identify opportunities for collaborative working, sharing of good practice and learning between organisations.

Over the last two assurance cycles NHS England has requested ICBs to retain their focus on seeking evidence to support an organisations self assessment, particularly where organisations were self-assessed as partially or non-compliant in 2023, and were subsequently moving to fully compliant – in recognition that the majority of providers had indicated two year work programmes.

Gateshead Health NHS Foundation Trust

For the 2026-27 assurance cycle, we are asking ICBs to return to the practice of gaining confidence in their providers organisational compliance ratings across the **full range of standards**, regardless of the organisations compliance rating in 2025-26.

ICB's are requested to provide a summary brief at the September Regional Health Resilience Partnership (RHRP) outlining the process that has been agreed within their Local Health Resilience Partnership (LHRP) by which they will seek assurance from their providers.

ICBs are asked to have completed their local assurance processes, including any evidence reviews, peer reviews or check and challenge sessions and submitted the following documents to england.eprrney@nhs.net by close of play on Friday 30th October 2026 –

- Individual provider self-assessment returns (excel)
- Individual provider signed statement of compliance (word)
- ICB self-assessment returns (excel)
- ICB signed statement of compliance (word)
- ICB Assurance Reporting Template 2026/27

Regional Assurance Sampling – November 2026

The North East & Yorkshire regional team will undertake a "dip-sample" of core standards for this full review year, and will ask ICBs to provide their organisations assurance rating, and supporting evidence, for an identified core standard from each of the 10 domains.

We will write to ICBs during in October detailing which standards have been chosen as part of the dip sample and request ICBs to return all related information by close of play by Monday 2nd November. Any subsequent check & challenge meetings will take place with ICBs ahead of our formal assurance RHRP meeting.

Assurance Guidance

As with previous years we have provided ICBs and Providers with an assurance guidance document which outlines the elements which are required to demonstrate full compliance against a standard as outlined in the core standards self-assessment template, and any associated guidance pertaining to that area of work.

There have been no significant changes to this document which is being shared with ICB colleagues alongside this letter for ease of reference, and to support organisations in self-assessing their compliance, and in local confirm & challenge sessions having a consistent methodology to determine compliance.

NHS Gateshead Health NHS Foundation Trust

Assurance timescales

For ease we have summarised the EPRR Assurance key dates below –

- ***2nd September 2026*** – ICBs to present assurance methodology at RHRP
- ***w/c 19th October 2026*** – NHSE NEY to request dip-sample information
- ***30th October 2026*** – deadline for submission or full assurance returns
- ***2nd November 2026*** – deadline for ICBs to submit dip-sample evidence
- ***w/c 9th November*** – regional review of dip sample submissions
- ***w/c 16th November*** – dip sample check & challenge window (if required)
- ***26th November 2026*** – Regional Sign off – ICB, Provider & Regional returns
- ***4th December 2026*** – Assurance Regional Health Resilience Partnership
- ***17th December 2026*** – National submission deadline

I recognise that the publication of the ICB and Regional blueprints and subsequent change programmes has placed additional burdens on EPRR professionals across the region, as well as impacting on resourcing and capacity across the wider NHS and want to take the opportunity to that you and your teams to your continued focus on improving our collective resilience amidst this organisational change.

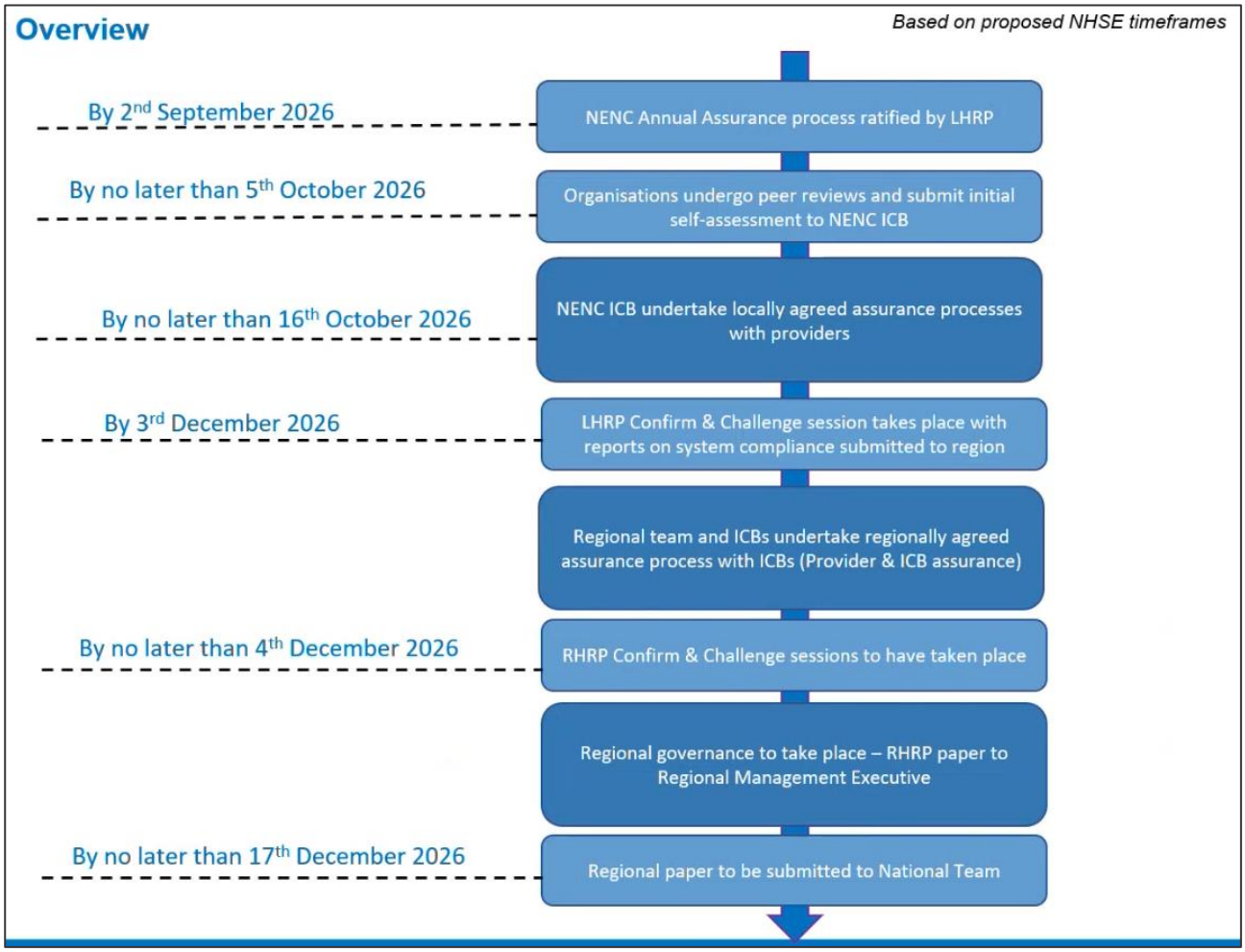
Myself and the team will continue to seek opportunities to support and assist over the coming months, but ahead of another assurance period can I take a moment to thank you in advance for your continued support and engagement in our regional assurance processes and to thank not only yourselves, but your teams in your hard work and efforts in the year to date.

Yours sincerely,

Paul Dickens
Deputy Director of EPRR & System Resilience
NHS England (North East & Yorkshire region)

Gateshead Health NHS Foundation Trust

Appendix 2 - EPRR Core Standards Assurance Process (NENC ICB Submission Timeline)



Gateshead Health
NHS Foundation Trust

Appendix 3 – Statement of Compliance

North East & Yorkshire Emergency Preparedness, Resilience and Response (EPRR) assurance 2026-2027

STATEMENT OF COMPLIANCE

Click here to enter text. has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Click here to enter text. will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Choose an item. (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board/governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

Date signed

Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

c - Responsible Officer Assurance Report presented by the Medical Director

NHS Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 3c

Report Title:	**Responsible Officer Assurance Report: Illustrative Designated Body Annual Board Report and Statement of Compliance (Reporting Period 1 April 2025 – 31 March 2026)**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29th September 2026			
Author:	Dr Catherine Kirkley – Associate Medical Director for Workforce Ross Peddie – Associate Director of Medical Staffing Ferne Clements – Medical Staffing Manager Carol O'Flaherty – Head of People Services			
Executive Sponsor:	Carmen Howey – Medical Director			
Report presented by:	Carmen Howey – Medical Director			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	Review the content of this report and confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Medical Workforce Group (MWG) – Wednesday 16th September 2026 Executive Management Committee (EMC) – Thursday 24th September 2026 (Paper not discussed at time of sharing for Board of Directors, any updates to be given verbally)			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety*	This report sets out the information and metrics that the Trust is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards for the period of the 1st April 2025 – 31st March 2026. The Trust continues to run a robust process for appraisal and revalidation, which it has done since the revalidation			

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• *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	process was introduced, and the Trust has made strong progress against the actions in the 2024/25 assurance report with only 4 actions outstanding from the previous reporting window. In the reporting window 265 appraisals were undertaken. Revalidation operates at the trust, with continued co-operation between the Medical Staffing Team and Medical Directors Office to ensure recommendations are sent in a timely manner. The Trust has implemented actions to address the identified risks in the 2024/25 report including the risk and challenge associated with the lack of a dedicated professional standards function within the Medical Staffing Team, which has been resolved via recruitment into a Professional Standards role and the mitigation of the data quality issues identified with GMC Connect which has been mitigated with new processes.	
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	Board of Directors is asked to review the content of this report and review if the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013). The RO statement of compliance will then be submitted to the national team ahead of the deadline of the 31st October 2026.	
Trust strategic priorities that the report relates to:	☒	Excellent patient care
	☒	Great place to work
	☒	Working together for healthier communities
	☐	Fit for the future
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	The RO report provides assurances to the Trust Board and to NHS England that the Trusts compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards is achieved. Professional Standards are key to achieve a number of the Trusts strategic priorities. **Excellent Patient Care:** • By supporting doctors in identifying and addressing areas for improvement, medical	

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	appraisals ultimately contribute to enhanced patient care. • The focus on professional development and quality improvement helps doctors to refine their skills, update their knowledge, and provide the best possible care to their patients. • The appraisal process also encourages doctors to consider feedback from colleagues and patients, which can further inform their practice and improve the quality of care they deliver. **Great Place to Work:** • Medical appraisals are a cornerstone of the revalidation process, which is how doctors demonstrate to the General Medical Council (GMC) that they are fit to practice. • The appraisal process helps doctors gather the necessary supporting information for revalidation, such as evidence of continuing professional development (CPD), quality improvement activity (QIA), and feedback from colleagues and patients. • By participating in regular appraisals, doctors can proactively address any potential areas for improvement and demonstrate their ongoing commitment to professional development. **Working together for healthier communities:** • Participating in medical appraisals is a mandatory requirement for all licensed doctors in the UK. • By engaging with the appraisal process, doctors demonstrate their commitment to meeting the professional standards set by the GMC. • Appraisals help doctor to demonstrate they are up-to-date with best practice, maintaining competence, and providing safe and effective care.

Links to CQC Key Lines of Enquiry (KLOE):	Caring ☐	Responsive ☐	Well-led ☒	Effective ☐	Safe ☐
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised					

on our risk management system with risk reference number):			
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☒	**Not applicable** ☐

Annex A

Illustrative Designated Body Annual Board Report and Statement of Compliance

This template sets out the information and metrics that a designated body is expected to report upwards, through their Higher Level Responsible Officer, to assure their compliance with the regulations and commitment to continual quality improvement in the delivery of professional standards.

Section 1 – Qualitative/narrative
Section 2 – Metrics
Section 3 - Summary and conclusion
Section 4 - Statement of compliance

Section 1 Qualitative/narrative

All statements in this section require yes/no answers, however the intent is to prompt a reflection of the state of the item in question, any actions by the organisation to improve it, and any further plans to move it forward. You are encouraged therefore to provide concise narrative responses

Reporting period 1 April 2025 – 31 March 2026

1A – General

The board/executive management team of:

Dr Sean Fenwick – Group Chief Executive
Dr Carmen Howey – Group Medical Director
Beth Swanson – Group Chief Nurse and Professional Lead for Midwifery and Allied Health Professionals
Amanda Venner - Group Director of People and OD
Kris Mackenzie - Group Director of Finance

can confirm that:

1A(i) An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Y/N	Yes
Action from last year:	Dr Carmen Howey, Group Medical Director to continue as Responsible Officer. Dr Catherine Kirkley – Associate Medical Director for Medical Workforce to continue as the Clinical Appraisal Lead.
Comments:	Dr Carmen Howey, Group Medical Director and Consultant Community Paediatrics, was appointed and took up the substantive post on 1st July 2024 in the previous reporting period. Dr Howey is now the Responsible Officer for the Trust. Communications sent to clinical colleagues and appropriate medical workforce groups updated that the Trusts responsible officer was Dr Carmen Howey following appointment. Dr Catherine Kirkley – Associate Medical Director for Medical Workforce continues as the Clinical Appraisal Lead and has undertaken RO training to assist in her role.
Action for next year:	Dr Carmen Howey, Group Medical Director to continue as Responsible Officer. Dr Catherine Kirkley – Associate Medical Director for Medical Workforce to continue as the Clinical Appraisal Lead.

1A(ii) Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Y/N	Yes
Action from last year:	Review of the appraisal software and procurement exercise to run in next reporting window beginning in December 2025. Appraisal delivery against PAs to be monitored and feedback to individuals and number of recruited appraisers to continue to be monitored.
Comments:	Appraisal system licence extended to December 2026, review to form action for next years reporting window.

	Associate Medical Director (AMD) for Workforce continues to monitor appraisal delivery for recruited Trust Appraisers.
Action for next year:	Stakeholder Engagement to be carried out for Trust appraisers and appraisees for appraisal system with the current offer to be reviewed. Business Case to follow if required. E-Job Planning Implementation to support with review of appraiser PAs Trust wide.

1A(iii)An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

Y/N	Yes
Action from last year:	To ensure new starters are connected on the start date, the start date added to MST calendar once this is confirmed with medical recruitment and connection made on the day. For leavers People Data and Information team inform MST once a medical termination has been processed and the disconnect is actioned on this date. When doctors connect or disconnect notifications are received into centralised inbox which is monitored daily to ensure these can be checked for accuracy. A monthly check is then completed using the monthly starters and leavers report which is sent to the Medical Staffing Team. This report is used to ensure that the starters are connected to GMC Connect, and the leavers are disconnected (if already not actioned). This process has been shared with the GMC ELA for assurances. This process is currently managed by the Medical Staffing Team administrator as the Trust currently does not have a formal professional standards team. A Medical Staffing Team restructure to be action to establish a dedicated substantive professional standard function in the Medical Staffing Team.
Comments:	New processes established and embedded into Medical Staffing to ensure accuracy of prescribed connections and ensuring this is maintained. Medical Staffing Co-ordinator with specific Professional Standards portfolio recruited into the team to ensure a dedicated Professional Standard capacity in the team.

Action for next year:	To continue with the processes / actions implemented in the current reporting year.

1A(iv) All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Y/N	Yes
Action from last year:	Review PP33 Revalidation and Appraisal Policy for Senior Medical Staff.
Comments:	Policy PP33 reviewed and discussed at Medical Workforce Group (MWG) 19/09/2025 and 19/11/2025 prior to ratification via the Trusts processes.
Action for next year	Ensure Policy PP33 is ratified and published. (Ratification on 15/05/2026, published on the intranet on the 08/06/2026)

1A(v) A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

Y/N	Yes
Action from last year:	Engage with alliance partners and attend and support any regional peer review exercises. If no formal peer review exercises planned for the reporting window Associate Medical Director for Workforce to continue to network and discuss with regional peers.
Comments:	Great North Healthcare Alliance & Strategy Director conducted scoping exercise including review of appraisal process and policies. Trust information submitted and summary report shared with all Trusts highlighting little variation in policy and processes.
Action for next year:	Continue to engage with alliance partners and attend and support any regional peer review exercises.

1A(vi) A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

Y/N	Yes
Action from last year:	The standard process would be followed as outlined in the comments. No deviation would take place from this.
Comments:	Those medical staff be it in a locum or Locally Employed Doctor post follow the same appraisal, revalidation and governance processes. For locum Doctors approval is always requested from the agency for the Trust to undertake this on the agency's behalf.
Action for next year	Awaiting national guidance due October 2026 for enhanced appraisal for LED's, which will be implemented in year.

1B – Appraisal

1B(i) Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Y/N	Yes
Action from last year:	Medical Staffing Team to review structure and plan to substantiate a professional standard post to support with the appraisal process for doctors and ensure the reporting and information is provided to cover the doctors whole practice.
Comments:	Medical Staffing Co-ordinator with specific Professional Standards portfolio recruited into the team to ensure a dedicated Professional Standard capacity in the team. Each Senior Medical Staff member is provided with the relevant reports to cover their scope of practice which may include: Complaints report Clinical Incidents report Clinic and / or theatre activity Healthcare Evaluation Data (HED) revalidation report

	Core skills report And if required private practice reports from either Newcastle Nuffield, Washington Spire and Tyneside Surgical Services (TSS).
Action for next year:	Medical Staffing Team to continue to embed the new professional standards team structure implemented to support with the appraisal process for doctors and ensure the reporting and information is provided to cover the doctors whole practice.

1B(ii) Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

Y/N	Yes
Action from last year:	Continue with the standard recording of reasons above.
Comments:	The standard recording would be followed as outlined in the comments above. No deviation would take place from this.
Action for next year:	Continue with the standard recording of reasons above.

1B(iii) There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Y/N	Yes
Action from last year:	Review PP33 Revalidation and Appraisal Policy for Senior Medical Staff.
Comments:	Trust Policy PP33 Revalidation and Appraisal Policy for Senior Medical Staff is monitored in line with Trust Guidance (last review and update was 22nd February 2024). Policy PP33 reviewed and discussed at Medical Workforce Group (MWG) 19/09/2025 and 19/11/2025 prior to ratification via the Trusts processes.
Action for next year:	Ensure Policy PP33 is ratified and published.

	(Ratification on 15/05/2026, published on the intranet on the 08/06/2026)

1B(iv) Our organisation has the necessary number of trained appraisers[1] to carry out timely annual medical appraisals for all its licensed medical practitioners.

Y/N	Yes
Action from last year:	The Trust to continue to look to recruit further appraisers to add to the Trust medical appraiser faculty. Medical appraiser's numbers to be monitored and feedback annually.
Comments:	At present the Trust has 31 trained appraisers for approximately 363 connections (number accurate from the last day of the review period). This would require an average of 12 appraisals undertaken per year. This would meet the benchmark set out in the statement of compliance (5 – 20, footnote 1).
Action for next year:	The Trust to continue to look to recruit further appraisers to add to the Trust medical appraiser faculty. Medical appraiser's numbers to be monitored and feedback annually.

1B(v) Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

Y/N	Yes
Action from last year:	Plan to standardise appraisers quality assurance statement to ensure appraisers are fulfilling the professional standards expected from the appraiser role. Feedback to be quantified and reported back into Medical Workforce Group as part of the group's core metrics to measure the quality of appraisals.

[1] While there is no regulatory stipulation on appraiser/doctor ratios, a useful working benchmark is that an appraiser will undertake between 5 and 20 appraisals per year. This strikes a sensible balance between doing sufficient to maintain proficiency and not doing so many as to unbalance the appraiser's scope of work.

Comments:	All appraisal output forms are reviewed and returned where not appropriately completed. Feedback from the appraisee is collected and inputted into the system via a feedback survey. The report is not released until the feedback is provided.
Action for next year:	Feedback to be quantified and reported back into Medical Workforce Group as part of the groups core metrics to measure the quality of appraisals.

1B(vi) The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Y/N	Yes
Action from last year:	Quality assurance information to be reported via Medical Workforce Group as part of the standard agenda and escalated via the trusts assurance reports.
Comments:	All input forms are quality assured to make sure the relevant Supporting Information is included within an individual's annual appraisal. All output forms are monitored by the Medical Staffing Team to ensure meeting expected standards. A standard template has been provided to all appraisers so there is an expectation in terms of output for commentary. This has not feed into the MWG metrics and will remain an action for next year.
Action for next year:	Quality assurance information to be reported via Medical Workforce Group as part of the standard agenda and escalated via the Trusts assurance reports.

1C – Recommendations to the GMC

1C(i) Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Ensure new SOP for GMC connect listings is followed and GMC Connect listings are all updated and relevant.
Comments:	GMC prescribed connections process embedded to ensure no data quality issues as flagged in previous reporting period.

	0 late recommendations in the reporting period.
Action for next year:	To continue with the new SOP for GMC connect listings is followed and GMC Connect listings are all updated and relevant.

1C(ii) Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

Y/N	Yes
Action from last year:	Continue standard practice which is for the Responsible Officer to review the information relevant to the doctor one month prior to the due date of revalidation and for the doctor to be advised of the recommendation on the same working day.
Comments:	Once the relevant recommendation has been decided upon the Doctor is advised of this information the same working day.
Action for next year:	Continue standard practice which is for the Responsible Officer to review the information relevant to the doctor one month prior to the due date of revalidation and for the doctor to be advised of the recommendation on the same working day.

1D – Medical governance

1D(i) Our organisation creates an environment which delivers effective clinical governance for doctors.

Y/N	Yes
Action from last year:	Continue to hold and provide supporting information for Doctors appraisal related to clinical governance.

Comments:	The Trust has various departments where information is held for effective governance for Doctors which culminates in all the relevant Supporting Information being provided to a Doctor for appraisal. Departments include People, Data and Information, Complaints, PALs, Patient Safety and a number of other reports are 'pulled' by the Medical Staffing team from internal Business Intelligence systems.
Action for next year:	Continue to hold and provide supporting information for doctors appraisal related to clinical governance.

1D(ii) Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

Y/N	Yes
Action from last year:	Ratify MHPS Policy (PP55) following review in 2024/25. Review number of MHPS Case Investigators and Case Managers and provide recommendations for future training. Flow chart being developed to ensure consistency of approach of management of local concerns, storage of information about concerns and escalation to Medical Director.
Comments:	Systems are in place to alert the Medical Directors office should conduct or performance fall out of professional requirement. Where there are any initial concerns relating to conduct or performance local procedures would be followed in line with 'Maintaining High Professional Standards' PP55. Relevant reporting for medical appraisal and governance can be seen in section 1Di as above. Policy PP55 ratified on the 26/06/2025. Review of MHPS trained case investigators and managers completed. Recommendation that the Trust is in a position of having enough trained case managers and investigators for the predicted number of MHPS investigations per year therefore there are no recommendations to increase the pool of trained staff.

Action for next year:	Ensure policy is implemented and monitored.

1D(iii) All relevant information is provided for doctors in a convenient format to include at their appraisal.

Y/N	Yes
Action from last year:	Continue standard practice for providing information for revalidation introduction.
Comments:	Each Senior Medical Staff member is provided with the relevant reports to cover their scope of practice which may include: Complaints report, Clinical incidents report, Clinic and / or theatre activity, Healthcare Evaluation Data (HED) revalidation report, core skills report and if required private practice reports from either Newcastle Nuffield, Washington Spire and Tyneside Surgical Service (TSS).
Action for next year:	Continue standard practice for providing information for revalidation introduction.

1D(iv) There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Y/N	Yes
Action from last year:	Ratify MHPS Policy following review in 2024/25. Flow chart being developed to ensure consistency of approach of management of local concerns, storage of information about concerns and escalation to Medical Director.
Comments:	MHPS Policy PP55 ratified on the 26/06/2025. A process is in place by the Medical Director's office where any concerns would be investigated and intervention for capability, conduct, health and fitness to practise concerns

	reviewed in line with 'Maintaining High Professional Standards' PP55.
Action for next year:	Continue to ensure concerns would be investigated and intervention for capability, conduct, health and fitness to practise concerns reviewed in line with 'Maintaining High Professional Standards' PP55.

1D(v) The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

Y/N	Yes
Action from last year:	Continue with the above confidential reporting of concerns and issues via Executive Management Team (EMT) to the Trust Board as part of the Reportable Issues Log in relation to Doctors who are subject to Maintaining High Professional Standards review. In addition strengthen oversight by incorporating into the next Annual Report further details regarding the following: • Total number of concerns managed at a local level following discussion with the MD Office, type of concerns, resolution, area of practice, country of primary medical qualification any protected characteristics. • Total number of cases discussed with GMC ELA and PPAS where a referral to the GMC was not made or when the doctor self-referred. • Total number of cases which progressed to a Decision Making Group where the decision was not to progress to an MHPS investigation. Any cases where it was recognised by the MD Office that there was a Conflict of Interest or Appearance of Bias risk in relation to managing concerns regarding a doctor's practice or in relation to a revalidation recommendation and how these were managed.
Comments:	Maintaining High Professional Standards (MHPS) Assurance Report reported to the People and OD Committee (PODC) outlining a breakdown of concerns raised. Reporting period to PODC is annual.

	Concerns and issues are reported confidentially via Executive Management Team (EMT) to the Trust Board in relation to Doctors who are subject to Maintaining High Professional Standards review. Any member of staff can raise concerns through local routes regarding any aspect of a Doctors performance or 10 professionalism. There is an additional mechanism for any staff member to raise concerns confidentially via the Freedom to Speak up Guardian
Action for next year:	Continue with established board reporting framework.

1D(vi) There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

Y/N	Yes
Action from last year:	Standard procedures would be followed as above using the MPfIT form.
Comments:	The MPfIT form is used when necessary to transfer information to other Responsible Officers. The region has an effective network between ROs to allow information to be released and shared when necessary. Also the excellent relationship between Medical Director's office and the GMC ELA allows timely intervention and action.
Action for next year:	Standard procedures would be followed as above using the MPfIT form.

1D(vii) Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Y/N	Yes

Action from last year:	Ratify policy that has been reviewed to strengthen the wording in the MHPS policy in relation to ensuring that processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination.
Comments:	MHPS Policy PP55 ratified on the 26/06/2025. Designated Board member (NED) provides a point of contact and support to any doctor being investigated as part of MHPS and holds the Case Manager to account regarding the progress of the investigation. PPAS are consulted in relation to any doctor being investigated through MHPS as is the GMC ELA. This provides a level of external scrutiny of our internal processes
Action for next year:	Ensure policy is being followed and continue with embedded practice and scrutiny.

1D(viii) Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

Y/N	Yes
Action from last year:	Continue to follow best practice recommendations and following MHPS when pursuing necessary disciplinary actions. Ensure reviewed policy is ratified in next reporting cycle.
Comments:	MHPS Policy PP55 ratified on the 26/06/2025. Current best practice recommendations are followed by the Medical Director's office and the supporting People & OD team. 'Maintaining High Professional Standards' is adhered to when pursuing necessary disciplinary actions
Action for next year:	Continue to follow best practice recommendations and following MHPS when pursuing necessary disciplinary actions.

1D(ix) Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

Action from last year:	Continue to implement highlighted policies and review alongside policy review timeline.
Comments:	Professional standards for all healthcare professionals are managed in accordance with the following policies: • Professional Registration Policy (Expiry 11/06/2029) • Revalidation and Appraisal Policy for Senior Medical Staff (Expiry 08/06/2029) • Appraisal policy (for all non-medical colleagues) (Expiry 14/11/2028) • Managing Performance Policy (Expiry 31/07/2029) Concerns where professional standards may not be being met due to conduct are management through the Investigations and Disciplinary Policy.
Action for next year:	Continue to implement highlighted policies and review alongside policy review timeline. (No policy due review in next reporting period)

1E – Employment Checks

1E(i) A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Y/N	Yes
Action from last year:	All employment checks will continue to be undertaken via the recruitment team through TRAC as standard practice.
Comments:	All necessary employment checks are undertaken by the Trusts recruitment team
Action for next year:	All employment checks will continue to be undertaken via the recruitment team through TRAC as standard practice.

1F – Organisational Culture

1F(i) A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

Y/N	Yes
Action from last year:	Continue to implement the 'clinically led, management supported' model and governance structures. Continue to develop the clinical leads development programme to support clinical leaders across the Trust.
Comments:	The Trust has a culture which encourages colleagues to speak up and raise concerns, this is outlined in our Freedom to Speak up policy. The Trust has a Culture Programme Board to support the development of a zero tolerance culture and enable an environment where clinical care can flourish and be continually enhanced. A new Trust AMD for Patient Safety and Quality has been appointed. They have supported engagement with the Civility Saves Lives agenda including a dedicated session at Clinical Strategy Group (CSG).
Action for next year:	Review the Trusts Clinical Lead Development offer and leadership development offer to Clinical Leads to support attendance and engagement.

1F(ii) A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

Y/N	Yes
Action from last year:	Group Violence at Work Policy to be reviewed. Trust reducing violence and aggression meeting now set up and running. Continue to promote and engage with the Staff Networks to ensure that the voice of all of our workforce is heard. Staff networks at the Trust current include:

	LGBT+ Network GEM (Global Ethnic Majority) Network Women's Network D-Ability Network Neurodiversity Network
Comments:	Group Violence at Work Policy (RM10) Ratified 16/01/2026. Trust reducing violence and aggression meeting now set up and running.
Action for next year:	Continue to promote and engage with the Staff Networks to ensure that the voice of all of our workforce is heard. Staff networks at the Trust current include: LGBT+ Network GEM (Global Ethnic Majority) Network Women's Network D-Ability Network Neurodiversity Network

1F(iii) A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

Y/N	Yes
Action from last year:	Begin review of the Trust PP35 Freedom to Speak up policy in accordance with review period. Continue with exec team brief, CEO roadshows, and other methods to increase visibility of the Trusts executive team. Continue to promote the Trusts Freedom to Speak Up Guardian and champions.
Comments:	PP35 Freedom to Speak Up Policy ratified 26/02/2026. Interactive Exec Team brief meetings running on Teams monthly.
Action for next year:	Continue with exec team brief, CEO roadshows, and other methods to increase visibility of the Trusts executive team. Continue to promote the Trusts Freedom to Speak Up Guardian and champions

1F(iv) Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

Y/N	Yes
Action from last year:	Begin review of the Group Grievance Policy in accordance with review period.
Comments:	Group Grievance Policy (PP02) reviewed in reporting window but not ratified in the reporting period.
Action for next year:	Ratify the Group Grievance Policy (PP02) (Ratified 27/07/2026)

1F(v) Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

Y/N	Yes
Action from last year:	Include in Chair briefs the clarity of the role of the Cultural Ambassador in the meetings. Ensure that country of primary medical qualification and protected characteristics are recorded in the processes associated with addressing concerns for doctors and ensure that this is collated as part of the Annual Report and any issues of potential discrimination are explored.
Comments:	In templates for formal processes, including disciplinary, colleagues are asked if they would like to be supported by a Cultural Ambassador during the meeting.
Action for next year:	Ensure Board Assurance Report on MHPS contains the protected characteristics.

1G – Calibration and networking

1G(i) The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not

restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

Y/N	Yes
Action from last year:	Continue to review via the RO network.
Comments:	This would be reviewed via the Responsible Officer network held on a regional / quarterly basis.
Action for next year:	Continue to review via the RO network.

Section 2 – metrics

Year covered by this report and statement: 1 April 2025 – 31 March 2026.

All data points are in reference to this period unless stated otherwise.

The number of doctors with a prescribed connection to the designated body on the last day of the year under review	363
Total number of appraisals completed	304
Total number of appraisals approved missed	12
Total number of unapproved missed	38
The total number of revalidation recommendations submitted to the GMC (including decisions to revalidate, defer and deny revalidation) made since the start of the current appraisal cycle	25
Total number of late recommendations	0
Total number of positive recommendations	20
Total number of deferrals made	5
Total number of non-engagement referrals	0
Total number of doctors who did not revalidate	0
Total number of trained case investigators	14
Total number of trained case managers	8
Total number of concerns received by the Responsible Officer[2]	3
Total number of concerns processes completed	3
Longest duration of concerns process of those open on 31 March (working days)	176
Median duration of concerns processes closed (working days)[3]	87
Total number of doctors excluded/suspended during the period	0
Total number of doctors referred to GMC	0

[2] Designated bodies' own policies should define a concern. It may be helpful to observe https://www.england.nhs.uk/publication/a-practical-guide-for-responding-to-concerns-about-medical-practice/, which states: *Where the behaviour of a doctor causes, or has the potential to cause, harm to a patient or other member of the public, staff or the organisation; or where the doctor develops a pattern of repeating mistakes, or appears to behave persistently in a manner inconsistent with the standards described in Good Medical Practice.*

[3] Arrange data points from lowest to highest. If the number of data points is odd, the median is the middle number. If the number of data points is even, take an average of the two middle points.

Total number of appeals against the designated body's professional standards processes made by doctors	N/A
Total number of these appeals that were upheld	N/A
Total number of new doctors joining the organisation	67
Total number of new employment checks completed before commencement of employment	67
Total number claims made to employment tribunals by doctors	0
Total number of these claims that were not upheld[4]	N/A

Section 3 – Summary and overall commentary

This comments box can be used to provide detail on the headings listed and/or any other detail not included elsewhere in this report.

General review of actions since last Board report
The Trust continues to run a robust process for appraisal and revalidation, which it has done since the revalidation process was introduced, and the Trust has made strong progress against the actions in the 2024/25 assurance report, with only 4 actions deemed outstanding from the 2024/25 assurance report.
Actions still outstanding
General: Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role. • Review of the appraisal software and procurement exercise to run in next reporting window beginning in December 2025. 2025/26: Licence extended with current appraisal system provider to December 2026 and action to review with stakeholders included as an action for this year's report. Stakeholder engagement planned July – August 2026. **Appraisal:** Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events,

[4] Please note that this is a change from last year's FQAI question, from number of claims upheld to number of claims not upheld".

peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

- Feedback to be quantified and reported back into Medical Workforce Group as part of the groups core metrics to measure the quality of appraisals.

  2025/26: Reporting of quantified information still to be included in the MWG Core Metrics for appraisal quality. Action included for next years reporting period.

Our organisation has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

- The Trust to continue to look to recruit further appraisers to add to the Trust medical appraiser faculty. Medical appraiser's numbers to be monitored and feedback annually.

  2025/26: In the previous reporting window, the Trust had 31 trained appraisers, in this reporting window the Trust has 31 which hasn't increased the Trusts appraisers. Actions for next year to focus on increasing the number of Trust appraisers.

Organisational Culture

Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

- Begin review of the Group Grievance Policy in accordance with review period.

  2025/26: Group Grievance Policy (PP02) reviewed in reporting window but not ratified in the reporting period.

Current issues

The issues highlighted in the 2024/25 RO Report have been resolved via the completed actions so no highlighted issues for the 2025/26 report.

Actions for next year (replicate list of 'Actions for next year' identified in Section 1):

General:

An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

- Dr Carmen Howey - Group Medical Director to continue as Responsible Officer.

- Dr Catherine Kirkley - Associate Medical Director for Medical Workforce to continue as the Clinical Appraisal Lead.

Our organisation provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

- Stakeholder Engagement to be carried out for Trust appraisers and appraisees for appraisal system with the current offer to be reviewed. Business Case to follow if required.
- E-Job Planning Implementation to support with review of appraiser PAs Trust wide.

An accurate record of all licensed medical practitioners with a prescribed connection to our responsible officer is always maintained.

- To continue with the processes / actions implemented in the current reporting year.

All policies in place to support medical revalidation are actively monitored and regularly reviewed.

- Ensure Policy PP33 is ratified and published. (Ratification on 15/05/2026, published on the intranet on the 08/06/2026)

A peer review has been undertaken (where possible) of our organisation's appraisal and revalidation processes.

- Continue to engage with alliance partners and attend and support any regional peer review exercises.

A process is in place to ensure locum or short-term placement doctors working in our organisation, including those with a prescribed connection to another organisation, are supported in their induction, continuing professional development, appraisal, revalidation, and governance.

- Awaiting national guidance due October 2026 for enhanced appraisal for LED's, which will be implemented in year.

Appraisal

Doctors in our organisation have an annual appraisal that covers a doctor's whole practice for which they require a GMC licence to practise, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

- Medical Staffing Team to continue to embed the new professional standards team structure implemented to support with the appraisal process for doctors

and ensure the reporting and information is provided to cover the doctors whole practice.

Where in Question 1B(i) this does not occur, there is full understanding of the reasons why and suitable action is taken.

- Continue with the standard recording of reasons above.

There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

- Ensure Policy PP33 is ratified and published. (Ratification on 15/05/2026, published on the intranet on the 08/06/2026)

Our organisation has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

- The Trust to continue to look to recruit further appraisers to add to the Trust medical appraiser faculty. Medical appraiser's numbers to be monitored and feedback annually.

Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent).

- Feedback to be quantified and reported back into Medical Workforce Group as part of the groups core metrics to measure the quality of appraisals.

The appraisal system in place for the doctors in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

- Quality assurance information to be reported via Medical Workforce Group as part of the standard agenda and escalated via the trusts assurance reports.

Recommendations to the GMC

Recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to our responsible officer, in accordance with the GMC requirements and responsible officer protocol, within the expected timescales, or where this does not occur, the reasons are recorded and understood.

- To continue with the new SOP for GMC connect listings is followed and GMC Connect listings are all updated and relevant.

Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted, or where this does not happen, the reasons are recorded and understood.

- Continue standard practice which is for the Responsible Officer to review the information relevant to the doctor one month prior to the due date of revalidation and for the doctor to be advised of the recommendation on the same working day.

Medical Governance

Our organisation creates an environment which delivers effective clinical governance for doctors.

- Continue to hold and provide supporting information for doctors appraisal related to clinical governance.

Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation.

- Ensure policy is implemented and monitored.

All relevant information is provided for doctors in a convenient format to include at their appraisal.

- Continue standard practice for providing information for revalidation introduction.

There is a process established for responding to concerns about a medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

- Continue to ensure concerns would be investigated and intervention for capability, conduct, health and fitness to practise concerns reviewed in line with 'Maintaining High Professional Standards' PP55.

The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors and country of primary medical qualification.

- Continue with established board reporting framework.

There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to our organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.

- Standard procedures would be followed as above using the MPfIT form.

Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

- Ensure policy is being followed and continue with embedded practice and scrutiny.

Systems are in place to capture development requirements and opportunities in relation to governance from the wider system, e.g. from national reviews, reports and enquiries, and integrate these into the organisation's policies, procedures and culture. (Give example(s) where possible.)

- Continue to follow best practice recommendations and following MHPS when pursuing necessary disciplinary actions.

Systems are in place to review professional standards arrangements for all healthcare professionals with actions to make these as consistent as possible (Ref Messenger review).

- Continue to implement highlighted policies and review alongside policy review timeline. (No policy due review in next reporting period)

Employment Checks

A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

- All employment checks will continue to be undertaken via the recruitment team through TRAC as standard practice.

Organisational Culture

A system is in place to ensure that professional standards activities support an appropriate organisational culture, generating an environment in which excellence in clinical care will flourish, and be continually enhanced.

- Review the Trusts Clinical Lead Development offer and leadership development offer to Clinical Leads to support attendance and engagement.

A system is in place to ensure compassion, fairness, respect, diversity and inclusivity are proactively promoted within the organisation at all levels.

- Continue to promote and engage with the Staff Networks to ensure that the voice of all of our workforce is heard. Staff networks at the Trust current include:

  LGBT+ Network
  GEM (Global Ethnic Majority) Network
  Women's Network
  D-Ability Network
  Neurodiversity Network

A system is in place to ensure that the values and behaviours around openness, transparency, freedom to speak up (including safeguarding of whistleblowers) and a learning culture exist and are continually enhanced within the organisation at all levels.

- Continue with exec team brief, CEO roadshows, and other methods to increase visibility of the Trusts executive team.
- Continue to promote the Trusts Freedom to Speak Up Guardian and champions

Mechanisms exist that support feedback about the organisation' professional standards processes by its connected doctors (including the existence of a formal complaints procedure).

- Ratify the Group Grievance Policy (PP02) (Ratified 27/07/2026)

Our organisation assesses the level of parity between doctors involved in concerns and disciplinary processes in terms of country of primary medical qualification and protected characteristics as defined by the Equality Act.

- Ensure Board Assurance Report on MHPS contains the protected characteristics.

Calibration and networking

The designated body takes steps to ensure its professional standards processes are consistent with other organisations through means such as, but not restricted to, attending network meetings, engaging with higher-level responsible officer quality review processes, engaging with peer review programmes.

- Continue to review via the RO network.

Overall concluding comments (consider setting these out in the context of the organisation's achievements, challenges and aspirations for the coming year):

The Trust continues to run a robust process for appraisal and revalidation, which it has done since the revalidation process was introduced, and the Trust has made strong progress against the actions in the 2024/25 assurance report with only 4 actions outstanding from the previous reporting window. In the reporting window 265 appraisals were undertaken. Revalidation operates at the trust, with continued co-operation between the Medical Staffing Team and Medical Directors Office to ensure recommendations are sent in a timely manner. The Trust has implemented actions to address the identified risks in the 2024/25 report including the risk and challenge associated with the lack of a dedicated professional standards function within the Medical Staffing Team, which has been resolved via recruitment into a Professional Standards role and the mitigation of the data quality issues identified with GMC Connect which has been mitigated with new processes.

Section 4 – Statement of Compliance

The Board/executive management team have reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of the designated body:	Gateshead Health NHS Foundation Trust.

Name:	Dr Sean Fenwick
Role:	Chief Executive
Signed:	
Date:	

Name of the person completing this form:	Ross Peddie – Associate Director of Medical Staffing
Email address:	ross.peddie@nhs.net

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

NHS Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 3d

Report Title:	**Maternity Integrated Oversight Report September 2026**			
Name of Meeting:	Trust Board – Part 1			
Date of Meeting:	29th September 2026			
Author:	Mrs Karen Parker Associate Director of Midwifery/SCBU			
Executive Sponsor:	Beth Swanson, Chief Nurse and Professional Lead for Midwifery and AHPs			
Report presented by:	Karen Parker			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	This report presents an overview of maternity and neonatal metrics for August 2026			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Obstetrics & Gynaecology Safecare 10/9/2026 Division of Surgery, Women's Health and Children Operational Board 30/9/2026 Safety Champions 18/9/2026 Safecare Steering Group 15/9/2026			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	**Alert** • New case reported to MNSI – awaiting triage **Advise** • Health inequalities dashboard – due quarterly update but data available not updated – query raised with NHSE dashboard team • New risk – unfilled clinical leadership roles & lack of perinatal mortality & morbidity meeting • 10-point plan for Maternity & Neonatal services benchmarking (separate paper) **Assure** • Guidelines ratified – Unauthorised access & abduction policy, Anaemia in pregnancy, CGL (Change, Grow, Live) pathway			

Gateshead Health NHS Foundation Trust

	• Positive exceptions - Folic acid ICB medication assurance update, Self-referral to Maternity services pathway, patient feedback, £12m estates funding confirmed				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	Accept as monthly perinatal report				
Trust strategic priorities that the report relates to:	☒	Excellent patient care			
	☐	Great place to work			
	☒	Working together for healthier communities			
	☐	Fit for the future			
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	Centre of excellence for Women's Health				
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	2984 & 3107 – Maternity estates 4882 – Neonatal workforce 2456 – Infant abduction 4852 – MEOWS 4712 – Antenatal clinic capacity 4897 & 4909 - Badgernet				
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒		

Gateshead Health NHS Foundation Trust

Maternity
Integrated Oversight Report

Maternity data from August 2026

Executive Summary

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

- New case to be reported to MNSI for triage

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

- Health inequalities dashboard – due quarterly update but data available not updated – query raised with NHSE dashboard team
- New risk – unfilled clinical leadership roles & lack of perinatal mortality & morbidity meeting
- 10-point plan for Maternity & Neonatal services benchmarking (separate paper)
- MNSI quarterly Trust update (Part 2)

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

- New/updated guidelines – Unauthorised access & abduction policy, Anaemia in pregnancy, CGL (Change, Grow, Live) pathway
- Positive exceptions - Folic acid ICB medication assurance update, Self-referral to Maternity services pathway, patient feedback, £12m estates funding confirmed

Slide No.!	Metric *data reporting is for preceding month - January 2026 report is December 2025 data	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Notes
Monthly reports														
	Minimum board measures data set	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	Monthly Maternity dashboard activity data	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	Maternity Incentive Scheme compliance	✓	✓					✓		✓				
	Maternity Outcomes Signal (MOSS)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	Regional Heatmap	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
	MDT workforce	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Exception reports (as required)														
	SPC exception reports	✓	✓	0	0	0	0	0	2	1				CO monitoring at booking & 36 weeks
	PSII/MNSI/perinatal mortality – new & completed cases	0	✓	0	✓	0	✓	0	0	0				
	Risk register – new emerging risks & updates	✓	✓	✓	✓	✓	✓	✓	✓	✓				
Quarterly reports		Q2 2025/ 26	Q3 2025/26			Q4 2025/26			Q1 2026/27			Q2 2026/27		
	Perinatal Mortality Review Tool (PMRT)	✓				✓				✓				Quarterly MNSI update & Q1 M&M report
	Transitional Care & ATAIN (avoiding term admissions to neonatal units)				✓			✓		✓			✓	
	SBLCB (Saving Babies Lives Care Bundle)		✓						✓			✓		
	MCB (Maternal Care Bundle)								✓					
	Complaints, Compliments & Incidents	✓			✓			✓			✓			
	Maternity Inequalities Dashboard			✓			✓			✓			✓	Data error noted on dashboard – query raised to NHSE
Bi-annual reports		Q1 & Q2 2025/ 26	Q3 & Q4 2025/26						Q1 & Q2 2026/27					
	Legal NHSR Scorecard/DofC compliance	✓						✓	✓			✓		

2026/27		April	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March
Number of perinatal losses		1	1	1	0	0							
Number of MNSI cases		1	0	0	0	1 awaiting MNSI triage							
Number of incidents logged as moderate harm or above		0	0	0	0	1							
Minimum obstetric safe staffing on labour ward		100%	100%	100%	100%	100%							
Service user feedback	FFT "Overall how was your experience of our service" – total score for very good and good responses	100%	100%	100%	83.3%*								
	Complaints	4	3	0	1	3							
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust		0	0	0	0	0							
Coroner Reg 28 made directly to Trust		0	0	0	0	0							
MOSS Safety Signals		0	0	0	0	0							
Regional Heatmap Score		23	23	17	23	23							

*1FFT report from July rated **Very Poor** – *"midwives and doctors were absolutely amazing but patient is coeliac and unable to be catered for"*, good/very good responses mentioned longer visiting hours as area for improvement, only 5 responses in July

Maternity Dashboard 2026/27 – August 2026

Maternity

Gateshead Health NHS Foundation Trust

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Total Births	Aug 26	163	-			152	125	180
Spontaneous vaginal deliveries	Aug 26	75	-			64	48	80
Assited births	Aug 26	88	-			88	66	109
Induction of Labour	Aug 26	53	-			53	29	78
Maternity Readmissions	Aug 26	1	-			2	-2	6
Neonatal Readmissions	Aug 26	6	-			5	-3	13
Smoking at time of booking	Aug 26	5.63%	15.00%		P	5.34%	1.13%	9.55%
Smoking at time of delivery	Aug 26	0.62%	6.00%		?	3.37%	-2.28%	9.03%
In area CO at booking	Aug 26	88.03%	90.00%		P	96.24%	92.03%	100.44%
In area CO at 36 weeks	Aug 26	77.18%	80.00%		?	87.12%	79.83%	94.42%
Admitted directly to NNU (SCBU) (>37 weeks)	Aug 26	9	4		?	7	-2	16
Percentage Admitted directly to NNU (SCBU) (>37 week	Aug 26	5.88%	6.00%		?	5.20%	-1.34%	11.74%
Preterm birth rate <=36+6 weeks at birth	Aug 26	6.13%	6.00%		?	5.78%	0.06%	11.50%
Apgar < 7 (NMPA Definition)	Aug 26	4	-			4	-3	11
Apgar < 7 Percentage (NMPA Definition)	Aug 26	2.55%	-			2.68%	-1.77%	7.13%
Spontaneous Vaginal Births (%)	Aug 26	46.01%	-			42.31%	33.03%	51.59%
Induction Rate	Aug 26	32.92%	-			35.55%	20.10%	51.00%
Instrumental Delivery Rate	Aug 26	9.20%	-			11.49%	3.25%	19.73%
Elective C Section Rate	Aug 26	16.56%	-			20.80%	14.27%	27.33%
Emergency C Section Rate	Aug 26	27.61%	-			25.34%	15.52%	35.16%
C Section Rate	Aug 26	44.17%	-			46.14%	38.79%	53.49%
3rd or 4th degree tear (Total) Precentage	Aug 26	0.62%	3.00%		?	1.24%	-1.33%	3.81%
Massive PPH >=1.5L (All births)	Aug 26	5	2		?	6	0	11
Breastfeeding: Percentage of Initiated Breasfeeding	Aug 26	79.50%	66.20%		P	78.88%	67.04%	90.73%
Breastfeeding: Breasfeeding at Discharge (Transfer to C	Aug 26	68.39%	56.20%		?	63.46%	55.19%	71.72%

CO monitoring at booking & 36 weeks remain low flag

Safe

Responsive

Effective

Maternity Dashboard 2026/27 – August 2026
Exception report – CO monitoring at 36 weeks

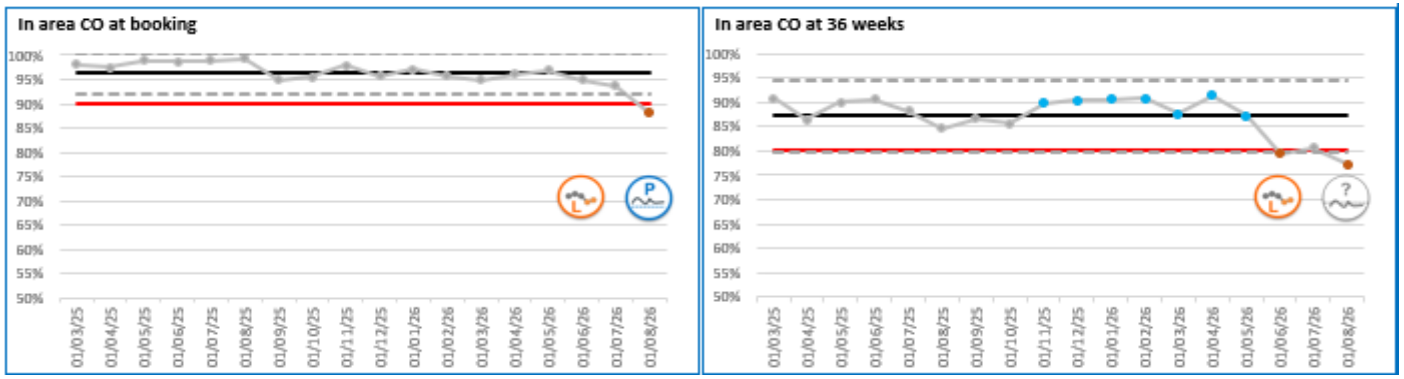
Maternity

Gateshead Health NHS Foundation Trust

Safe

Responsive

Effective



Situation

- Ongoing SPC trigger – low compliance with CO monitoring at 36 weeks, reducing compliance at booking now triggering

Background

- Saving Babies Lives Care Bundle Element 1 – smoking in pregnancy
- All pregnant people should have CO monitoring at booking &36 weeks

Assessment

- Target compliance = 90% at booking, 80% at 36 weeks
- Current compliance = 88% at booking & 77% at 36 weeks - previously sustained target compliance

Recommendation

- Reminder sent to all staff – focus on community & outpatient settings, review of missed opportunities to identify any barriers, individual training updates
- Mandatory smoking session not on 2026/27 TNA – explore ad hoc refresher sessions
- Audit CO monitoring equipment to ensure sufficient, working monitors in service

Maternity Incentive Scheme – Year 8

Gateshead Health NHS Foundation Trust

Overview of progress on MIS year 8 safety action requirements

NHS Resolution

Safety Action	Not started	Compliance risk	In progress & on track	Meets compliance	Fully embedded	Total sub-actions
A	1	0	4	1	1	7
B	0	0	5	0	0	5
C	0	0	6	0	0	6
D	0	0	2	0	0	2
E	0	0	2	1	0	3
F	1	0	2	1	0	3
Local work	0	0	0	0	0	0
National	0	0	0	0	0	0
Total	2	0	21	3	1	

- Mid-year assurance visit from NHSR team:
  - 27 August 2026
  - Safety Action D evidence reviewed & discussed
  - Positive verbal feedback on the day
  - Formal written report to follow (received 14/9/26 – for next IOR)
- Areas for focus:
  - Medical workforce:
    - neonatal BAPM compliance (medical)
    - Obstetric leadership roles
  - Neonatal nursing workforce – workforce review underway & LMNS action plan

Gateshead MOSS August 2026

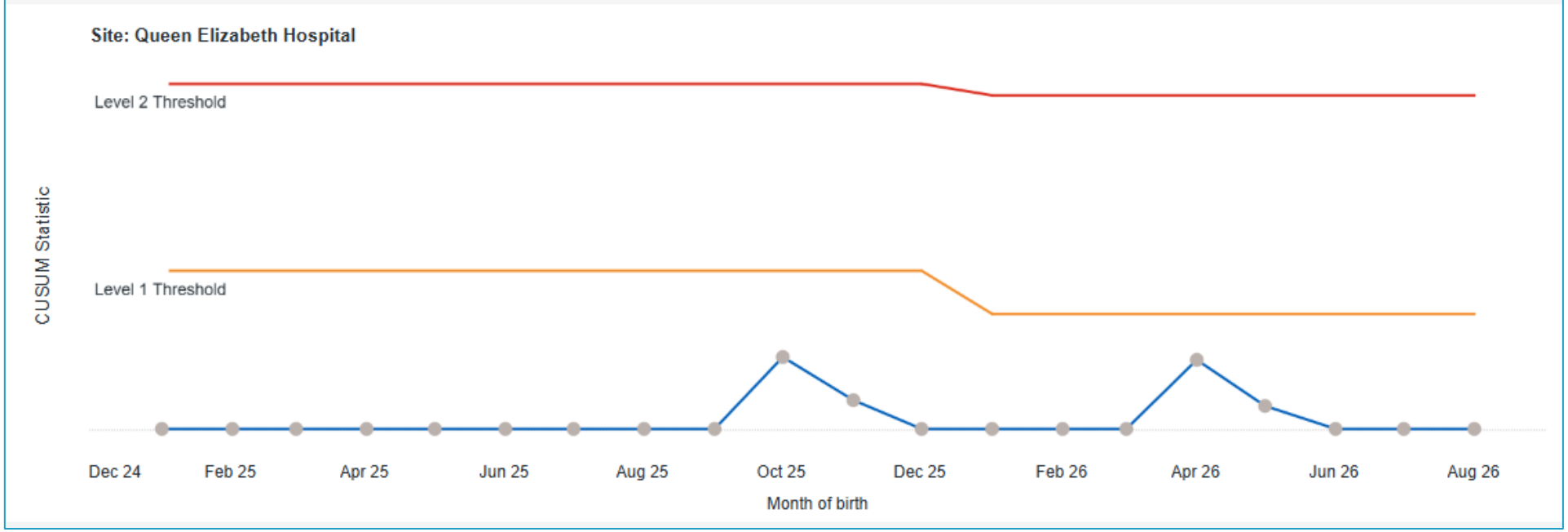
Gateshead Health NHS Foundation Trust

Maternity Outcomes Signal - Cumulative sum (CUSUM) - Gateshead Health NHS Foundation Trust

This chart produces 'signals' of potential safety issues in maternity care arising during labour and birth using term stillbirths and term neonatal deaths up to 28 days.

The maternity unit's perinatal leadership team should carry out a critical safety check when any signal arises to make sure care on the labour ward is safe. Further guidance on this is available in the MOSS Standard Operating Procedures.

Chart guidance can be found using the "I" icon.



Summary:

- 0 safety alarms or alerts – no action required
- Annual MOSS drill required to test governance responses to a safety signal

NENC Regional heatmap August 2026

Gateshead Health NHS Foundation Trust

Regional Maternity Heatmap

Data refreshed: 21/08/2026 16:00:01

Scoring

Region: North East and Yorkshire

NHS England

Heatmap month: August 2026

Provider	Overall score	CQC Mat overall rating	Stake holder concerns	CQC S29a	CQC s31	Ext. ind. review	Coroner reg 28	Mat Oversight	MIS	CNST repay ment	Eth. DQ	CQC Mat Survey	SBL	Midw ives vac.	MSW vac.	Obs vac.	Unfilled roles	Snr L'ship not in post	Safety champs	Birthrate + (last 3 yrs)	Neonatal death rate	Perinatal death rate	Stillbirth rate
[redacted]	62.0	5.0	5	5	0	5	0	5	4	1	0	2	3	2	2		0	5	0	0	5	5	3
	44.0	3.0	5	0	0	0	0	5	0	0	0	2	5	1	2		3	0	0	0	5	5	3
	35.0	5.0	4	0	0	0	0	3	3	0	0	3	5	1	1		1	0	0	0	3	3	3
	30.0	2.0	3	0	0	0	0	2	0	0	0	0	3	2	5		0	0	0	0	5	5	3
	29.3	2.3	4	0	0	0	0	0	2	0	0	3	4	1	3		1	0	0	0	3	3	3
	29.0	1.0	2	0	0	0	5	0	0	0	0	2	1	0	2		0	5	0	0	5	3	3
	28.0	1.0	4	0	0	0	0	0	0	0	0	3	2	1	3		0	5	0	0	3	3	3
	28.0	3.0	5	0	0	0	0	0	0	0	0	2	3	0	4		3	0	0	1	1	3	3
	27.0	3.0	4	0	0	0	0	0	0	0	0	2	4	0	5		1	0	0	1	1	3	3
	26.0	5.0	4	0	0	0	0	2	0	0	0	2	3	2	1		3	0	0	0	0	1	3
	25.0	1.0	1	0	0	0	0	0	0	0	0	3	2	1	3		1	5	0	1	1	3	3
	25.0	3.0	2	0	0	0	0	3	2	0	0	2	5	0	0		1	0	0	0	1	3	3
	23.0	3.0	2	0	0	0	0	0	0	0	0	2	1	0	5		1	0	0	0	3	3	3
GATESHEAD HEALTH NHS FOUNDATION TRUST	23.0	1.0	3	0	0	0	0	0	0	0	0	0	2	1	1		1	5	0	0	3	3	3
[redacted]	23.0	3.0	1	0	0	0	0	2	0	0	0	3	3	0	0		1	0	0	1	3	3	3
	22.0	3.0	4	0	0	0	0	0	0	0	0	2	3	2	0		1	0	0	0	1	3	3
	21.0	3.0	2	0	0	0	0	0	0	0	0	1	3	0	1		0	0	0	0	5	3	3
	21.0	1.0	3	0	0	0	0	0	0	0	0	0	2	0	3		1	0	0	0	5	3	3
	19.0	1.0	2	0	0	0	0	0	0	0	0	2	1	1	4		1	0	0	0	1	3	3

*lower score is better

No change in heatmap score

NENC Regional heatmap August 2026

Gateshead Health NHS Foundation Trust

Regional Maternity Heatmap

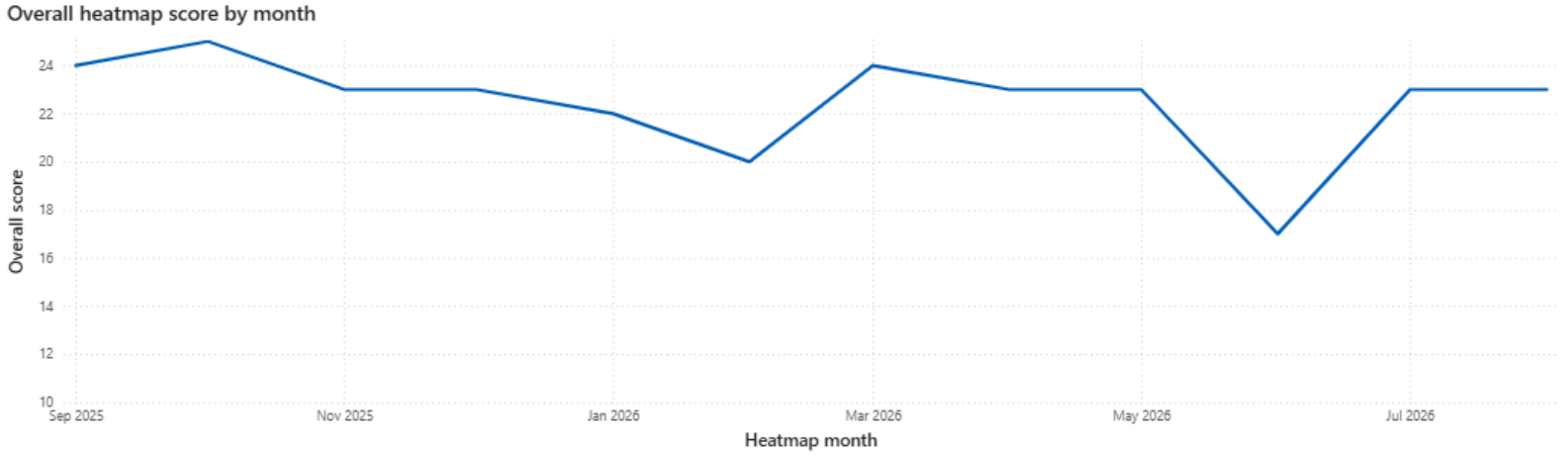
Data refreshed: 21/08/2026 16:00:01

Provider Scoring Summary

Region: North East and Yorkshire

NHS England

Select a trust: GATESHEAD HEALTH NHS FOUNDATION TRUST



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

*lower score is better

MDT workforce update - August 2026

Gateshead Health NHS Foundation Trust

Staff group	Workforce gaps			Bank usage	Minimum staffing requirements	Risks & escalations (Risk register ID where applicable)
	Vacancy rate	Sickness rate	Maternity leave rate			
	Target <2.5%	Target <4.9%				
Midwifery	-4.1%	4.6%	5.4%			Maternity theatre staffing #4859
Midwife Support workers & Healthcare Assistants	-19.8%	4.1%	2.7%			Women's Health Clinic HCA staffing #4729
Obstetric Consultants **Resident doctors**		2.4%			Minimum Consultant staffing on labour ward 100%	Antenatal Clinic Capacity #4712
Neonatal Nurses	13.9%	13.2%	0%		BAPM compliance – workforce review underway against 2025 standards QIS compliance 90%	SCBU/ANNP workforce #2275 Out to recruitment for Band 5 neonatal nurse (permanent, temp & bank)
Paediatric Consultants **Resident doctors** **ANNP**					BAPM compliance: Current ANNP gap of -1.54wte (but 1wte ANNP trainee in post & 1wte ANNP due to commence in Sept 2026)	SCBU/ANNP workforce #2275 Out to recruitment for ANNP (permanent & bank) Paediatric Consultant recruitment complete with neonatal interest
Obstetric Anaesthetists					Obstetric anaesthetist immediately available for the obstetric unit 24 hours a day with clear lines of communication to anaesthetic Consultant 100%	

MDT workforce update - August 2026

Gateshead Health NHS Foundation Trust

Red Flags		No	Factors		No	Actions		No
LWC supernumerary	↑	10	Unexpected midwife sickness/absence	↓	17	Delay to commence IOL/planned procedure	↓	7
1-1 care in labour	=	0	Midwife redeployed to other area	↓	3	Delay in transfer to theatre	=	1
Delay in IOL	↓	6	Midwife on transfer duties	↑	5	2nd theatre in use	=	2
Delay in meeting LSCS timing	↑	1	Support staff less than rostered numbers	↑	34	Delay in ongoing IOL	↓	12
Missed or delayed care	=	0	Midwife scrubbed in theatre	↓	23	Unable to perform ward round due to acuity	=	0
Delay in triage	=	0	2 or more Band 5 midwives on duty	↓	44	Redeploy staff internally	↑	34
			Unable to provide 2nd midwife for emergency theatre	=	3	Staff unable to take breaks/working late	↓	1
			Unable to fill vacant shift	↑	3	Specialist midwife/manager working clinically	↓	0
						Escalate to manager on call	↑	3
Total	↑	17		↓	132		↓	68

1 request for mutual aid & 1 suspension of homebirth service in August 2026

Gateshead Health NHS Foundation Trust

Delays to triage red flag data

- Birthrate+ acuity tool is completed on labour ward & therefore triage delay data is not included
- Separate monitoring of triage times via BSOTS project in place – commenced June 2026
  - June 2026 – 18 breaches >30 minute triage
  - July 2026 – 8 breaches >30 minute triage
  - August 2026 – 24 breaches >30 minute triage
    - Only 12 reported via InPhase
    - Increased number of overall attendances at PAU:
      - monthly increase in births
      - significant impact on PAU from patient's requiring obstetric review with no antenatal clinic capacity
  - *September 2026 (until 10/9/26) – breaches already almost reached total August numbers

- Formal post-implementation audit underway
- National triage specification self assessment in progress (10-point plan)

Risk register – new emerging risks & updates

Risk ID	Division	Description	Initial Grade	Current Grade	Target Grade	Comments
Top Service Risks						
2984	Surg2	There is a risk to our ability to continue to run maternity services from the designated building due to a catastrophic failure of the steam supply, resulting in enactment of a business continuity plan	20	20	8	No change
4852	Surg2	There is a risk of missed deterioration to mothers or babies in maternity theatre and/or on labour ward due to an outdated and inadequate workforce model that does not meet national guidance for safe obstetric theatre staffing. This could result in avoidable patient harm which could result in delay to meet emergency delivery timing standards, delays to elective caesarean section lists, avoidable admissions to SCBU, perinatal death, severe harm or never events.	20	15	5	No change
3107	Surg2	There is a risk of delayed treatment due to maternity estate being in a separate building resulting in the potential for severe harm to mothers & babies	20	15	5	No change
4712	Surg2	Risk that we do not have sufficient antenatal clinic capacity within Consultant job pans, resulting in reduced service provision	15	9	6	Risk reviewed & reduced to 9 as 20-week pilot commenced in July to enhance capacity, for review on completion of pilot Obstetric Consultants to discuss further with risk owner

Risk register – new emerging risks & updates

Risk ID	Division	Description	Initial Grade	Current Grade	Target Grade	Comments
Risk review						
4882	Surg2	There is a risk of delayed or missed reviews of babies in the maternity and neonatal service. Due to the current medical workforce model that is not compliant with national safe standards for SCU Level 1 neonatal settings. This could result in missed opportunities to prevent deterioration, delays to urgent assessment and intervention, and harm to babies in the neonatal and maternity service.	15	9	6	No change
4897	Surg2	There is a risk of missed or delayed clinical risk identification, clinical decision making and care delivery in maternity and neonatal services. This is caused by recurrent BadgerNet system instability, unreliability, functional and clinical safety defects and supplier-identified safety issues (including system crashes, data loss, and delayed or ineffective resolution of known issues by the supplier.) Resulting in compromised patient safety, potential harm to mothers and babies, increased scrutiny from regulators, loss of clinical confidence in digital systems, and reputational and assurance impacts at Board, Audit Committee and regional level.	20	10	5	No change
4909	Surg2	There is a risk that there may be historical cases of poor perinatal outcomes as a result of incorrect risk assessment population on the Badgernet maternity system. Resulting in potential harm to mothers and babies.	10	5	5	Risk closed as harm review completed & no harm identified
2456	Surg2	Risk of infant abduction, due to key areas of weakness within the maternity unit identified as part of the infant abduction exercise. The resulting impact could be catastrophic for babies and families	10	10	5	No change – reception staffing challenges managed

Risk register – new emerging risks & updates

Gateshead Health NHS Foundation Trust

Risk ID	Division	Description	Initial Grade	Current Grade	Target Grade	Comments
Risk review						
	Surg2	Gaps in Obstetric leadership roles against National role descriptors. No perinatal Mortality & Morbidity meeting with paediatric & obstetric involvement				NEW RISK To be discussed at divisional risk management meeting

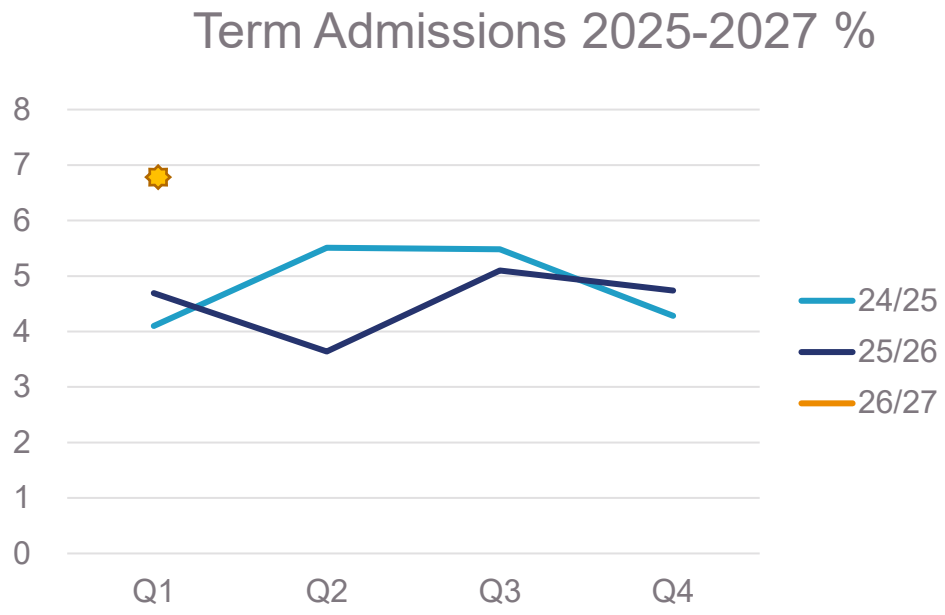
ATAIN Q1 2025/26

Gateshead Health NHS Foundation Trust

Using Badger Neonatal Report	April	May	June
Admitted to NNU (SCBU) (>37 weeks)	7	10	12
Live Births > 37 Weeks	131	149	140
Percentage Admitted directly to NNU (SCBU) (>37 weeks)	5.34%	6.71%	8.57%
Quarterly	6.9%		

	Issue	Action	Update	Lead	Date for completion
1	**Timing of admission to SCBU**	• KA deep dive audit into how quickly babies are being admitted to SCBU, particularly from caesarean sections.		KA	
2	**Golden Hour**	• Documentation of first feed – ensure staff are submitting correct time for feed. • Focus not just on “at risk” babies but all babies		KA	
3	**Level of Seniority** Paediatric seniority at emergency deliveries	• KA liaising with paediatric colleagues. Gathering guidance from across NENC to standardise on a local level.		KA	
4	**Discrepancy in Data** Issue between Badgernet / Maternity Dashboard / Inphase. Difficult to ensure all term admissions are captured.	• System C contacted re term admissions not on list – advised due to how baby’s are documented. Support from System C for correct process to share with staff. KA to share with neonatal staff..		KA / CR / JR	

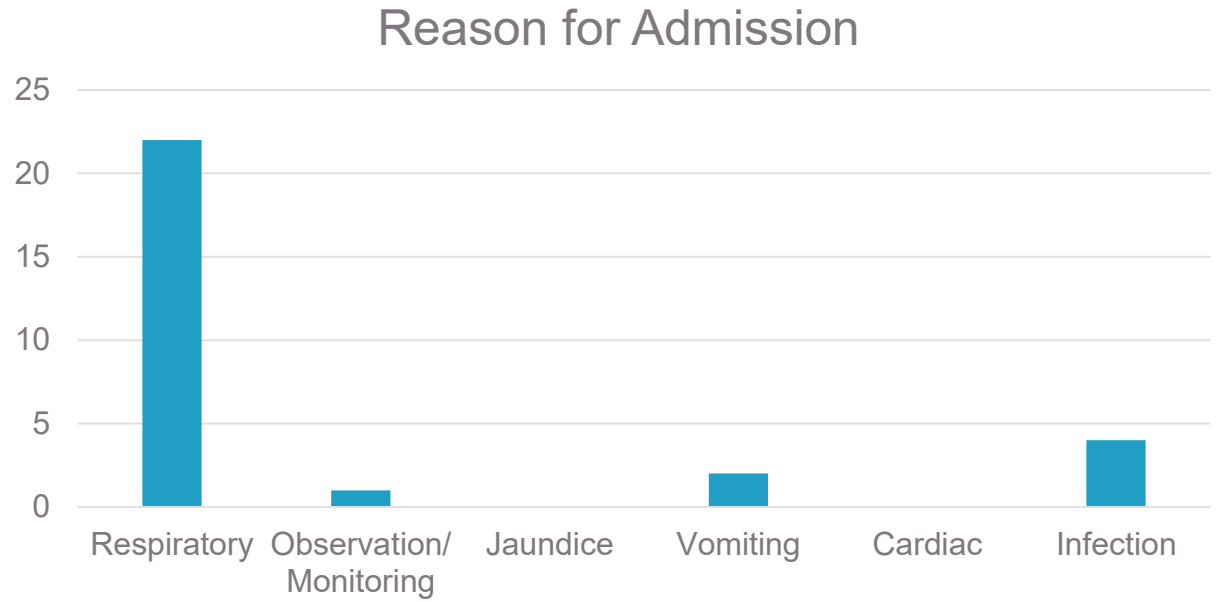
Term admission rate (target <6%)



According to our ATAIN data there were 29 term admissions to SCBU in Q1 of 2026-27 which equates to 6.9% of all livebirths >37/40.

June demonstrated the highest amount of admissions within Q1 with 12 babies admitted.

Reason for Admission

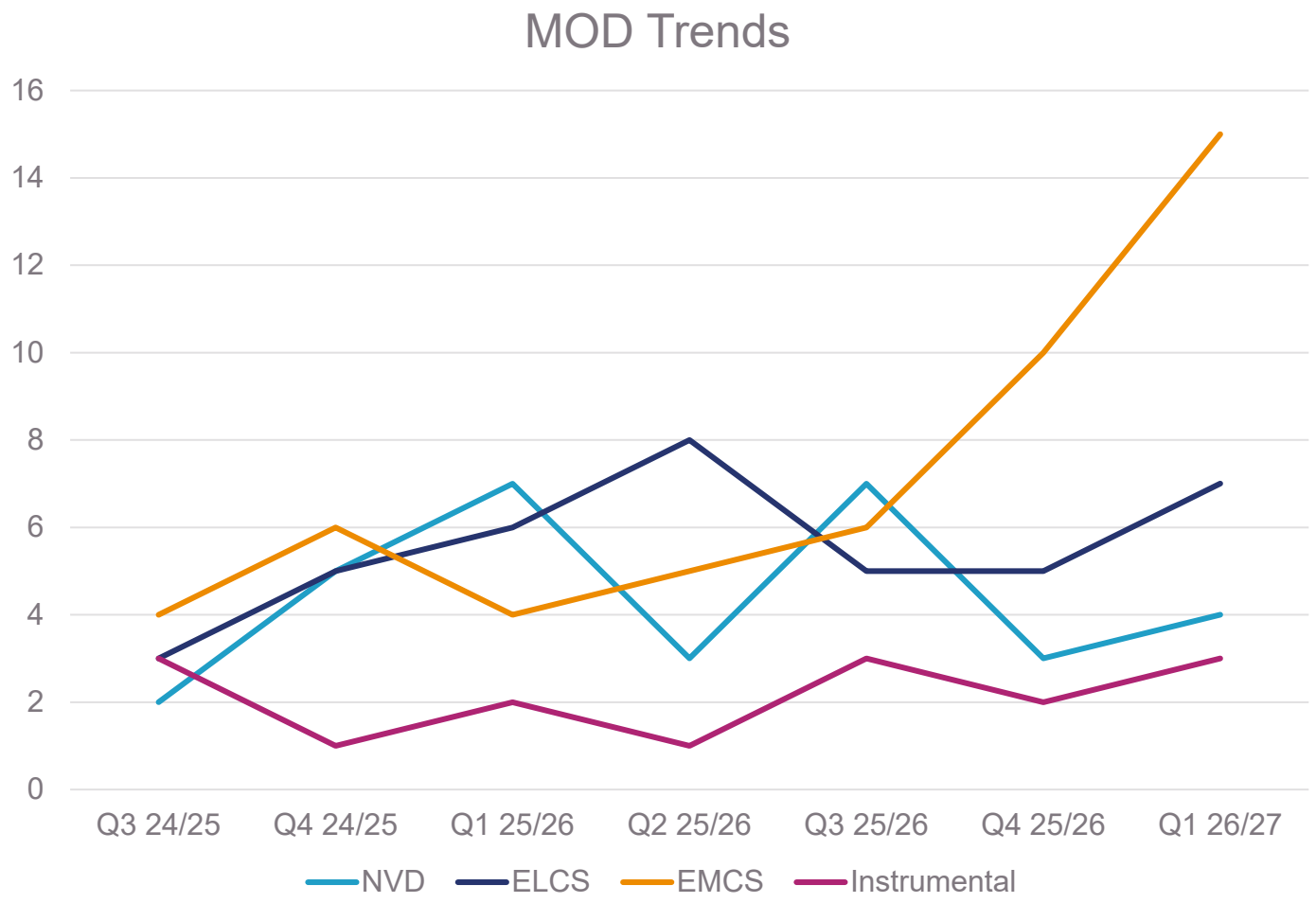


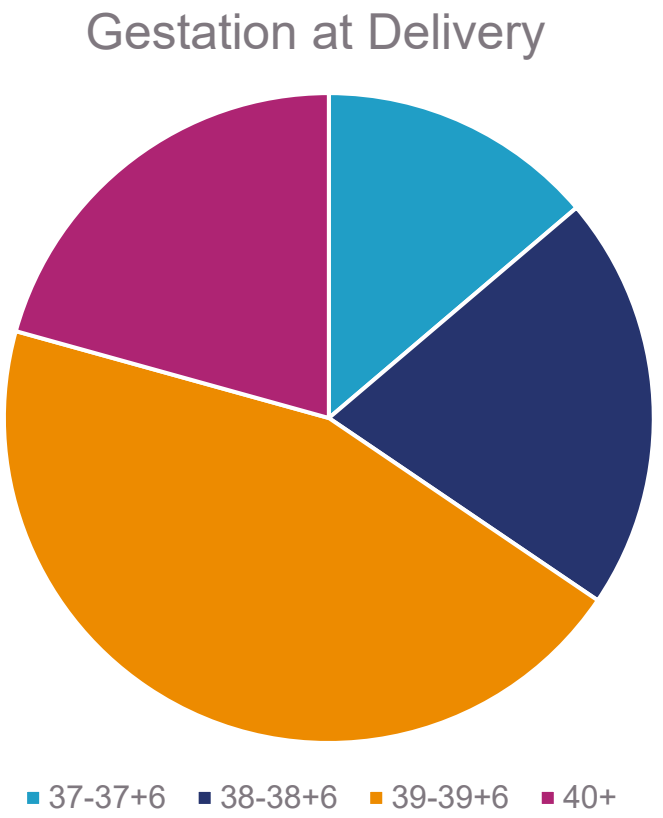
Q1: Respiratory support was main reason for admission, with 22 babies being admitted for respiratory support.

This report summarises the reviews of all the cases to identify any themes, extract learning to reduce the number of term admissions to SCBU.

Trends

Gateshead Health NHS Foundation Trust





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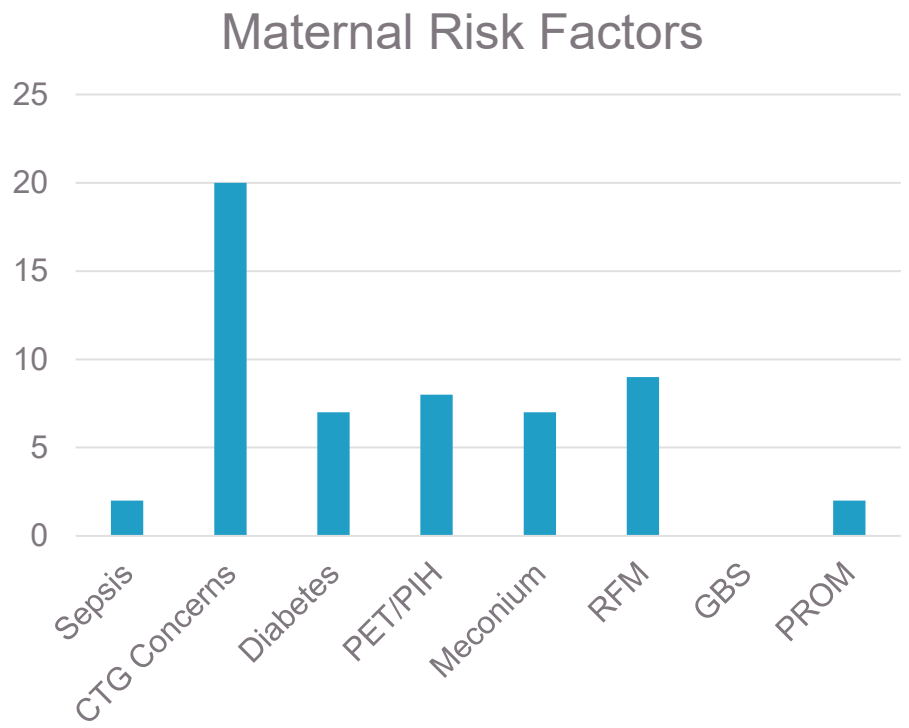
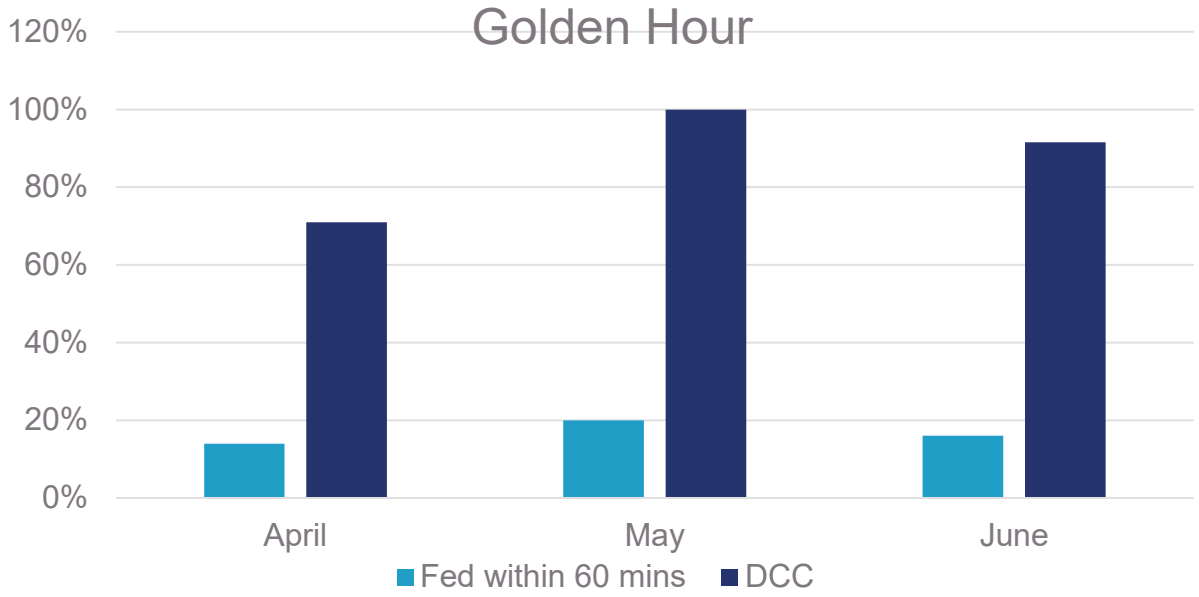
Maternal Risk Factors

- 51.7% (13) of babies admitted to SCBU were born via EMCS.
- 68.9% (20) of babies admitted to SCBU had CTG concerns prior to delivery.
- 31% (9) of babies admitted to SCBU were born to mothers who had reported RFM or had RRFM.
- 27.6% (8) of the babies admitted to SCBU were born to mum's who had IV oxytocin in labour.
- 27.6% (8) of the babies admitted to SCBU were born to mum's who had PIH or PET.

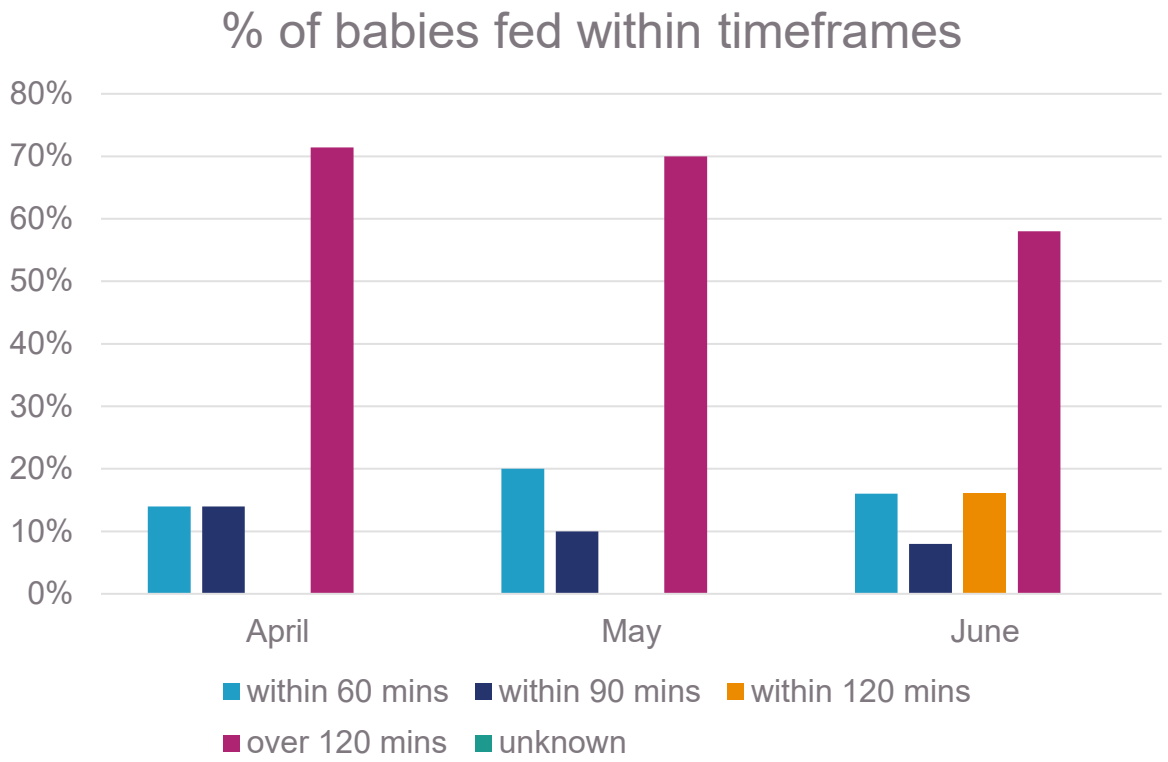


Golden Hour – DCC and feeding within 1 hour



- 89.6% (26) babies received appropriate DCC.
- 17.2% of babies born in Q1 26-27 were fed within the first 60 minutes of birth, a decrease from 35% from Q4 25-26.

From May 2024 the time of initial feed, up to 120mins, was audited as part of ATAIN.



Culture survey action plan review

Maternity

Gateshead Health NHS Foundation Trust

Culture survey repeated as part of NHSE perinatal leadership & culture work – reported with action plan in November 2025& update in January 2026 IOR

Due to lack of robust perinatal Quad – whilst culture work has been ongoing within the department, no formal review of the actions completed, impact or new actions has taken place

Year 8 MIS

F4	**Perinatal Culture Improvement Plan** Trusts must demonstrate that they have an agile perinatal culture improvement plan in place which triangulates data and engagement from multiple sources, uses recognised improvement methodology to evidence progress and impact, and is reviewed by the Trust Board at least six monthly.

NHSE 10-point plan for Maternity & Neonatal services

5. Addressing inequalities in maternity and neonatal outcomes		
	5.1	Have staff been released to complete the Perinatal Equity and Anti-Discrimination Programme with full participation across multidisciplinary teams?

Perinatal culture action plan & PEADP

Gateshead Health NHS Foundation Trust

Site name	Role	Name	Professional Group (use drop down)	Job title
Gateshead Health	Programme Lead (senior leader) - SRO	Karen Parker	Midwifery	Associate Director of Midwifery/SCBU
Gateshead Health	Programme Lead (general manager)	Alex Diggles	Operations	Service Line Manager
Gateshead Health	Senior Leader	Rohit Garkoti	Anaesthetics	Anaesthetic Consultant
Gateshead Health	Senior Leader	Sahana Chandraiah	Neonates - Medical	Paediatric Consultant
Gateshead Health	Senior Leader/Staff listening lead	Kerry Gowland	HR / EDI / QI	Organisational Development Practitioner
Gateshead Health	Senior Leader/MNVP lead	Gayle Cain	Service user / MNVP	MNVP Leads
Gateshead Health	Trust executive sponsor	Beth Swanson	Exec/Non-Exec	Chief Nurse
Gateshead Health	Business Intelligence/Data Analytics	Mark Scobie	Data/Analytics	Senior Information Analyst
Gateshead Health	Guideline lead	Kate Griffin	Midwifery	Labour Ward Coordinator
Gateshead Health	Maternity Matron	Mary Jobson	Midwifery	Maternity Matron
Gateshead Health	Senior Leader	TBC	Obstetrics	Consultant
Gateshead Health Trust	Senior Leader	Victoria Kemp	Midwifery	Midwifery Matron
Gateshead Health	Guideline/Policy Lead	Josie Downes	Neonates - Nursing	SCBU Ward Manager

Perinatal culture action plan & PEADP

Gateshead Health NHS Foundation Trust

Site name	Participant group	Name	Professional Group (use drop down)	Job title
Gateshead Health	Clinical Leader	Sally Bell	Midwifery	PAU Ward Manager
Gateshead Health	Clinical Leader	Pav McIntyre	Other	Sonography Manager
Gateshead Health	Clinical Leader	Lindsey Nichol	Midwifery	Community Team Leader
Gateshead Health	Clinical Leader	Marissa Jones	Midwifery	Lead for Risk, Safety & Quality
Gateshead Health	Clinical Leader	Ubong Mbaba	Obstetrics	Resident Doctor
Gateshead Health	Clinical Leader	Louise Swan	Other	Admin Team Leader
Gateshead Health	Clinical Leader	Pauline Simpson	Midwifery	Labour Ward Coordinator
Gateshead Health	Clinical Leader	Helen Phillips	Midwifery	Ward Manager

Perinatal culture action plan & PEADP

- Launch meeting – Karen
- Bespoke Trust preparation call – Karen & Jill attended
- Webinar – 8th September – Gateshead attendees tbc & slides shared

Gateshead Health NHS Foundation Trust

Perinatal Equity & Anti-Discrimination Programme

The Perinatal Equity and Anti-Discrimination Programme

NHS England

Information for Participants

Alignment with existing work

Perinatal Equity & Anti-Discrimination Programme

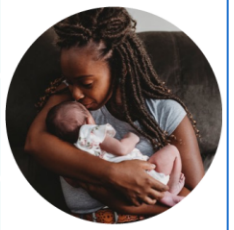
The Perinatal Equity and Anti-Discrimination Programme

Tackling racism and discrimination through culture change

Responds to and aligns with:
- Amos Report
- Nottingham Report
- Leeds and Sussex investigations
- Staff survey / WRES data
- Maternity Incentive Scheme

Supports Implementation of National and Local Equity Work:
- Equity dashboard
- Thrive
- LMNS Equity and Equality Plans
- Changing & Growing Together
- Debiasing the curriculum

Supports equity of implementation of national improvement initiatives:
- SPEN/MOSS
- Maternal Care Bundle
- Impacted Fetal Head (ABC)
- Triage Specification
- MEWS & NEWTT-2
- MNIST



The Programme

Perinatal Equity & Anti-Discrimination Programme

1 Raising Awareness and Naming Racism
- Conversations with Trust senior leaders
- Webinars to introduce anti-racist concepts, prompt personal reflection and outline programme

2 Identifying Local Challenges
Support to gather and triangulate information to understand what it feels like to be a service user or staff member from a marginalised group attending your unit

3 Engaging Senior Leadership & Guideline Leads
Enabling leaders to address discrimination and inequity and create environments in which all feel safe. Support to develop inclusive guidelines and policies

4 Empowering Leaders in the Clinical Environment
Enabling participants to recognise their own accountability, empowerment to address all forms of discrimination and equipping them with practical tools

5 Creating Cultural Change
Utilising insights from step 2 to build objectives into existing culture improvement plans, facilitated by a repository of practical resources and interventions

6 Sustaining Improvements
- Anti-Racism Framework
- Communities of practice to share learning and good practice across services locally
- Accountability through existing governance arrangements

The NHS Race Health Observatory, will be delivering steps 2, 3 % 4 of the programme. They are working alongside the White Ribbon Alliance UK, Inspiring Hope and Aqua. This is a creative and innovative consortium with vast experience in transformative work to address racism and discrimination.

3

Who is PEADP aimed at?

Perinatal Equity & Anti-Discrimination Programme

Senior Leaders – up to 7 per site – steps 1, 2 & 3:

Those **responsible for the strategic leadership of perinatal services:**
- Multi-disciplinary, perinatal and, where possible, include an MNVP lead
- Consider clinical matrons, HR/OD leads, board safety champion and anaesthetic colleagues
- Nominate up to 2 implementation leads to drive the work forwards

Guideline/Governance Leads – 2 per site (one maternity and one neonatal) – steps 1 & 3

Those who take **responsibility for the creation and updating of guidelines and policy**
- Should include both a maternity and neonatal lead

Clinical Leaders – places allocated according to size of Trust (no. of births) 8 – 14 – steps 1 & 4

Those **responsible for the day-to-day clinical leadership of perinatal services and interacting with service users and staff**
- Clinical matrons, labour ward coordinators, lead neonatal nurses, resident doctors, community managers
- Those who support with **motivating and driving local culture change**

4

Perinatal Equity and Anti-Discrimination Programme

Why working with us can make a difference

ACTIVITY	INPUTS	OUTPUTS	OUTCOMES	IMPACT
Work with experts in race equity and perinatal improvement	Building understanding of drivers for poor outcomes Capturing and collating local data Engaging with staff and local communities Analysing and understanding what local data shows Leadership sessions to build understanding, ownership and confidence in anti-racism	Greater clarity on anti-racist role as a leader Confidence in using practical skills and tools in anti-racism for NHS leaders in a range of settings Methods for using data and lived experience to inform decisions Confidence and skills to build equity into everyday leadership practice and build safer cultures Greater skills and confidence to lead anti-racism and anti-discrimination focused improvement	Behavioural, cultural and organisational change Clear, evidence based local priorities to address discrimination and racism in perinatal care Improvement activities focused on anti-discrimination and improvement	Improved experiences & outcomes for service users from Black, Asian and ethnically minoritised backgrounds and improved working lives for staff from these groups

NHS RACE & HEALTH OBSERVATORY · Advancing Quality Alliance · Inspiring Hope Consulta Qhope · The White Ribbon Alliance

What does this mean for you as a participant?

Identifying Local Challenges (Sep 26 to Jun 27) ***For senior leaders (including MNVPs) and guideline leads***

Preparation call with RHO (1hr) · Common Understanding prioritisation session (3 hrs) · Data coaching support (on demand) · Staff listening sessions (2 sessions x 1 hr) · Community engagement support, including: community listening sessions, community engagement training and coaching · Planning for sustainability (90 min)

Bespoke Training & Development (Sep 26 to Jun 27) ***For senior leaders, guideline leads, and clinical leads***

Senior Leaders (including MNVPs)	Anti-racism and anti-discrimination training (2 days, in-person, 14 hrs)	Attend an action learning set (1 hr)		
Guideline/ clinical leaders	Anti-racism and anti-discrimination training (Day 1, in-person)	Attend an action learning set (1 hr, virtual)	Anti-racism and anti-discrimination training (Day 2, in-person)	Attend an action learning set (1 hr, virtual)

NHS RACE & HEALTH OBSERVATORY · Advancing Quality Alliance · Inspiring Hope Consulta Qhope · The White Ribbon Alliance

Health

Theme	Actions to support	Values	Outcome	Update	Ongoing
Communication	Team meetings, newsletters, display posters, 1-1s	Openness, engagement, informative	Develop communication strategy	Monthly team meetings, ward/core team meetings, ward manager drop-in, quarterly newsletters	Development of comms strategy
Leadership	Leadership development, perinatal quad	Leaders will enact ICORE values, role modelling, lead by example	Zero tolerance	December 25 – SLM commenced, safety champions in post, no Obs CL	Establish perinatal Q&S/divisional meetings
Team working	Project Promise	Team working, positive relationships	Project Promise events, core teams, staff rotation	Funding utilised, end survey/LMNS feedback completed Postnatal culture work completed with POD Core teams in place	Establish social events group
Support offer	TRiM, PMA/PNA	Compassionate support, psychological safety	TRiM, PMA/PNA strategy	Working with Trust PNA lead to offer joint engagement, training, policy	Finalise joint PMA/PNA strategy
Work-life balance	Roster clinics, flexible working, TOIL, recruitment	Retention & recruitment	BR+, recruitment to vacancies, policies	BR+ agreed, recruitment ongoing Rotation/preceptorship review	Workforce concerns – theatre, WHC, ANNP, Band 3 Enhanced rostering work in maternity/SCBU

Positive exception reports

Gateshead Health
NHS Foundation Trust

Posts

Gateshead Health NHS - Staff
Michelle Telford · 1d

I would like to say a heartfelt thankyou to the Maternity Ward for the care and compassion that was shown to my daughter and son in law when they sadly lost their baby Noah on the 23rd Aug , and the care given to baby afterwards . As a family were able to use the Butterfly Suit for a few days spending precious time and making lifetime memories , we as a family will be forever grateful 💙

125

- ICB annual medication assurance audit
- Folic acid use for pregnant people with diabetes
- 97% compliance rate (1 person, not documented whether folic acid actually taken, although advised)

Gateshead's Queen Elizabeth Hospital set for £12m maternity revamp

There is to be "significant investment" in maternity services at the QE in Gateshead

Comments

By Sam Volpe Health Reporter
15:47, 09 Sep 2026

NHS
Gateshead Health
NHS Foundation Trust

Newly pregnant?

You can now **self-refer online** to Gateshead Maternity services with **no need to see your GP.**

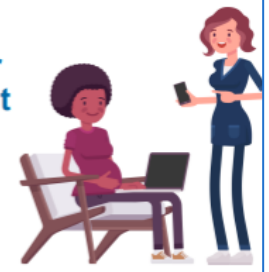
Follow the instructions below when you are around 6 weeks pregnant.

1 **Scan the QR code**

2 **Fill in a short form**

3 **A midwife will call you**

4 **Meet your midwife for your first appointment**



Gateshead Health

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

NHS Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 3di

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

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

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

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

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

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Maternity Non-Executive Director Safety Champion Report September 2026

1. Executive Summary

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

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

- Patient safety funding secured to fund maternity unit developments
- Changes to oversight (again)
- Staffing issues – progress

2. Introduction

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

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

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

3. Progress on issues

3.1. Very good news that £12m funding has been secured for our 10-phase building programme to improve the safety of the maternity unit with a new corridor to connect the unit to the main site. Additionally, a new SCBU will be built as part of this plan.

3.2. Multiple changes to the oversight of maternity have been added in the past few months. These are:

1. NHS E 10-point plan (with multiple sub-plans including the maternity care bundle and Maternity triage specification benchmarking tool)
2. MIS Year 8 update. A recent visit by the MIS national team was very positive.

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3. Thirlwall Inquiry – recommendations likely to be accepted and expectation of alignment by March 2027

Significant work has already been done on satisfying these requirements, where we are not fully compliant, plans are in place to close the gap. I am confident that we will be compliant with the 10-point plan and MIS year 8 by the deadlines. Thirlwall recommendations will require more discussion.

3.3. Staffing issues particularly in relation to the numbers of ANNPs (Advanced Neonatal Nurse Practitioner) remaining a work in progress. Recruitment for ANNPs has been challenging, the quality committee has been well sighted on the issues raised and the work to close the gap in this area.

We now have a newly appointed Obstetric Clinical Lead – Dr Rohit Garkoti, who is a consultant anaesthetist and we have also appointed a new Service Line Manager for Women's Health – Alex Diggles. Both are due to start in October 2026.

An issue with a gap in paediatric/neonatal clinical visibility was raised at the maternity safety champions meeting. A new perinatal quality assurance tier 2 meeting chaired by the medical director and chief nurse will form part of the approach to closing this gap.

4. Summary

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

ii) Maternity Staffing Report
Presented by the Associate Director of Midwifery/SCBU

Workforce and capacity

NHS Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 3dii

Report Title:	**Quarterly Midwifery, Maternity and Neonatal Workforce Report Q1 2026/27**			
Name of Meeting:	Trust Board			
Date of Meeting:	29 September 2026			
Author:	Karen Parker Associate Director of Midwifery and SCBU			
Executive Sponsor:	Beth Swanson Chief Nurse			
Report presented by:	Karen Parker			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☒	**Information:** ☒
	This report demonstrates compliance with the Maternity Incentive Scheme Year 8 Safety Action A – Workforce and Capacity			
Proposed level of assurance – *to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Nursing and Midwifery Workforce Group 20/8/2026 – verbally discussed at meeting with full paper circulated post-meeting POD Meeting 9/9/2026			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety*	**Alert** • Neonatal nursing workforce remains challenging as newly recruited staff await their start dates, support for safe staffing provided by additional hours, bank, midwifery support and exceptional use of agency staffing • Neonatal medical workforce remains challenging due to inability to recruit qualified ANNP **Advise** • **Assure** • Birthrate+ review will be commissioned by end of 2026 to inform 2027-2030 midwifery workforce			

Workforce and capacity

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• *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	requirements, this will include any recommendations from the National review and uplift required to accommodate increased mandatory training requirements • New SLM and Obstetric Clinical Leads appointed & due to commence by October 2026
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	**Board assurance statement:** The Board can be partially assured that perinatal safety systems are in place. Outcome measures are stable. However, concerns remain regarding neonatal workforce, and further work is required to demonstrate sustained improvement. **Actions required from Board:** ☐ Decision / approval ☐ Support / escalation X Assurance only

Trust strategic priorities that the report relates to:		
	☒	Excellent patient care
	☒	Great place to work
	☒	Working together for healthier communities
	☒	Fit for the future

Trust strategic objectives that the report relates to:	Women's Health Centre of Excellence Great place to work Fit for the future				
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☐	Responsive ☐	Well-led ☒	Effective ☒	Safe ☒

Risks / implications from this report (positive or negative):			
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	4852 – Maternity theatre workforce 4729 – Women's Health Clinic workforce 4882 – Neonatal workforce		
Has a Quality and Equality Impact Assessment (QEIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

Workforce and capacity

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Quarterly Midwifery, Maternity and Neonatal Workforce Report

Q1 2026/27

August 2026

Workforce and capacity

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1. Executive Summary

What is going well: • SLM & Clinical Leads appointed
What is of concern: • Obstetric clinical lead roles • Neonatal medical and nursing workforce • Antenatal clinic workforce – capacity (Obstetric), oversight and HCA support •
Emerging risks:
Improving/deteriorating trends: • Successful recruitment to vacant neonatal nursing posts – awaiting start of all new staff to recover full establishment • Unsuccessful attempt to recruit to qualified ANNP post – impact on Tier 1 of neonatal rota and safe neonatal staffing in line with BAPM recommendations

It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

Previously midwifery and neonatal nurse staffing data has been included in stand-alone staffing papers, however, to provide evidence for NHS Resolutions Maternity Incentive Scheme, a separate paper is now provided which also includes staffing data on other key groups, including obstetricians, and anaesthetics.

The purpose of this report is to provide the Board with an overview of midwifery, maternity and neonatal staffing and give assurance that there is an effective system of workforce planning and monitoring of safe staffing levels

The report covers the period of Q1 2026/27.

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2. Introduction

The MIS Year 8 core standards were published in March 2026. The standards reflect the essential components of safe and effective maternity and neonatal services - the foundations that every Trust should already have in place.

MIS is intended to be a practical tool that supports leaders to drive improvement, secure investment and strengthen governance supporting local accountability, rather than a reporting requirement in isolation.

Year 8 introduces a streamlined set of six core safety actions enabling Trusts to focus on the areas that have the greatest impact on outcomes.

Safety Action A – Workforce and Capacity

Core standards for Safety Action A are described in Appendix 1

A. Workforce and capacity (summary)

- Year 8 combines all maternity and neonatal workforce requirements into one multi-professional action.
- Sets clearer expectations for consultant presence, anaesthetic cover, neonatal staffing and locum use.
- Removes supernumerary coordinator and 1:1 labour care from MIS, but services should still monitor via red-flags.
- Adds operational capacity monitoring, including elective Caesarean activity via SitRep.
- Continues funded midwifery establishment (BirthRate+) and introduces funded neonatal establishment requirements.
- Confirms need for trained anaesthetic assistants and progress towards peri-operative team models.

3. Birthrate Plus Workforce Planning

Gateshead Maternity service completed its three-yearly Birthrate+ midwifery workforce assessment in 2023/24 and a paper describing the recommendations was presented to the Trust board in June 2024. Funded midwifery establishment was increased to meet the recommendations in October 2024.

The 2024 Birthrate+ assessment recommended the following staffing establishments:

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2024 Birth Rate BR Recommended wte	**98.76wte**
Specialist roles	**11.85wte**
Total wte	**110.61wte**

A repeat Birthrate+ assessment is being commissioned in Q3 2026/27.

4. Planned Versus Actual Midwifery Staffing Levels

Not currently reported for Midwifery and MSW numbers – work ongoing with workforce data team to understand templates and Healthroster dataset required for inclusion in future reports.

5. Unavailability Rates (vacancy, sickness, maternity leave)

Staff group	Vacancy rate	Sickness rate	Maternity leave rate
Midwifery	-4.3%	6.5%	5.6%
Midwife Support workers (includes HCAs)	-21.9%	6.1%	5.5%
Obstetric consultants Resident doctors	0 Consultant vacancies	2.4%	1 Consultant returned from Maternity Leave
Neonatal Nurses	1wte Band 5 vacancy	11.3%	0
ANNP	0.82wte ANNP vacancy 2 trainee ANNPs (not yet on rota)		
Neonatology consultants Resident doctors	1 vacancy in Tier 1		
Obstetric anaesthetists Resident doctors			

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Risks	Mitigations	Escalations
Long term sickness in neonatal nursing workforce	Bank, overtime & agency Trac submitted (awaiting approval) to recruit externally to additional bank, plus temporary Band 5 to cover sickness)	Time to progress recruitment to vacancies

6. Birthrate Plus Live Acuity Tool

Labour ward acuity

Labour ward coordinators complete the labour ward Birthrate+ acuity tool every four hours. If staffing and or patient demand/acuity changes, additional reports can be submitted to the tool to reflect changes in safe staffing and any actions required. Accurate oversight of staffing and acuity challenges for our unit require complete and accurate data input into the tool. Birthrate advise an overall compliance of 85% to obtain accurate data.

In Q1 2026/27, compliance with scheduled data entry times had dropped to 80.59% however there were 67 additional entries made. It is assumed that missed planned times were due to increased acuity and that the additional entries mitigated this. Overall, compliance is therefore 92.86%

The acuity tool captures workload on labour ward, including the level of care required for each patient based on how complex their care is (acuity) and matches this against the midwifery staffing on the labour ward every 4 hours. The data is inputted into the tool which then calculates this workload and produces a flag based on the staffing levels, this follows a RAG rating system – see below.

Green = Staffing levels meet the acuity of the workload on the labour ward at that time.
Amber = The staffing levels are up to 1 WTE midwife short, based on the workload.
Red = The staffing is greater than 1 WTE midwife short

Ongoing total acuity

2025/26	Q1	Q2	Q3	Q4
Staffing meets acuity	86%	79%	90%	84%
Short by up to 1 midwife	8%	13%	8%	11%
More than 1 midwife short	6%	8%	2%	5%
2026/27	Q1	Q2	Q3	Q4
Staffing meets acuity	82% ↓			
Short by up to 1 midwife	14% ↑			
More than 1 midwife short	4% ↓			

Overall quarterly labour ward midwifery staffing acuity*

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*Acuity is measured once any clinical or management actions have been taken such as redeployment of specialist staff

6.1 One to One Care in Labour

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Labour ward site 1	100%	100%	100%									

6.2 Supernumerary Labour Ward Coordinator

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Unable to maintain supernumerary status	1	2	1									
Unable to maintain supernumerary status (NOT providing 1-1 care)	6	7	6									
Number of reports per month	7	9	7									
Compliance	97%	95%	97%									

Mitigations	Action plan
• Robust escalation plan • Labour ward coordinators do not provide 1-1 care, unless for extremely short periods of time whilst escalation plan is enacted • Additional cord labour ward midwifery team in place for additional senior experience, support and succession planning	

Workforce and capacity

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7. Neonatal Capacity Pressures

Issue	Mitigations	Escalations
• Neonatal nursing gaps	• Experienced midwifery staff identified to support SCBU with additional training • Recruitment to all vacancies	• Time lag from identification of upcoming vacancies to starting in post (Trac submitted March 2026, start dates end of September)
• Neonatal medical gaps	• ANNP business case approved • Two ANNPs in training • Trac for bank ANNP posts submitted	• Unable to recruit to qualified ANNP post

8. Maternity and Neonatal Red Flag Incidents

Red flags are used by staff when staffing levels have been identified as impacting safety on the ward either by reduced staff numbers, skill shortfall or delay to care. Midwifery red flag events are a warning sign that something may be wrong with midwifery staffing and actions are required to maintain safety on the unit (NICE 2015).

Red flags are collected through the Birth Rate Plus acuity tool and reviewed by the Matrons.

The Red Flags included in the chart below are recommended by BR+, MIS and NICE (2015) to identify and escalate safer staffing concerns.

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Red Flags	Breakdown of Red Flags	Times occurred	Percentage
RF1	Delayed or cancelled time critical activity	3	6%
RF2	Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing)	0	0%
RF3	Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)	0	0%
RF4	Delay in providing pain relief	0	0%
RF5	Delay between presentation and triage	0	0%
RF6	Full clinical examination not carried out when presenting in labour	0	0%
RF7	Delay between admission for induction and beginning of process	22	46%
RF8	Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)	0	0%
RF9	Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour	0	0%
RF10	Coordinator unable to maintain supernumerary status	4	8%
RF11	Co-ordinator unable to maintain supernumerary status: NOT providing 1:1 care	19	40%
TOTAL		48	

*The % is rounded to nearest whole number

Red Flags events on labour ward Q1 2026/27

The main key themes are unchanged over the past 12 months are:

- Delays to commence induction of labour
- Coordinator unable to retain supernumerary status

It is important to note that whilst red flag reporting is evident, low reporting is likely linked to staff being too busy to raise a red flag. Matrons continue to support red flag reporting to ensure accurate documentation.

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Factors impacting safe staffing on Labour Ward

Number of Staffing Factors

01/04/2026 to 30/06/2026

Download Results

Factors	Breakdown of Factors	Times occurred	Percentage
SF1	Unexpected Midwife absence/sickness	73	17%
SF2	Unable to fill vacant shift	23	5%
SF3	Midwife on transfer duties	6	1%
SF4	MW redeployed to other area	13	3%
SF5	Support staff less than rostered numbers	84	19%
SF6	Midwife scrubbed in theatre	78	18%
SF7	DO NOT USE -Continuity team Midwife present	1	0%
SF8	DO NOT USE -Continuity team Midwife not available	5	1%
SF9	2 or more Band 5 Midwives on duty	141	32%
SF10	No MW available to provide fresh eyes (missed fresh eyes or>30 minute delay)	0	0%
SF11	Unable to provide a 2nd MW for emergency theatre case (trial in theatre or category 1/2/3 Emergency LSCS)	10	2%
TOTAL		434	

*The % is rounded to nearest whole number

Factors impacting red flag events Q1 2026/27

The main factors affecting midwife staffing on labour ward remain:

- Midwife scrubbed in theatre
- 2 or more Band 5 Midwives on duty
- Unexpected absence/sickness or inability to fill vacant shifts
- Support staff less than rostered numbers

A new factor was identified from Q2 2025/26 onwards relating to the recent period of midwifery recruitment which resulted in a transient supernumerary, junior cohort of midwifery workforce. Gateshead offers a robust induction period for newly qualified midwives which results in good levels of recruitment and retention. A high cohort of junior staff does create additional pressure on the senior teams as newly qualified midwives are unable to be escalated across the service until they have gained experience particularly on the labour ward.

Due to the outlier status that Gateshead holds with the continued use of midwives as scrub practitioners, UK midwifery training does not cover the scrub role and therefore new midwives joining the Gateshead service do not possess these skills. An implementation plan is currently being developed to utilise the approved business case to develop additional theatre team capacity and remove midwives from the scrub role by a phased recruitment and training programme. The timeline for this is 12 months.

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Actions taken in response to staffing deficits are reported under two categories; clinical actions and management actions.

Number of Clinical Actions

01/04/2026 to 30/06/2026

Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
CA1	Decline in utero transfer	0	0%
CA2	Delay in accepting transfers	0	0%
CA3	Delay in commencing IOL (as per Trust guidelines)	32	35%
CA4	Delay /cancel planned procedures e.g.ECV,Cervical suture	0	0%
CA5	Delay in transfer of cases to theatre e.g. perineal repair, MROP	1	1%
CA6	Delay El. LSCS >24hrs	0	0%
CA7	2nd theatre in use	3	3%
CA8	Delay in ongoing IOL/ ARM or augmentation	48	52%
CA9	Delay in admission for IOL from home	4	4%
CA10	Unable to perform ward round due to Acuity	4	4%
TOTAL		92	

*The % is rounded to nearest whole number

Number of Management Actions

01/04/2026 to 30/06/2026

Download Results

Actions	Breakdown of Actions	Times occurred	Percentage
MA1	Redeploy staff internally	93	80%
MA2	Redeploy staff from community	0	0%
MA3	Redeploy staff from training	0	0%
MA4	Staff unable to take allocated breaks	12	10%
MA5	Staff stayed beyond rostered hours	0	0%
MA6	Specialist Midwife working clinically	7	6%
MA7	Manager/Matron working clinically	0	0%
MA8	Staff sourced from bank/agency	0	0%
MA9	Utilise on call Midwife	0	0%
MA10	Escalate to Manager on call	4	3%
MA11	Maternity Unit on Divert	0	0%
MA12	Home Birth Service Suspended	0	0%
MA13	Requested mutual aid	0	0%
TOTAL		116	

*The % is rounded to nearest whole number

Workforce and capacity

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The main clinical actions taken to maintain safe staffing are delays to commence or continue Induction of Labour.

The main management actions taken to maintain safe staffing are to redeploy staff internally, staff unable to take breaks and specialist midwives working clinically via the escalation process.

The Maternity unit was not on divert during Q1 2026/27

9. Obstetric Workforce

Consultant attendance

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Establishment												
Vacancy rate	**0**	**0**	**0**									
Compliance with "Roles and Responsibilities of the Consultant providing acute care" (standard: ≥80%)	**Q1 audit underway**											

Issue	Plan	Escalation
Gaps in variety of recommended clinical lead posts No joint perinatal mortality and morbidity meeting	New SLM & CL appointed and Clinical Lead	

Short-term locum certification (obstetric workforce)

Issue	Plan	Escalation
1 long term Locum Consultant in post Resident Locum shifts covered using Bank	Trust-appointed therefore full pre-employment checks and Trust induction process completed	Compliant

Workforce and capacity

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10. Anaesthetic Workforce

Compliance for immediately available duty anaesthetist for the obstetric unit 24 hours a day

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
% Compliance	100%	100%	100%									

Compliance for immediately available duty anaesthetic assistants 24 hours a day

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
% Compliance	100%	100%	100%									

Plan	Escalation

11. Neonatal Medical Staffing

Neonatal medical funded posts	Gap to achieve BAPM standard	Mitigation	Plan
ANNP workforce 4.96wte funded 2wte trainees in post 2.12wte in post	0.82wte vacancy to recruit to	Bank & locum support for Tier 1 cover	Bank recruitment Recruitment to vacant qualified post
Medical workforce • **Tier 1** • **Tier 2** • **Consultant**	• Awaiting information • 1wte Tier 2 gap to BAPM •	• ANNP/locum • Recent successful Consultant recruitment	Fully established at 8wte Tier 2 until December 2026

Workforce and capacity

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12. Neonatal Nursing Staffing

Neonatal nursing funded posts	Gap to achieve workforce identified in neonatal nursing workforce calculator	Mitigation	Plan
15.69wte funded 13.84wte in post	1wte Band 5 neonatal nurse vacancy to recruit to	• New Band 7 supernumerary SCBU ward manager in post from July 2026 • Bank/overtime use • ANNP support for nursing staff • MSW/midwife support (with senior QIS neonatal nurse on shift)	All current nursing post vacancies in recruitment process Finance review to understand commissioned cots/funded activity Formal neonatal nursing establishment review

Plan	Escalation
• Out to recruitment for 1wte Band 5 • Exploring agency availability – on suitable neonatal nurses in NE agency • Additional cohort of midwives trained to support • Band 6 nurses progressing through recruitment process • Escalation process in place & understood • Meeting with finance colleagues to understand commissioned cots • New SCBU Band 7 supernumerary ward manager in post from July 2026 • Management of sickness absence with POD support in line with PP11 policy	

Workforce and capacity

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Plans have been shared with the ICB and the Neonatal Operational Delivery Network (ODN) : **Y/N**

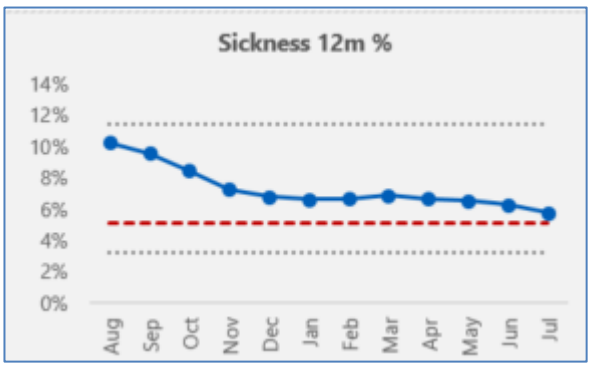
Recruitment and retention
Recruitment and retention remain a key priority for Gateshead Health. Any current vacancies within the midwifery establishment are recruited to on an ongoing basis to remain BR+ compliant.

Midwifery turnover is 6.2%, within the Trust target of <12%. The service has recruited 12 newly qualified midwives commencing employment in Autumn 2026. They have been allocated a combination of available permanent and temporary hours with the promise to convert to permanent as available. This has been supported by funding from NHSE graduate support scheme.

All of our own student midwives have secured employment on qualification, with several choosing to stay at Gateshead.

Recent developmental and promotional vacancies have been recruited to internally, enabling career growth opportunities to Gateshead midwives.

Unavailability
Sickness/staff absence
Sickness absence levels within the midwifery teams remain high at 6.5% (Q1) which is above the NHS target of 5.1%; however, sickness levels have shown steady improvement over the past 12-months.



Overall sickness absence levels in SCBU are higher at 11.3% (Q1) and the service has seen an increase in staff turnover at the start of the last quarter. Three senior neonatal nurses have left for other specialist opportunities and 1 ANNP has retired. However, despite this, sickness rates have continued to reduce and once the successfully recruited nurses take up their posts, the service expects to see a significant improvement in staffing levels, BAPM compliance and staff well-being.

Work continues with POD to review sickness and absence reasons and work with staff to support them to return to work safely.

Workforce and capacity

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Maternity leave
The demographic of the midwifery workforce is predominantly female and therefore has traditionally incurred higher levels of maternity and parental leave. Current levels are 5.6%. The service has approval for temporary recruitment to cover the current high levels of maternity leave.

The regional midwifery team (NEY) are undertaking a review of maternity leave cover and uplift for all Norther East and Yorkshire Trusts to understand the variation that exists.

Right skills

Mandatory Maternity Training:
Gateshead Health Maternity Service have again been key partners in the development of the 2026/27 North East and North Cumbria Maternity Training Faculty. Multi-disciplinary training is widely recognised as an essential component of a safe Maternity Service and as such, all Trusts in NENC have adopted the agreed 4-day syllabus with standardised content and competency assessment in line with the Core Competencies Framework and enabling compliance with Safety Action 8 of Year 7 of the Maternity Incentive Scheme. The service reported full compliance with >90% attendance with the relevant midwifery training requirements for the Year 7 MIS scheme.

The mandated training programmed for 2026/27 to enable compliance with MIS Year 8 has had approval by the LMNS/ICB and commenced on 1 April 2026.

This has increased the mandated training time to 4 full days/year, in addition to Trust-specified mandatory training (ESR, medical devices, safeguarding). The current 21% uplift is not sufficient to support the additional training time mandated and therefore the 2026 Birthrate+ review will incorporate any national recommendations for additional training uplift.

Leadership:
The service has recently recruited internally to a temporary part time community Maternity Matron secondment to support the current Matron in an exciting Midwifery Workforce Research Fellowship. All members of the senior midwifery team have been supported to attend relevant leadership programmes including MSc Global Healthcare Leadership with CMI accreditation, Dare to Lead, Rosalind Franklin and the new Leading Forward Gateshead Health Programme.

Midwifery ward managers are allocated 1-2 days/week for management duties where possible but are utilised to support the clinical workload in times of escalation. Leadership training continues to be provided via RCM opportunities and all Labour Ward Coordinators have attended the bespoke programme at Teesside University as recommended in the Ockenden report. Expanded core teams in all areas are becoming embedded and adding value, ward-specific experience and succession planning to these teams.

Healthcare Assistants (HCA) and Maternity Support Workers (MSW):
Birthrate+ does not mandate numbers for support staff however there is a recommendation included in the workforce report. They are a vital part of the workforce providing key safety critical roles in Maternity Theatre, support of a Transitional Care service and in outpatient/antenatal care pathways.

Ward area	BR+	Budgeted establishment
Delivery suite & Maternity Theatre	10.84wte	19.44wte
Ante/Postnatal ward	10.84wte	
PAU	1.81wte	

Workforce and capacity

NHS Gateshead Health NHS Foundation Trust

Antenatal clinic	4.07wte	4.70wte
Community	*community MSWs included in midwifery establishment	*3.17wte
Total	29.58wte	27.31wte

Table 4: Additional support staff wte (Gateshead Health Birthrate+ Report 2023/24)

Additional cover for maternity theatres is offered via bank shifts to ensure two HCA staff present in theatre to protect the safety critical count role. Available bank shifts are on Healthroster but appropriately, skilled staff are currently unable to fill all the shifts required. A snap shot audit during December 2025, revealed 10/67 occasions when there was less than two HCAs to support theatre cases. Once the successful Maternity Theatre staffing business case is fully implemented, it is anticipated that HCA bank spend can be reduced.

The MSW workforce are a key part of the Neonatal Transitional Care service. The service is fully recruited to current MSW vacancies.

Right place, right time

Headroom:
Gateshead Health headroom is currently calculated at 21%, which is broken down by annual leave 13%, Study leave & training 4% and Sickness absence 4%. There is a wide variance in the headroom reported by regional and national maternity teams to reflect the time requirements of mandatory maternity safety training (from 21% up to 25% or more). It is understood that discussions are underway to review whether a national steer would be helpful for Trusts in ensuring appropriate time is factored into staffing establishments to enable national training requirements to be met. The 2026 Birthrate+ review will incorporate any national recommendations for additional training uplift.

Bank/agency use:
The midwfery service does not use agency staff to support midwifery or support staff vacant shifts. Bank usage is variable; trending downwards in midwifery and increasing in SCBU.

Midwifery bank spending

Neonatal nurse bank spending

Use of on-call midwife (out of hours):
The acute on-call midwife was utilised on one occasion for a total of 4 hours during Q1 as part of the out of hours escalation process to provide support to labour ward.

The community on-call midwife was utilised on 2 occasions (two midwives each call-out for homebirth support), for a total of 18.34 hours worked.

Workforce and capacity

NHS Gateshead Health NHS Foundation Trust

13. Recommendations

This report should be received as the Year 8 MIS neonatal staffing update for Q1 2026/27.

Ongoing support continues to be provided by the People and Organisational Development team to manage sickness absence in line with the Supporting Attendance at Work policy (PP11).

Three-yearly Birthrate+ report will be commissioned in 2026 for reporting in early 2027 to inform the maternity workforce requirements for 2027-2030.

Workforce and capacity

NHS Gateshead Health NHS Foundation Trust

Appendix 1 - Core Standards for Safety Action A

NHS Resolution

Safety Action A

Safety Action A – Workforce and capacity

Outcome

Board oversight of effective multidisciplinary (MDT) workforce and capacity planning. Ensuring the maternity and neonatal service have funded establishments for obstetric, midwifery, neonatal, anaesthetic, and perioperative teams meeting nationally recognised workforce standards.

Why

- National and local reviews (including Ockenden, Kirkup, MBRRACE, NHS Resolution claims) repeatedly highlight that workforce shortfalls (including rota gaps, lack of trained multi-professional team and insufficient senior presence) and capacity constraints resulting in delays to planned caesarean births are key contributors to avoidable harm, and poor experiences for women, babies, and staff.
- Workforce pressures affect staff morale, retention, and the ability to deliver high quality care.
- Understanding and measuring workforce and capacity issues is the first step to improvement (H. James Harrington, *Area Activity Analysis: Aligning Work Activities and Measurements to Enhance Business Performance*, McGraw-Hill, 1999).

What are the minimum requirements that must be completed to achieve this outcome?

Staffing

1. **Consultant attendance (obstetric workforce)**
   Compliance with RCOG "Roles and Responsibilities of the Consultant providing acute care" standard: ≥80% consultant presence in defined acute care situations.
2. **Short-term locum certification (obstetric workforce)**
   Trusts must ensure locum certification and maintain a local (Trust-specific), continuously updated database of all short-term locums (≤2 weeks) working on tier 2/3 obstetric rotas. Eligibility must be verified before first engagement and reviewed annually for all locums on the register.
3. **Neonatal workforce establishment (nursing & medical)**
   Trusts must have a clear plan for a fully funded neonatal nursing and medical establishment that aligns with the relevant BAPM standards for their unit designation (Neonatal Intensive Care Unit (NICU), Local Neonatal Unit (LNU), Special Care Unit (SCU)) and the neonatal nursing workforce calculator output (2020).

   MIS acknowledges the updated medical staffing standards for LNU and SCU (Recommended Medical Workforce Standards for Local and Special Care

Advise / Resolve / Learn 17

Workforce and capacity

NHS Gateshead Health NHS Foundation Trust

NHS Resolution

Neonatal Units in the UK | British Association of Perinatal Medicine). As this is new and includes significant changes, for year 8 the previous staffing standards (BAPM_Service_Quality_Standards_FINAL.pdf) or the updated version will be accepted as meeting the requirements.

4. **Midwifery workforce establishment**
   Trusts must have a fully funded midwifery establishment that aligns with a Birthrate Plus (BR+) review completed within the last three years as a minimum baseline. In addition, further adjustments based on professional judgement of the Director and Head of Midwifery should be added where appropriate. Regional Chief Midwives are able to support this process if required.

5. **Anaesthetic workforce**
   Trusts must ensure that obstetric services have a duty anaesthetist available 24/7 in line with ACSA standards 1.7.2.1 and a trained anaesthetic assistant available 24/7 in line with ACSA standards 1.3.1.2.

Capacity to deliver planned and emergency care

Trusts must demonstrate that capacity is sufficient to deliver timely elective and emergency maternity/neonatal care. **Trusts do not need to prove that delays never occur. They must demonstrate that delays are detected, analysed, reported and that persistent issues are escalated.**

6. **Planned Caesarean birth capacity mapping**
   Trusts must undertake annual demand–capacity mapping for planned Caesarean birth lists, covering the full pathway (preoperative assessment → theatre → recovery → postnatal ward). Trusts should use existing NHS England regional maternity SitRep data wherever possible to avoid duplication.

Governance, escalation, and improvement

7. **Board and governance oversight** (as detailed in Safety Action F)
   Trusts must have a governance system that ensures workforce and capacity risks are monitored, scrutinised and escalated appropriately. This should include a six-monthly integrated workforce report covering maternity and neonatal staffing levels and rota gaps across medical, midwifery, neonatal, anaesthetic and perioperative teams.

e - Nurse Staffing Exception Report
Presented by the Chief Nurse

NHS
Gateshead Health
NHS Foundation Trust

Report Cover Sheet Agenda Item: 3e

Report Title:	Nursing Staffing Exception Report- June and July 2026			
Name of Meeting:	Board of Directors			
Date of Meeting:	29 September 2026			
Author:	Helen Larkin, Clinical Lead for E-Rostering			
Executive Sponsor:	Beth Swanson, Chief Nurse			
Report presented by:	Beth Swanson, Chief Nurse			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	This report is to provide assurance to the Board that staffing establishments are being monitored on a shift-to-shift basis to provide adequate staffing levels.			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Not applicable			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	This report provides information relating to ward staffing levels (funded against actual) and details of the actions taken to address any shortfalls within the month of June and July 2026. **Alert** June and July 2026 continued to present workforce challenges across a number of inpatient areas, primarily associated with Healthcare Assistant vacancies, sickness absence, maternity leave and periods of increased patient acuity and dependency. A number of wards reported staffing levels below the Trust's 80% exception threshold, with the most significant exceptions occurring within Ward 28, Critical Care, SCBU and JASRU. Nursing red flag reports increased during July, reflecting ongoing staffing and operational pressures across some clinical areas, as well as increased reporting compliance. Despite these challenges, staffing risks were actively managed through established escalation and mitigation processes			

<table>
<tr><td></td><td colspan="6">Continued scrutiny includes Ward 21, Ward 28 and Critical Care.

Advise
The Trust's Registered Nurse vacancy rate remains low at 2.5%, and targeted recruitment activity continues across both registered and non-registered nursing workforces. Healthcare Support Worker vacancy levels have reduced for three consecutive months, from 14.1% in May to 12.4% in July. Recruitment initiatives include the appointment of newly qualified nurses, progression of Nursing Associates and deployment of 26 Healthcare Apprentices from September 2026. Nursing establishments have also recently been reviewed through the Safer Nursing Care Tool methodology, with revised nurse-to-patient ratios now implemented across inpatient services.

Assure
Partial assurance is provided. Staffing was maintained safely overall during June and July through twice-daily acuity and dependency assessment, professional judgement, redeployment and temporary staffing arrangements. No physical harm was identified within the 12 staffing incidents reported during the period. However, assurance remains partial due to continuing Healthcare Assistant vacancies, recurrent staffing exceptions within a small number of clinical areas, an increase in nursing red flags from 37 to 62 during July, and ongoing improvement requirements regarding closure of red flag documentation. Areas requiring continued scrutiny include Ward 21, Ward 28 and Critical Care.</td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td colspan="6">The Board is asked to:
receive the report for partial assurance
note the work being undertaken to address the shortfalls in staffing and support ongoing actions to mitigate risk</td></tr>
<tr><td rowspan="4">Trust strategic priorities that the report relates to:</td><td>☒</td><td colspan="5">Excellent patient care</td></tr>
<tr><td>☒</td><td colspan="5">Great place to work</td></tr>
<tr><td>☐</td><td colspan="5">Working together for healthier communities</td></tr>
<tr><td>☒</td><td colspan="5">Fit for the future</td></tr>
<tr><td>Trust strategic objectives that the report relates to (2025 to 2030 strategy):</td><td colspan="6">List strategic objective here</td></tr>
<tr><td>Links to CQC Key Lines of Enquiry (KLOE):</td><td>Caring
☒</td><td>Responsive
☒</td><td>Well-led
☐</td><td>Effective
☒</td><td colspan="2">Safe
☒</td></tr>
<tr><td colspan="7">Risks / implications from this report (positive or negative):</td></tr>
</table>

Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	There were six nurse-staffing incidents raised via InPhase during the month of June. Areas who reported are AAA Screening, DART, SDEC and Maternity. There were six nurse-staffing incidents raised via InPhase during the month of July. Areas who reported are AAA Screening, JASRU, Ward 25 and Peapod and Community. These are highlighted within this report. Risk 4854- Risk to safe delivery of patient care due to the significant vacancy position of Healthcare Assistants within the Trust.		
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

Gateshead Health NHS Foundation trust
Nursing and Midwifery Staffing Exception Report for June and July 2026

Executive Summary

This report provides an exception overview of Nursing and Midwifery staffing for June and July 2026. Whilst average fill rates remained broadly stable during the reporting period, a number of wards fell below the 80% staffing threshold and are therefore reported by exception, largely due to Healthcare Assistant vacancies, sickness absence and maternity leave. The Trust continues to mitigate daily operational pressures through Matron-led professional judgement, redeployment based on patient acuity and demand, and targeted recruitment activity.

Across June and July 2026, Trust-wide fill rates remained broadly stable, with Registered Nurse vacancy rates remaining low at 2.4% to 2.5%. The principal workforce challenge continues to relate to Healthcare Support Worker vacancies; however, vacancy rates reduced from 14.1% in May to 12.4% in July, demonstrating continued improvement. Temporary staffing, redeployment, professional judgement and daily staffing escalation processes continue to provide effective mitigation.

Whilst a number of wards reported fill rates below the 80% exception threshold, Staffing was maintained safely overall during June and July through twice-daily acuity and dependency assessment, professional judgement, redeployment and temporary staffing arrangements. No physical harm was identified within the 12 staffing incidents reported during the period.

Recruitment activity has continued across both the substantive workforce and staff bank. The report provides partial assurance due to continuing Healthcare Assistant vacancies, recurrent staffing exceptions within a small number of clinical areas, an increase in nursing red flags from 37 to 62 during July, and ongoing improvement requirements regarding closure of red flag documentation. Areas requiring continued scrutiny include Ward 21, Ward 28 and Critical Care.

The Board is asked to note the current position and support the actions being taken to strengthen workforce resilience and staffing governance.

June and July 2026 Reporting overview

Metric	June 2026	July 2026	Trend
RN Day Fill Rate	90.1%	89.2%	↓
RN Night Fill Rate	97.6%	98.2%	↑
HCA Day Fill Rate	95.2%	92.1%	↓
HCA Night Fill Rate	106.8%	105.9%	↔
RN Vacancy Rate	2.4%	2.5%	↔
HCA Vacancy Rate	13.0%	12.4%	↑ Improvement

1. Introduction

This report provides monthly assurance regarding nurse staffing levels and staffing exceptions in line with the NHS England Developing Workforce Safeguards framework, including assurance against Recommendation 8 (triangulating staffing metrics) and supporting assurance against Recommendations 13 (dynamic risk assessment and escalation) and 14 (Escalation of persistent risk).

Included within the report are staffing exceptions for Gateshead Health NHS Foundation Trust during the month of June and July 2026. The purpose of this report is to monitor at ward level how hours are being filled by registered nurses and midwives and unregistered care staff; and to monitor care hours per patient day. The key purpose is to obtain assurance that wards are being safely staffed. The Trust submit monthly care hours per patient day (CHPPD) as a national requirement to NHS Digital and are available via The Model Health System. This supports organisations with benchmarking of their staffing and identify areas of potential unwarranted variations.

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

2. Staffing

The actual ward staffing against the planned, budgeted establishments from June are presented in Table 1 and July in Table 2. Trust in-patient ward staffing levels are presented within this report in Appendix 1a and b, broken down into each ward areas staffing.

Table 1: Whole Trust wards staffing June 2026

Day	Day	Night	Night
Average fill rate - registered nurses/midwives (%)	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
⇩ **90.1%**	⇧ **95.2%**	⇧ **97.6%**	⇩ **106.8%**

Table 2: Whole Trust wards staffing July 2026

Day	Day	Night	Night
Average fill rate - registered nurses/midwives (%)	**Average fill rate - care staff (%)**	**Average fill rate - registered nurses/midwives (%)**	**Average fill rate - care staff (%)**
⇩ **89.2%**	⇩ **92.1%**	⇧ **98.2%**	⇩ **105.9%**

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

Exceptions:

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

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

The exceptions to report for June are as below:

June 2026	
Registered Nurse Days	**%**
SCBU	61.3%
Sunniside Unit	77.6%
Ward 28	68.4%
Registered Nurse Nights	
JASRU	71%
Sunniside Unit	67.7%
Ward 09	79.3%
Healthcare Assistant Days	**%**
Critical Care Dept	42.0%
SCBU	50.4%
Ward 21 Trauma & Ortho	73.4%
Ward 28	38.2%
Healthcare Assistant Nights	**%**
Critical Care Dept	21.7%
Ward 28	51.3%

The exceptions to report July are as below:

July 2026	
Registered Nurse Days	**%**
SCBU	69.9%
Ward 09	74.8%
Ward 22	79.6%
Ward 28	64.4%
Registered Nurse Nights	
JASRU	78.0%
Sunniside	68.5%
Healthcare Assistant Days	**%**
Critical Care	42.2%
Ward 21	71.9%
Ward 27	79.6%
Ward 28	30.5%
Healthcare Assistant Nights	**%**

Critical Care	36.6%
Ward 28	47.8%

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

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

2. Triangulation and actions taken

The following areas reported staffing below the Trust's 80% exception threshold and have been reviewed alongside vacancy levels, red flags, incidents, patient occupancy and mitigations.

Critical Care Department
Critical Care reported sustained HCA staffing challenges during both months, with day fill rates of 42.0% in June and 42.2% in July, alongside night fill rates of 21.7% and 36.6% respectively. These deficits are associated with a known vacancy position of 5.6 WTE following establishment redesign and remain associated with minimal residual risk. Recruitment plans include direct recruitment to Band 3 posts and allocation of Healthcare Apprentices from September 2026.

Ward 28
Ward 28 remained the most significant staffing exception throughout the reporting period, with RN day fill rates reducing from 68.4% in June to 64.4% in July. HCA fill rates remained below 52% across both months. Despite these figures, daily reviews of occupancy, acuity and dependency concluded that staffing remained clinically appropriate and low residual risk. Importantly, no staffing incidents or nursing red flags were reported during either month. Average bed occupancy remained low at 42% during June and 33% during July.

SCBU
SCBU reported RN day fill rates of 61.3% in June and 69.9% in July. Whilst remaining below threshold, this reflects a significant improvement. July data demonstrated substantial HCA support, with day fill rates of 183.1%. No staffing incidents or red flags were raised and average occupancy remained relatively low at approximately 30 and 42% across the reporting periods.

JASRU
JASRU reported RN night fill rates below threshold during both months, improving from 71.0% in June to 78.0% in July. Risks were mitigated through significantly enhanced HCA cover, with fill rates of 139.0% in June and 133.1% in July. Three red flags were reported during July relating to patient acuity and RN availability. Recruitment to substantive RN vacancies is planned through newly qualified nurse appointments

Sunniside Unit
Sunniside demonstrated significant improvement during the reporting period, with RN day fill rates increasing from 77.6% in June to 91.2% in July. Night RN fill rates remained below threshold; however, this was mitigated through enhanced HCA cover and established

overnight cross-cover arrangements with Cragside, where RN staffing remained above establishment. Three red flags were reported in July related to reduced RN cover. A review of the Mental Health Nursing establishments is expected in Q3.

Ward 9
Ward 9 experienced ongoing RN staffing pressures, with RN night fill rates of 79.3% during June and RN day fill rates reducing to 74.8% in July. The ward experienced an increase in RN vacancies during the reporting period and raised two red flags in July. Recruitment of newly qualified nurses is expected to improve staffing resilience on the ward.

Ward 21
Ward 21 reported HCA day fill rates below threshold in both months at 73.4% and 71.9%. Staffing was supported by supernumerary RNs providing additional clinical oversight. 18 red flags were reported during July, primarily relating to enhanced observation requirements and increased patient dependency. There remains an ongoing residual risk, which is closely being monitored with divisional oversight. Recruitment plans include deployment of Healthcare Apprentices and continued Band 3 recruitment to mitigate HCA shortfalls and enhanced care requirements.

Ward 22
Ward 22 became an exception area during July with RN day fill rates of 79.6%. Staffing pressures were associated with annual leave and three staff members on maternity leave. There are no substantive vacancies within budgeted establishment. Four red flags were reported during the month and mitigation was provided through temporary staffing support and staffing escalation processes.

Ward 27
Ward 27 reported HCA day fill rates of 79.6% during July, associated with vacancies, long-term sickness absence and maternity leave. One nursing red flag was reported. The ward is expected to benefit from the planned deployment of two Healthcare Apprentices.

3. Vacancies

RN vacancies remained stable throughout the reporting period at between 32.6 and 34.4 WTE, representing a vacancy rate of 2.4% to 2.5%. Most vacancies remain within the Band 5 workforce. Recruitment activity has been aligned to student nurse qualification cycles and newly qualified nurse appointments are expected to commence from September 2026.

The HCA vacancy position reduced from 68.1 WTE (13.0%) in June to 65.0 WTE (12.4%) in July, demonstrating a reduction for three consecutive months. Whilst this remains the Trust's most significant workforce risk and is reflected within Corporate Risk 4854, there is a continuation of targeted work through apprenticeship recruitment, substantive recruitment and expanding bank staffing capacity, expected to commence employment by October 2026.

4. Temporary Staffing

The below data outlines the Trustwide % of hours completed as bank hours from total hours worked.

RN

Metric	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun26	Jul-26
Bank %	2.6%	3.1%	3.2%	3.6%	3.0%	3.3%	2.6%

HCA

Metric	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun26	Jul-26
Bank %	9.3%	11.8%	10.1%	10.8%	10.2%	11.7%	10.7%

Temporary staffing usage remains low, with over 96% of RN hours and approximately 89% of HCA hours delivered by substantive staff during June and July 2026. Whilst temporary staffing utilisation remains relatively low, this should be considered alongside staffing fill rates, vacancy levels and staffing mitigations, as low temporary staffing use in isolation does not necessarily indicate sufficient staffing availability.

5. Care Hours Per Patient Day (CHPPD)

CHPPD provides a single consistent way of recording and reporting deployment of staff working on inpatient wards/units, through calculating the hours of registered nurses to the hours of support workers and dividing the total by every 24 hours of inpatient admissions. CHPPD is relatively stable month on month, but they can show variation due to a number of factors including:

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

Trust-wide CHPPD remained stable, increasing slightly from 7.9 in June to 8.0 in July. This is broadly aligned with peer organisations and provides assurance that staffing resources continue to be deployed proportionately to patient need.

6. Monitoring Nurse Staffing via Incident Reporting system

There were six staffing incidents raised in June and six in July, including the levels of physical and psychological harm. Reported areas included Maternity services, JASRU and Ward 25 relative to this report. No incidents resulted in physical harm and only one incident reported low psychological harm. A breakdown of all staffing related incidents can be found in Appendix 2a and b.

7. Nursing Red Flags

Nursing red flags increased from 37 in June to 62 in July. The largest numbers reported within Ward 21, Ward 25 and Ward 24. The increase in red flag reporting is reflective of higher patient acuity and increased staffing pressures as well as increased reporting compliance. Whilst it is recognised that compliance with closing red flag reporting within Safecare system remains low. Assurance from operational teams ensures action and mitigations are taken and in place in real time. Close working with the matrons and Clinical site team continues to improve documentation. A breakdown of red flag reporting per area can be found in Appendix 3.

8. Absence levels

The below data outlines the Trustwide Sickness % (12m) for both RN and HCA workforce

RN

Metric	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun26	Jul-26
Sickness (12m) %	5.8%	5.8%	5.8%	5.8%	5.9%	5.9%	6.0%

HCA

Metric	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun26	Jul-26
Sickness (12m) %	9.2%	9.1%	9.0%	9.0%	8.9%	8.7%	8.5%

Trust-wide sickness absence remained stable during the reporting period, with RN sickness increasing marginally from 5.8% to 6.0%, whilst HCA sickness improved from 9.2% to 8.5%. Overall sickness trends remain stable, with improvement within the HCA workforce. However, sickness absence continues to be a contributory factor to staffing exceptions within a small number of clinical areas.

A breakdown by in patient ward/department areas can be reviewed in appendix 4.

9. Governance

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

10. Recommendations

Despite ongoing workforce pressures, particularly within the HCA workforce, staffing levels continue to be actively monitored and managed through established governance processes. Recruitment pipelines remain positive, with vacancy levels continuing to improve and a number of recruitment initiatives underway, including the appointment of newly qualified nurses and the introduction of Band 2 Healthcare Apprentices. The Trust therefore remains assured that appropriate mitigation, oversight and escalation processes are in place to support the safe delivery of patient care. This is informed through triangulation of staffing incidents, nursing red flags, occupancy, acuity and dependency reviews, professional nursing judgement and divisional escalation processes. No physical harm attributable to nurse staffing shortages was reported through InPhase during the reporting period.

The Board is asked to:

- receive this report for partial assurance;
- note the workforce challenges described within the report and the mitigating actions in place;
- note the positive trajectory in reducing vacancy levels, particularly within the HCA workforce;
- support the continued implementation of recruitment, retention and workforce improvement initiatives to maintain safe staffing levels across the Trust.

Appendix 1a- Table 3: Ward by Ward staffing June 2026

Decrease from previous month Increase from previous month

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative patient count over the month	Registered midwives / nurses	Care Staff	Overall
Cragside Court	81.0%	98.1%	123.5%	152.1%	186	9.4	12.4	21.8
Critical Care Dept	81.9%	42.0%	94.0%	21.7%	244	29.9	2.1	32
Emergency Care Centre - EAU	93.4%	101.1%	97.0%	103.3%	1295	5.8	4.3	10.1
JASRU	85.8%	109.1%	71.0%	139.0%	582	3.5	4.2	7.7
Maternity Unit	88.3%	110.0%	109.2%	109.7%	535	16.1	5.1	21.2
Special Care Baby Unit	61.3%	50.4%	98.9%	83.9%	177	9	1.7	10.7
St. Bedes	98.3%	108.8%	109.9%	112.9	292	5.3	3.9	9.1
Sunniside Unit	77.6%	258.7%	67.7%	100.9%	298	4.4	5.4	9.8
Ward 08	104.3%	84.9%	105.1%	101.9%	616	4.7	2.6	7.2
Ward 09	113.8%	83.5%	79.3%	107.1%	858	2.5	2.0	4.5
Ward 10	111.0%	89.0%	81.5%	104.8%	768	3.3	2.1	5.5

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Ward 12	93.8%	128.5%	103.9%	157.7%	788	3.2	3.0	6.2
Ward 14 Medicine	83.4%	91.1%	86.6%	107.5%	765	3.2	2.2	5.4
Ward 14a Gastro	90.6%	95.6%	100.5%	93.5%	769	3.1	3.0	6.1
Ward 21 T&O	102.3%	73.4%	105.2%	115.2%	813	3.7	2.8	6.4
Ward 22	84.5%	107.7%	99.5%	105.1%	921	2.5	2.8	5.3
Ward 24	115.6%	89.0%	101.4%	98.8%	907	3.1	2.5	5.6
Ward 25	101.0%	114.4%	100.2%	108.2%	913	2.8	2.9	5.8
Ward 26	82.0%	101.4%	102.9%	97.7%	664	3.5	2.6	6.0
Ward 27	87.8%	92.6%	103.3%	106.7%	869	3.1	2.3	5.4
Ward 28	68.4%	38.2%	104.9%	**51.3%**	192	7.9	3.6	11.5
QUEEN ELIZABETH HOSPITAL - RR7EN	**90.1%**	95.2%	**97.6%**	**106.8%**	**13452**	4.7	3.1	7.9

Appendix 1b- Table 4: Ward by Ward staffing July 2026

Decrease from previous month Increase from previous month

	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative patient count over the month	Registered midwives / nurses	Care Staff	Overall
Cragside Court	82.3%	102.0%	101.4%	153.8%	222	7.7	11.1	18.8
Critical Care Dept	82.8%	42.2%	93.2%	36.6%	274	27.5	2.1	29.7
Emergency Care Centre - EAU	92.2%	91.7%	97.0%	91.6%	1247	6.1	4.2	10.3
JASRU	80.9%	112.9%	78.0%	133.1%	592	3.6	4.3	7.9
Maternity Unit	92.7%	106.5%	106.1%	123.5%	640	14.3	4.5	18.8
Special Care Baby Unit	69.9%	183.1%	105.1%	84.2%	143	12.7	3.1	15.8
St. Bedes	85.3%	103.8%	104.5%	103.7%	300	4.8	3.7	8.5
Sunniside Unit	91.2%	245.0%	68.5%	130.0%	316	4.9	5.7	10.5
Ward 08	102.4%	83.4%	107.7%	100.5%	622	4.8	2.6	7.3
Ward 09	74.8%	81.7%	84.5%	107.0%	827	2.9	2.1	5.0
Ward 10	99.8%	90.2%	91.3%	101.3%	784	3.3	2.1	5.4

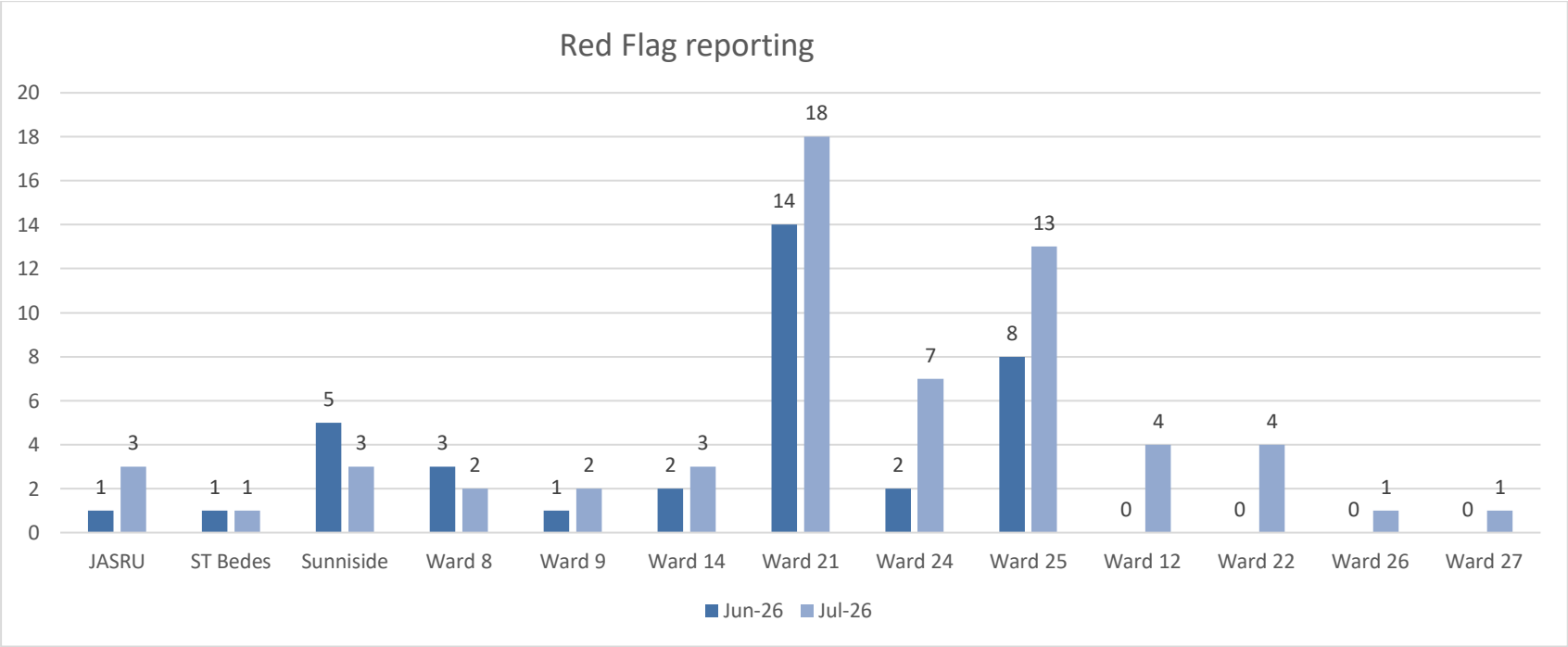
	Day		Night		Care Hours Per Patient Per Day (CHPPD)			
Ward	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Average fill rate - nurses/midwives (%)**	**Average fill rate - care staff (%)**	**Cumulative patient count over the month**	**Registered midwives / nurses**	**Care Staff**	**Overall**
Ward 12	84.6%	111.8%	100.0%	150.7%	823	2.9	2.7	5.6
Ward 14 Medicine	85.5%	98.4%	100.1%	101.9%	783	3.5	2.3	5.7
Ward 14a Gastro	93.2%	87.6%	101.5%	86.9%	800	3.2	2.7	5.9
Ward 21 T&O	111.4%	71.9%	108.3%	117.5%	843	3.9	2.8	6.7
Ward 22	79.6%	109.0%	101.5%	103.7%	949	2.4	2.8	5.2
Ward 24	103.8%	94.5%	104.1%	98.6%	939	2.9	2.5	5.5
Ward 25	100.9%	105.7%	104.8%	100.1%	870	3.1	3.0	6.1
Ward 26	85.4%	97.2%	100.8%	105.0%	662	3.6	2.7	6.3
Ward 27	95.9%	79.6%	103.4%	116.4%	874	3.4	2.2	5.6
Ward 28	64.4%	30.5%	93.4%	47.8%	158	9.1	3.8	12.9
QUEEN ELIZABETH HOSPITAL - RR7EN	**89.2%**	**92.1%**	**98.2%**	**105.9%**	**13668**	4.9	3.1	8.0

Appendix 2a InPhase submitted in relation to nurse staffing- June 2026.

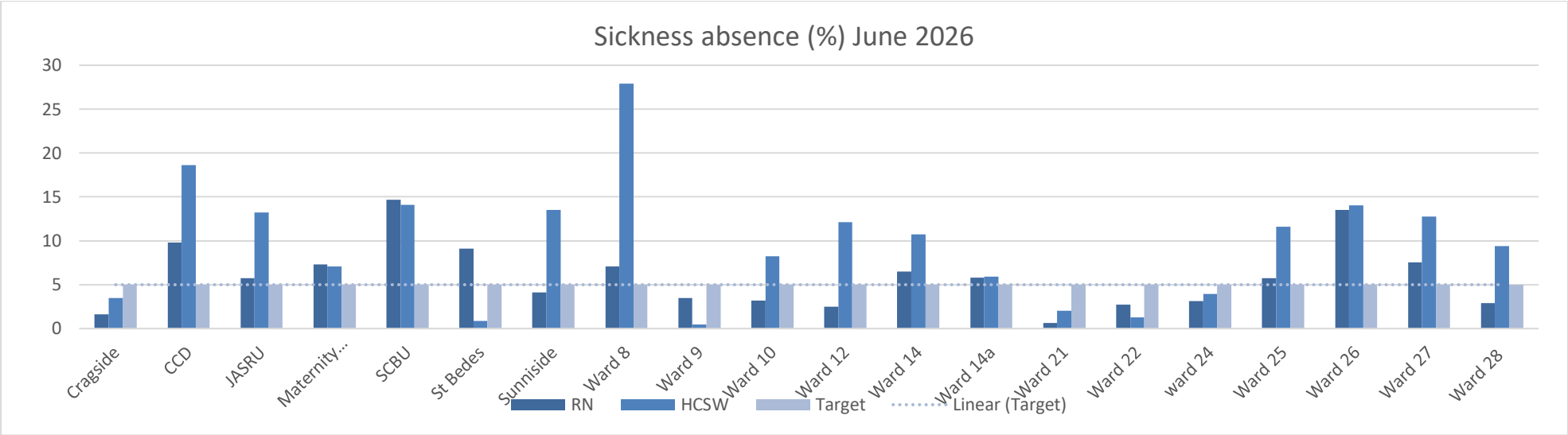
Incident Date.	Investigating Department	Category(s)	Subcategory	Level of Physical Harm	Level of Psychological Harm
4/6/26	AAA Screening	Staffing/resource issue	Staffing insufficient staff (other)	No physical harm	No psychological harm
5/6/26	DART	Staffing/resource issue	Insufficient nurses (due to staff shortages/ unfilled shifts)	No physical harm	No psychological harm
16/6/26	SDEC	Staffing/resource issue	Staffing – delay / difficulty obtaining clinical assistance	No physical harm	No psychological harm
23/6/26	SDEC	Staffing/resource issue	Insufficient nurses (due to staff shortages/ unfilled shifts)	No physical harm	No psychological harm
18/6/26	AAA Screening	Staffing/resource issue	Staffing-insufficient staff (other)	No physical harm	No psychological harm
27/6/26	Maternity (delivery suite)	Staffing/resource issue	Staffing-insufficient staff (other)	No physical harm	No psychological harm

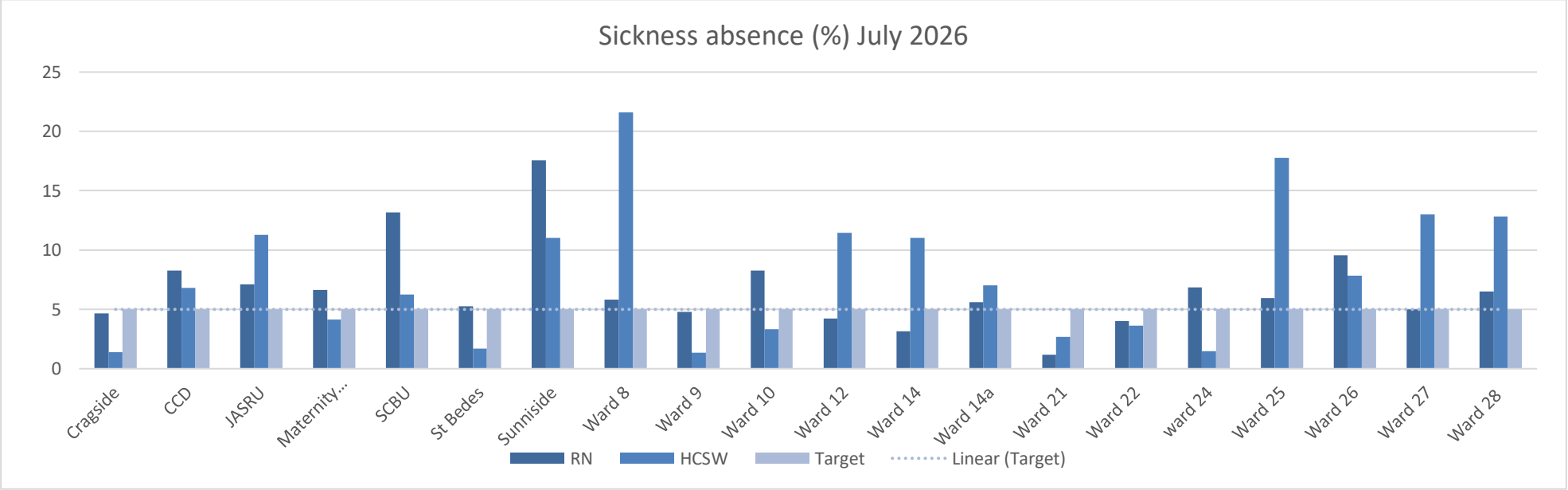
Date.	Investigating Department	Category(s)	Subcategory	Level of Physical Harm	Level of Psychological Harm
1/7/26	AAA Screening	Staffing/resource issue	Staffing insufficient staff (other)	No physical harm	No psychological harm
11/7/26	JASRU	Staffing/resource issue	Staffing insufficient staff (other)	No physical harm	No psychological harm
12/7/26	Ward 25	Staffing/resource issue	Staffing insufficient staff (other)	No physical harm	No psychological harm
13/7/26	PeaPod	Staffing/resource issue	Staffing insufficient staff (other) Incident	No physical harm	No psychological harm
23/7/26	Peapod	Staffing/resource issue	Staffing-insufficient staff (other)	No physical harm	Low psychological harm
29/7/26	Central Locality	Staffing/resource issue	Staffing-insufficient staff (other)	No physical harm	No psychological harm

Appendix 3- Red flag reporting June and July 2026



Appendix 4- Sickness absence reporting June and July 2026.





4. GREAT PLACE TO WORK

a - WRES and WDES Report
Presented by the Executive Director of People and Organisational Development

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 4a

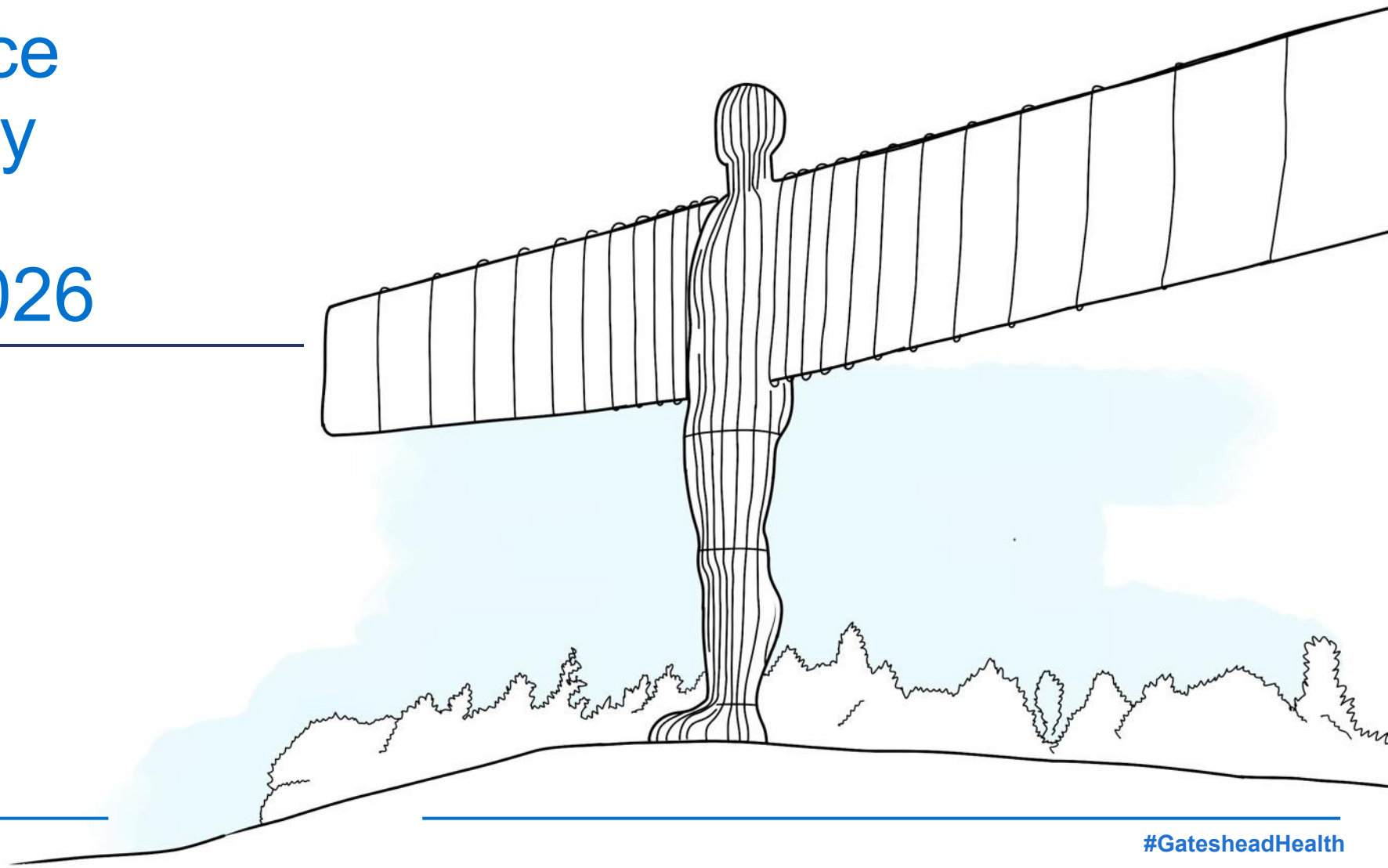
Report Title:	**WRES / WDES Reports**			
Name of Meeting:	Trust Board			
Date of Meeting:	29 September 2026			
Author:	Sophia Grainger, Head of Staff Experience			
Executive Sponsor:	Amanda Venner, Executive Director People and OD			
Report presented by:	Amanda Venner, Executive Director People and OD			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	Board to be well sighted of the data and associated actions collected in respect of the Workforce Race and Disability standards, prior to this being uploaded and publicly available.			
Proposed level of assurance – <u>to be completed by paper sponsor</u>:	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by:	People and OD Committee – September 2026			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	Whilst the Trust has made progress in workforce diversity and disability disclosure, the WRES and WDES data continues to identify significant inequalities in; • recruitment outcomes, • career progression, • senior representation, and • experiences of bullying, harassment and discrimination for both Global Ethnic Majority and disabled colleagues. There remains no Global Ethnic Majority representation at VSM or Board level, and perceptions of equal opportunities for career progression have reduced across staff groups. Disabled colleagues also continue to report poorer workplace experiences and lower confidence that reasonable adjustments are effectively in place. The Trust has refreshed its EDI programme and governance framework to address these issues, including inclusive recruitment initiatives, civility and inclusion training, staff network engagement, development of the EDI Dashboard, Disability Confident accreditation, Oliver McGowan Training, and strengthened oversight through the Equality, Diversity and Inclusion Strategy. The reports demonstrate improving workforce diversity and increased disability			

<table>
<tr><td></td><td colspan="5">declaration rates, providing greater confidence in the quality of workforce data and organisational transparency.</td></tr>
<tr><td>Recommended actions for this meeting:</td><td colspan="5">The Board is asked to note the findings of the WRES and WDES submissions, recognise both the areas of improvement and continuing disparity, and support delivery of the associated action plans.

The Board is asked to confirm publication of these statutory reports on the Trust website, noting the associated actions.</td></tr>
<tr><td rowspan="4">Trust Strategic Aims that the report relates to:</td><td>☐</td><td colspan="4">Excellent patient care</td></tr>
<tr><td>☒</td><td colspan="4">Great place to work</td></tr>
<tr><td>☐</td><td colspan="4">Working together for healthier communities</td></tr>
<tr><td>☐</td><td colspan="4">Fit for the future</td></tr>
<tr><td>Trust strategic objectives that the report relates to:</td><td colspan="5">2- Great Place to work
• We will care for our people, creating a fair, inclusive and respectful environment where everyone can thrive in their role</td></tr>
<tr><td>Links to CQC KLOE</td><td>Caring
☒</td><td>Responsive
☐</td><td>Well-led
☐</td><td>Effective
☒</td><td>Safe
☐</td></tr>
<tr><td colspan="6">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number)</td><td colspan="5">4797 - There is a risk that the Trust does not consistently prevent, identify or address organisational and cultural factors contributing to negative staff experiences, due (but not limited to) inconsistent leadership behaviours, inequitable practices, organisational pressures and working conditions, resulting in colleagues feeling undervalued or unsupported, disengagement, increased turnover, burnout and sickness absence, with potential impacts on staff wellbeing, team cohesion and the quality and safety of patient care.</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td colspan="2">Yes
☐</td><td colspan="2">No
☐</td><td>Not applicable
☒</td></tr>
</table>

Gateshead Health NHS Foundation Trust

WDES (Workforce Disability Equality Standard) Report 2025 - 2026



Gateshead Health NHS Foundation Trust

Contents

We know there is more to do.

Gateshead Health NHS Foundation Trust

I want to be open: staff with disabilities do not always have positive experiences of fairness, safety or opportunity at Gateshead Health. They are having worse experiences than any other group of staff, and that is not ok.

Our workforce data and colleague feedback matter. They show that barriers, bias and unequal outcomes remain. We need to acknowledge this honestly and respond with focus, care and sustained action.

I want every colleague to feel they belong, can speak up safely and have the same opportunity to progress. There is more to do, and we are committed to doing it.

Every leader and every team must reflect honestly on what is happening, take responsibility for improvements within their control and work together to make a difference.

We must all;

- **Challenge prejudice and discrimination.**
- **Remove barriers in our systems.**
- **Act on what staff tell us.**

Measure whether our actions improve people's experiences — and keep learning as we go.

Our colleagues deserve fairness, respect and opportunity. Together, we can and must keep improving.

Amanda Venner, Executive Director of People and OD
Gateshead Health NHS Foundation Trust

WDES Metrics

Gateshead Health NHS Foundation Trust

Workforce indicators : For each of these four workforce Indicators, compare the data for Disabled and Non-Disabled staff	DATA SOURCE
1. Percentage of staff in each of the AfC Bands 1-9, VSM (including executive board members), Medical and Dental and other staff , compared with the percentage of staff in the overall workforce disaggregated by: - Non-Clinical staff - Clinical staff -of which Non-Medical staff - Medical and Dental staff	ESR
2. Relative likelihood of staff being appointed from shortlisting across all posts (both external and internal posts).	ESR
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	PEOPLE AND OD RECORDS
4. Relative likelihood of staff accessing non-mandatory training and CPD	PEOPLE AND OD RECORDS
National NHS Staff Survey indicators For each of the four staff survey indicators, compare the outcomes of the responses for Disabled and Non-Disabled staff	DATA NHSS
5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months **6.** Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months **7.** Percentage of staff believing that the trust provides equal opportunities for career progression or promotion **8.** In the last 12 months have you personally experienced discrimination at work from any of the following? - Manager/team leader or other colleagues **Board representation indicator: For this indicator, compare the difference for white and BME staff** **9.** Percentage difference between the organisations' Board membership and its overall workforce disaggregated: - By voting membership of the Board - By executive membership of the Board	DATA SOURCE ESR

Key findings 2025 – 2026

Gateshead Health NHS Foundation Trust

Workforce representation
There was a rise of 1.82% in staff indicating a disability, rising from 5.2% in 2024 to 7.0% in 2026

Disciplinary Process
- The data shows that the *relative likelihood of disabled staff entering the formal capability process* compared to non-disabled staff has dropped from 3.24 last year to 2.66 this year

Reasonable adjustments are undertaken
- **73.7%**of staff with disabilities stated that the Trust had made adequate adjustments for them to carry out their work. This figure though, has decreased by **7%** (**80.7%** to **73.7%**)

Pressure to come to work
- Shows an increase for staff who have a Disability by **2.8%** (up from **25.3%)**
- For non-disabled staff, this figure has also increased by **1.3%** (up from **14%)**

Career Progression
- Disabled staff and Non-Disabled Staff held a stronger belief that the Trust provided equal opportunities for career progression or promotion. This figure has however decreased in 2025
- For Disabled staff by 9.7% (61% to 51.3%)
- For Non-Disabled staff by 8.5% (65.8% to 57.3%)

Staff satisfaction with the extent to which the Trust values their work
- The figures show that there has been a consistency around the 30% mark for Disabled groups and the mid 45% for Non-Disabled staff.
- Data shows a 7.2% difference between the two groups (2025). This figure is marginally better than the 2024 figure which was indicating a 7.6% difference.

Recruitment
Data collected shows that the likelihood of Non-Disabled applicants being appointed compared with Disabled applicants was 1.32

Board Representation
The difference between Disabled representation on the board and in the workforce was +1.8%.

Harassment and Bullying
Decrease by 0.1% abuse from Patients , relatives or public
Increase of 0.5% abuse from Managers
Decrease of 1.2% abuse from Colleagues
Decrease of 4.3% of individuals or colleagues reporting harassment / abuse

Key achievements from last 12 months

Gateshead Health NHS Foundation Trust

- Oliver McGowan Mandatory Training rolling out across the Trust to build knowledge in supporting patients and staff with learning difficulties.
- Level 2 Disability Confident accreditation achieved.
- Project Choice programme continues to provide work experience opportunities for individuals with additional learning needs.
- Launched a new ‘Supporting Staff with their Mental Health’ guide, providing practical support and signposting for staff and managers.
- Strengthened prevention-focused approaches to staff wellbeing, using absence and health needs data to target support, improve early intervention, and identify trends affecting staff health and retention.
- ADHD guidance introduced to support managers and colleagues.
- Recruitment and Selection programme updated to strengthen consideration of reasonable adjustments.
- ESR self-service promoted to improve the recording of disability and protected characteristic data.
- Disability Rights Month, Neurodiversity Celebration Week and wider EDI initiatives promoted in partnership with the D-Ability Network.
- Culture and Experience Day introduced as a core leadership development programme, covering civility, discrimination, bullying and harassment, sexual safety, and inclusive leadership.
- Inclusivity training available to all staff to increase awareness and understanding of equality, diversity and inclusion.
- Civility Awareness Training available to all staff to support respectful workplace behaviours and challenge incivility.
- Staff Experience and Inclusion Group established, with staff network representation helping shape culture and EDI initiatives.
- ESR self-service functionality available for staff to update personal and protected characteristic information.

Gateshead Health NHS Foundation Trust

WDES Indicator 1 (1of 3) Overall
Percentage of Staff declaring a disability compared to percentage of Staff not declaring their disability status

	19/20	20/21	21/22	22/23	23/24	24/25	25/26
Disabled	5.41%	5.33%	5.22%	5.24%	5.34%	5.35%	7.0%
Non - Disabled	79.91%	82.04%	83.04%	87.35%	86.19%	86.67%	86.10%
Unknown	14.68%	12.63%	11.74%	7.41%	8.47%	7.98%	6.90%

The NHS Staff Survey offers another estimate of the representation of Disabled staff in the workforce. Typically, a greater percentage of survey respondents declare whether they have a disability or not than do staff through ESR although not all staff respond to the staff survey.

The NHS Staff Survey asks, **"Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?"**

In the 2025 Staff Survey**, the overall staff results** show that:
- **7.0% of staff** declared that they had a disability.
- **86.10%** of respondents declared that they did not have a disability.
- **There has been an increase by 1.7% of staff declaring a disability**
- There has been a decrease by **0.57%** of staff who do not have a disability
- There has also been a decrease by **1.08%** of staff who have either not declared their disability status or their disability is unknown.

Action 3 in the action plan aims to support improvement with this indicator

WDES Indicator 1(2 of 3) Non-clinical

Percentage of Staff declaring a disability compared to percentage of Staff not declaring their disability status

Pay Band		Disabled		Non-Disabled		Unknown		Overall Total
Under Band 1	Headcount	0	0.0%	0	0.0%	0	0.0%	0
Bands 1	Headcount	0	0.0%	0	0.0%	0	0.0%	0
Bands 2	Headcount	44	6.8%	572	88.5%	30	4.6%	646
Bands 3	Headcount	26	9.2%	246	87.2%	10	3.5%	282
Bands 4	Headcount	18	7.1%	223	88.5%	11	4.4%	252
Bands 5	Headcount	10	6.5%	137	89.0%	7	4.5%	154
Bands 6	Headcount	7	7.7%	82	90.1%	2	2.2%	91
Bands 7	Headcount	7	9.9%	62	87.3%	2	2.8%	71
Bands 8a	Headcount	1	3.7%	25	92.6%	1	3.7%	27
Bands 8b	Headcount	3	8.8%	31	91.2%	0	0.0%	34
Bands 8c	Headcount	0	0.0%	9	90.0%	1	10.0%	10
Bands 8d	Headcount	0	0.0%	10	90.9%	1	9.1%	11
Bands 9	Headcount	0	0.0%	7	100.0%	0	0.0%	7
VSM	Headcount	0	0.0%	4	100.0%	0	0.0%	4
Cluster 1: AfC Bands <1 to 4	Auto-Calculated	88	7.5%	1041	88.2%	51	4.3%	1180
Cluster 2: AfC bands 5 to 7	Auto-Calculated	24	7.6%	281	88.9%	11	3.5%	316
Cluster 3: AfC bands 8a and 8b	Auto-Calculated	4	6.6%	56	91.8%	1	1.6%	61
Cluster 4: AfC bands 8c to VSM	Auto-Calculated	0	0.0%	30	93.8%	2	6.3%	32
Total Non-Clinical	Auto-Calculated	116	7.3%	1408	88.6%	65	4.1%	1589

Cluster 1 shows that in Bands 1- 4 (7.5%) of staff are disabled
Cluster 2 shows that in Bands 5-7 (7.6%) of staff are disabled.
Cluster 3 shows that in Bands 8a – 8b (6.6%) of staff are disabled.
However, it is important to note that while percentages may be virtually similar, number of staff in all of the clusters are not the same.

Similarly for staff who are **not disabled,** in the same clusters the figures are in the top 80% - 90%

Overall:

- **7.3 %** of staff have declared that they have a disability
- **88.6%** indicate they are **not disabled** and
- The disability of **4.1%** is unknown

Action 3 in the action plan aims to support improvement with this indicator

WDES Indicator 1(3 of 3) Clinical

Percentage of Staff declaring a disability compared to percentage of Staff not declaring their disability status

Gateshead Health NHS Foundation Trust

Pay Band		Disabled		Non-Disabled		Unknown		Overall Total
Under Band 1	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Bands 1	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Bands 2	Headcount	22	11.46%	155	80.73%	15	7.81%	192
Bands 3	Headcount	38	6.14%	538	86.91%	43	6.95%	619
Bands 4	Headcount	13	7.14%	164	90.11%	5	2.75%	182
Bands 5	Headcount	69	7.42%	726	78.06%	135	14.52%	930
Bands 6	Headcount	51	7.32%	607	87.09%	39	5.60%	697
Bands 7	Headcount	27	6.32%	376	88.06%	24	5.62%	427
Bands 8a	Headcount	8	6.35%	114	90.48%	4	3.17%	126
Bands 8b	Headcount	2	6.45%	26	83.87%	3	9.68%	31
Bands 8c	Headcount	0	0.00%	6	100.00%	0	0.00%	6
Bands 8d	Headcount	0	0.00%	5	100.00%	0	0.00%	5
Bands 9	Headcount	0	0.00%	2	100.00%	0	0.00%	2
VSM	Headcount	0	0.00%	1	100.00%	0	0.00%	1
Cluster 1: AfC Bands <1 to 4	Auto-Calculated	73	7.4%	857	86.3%	63	6.3%	993
Cluster 2: AfC bands 5 to 7	Auto-Calculated	147	7.2%	1709	83.2%	198	9.6%	2054
Cluster 3: AfC bands 8a and 8b	Auto-Calculated	10	6.4%	140	89.2%	7	4.5%	157
Cluster 4: AfC bands 8c to VSM	Auto-Calculated	0	0.0%	14	100.0%	0	0.0%	14
Total Non-Clinical	Auto-Calculated	230	7.1%	2720	84.5%	268	8.3%	3218

		Disabled		Non-Disabled		Unknown		Overall Total
Medical & Dental Staff, Consultants	Headcount	7	2.90%	212	87.97%	22	9.13%	241
Medical & Dental Staff, Non-Consultants career grade	Headcount	2	8.33%	21	87.50%	1	4.17%	24
Medical & Dental Staff, Medical and dental trainee grades	Headcount	6	6.82%	82	93.18%	0	0.00%	88
Total Medical and Dental	Auto-Calculated	15	4.25%	315	89.24%	23	6.52%	353
Number of staff in workforce	**Auto-Calculated**	**361**	**7.00%**	**4443**	**86.10%**	**356**	**6.90%**	**5160**

Out of the 3218 Clinical staff overall:

- **7.1%** have declared a disability
- **84.5%** are not Disabled
- **8.3%** of staff members disability status is unknown

Specifically with the **Medical and Dental category**

- **4.25%** have declared a Disability
- **89.24%** are not Disabled
- **6.25%** of staff members disability status is unknown

Gateshead Health NHS Foundation Trust

Indicator 2

The relative likelihood of non-disabled applicants being appointed from shortlisting compared to Disabled applicants

2025/2026		Disabled	Non-Disabled	Unknown	Overall Total
Number of shortlisted applicants	Headcount	237 (9.8%)	2180 (90.2%)	0	2417
Number appointed from shortlisting	Headcount	44 (7.62%)	533 (92.4%)	0	577
Likelihood of shortlisting/appointed	Auto-Calculated	0.18	0.24	0	
Relative likelihood of non-disabled candidates being appointed from shortlisting compared to Disabled candidates	Auto-Calculated	1.31			

Previous Years Indicators	19/20	20/21	21/22	22/23	23/24	24/25
	1.53	0.3	1.09	1.09	0.99	0.95

Action 1 and 4 in the action plan aims to support improvement with this indicator

A figure less than 1.0 would mean that disabled applicants are more likely to be appointed than non-disabled applicants

In respect of the 2025/26 figures:

- 237 **(9.8%)** Disabled candidates were shortlisted out of a total of 2417, resulting in 44 **(7.62%)** candidates being appointed
- In comparison, 2180 **(90.2%)** Non-Disabled candidates were shortlisted out of a total of 2417 resulting in 533 **(92.4%)** candidates being appointed
- Data captured shows that Relative likelihood of non-disabled candidates being appointed from shortlisting compared to Disabled candidates' applicants is 1.31.
- This means that shortlisted non-disabled candidates were **31% more likely to be appointed** than shortlisted disabled candidates in 2025/26.
- This has worsened from last year (0.95-1.31)

As a Disability Confident employer, the Trust is committed to creating an inclusive and supportive workplace for everyone. We want to ensure that all our employees have access to the tools, adjustments, and support they need to thrive in their roles from when they start working for the Trust.

Indicator 3

The relative likelihood of Disabled staff entering the formal capability process compared to non-disabled staff

2025/2026		Disabled	Non-Disabled	Unknown	Overall Total
Average number of staff entering the formal capability process over the last 2 years for any reason. (i.e. Total divided by 2.)	Headcount	8 (16.32%)	37 (75.5%)	4 (81.6%)	49
Of these, how many were on the grounds of ill-health?	Headcount	0	0	0	0
Likelihood of staff entering the formal capability process	Auto-Calculated	0.02	0.008	0.01	
Relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff	Auto-Calculated	2.66			

Previous Years Indicators	19/20	20/21	21/22	22/23	23/24	24/25
	0	0.01	0	0	1.54	3.24

The Trust will ensure that all steps and reasonable adjustments are put in place for disabled individuals before any formal process starts.

This metric is based on data from a two- year rolling average of the current year and the previous year.

- The metric applies to capability on the **grounds of performance** and not ill health.
- Therefore, Staff entering the capability process for reasons of **both** performance and ill health **are not** included in this count.

The data shows that the ***relative likelihood of disabled staff entering the formal capability process*** compared to non-disabled staff has dropped from 3.24 last year to 2.66 this year
The actual numbers show that :

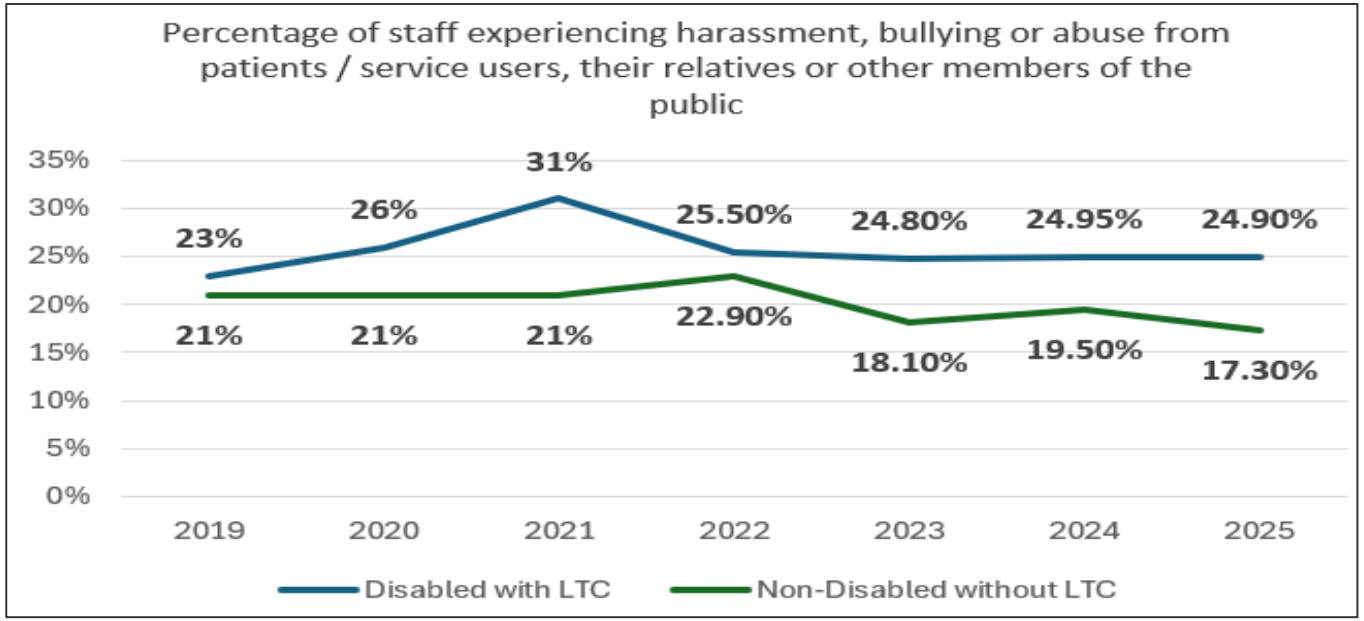
- **8 (16.32%)** members of disabled staff entered the formal capability process
- **37 (75.5%)** members of non-disabled staff entered the formal capability process
- **4 (8.16%)** members of staff entering the formal capability process, disability status is unknown

This means that disabled staff were **2.66 times as likely** as non-disabled staff to enter the formal performance capability process.
This improved from **3.24 times last year**, but a substantial disparity remains

Indicator 4a WDES Staff Survey Data 2025

In the last 12 months, percentage of staff experiencing harassment, bullying or abuse from patients / service users, their relatives or other members of the public

		2019	2020	2021	2022	2023	2024	2025
a) Patients/service users, their relatives or other members of the public	**Disabled with LTC**	**23%**	**26%**	**31%**	**25.50%**	**24.80%**	**24.95%**	**24.90%**
	Non-Disabled without LTC	21%	21%	21%	22.90%	18.10%	19.50%	17.30%



The percentage of staff who experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months:

- **Disabled staff experiences** of harassment, bullying or abuse has dropped by (**0.1% rounded up)**
- For **Non-disabled staff experiences this figure has dropped by 2.2%**
- In comparing the **2025 data** there is a 7.6% difference of staff experiencing **harassment, bullying or abuse** in respect of Disabled v Non-disabled staff

While the overall position improved, the inequality has widened because improvement was concentrated among non-disabled staff.

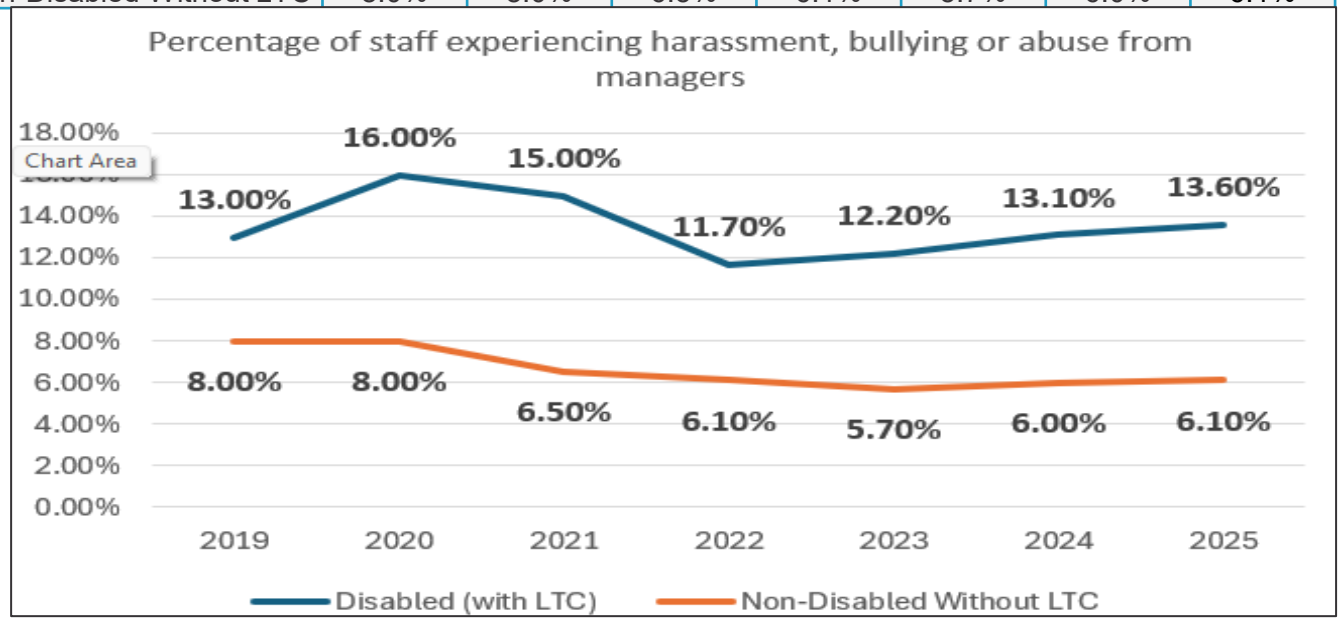
Action 2 in the action plan aims to support improvement with this indicator

Indicator 4b WDES Staff Survey Data 2025

In the last 12 months, percentage of staff experiencing harassment, bullying or abuse from managers

Gateshead Health NHS Foundation Trust

	2019	2020	2021	2022	2023	2024	2025
Disabled (with LTC)	13.0%	16.0%	15.0%	11.7%	12.2%	13.1%	13.6%
Non-Disabled Without LTC	8.0%	8.0%	6.5%	6.1%	5.7%	6.0%	6.1%



The percentage of staff who **experienced harassment, bullying or abuse from managers in the last 12 months:**

- The number of **disabled staff** experiencing harassment, bullying or abuse from managers in the last 12 months shows an increase of **0.5%** whereas for **non - disabled staff** the increase was **0.1%**
- **In the last year, the difference between** Disabled and Non-disabled staff experiencing **harassment, bullying or abuse from Managers is 7.5%.**
- Data collected also shows that disabled staff experiencing harassment, bullying or abuse from Managers has been relatively consistent
- The number of disabled staff experiencing harassment bullying or abuse from their managers is more than twice as likely compared to Non- disabled staff

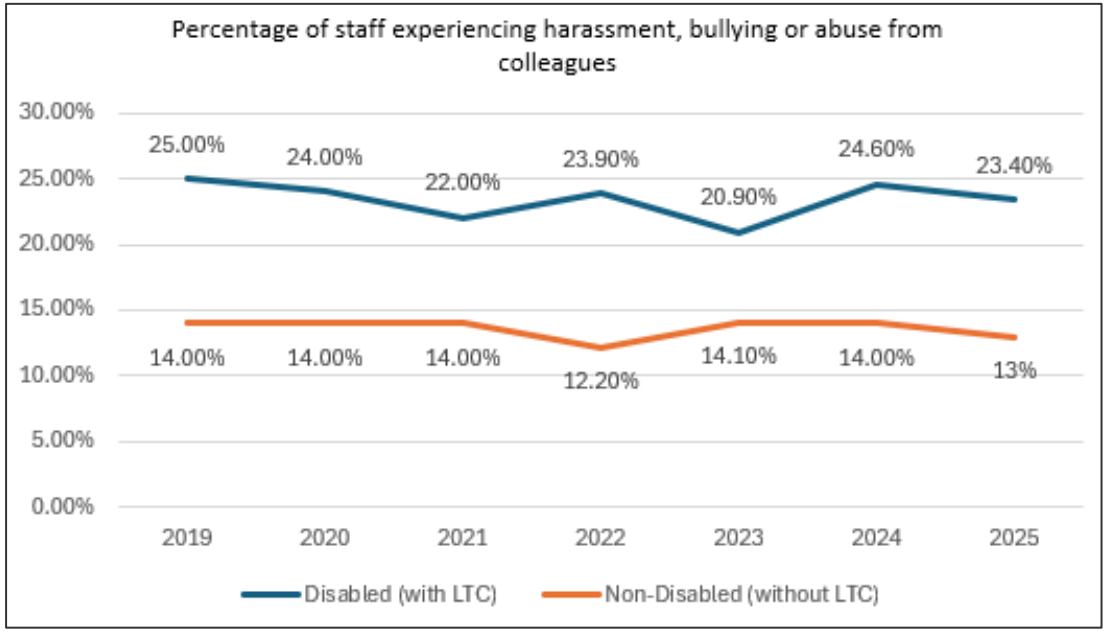
Action 2 in the action plan aims to support improvement with this indicator

Indicator 4c WDES Staff Survey Data 2025

In the last 12 months, percentage of staff experiencing harassment, bullying or abuse from colleagues

Gateshead Health NHS Foundation Trust

	2019	2020	2021	2022	2023	2024	2025
Disabled (with LTC)	25.0%	24.0%	22.0%	23.9%	20.9%	24.6%	23.4%
Non-Disabled (without LTC)	14.0%	14.0%	14.0%	12.2%	14.1%	14.0%	13%



- Disabled staff **23.4%**, are nearly twice as likely to experience harassment, bullying or abuse than non-disabled staff **13%**
- For non-disabled staff the percentages have remained mostly consistent at **14%** apart from a dip in 2022 **(12.2**%). This figure has **increased** to the **14%** mark with a very small decrease **(1.0%)** in 2025
- Comparing the 2025 data, the difference between the percentages of staff **experiencing harassment, bullying or abuse from other colleagues in the last 12 months shows a differential** for Staff with disabilities compared to staff who do not have a disability - the 2025 data showing a difference of **10.4%.** There is a minuscule difference from the 2024 figures where it was **10.6%**
- It is also interesting to note that for Disabled groups the figure stands at a consistent 25+% mark with a very small dip in 2023. In a similar vein, non disabled groups also fall into the 14+% category.

Action 2 in the action plan aims to support improvement with this indicator

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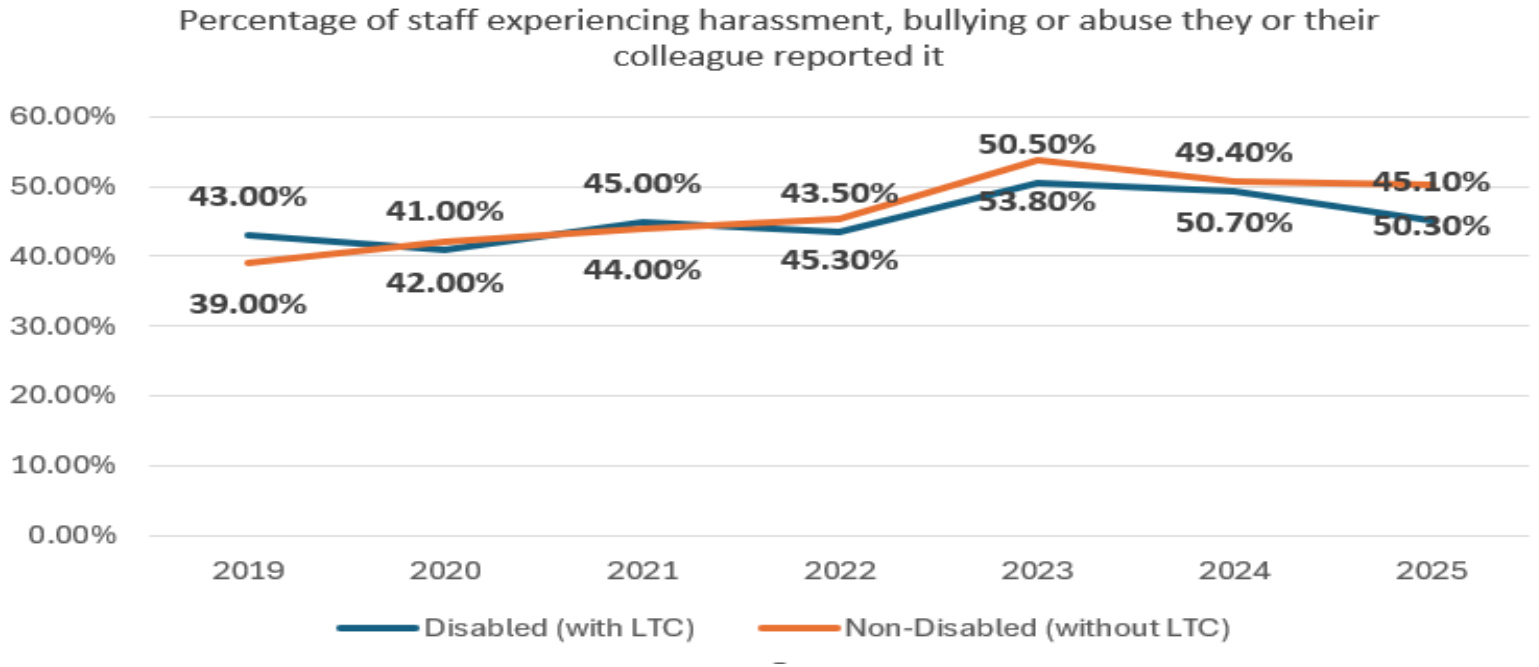
Indicator 4d | Indicator 5 | Indicator 6 | Indicator 7 | Indicator 8 | Indicator 9 | Indicator 10

Indicator 4d WDES Staff Survey Data 2025

In the last 12 months, percentage of staff experiencing harassment, bullying or abuse they or their colleague reported it

	2019	2020	2021	2022	2023	2024	2025
Disabled (with LTC)	43.0%	41.0%	45.0%	43.5%	50.5%	49.4%	45.1%
Non-Disabled (without LTC)	39.0%	42.0%	44.0%	45.3%	53.8%	50.7%	50.3%



Action 2 in the action plan aims to support improvement with this indicator

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, **45.1%**, and for non-disabled staff, **50.3%**
- fewer than half of disabled staff who experienced harassment, bullying or abuse said it was reported.
- For both groups there has been a slight drop in this metric in 2025
- Signing up to the Z tolerance, delivering Incivility Saves Lives, and the ongoing work around harassment and bullying may well account for the rise in reporting.
- While a poster campaign around Incivility has been produced, aspects pertaining specifically to addressing Disability equality will be actioned e.g. Recruitment, Inclusivity training.
- under-reporting remains a concern, with disabled staff less likely to report incidents.

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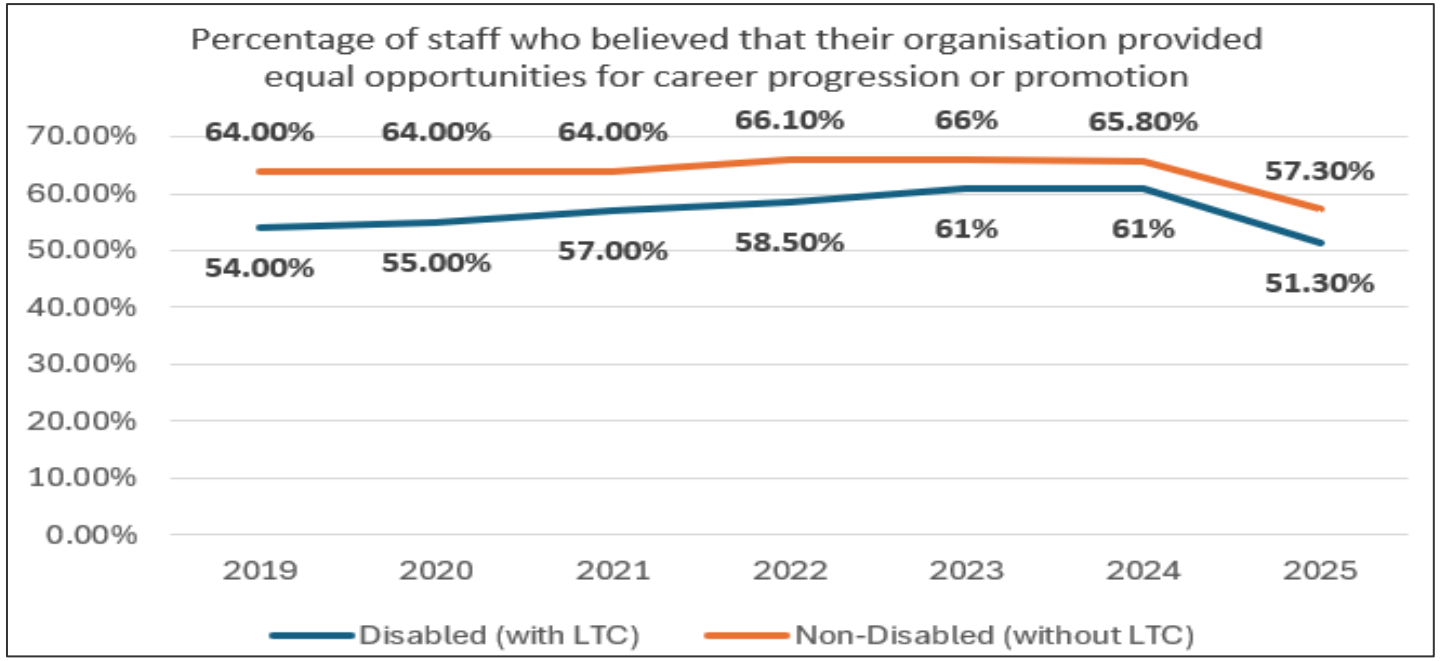
WDES Indicator 5

The percentage of staff who believed that their organisation provided equal opportunities for career progression or promotion

Gateshead Health NHS Foundation Trust

	2019	2020	2021	2022	2023	2024	2025
Disabled (with LTC)	54.0%	55.0%	57.0%	58.5%	61%	61%	51.3%
Non-Disabled (without LTC)	64.0%	64.0%	64.0%	66.1%	66%	65.8%	57.3%



- Since 2019 to date, **Disabled staff and Non-Disabled Staff held a stronger belief that the Trust provided equal opportunities for career progression or promotion.**
- For Disabled staff - The data has fluctuated in the 55% mark to a highest in 2023/2024, but decreased in 2025 by **9.7% to 51.3%**
- For Non-Disabled staff the figure has been in the mind 60%, but has dropped by 8.5% (**65.8% to 57.3%)**
- confidence in fair career progression has fallen sharply for everyone and remains lower among disabled staff.
- only about half of disabled staff believe promotion opportunities are equal

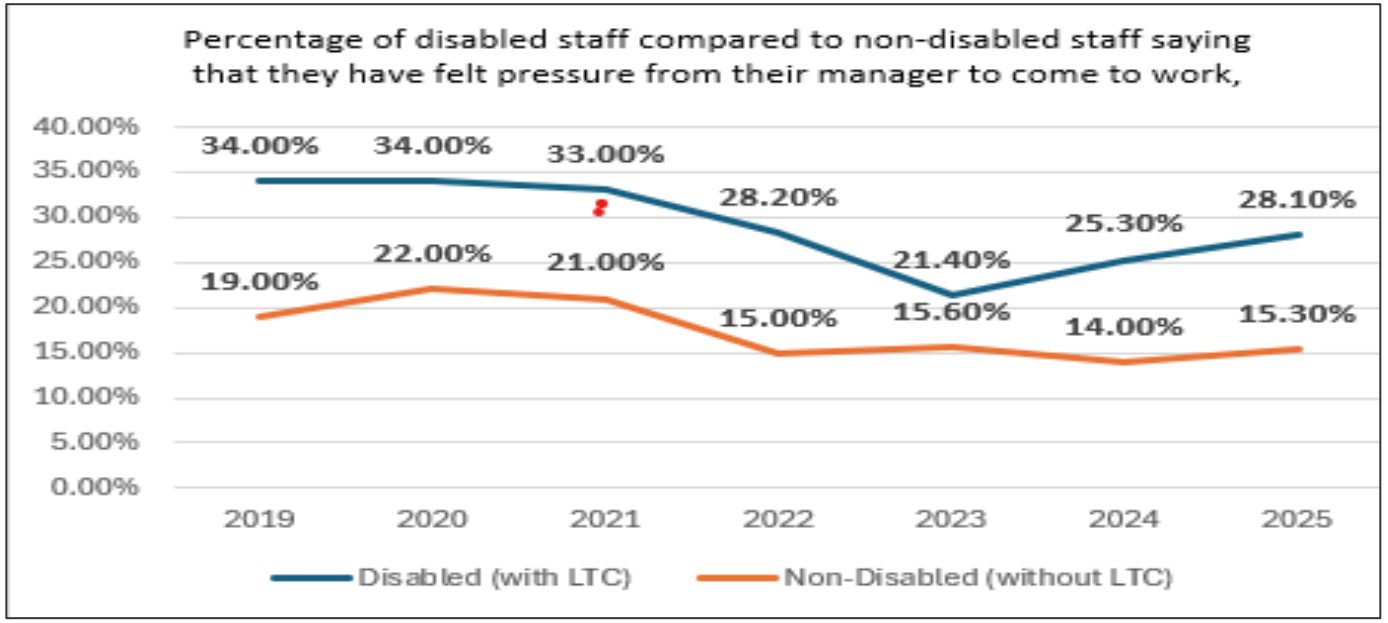
Action 1 and 4 in the action plan aims to support improvement with this indicator

WDES Indicator 6

Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Gateshead Health NHS Foundation Trust

	2019	2020	2021	2022	2023	2024	2025
Disabled (with LTC)	34.0%	34.0%	33.0%	28.2%	21.4%	25.3%	28.1%
Non-Disabled (without LTC)	19.0%	22.0%	21.0%	15.0%	15.6%	14.0%	15.3%



Action 3 in the action plan aims to support improvement with this indicator

The percentage of staff who felt pressure from their manager to come to work despite not feeling well enough to perform their duties:

- Shows an increase for staff who have a Disability by **2.8%** (up from **25.3% to 28.1%)**
- For non-disabled staff, this figure has also increased by **1.3%** (up from**14% to 15.3%)**
- Disabled staff are nearly **twice as likely** to feel pressured to work when too unwell
- Previous indications around this indicator were linked to Covid, however, staff have reported that their personal health is often compromised due to the pressure to come to work. This is reflected within the latest data collected.

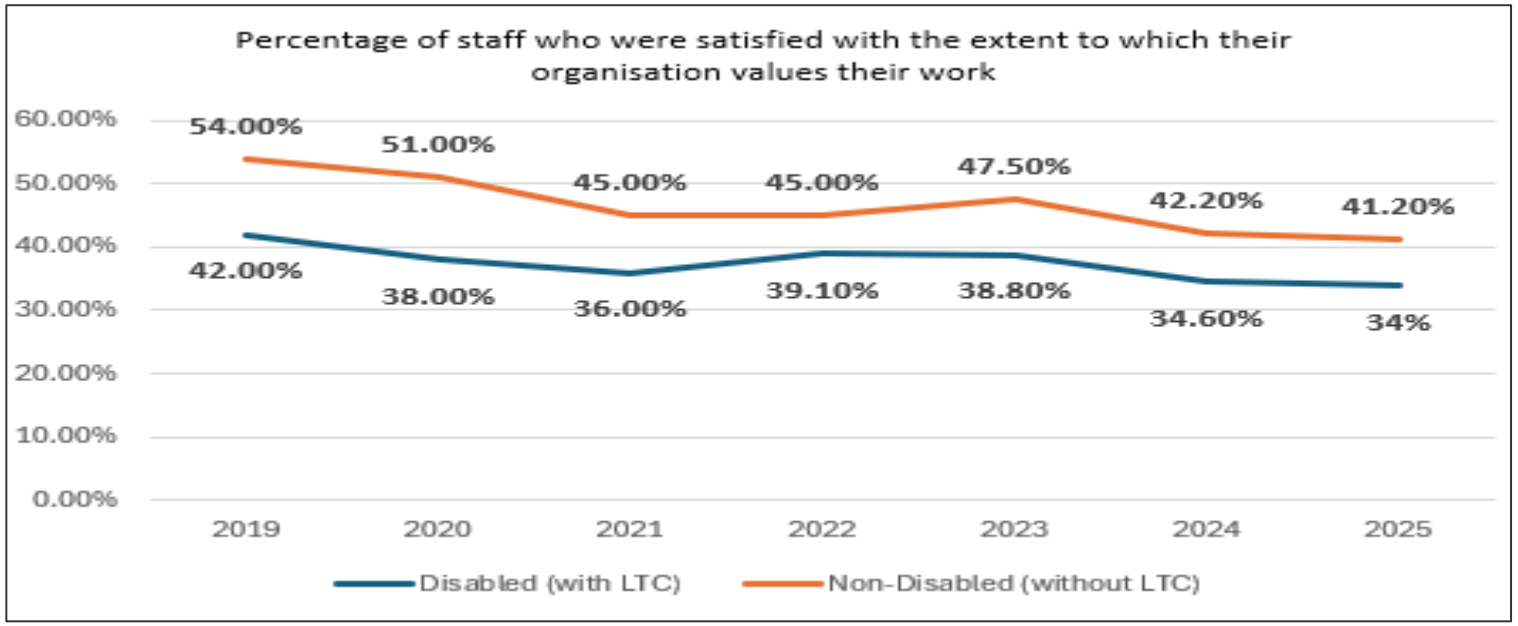
- Information from the staff network has also indicated disabled staff will come to work whilst not feeling well through fear of triggering sickness stages in the absence policy. Additionally, Managers may not take the individuals disability into account and the network has also indicated that for some colleagues the pressure to come to work may be self imposed and this needs to be explored further.

WDES Indicator 7

The percentage of staff who were satisfied with the extent to which their organisation values their work

Gateshead Health NHS Foundation Trust

	2019	2020	2021	2022	2023	2024	2025
Disabled (with LTC)	42.0%	38.0%	36.0%	39.1%	38.8%	34.6%	34%
Non-Disabled (without LTC)	54.0%	51.0%	45.0%	45.0%	47.5%	42.2%	41.2%



The percentage of staff who were satisfied with the extent to which their organisation values their work:

- The data shows that Disabled staff continue to feel that their work is less valuable to the organisation than Non-Disabled staff. The figures show that there has been a consistency around the 30% mark for Disabled groups and the mid 45% for Non-Disabled staff.
- Data shows a **7.2% difference** between the two groups (2025). This figure is marginally better than the 2024 figure which was indicating a **7.6%** difference.

- The difference between disabled and non-disabled staff suggests that there is a greater need to fully understand the experiences and improve the ways in which people feel valued and heard.

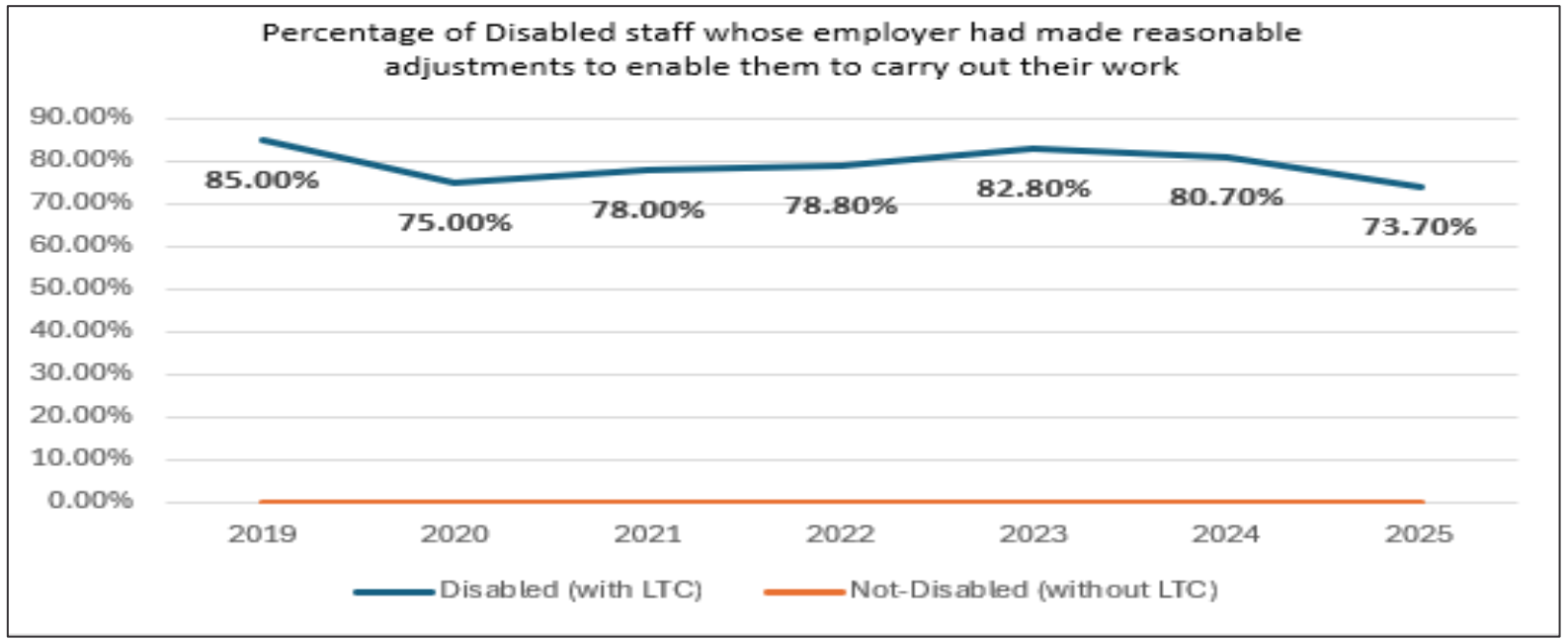
Action 3 in the action plan aims to support improvement with this indicator

WDES Indicator 8

The percentage of Disabled staff whose employer had made reasonable adjustments to enable them to carry out their work

Gateshead Health NHS Foundation Trust

	2019	2020	2021	2022	2023	2024	2025
Disabled (with LTC)	85.0%	75.0%	78.0%	78.8%	82.8%	80.7%	73.7%
Not-Disabled (without LTC)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0%



- Nearly **three in four disabled staff (73.7%)** say they receive adequate reasonable adjustments.
- This fell sharply from **80.7% in 2024**—a **7-point decline**.
- Undeclared disabilities may mean the full need is not visible.
- Most disabled colleagues receive support, but provision has worsened and over a quarter do not report adequate adjustments.

Action 3 in the action plan aims to support improvement with this indicator

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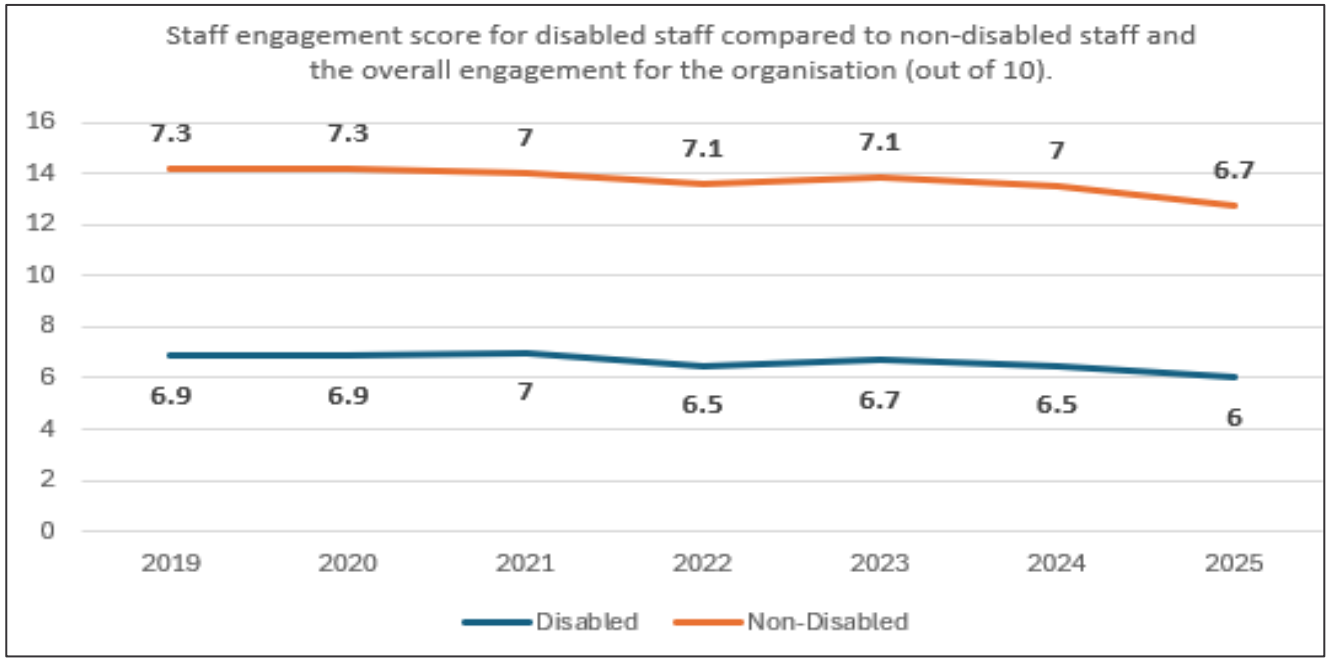
WDES Indicator 9
The NHS staff survey-based staff engagement score

Gateshead Health NHS Foundation Trust

	Staff engagement score for disabled staff compared to non-disabled staff and the overall engagement for the organisation (out of 10).						
	2019	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**
Disabled	6.9	6.9	7.0	6.5	6.7	6.5	6
Non-Disabled	7.3	7.3	7.0	7.1	7.1	7.0	6.7



- This indicator shows that over the last 7 years the engagement score for Disabled groups have been consistently around the mid 6.5 mark, whilst for the non-disabled groups has stood at 7.

- The staff engagement score from 2025 for Disabled groups has dropped by 0.5 and Non-disabled staff has dropped by 0.3

- The decrease suggests that work needs to be carried out to understand why disabled staff have worst experience at the Trust compared to other groups, to help us improve the ways in which staff feel valued, supported and heard.

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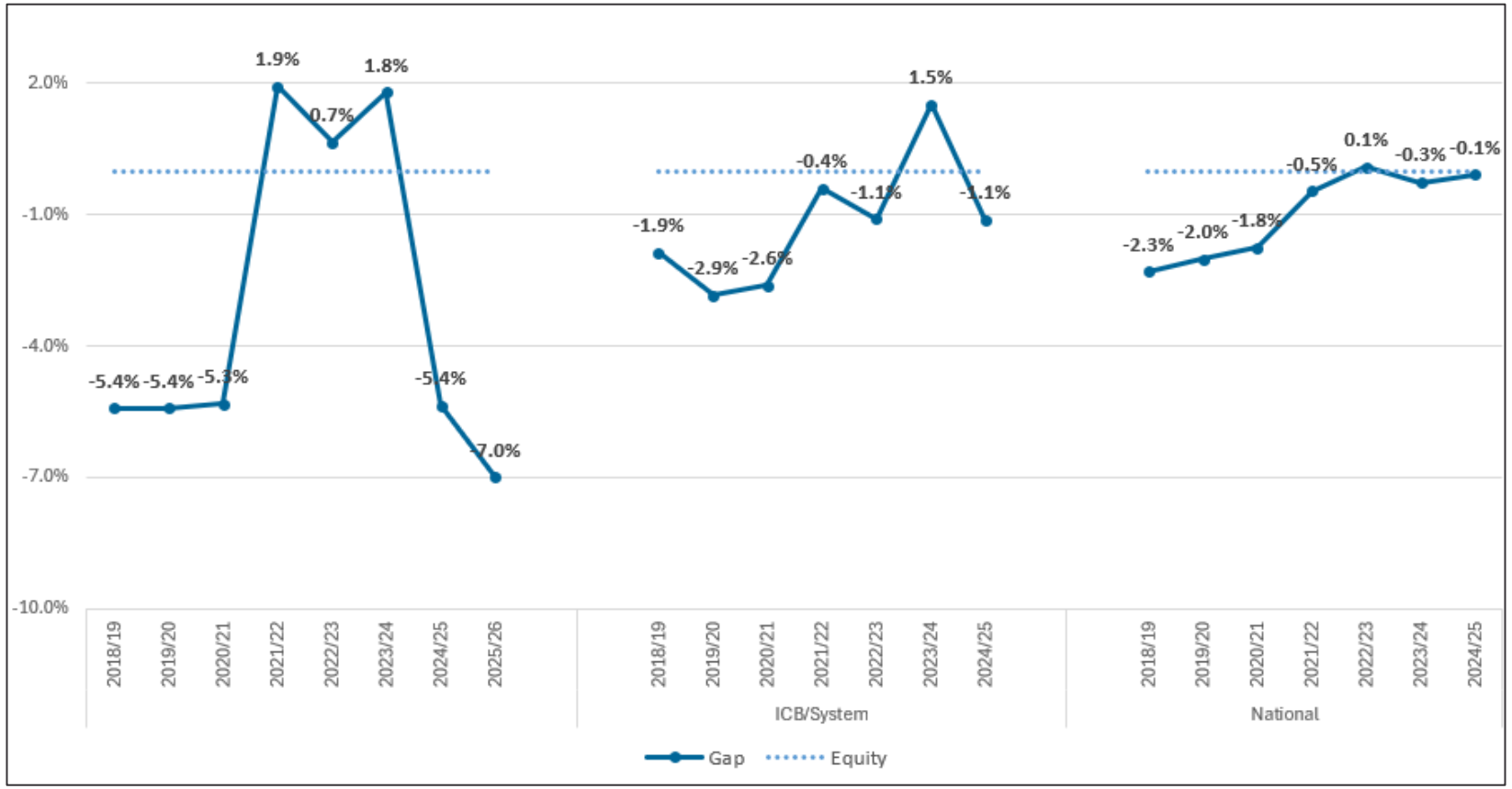
WDES Indicator 10
Overall board membership

Gateshead Health NHS Foundation Trust



As at the end of March 2026:

- the difference between Disabled representation on the board and in the workforce was the same as the previous year +1.8%.
- Disabled members were at least proportionately represented on the board in terms of a headcount.

Action 4 in the action plan aims to support improvement with this indicator

Contents | Indicator 1 | Indicator 2 | Indicator 3 | Indicator 4a | Indicator 4b | Indicator 4c
Indicator 4d | Indicator 5 | Indicator 6 | Indicator 7 | Indicator 8 | Indicator 9 | Indicator 10

Gateshead Health NHS Foundation Trust

WDES action plan

No	Action	WRES Indicator
1	**To reduce inequalities in recruitment, career progression, leadership development and access to opportunities.** 1. Strengthen Recruitment and Selection Policy so all recruitment at Band 8a and above and wherever possible at all levels, there is consideration for diversity of the applicants and reflect this within the panel representation i.e. interview panel members that have a disability. 2. Actively promote the CPD and development offer via staff networks to increase awareness of development opportunities beyond mandatory learning to enhance skills and in-turn, employability prospects.	Indicators 2, 5
2	**To reduce experiences of bullying, harassment, discrimination and incivility.** 1. Arrange specific, targeted civility awareness sessions and FTSU sessions with all staff networks, to raise awareness and support confidence in raising concerns, incorporating changes to the grievance policy and let them know about triangulation meetings. 2. Triangulate staff survey data where there are high levels of incivility reported through the staff survey, and high levels of protected characteristics to deliver targeted civility awareness sessions and offer managers support. 3. Training for commissioning managers on recognising bias, making decisions cases proceed to formal processes etc.	Indicators 4abcd,

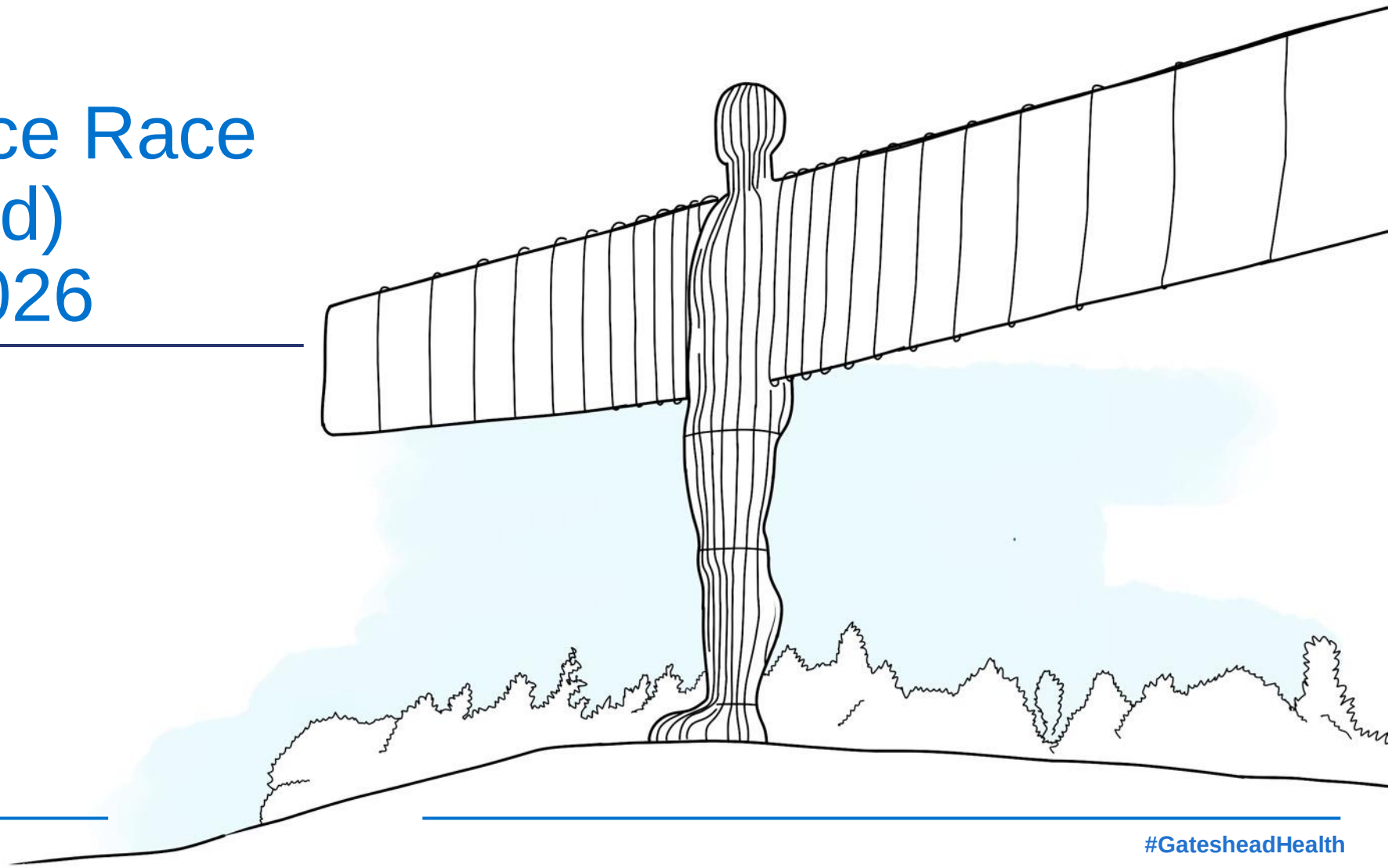
Gateshead Health NHS Foundation Trust

WDES action plan

No	Action	WRES Indicator
3	**To create a workplace where disabled colleagues feel supported, valued and able to thrive.** 1. Launch the Reasonable Adjustments Passport and associated guide for managers to support individuals with long-term health conditions or disabilities. 2. Strengthen manager capability around disability inclusion and neurodiversity through awareness and development. 3. Increase disability declaration rates through promotion via the staff networks	Indicators 1, 6, 7, 8
4	**To strengthen leadership accountability and ensure EDI outcomes are embedded within organisational governance arrangements.** 1. Introduce / strengthen EDI objectives into Executive and senior leader appraisal arrangements, need to be aligned to the priorities and actions agreed within this paper. 2. Develop a Non-Executive Director development programme to increase diversity 3. Align a member of the executive team to the staff networks acting as an ally and a key contact outside of the Executive Director of People and OD 4. Raise awareness of the governance arrangements around EDI with staff networks to assure them issues are tacked and discussed appropriately	Indicators 2, 5, 10

Gateshead Health
NHS Foundation Trust

WRES (Workforce Race Equality Standard) Report 2025 - 2026



Gateshead Health NHS Foundation Trust

Contents

We know there is more to do.

Gateshead Health NHS Foundation Trust

I want to be open: staff from a Global Ethnic Majority do not always have positive experiences of fairness, safety or opportunity at Gateshead Health.

Our workforce data and colleague feedback matter. They show that barriers, bias and unequal outcomes remain. We need to acknowledge this honestly and respond with focus, care and sustained action.

I want every colleague to feel they belong, can speak up safely and have the same opportunity to progress. There is more to do, and we are committed to doing it.

Every leader and every team must reflect honestly on what is happening, take responsibility for improvements within their control and work together to make a difference.

We must all;

- **Challenge racism and discrimination.**
- **Remove barriers in our systems.**
- **Act on what staff tell us.**

Measure whether our actions improve people's experiences — and keep learning as we go.

Our colleagues deserve fairness, respect and opportunity. Together, we can and must keep improving.

Amanda Venner, Executive Director of People and OD
Gateshead Health NHS Foundation Trust

WRES indicators

Gateshead Health NHS Foundation Trust

There are **nine** WRES indicators.

- **Four** of the indicators focus on workforce data
  1. Percentage of staff in each of the AfC Bands 1-9, VSM, Medical and Dental and other staff , compared with the percentage of staff in the overall workforce
  2. Relative likelihood of staff being appointed from shortlisting across all posts (both external and internal posts).
  3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
  4. Relative likelihood of staff accessing non-mandatory training and CPD

- **Four** are based on data from the national NHS Staff Survey questions and
  5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
  6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
  7. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion
  8. In the last 12 months have you personally experienced discrimination at work from any of the following- Manager/team leader or other colleagues

- **One** indicator focuses upon BME representation on boards.
  9. Percentage difference between the organisations' Board membership and its overall workforce

Based on the requirement from the National team, the Trust submitted the WRES data for Indicators 1 - 4 and indicator 9 on the National Data Collection Framework (DCF) before the end of 31st May 2026. The staff survey results for Indicators 5 to 8, are taken directly from the WRES publications available on the NHS Staff Survey website.

In the previous years there was information that was included within the indicators captured from the National Benchmarking report produced for the Trust. The next Benchmarking report (2025/ 2026) will not be available until October / November 2026 and as such this information is not included.

Definitions

Term	Definitions as per Technical Guidance by NHS England WRES Team.
White Staff	Includes White British, Irish and Eastern European and any “White other”.
BME Staff	Staff that are from a Black or Minority Ethnic background that are not white. *Internally we use the term Global Ethnic Majority - GEM*
Unknown	Refers to anyone who has not declared ethnicity.
Non-Mandatory Training	Any learning, education, training, or staff development activity undertaken by an employee, the completion of which is neither a statutory requirement (e.g. fire safety training) or mandated by the organisation. Accessing non-mandatory training and CPD, in this context refers to courses and developmental opportunities for which places were offered and accepted.

Key achievements from last 12 months

Gateshead Health NHS Foundation Trust

- Recruitment and Selection programme revised with an enhanced focus on inclusive recruitment practices.
- Culture and Experience Day introduced as a core leadership development programme, covering civility, discrimination, bullying and harassment, sexual safety, and inclusive leadership.
- Inclusivity training available to all staff to increase awareness and understanding of equality, diversity and inclusion.
- Civility Awareness Training available to all staff to support respectful workplace behaviours and challenge incivility.
- Staff Experience and Inclusion Group established, with staff network representation helping shape culture and EDI initiatives.
- Culture, Insight and Triangulation Meeting introduced to review EDI concerns alongside workforce and Freedom To Speak Up data and escalate issues where required.
- EDI Dashboard developed and regularly reported through the Trust's governance structure.
- First Ethnicity Pay Gap Report produced and presented to a Tier 1 Committee.
- Bespoke EDI awareness sessions delivered in response to local team needs.
- South Asian Heritage Month, Black History Month and other EDI initiatives actively promoted in partnership with the GEM Network.
- ESR self-service functionality promoted to improve the recording of protected characteristic data.
- Cultural Ambassador Programme reviewed to strengthen its future impact and effectiveness.

Key WRES findings 2025 – 2026

Gateshead Health NHS Foundation Trust

Workforce representation
- There was a 0.29% increase of BME staff, rising from 10.28% in 2024/25 to 11.18% in 2025/26.
- No representation at Very Senior Managers.
- Of the total 353 members of Medical staff, 59.49% are White and 35.98% are BME,
- 4.53% have not declared their ethnicity.
- BME representation was nearly half across all Medical roles, compared with White Staff

Harassment and Bullying
- BME Staff experiencing harassment, bullying or abuse from patients' relatives or public has decreased by 1.4% to 24.4%. Similarly, a small decrease for White staff but still around 19% - 25% across all the reporting years for both groups.
- Harassment, bullying or abuse from staff for both BME and White staff decreased (0.2% and 0.5% respectively). However, the figures are virtually the same as the above metric
- Harassment bullying or abuse from Managers / team leader or other colleagues for BME groups has increased by 0.2% up from 17.1%. For White staff, this figure has not changed, and still sits at 5.8% over the same period.

Recruitment
- The relative likelihood of appointment for White staff has increased to 2.7.
- The Ethnicity disparity for BME groups is 1.3.

Formal Disciplinary
The data indicates that whilst the disciplinary headcount for White staff stands at 60, for BME staff this figure is 7. In terms of ratios, for this KPI, the BME ratio has increased from 1.1 to 1.2 This figure has been on an increase since 2023/24.

Career Progression
- Percentage of staff believing that the trust provides equal, opportunities for Career Progression or Promotion
- In comparison with Data from last year, opportunities for BME staff have decreased by 6.2% and
- For White Staff this figure has also decreased by 9.7%

Board Representation
Out of the total 15 White Board members, 7 are Executive Board members and 7 Non- Exec Board Members.
There is no BME representative

WRES Indicator 1 (1 of 3)
Percentage of BME staff vs VSM AFC Non-Clinical (headcount)

Gateshead Health NHS Foundation Trust

Non-Clinical Staff		BME		White		Unknown		0verall Total
Under Band 1	Headcount	0	0.0%	0	0.0%	0	0.0%	0
Bands 1	Headcount	0	0.0%	0	0.0%	0	0.0%	0
Bands 2	Headcount	46	7.1%	583	90.2%	17	2.6%	646
Bands 3	Headcount	7	2.5%	271	96.1%	4	1.4%	282
Bands 4	Headcount	6	2.4%	243	96.4%	3	1.2%	252
Bands 5	Headcount	4	2.6%	145	94.2%	5	3.2%	154
Bands 6	Headcount	6	6.6%	84	92.3%	1	1.1%	91
Bands 7	Headcount	2	2.8%	68	95.8%	1	1.4%	71
Bands 8a	Headcount	1	3.7%	26	96.3%	0	0.0%	27
Bands 8b	Headcount	0	0.0%	34	100.0%	0	0.0%	34
Bands 8c	Headcount	0	0.0%	10	100.0%	0	0.0%	10
Bands 8d	Headcount	0	0.0%	11	100.0%	0	0.0%	11
Bands 9	Headcount	0	0.0%	7	100.0%	0	0.0%	7
VSM	Headcount	0	0.0%	4	100.0%	0	0.0%	4
Cluster 1: AfC Bands <1 to 4	Auto-Calculated	59	5.0%	1097	93.0%	24	2.0%	1180
Cluster 2: AfC bands 5 to 7	Auto-Calculated	12	3.8%	297	94.0%	7	2.2%	316
Cluster 3: AfC bands 8a and 8b	Auto-Calculated	1	1.6%	60	98.4%	0	0.0%	61
Cluster 4: AfC bands 8c to VSM	Auto-Calculated	0	0.0%	32	100.0%	0	0.0%	32
Total Non-Clinical	**Auto-Calculated**	**72**	**4.5%**	**1486**	**93.5%**	**31**	**2.0%**	**1589**

As of 31st March 2026, the total Headcount of BME staff represented **5.0 %** compared with **93%** White staff across all **Non-Clinical AfC roles.**

Cluster Bands - 1 to 4 and under (administrative and technical support roles, estates office) show that:
- BME representation was **5.0%** and White **93%**
- **2%** of staff personnels ethnicity is unknown

Cluster 2 - Band 5 to 7 (graduate and management level roles) shows:
- BME representation was **3.8% and** White was **94%%**
- **2.2%** of staff personnels ethnicity is unknown

Cluster band 8a – 8b
- BME representation was **1.6%** and White was **98.4%**

Cluster band 8c – VSM
- BME representation was **0%** and White was **100%**

The data shows that as the Banding increases, the representation of **BME Staff** decreases. **Band 2** has the highest number at **46 staff (7.1%)** in comparison White staff at the same Band have a high representation **583 Staff** (**90.2%**). **These high percentages for White staff are reflected through Bands 2 to VSM**

There is no BME representation above 8B

There is no BME staff representation at VSM

Action 1 and 3 in the action plan aims to support improvement with this indicator

WRES Indicator 1 (2 of 3)
Percentage of BME staff vs VSM AFC Clinical (headcount)

Gateshead Health NHS Foundation Trust

Clinical Staff		BME		White		Unknown		Overall Total
Under Band 1	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Bands 1	Headcount	0	0.00%	0	0.00%	0	0.00%	0
Bands 2	Headcount	13	6.77%	178	92.71%	1	0.52%	192
Bands 3	Headcount	37	5.98%	578	93.38%	4	0.65%	619
Bands 4	Headcount	10	5.49%	170	93.41%	2	1.10%	182
Bands 5	Headcount	244	26.24%	664	71.40%	22	2.37%	930
Bands 6	Headcount	54	7.75%	636	91.25%	7	1.00%	697
Bands 7	Headcount	18	4.22%	404	94.61%	5	1.17%	427
Bands 8a	Headcount	3	2.38%	123	97.62%	0	0.00%	126
Bands 8b	Headcount	0	0.00%	30	96.77%	1	3.23%	31
Bands 8c	Headcount	0	0.00%	6	100.00%	0	0.00%	6
Bands 8d	Headcount	0	0.00%	5	100.00%	0	0.00%	5
Bands 9	Headcount	0	0.00%	2	100.00%	0	0.00%	2
VSM	Headcount	0	0.00%	1	100.00%	0	0.00%	1
Cluster 1: AfC Bands <1 to 4	Auto-Calculated	60	6.0%	926	93.3%	7	0.7%	993
Cluster 2: AfC bands 5 to 7	Auto-Calculated	316	15.4%	1704	83.0%	34	1.7%	2054
Cluster 3: AfC bands 8a and 8b	Auto-Calculated	3	1.9%	153	97.5%	1	0.6%	157
Cluster 4: AfC bands 8c to VSM	Auto-Calculated	0	0.0%	14	100.0%	0	0.0%	14
Total Clinical	**Auto-Calculated**	**379**	**11.8%**	**2797**	**86.9%**	**42**	**1.3%**	**3218**

As of 31st March 2026, the total Headcount of BME staff represented **11.8%** compared with **86.9%** White staff across all **Clinical AfC roles.**

Cluster 1 - Bands 1 to 4 and under (administrative and technical support roles,) show that:
- BME representation was **6.0%** and White **93.3%.** However far greater number of White staff in cluster compared with BME (926 v 60)

Cluster 2 - Band 5 to 7 (graduate and management level roles) shows:
- BME representation was **15.4% and** White was **83%. T**here are far greater numbers of White staff in this cluster compared with BME (1704 v 316)

Cluster 3- Band 8a – 8b
- BME representation was very low **1.9%** and White was **97.5%**

Cluster 4 - Band 8c – VSM
- BME representation was **0%** and White was **100%**

The data shows that as the Banding increases, the representation of **BME Staff** decreases significantly in comparison with their White counterparts. Biggest representation for BME staff is at **Band 5 (26.24%)**

In the Clinical Headcount Bands 8c to VSM shows that there were no BME representation

Action 1 and 3 in the action plan aims to support improvement with this indicator

Gateshead Health NHS Foundation Trust

WRES Indicator 1 (3 of 3)
Percentage of BME staff vs VSM Clinical (headcount)

Medical Staff		BME		White		Unknown		Overall Total
Medical & Dental Staff, Consultants	Headcount	**82**	34.02%	**151**	62.66%	**8**	3.32%	241
of which Senior Medical Managers	Headcount	**0**	0.00%	**2**	100.00%	**0**	0.00%	2
Medical & Dental Staff, Non-Consultants career grade	Headcount	**9**	37.50%	**15**	62.50%	**0**	0.00%	24
Medical & Dental Staff, Medical and dental trainee grades	Headcount	**36**	40.91%	**44**	50.00%	**8**	9.09%	88
Medical & Dental Staff, Other		**0**		**0**		**0**		0
Total Medical and Dental	Auto-Calculated	**127**	35.98%	**210**	59.49%	**16**	4.53%	353
Number of staff in workforce	Auto-Calculated	**578**	11.20%	**4493**	87.07%	**89**	1.72%	5160
The total figure indicated captures all staff who are in Non-Clinical, Clinical and Medical which equates to 5160								

Amongst Medical and Dental staff, the breakdown shows that overall:

- There are more White staff **59.49% than** BME staff **35.98%**

- At Medical & Dental Staff, Consultants Level, White staff compared with BME staff are nearly double **151 (62.66%) v 82 (34.2%)**
- 8 staff **(3.32%)** fall into the 'Unknown' category

Across the whole staff group, our BME colleagues make up **11.18** % of the workforce, an increase of **1.48%** from last year.

Action 1 and 3 in the action plan aims to support improvement with this indicator

Indicator 2

Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants

Gateshead Health NHS Foundation Trust

Relative **likelihood of white applicants** being appointed from shortlisting across **all** posts compared to BME applicants	**18/ 19**	**19/ 20**	**20/ 21**	**21/22**	**22 /23**	**23 /24**	**24 /25**	**25/ 26**
	3.08	1.8	0.70	0.72	0.69	0.83	0.59	2.7
						decrease by 0.24		Increase by 2.1
	Data collected for 2025/26 shows White applicants were 2.1 times more likely to be appointed from SL compared to BME applicants. The Ethnicity disparity in terms of BME groups is 1.3. Year on year fluctuation must also be taken into account. The higher the number, greater the chance of appointments.							

		BME	White	Unknown	Total
Number of shortlisted applicants	Headcount	660 (27.1%)	1770 (72.8%)	0	2430
Number appointed from shortlisting	Headcount	89 (15.2%)	493 (84.7%)	0	582
Likelihood of shortlisting/appointed	Auto-Calculated	0.13	0.27	0.000000	
Relative likelihood of White candidates being appointed from shortlisting compared to BME candidates	Auto-Calculated	2.06			

A relative likelihood over a figure of 1 indicates that white applicants have a greater likelihood of being appointed

- Previous data shows that BME were more likely to be appointed in comparison with their white colleagues in 2023/ 2024
- **T**he 2024/ 2025 figures show that the relative likelihood of white appointment had decreased by 0.24
- **There has been an increase in the 2025/2026 figures in that the relative likelihood of appointment for White staff has increased by 2.1 to 2.7**

Action 1 and 3 in the action plan aims to support improvement with this indicator

Indicator 3

Relative likelihood of BME staff entering the formal disciplinary process compared to white staff.

Gateshead Health NHS Foundation Trust

Relative **likelihood of BME staff** entering the formal disciplinary process compared to white staff.	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
	0.97	0	1.27	0	0	0.51	1.1	1.2
	The disciplinary data has been extracted from Selenity and adjusted accordingly. The data indicates that whilst the disciplinary Headcount for White staff stands at 60, for BME staff this figure is 7. In terms of ratios for this KPI, the BME ratio has increased from 1.1 to 1.2. It is important to note that this figure have been on an increase since 2023/24							

This data is captured form our internal reporting mechanisms.

- Data collected pertains to formal disciplinary processes on grounds of conduct issues. These figures do not capture the informal process.
- The Data shows that the figure has increased from 1.1 to 1.2 (reflecting 7 cases)
- The 2025/26 figure show an increase by 0.1

Due to the limited volume of cases, the data should be viewed as indicative rather than evidence of an established trend.

Indicator 4 - Non-mandatory Training

Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff

Gateshead Health NHS Foundation Trust

	2025/2026	BME	White	Unknown	Total
Number of staff accessing non-mandatory training and CPD in the financial year	Headcount	400 (13.5%)	2520 (85%)	47 (1.6%)	2967
Likelihood of staff accessing non-mandatory training and CPD	Auto-Calculated	0.69	0.56	0.52	
Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	Auto-Calculated	0.81			

Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME staff	19/20	20/21	21/22	22/23	23/24	24/25	25/26
	1.18	0.96	0	1	0.99	1.03	0.81

Aa at March 2026 the likelihood of white staff accessing non-mandatory training and CPD compared to BME staff was 0.81; not significantly different from "1.0" or equity.

Specifically, **2520 (85%)** of White staff accessed non-mandatory training compared to **400 (13.5%)** BME staff.

In % terms, the relative likelihood for staff accessing Non-Mandatory Training including those in the 'Not stated / Not Given' category show that

- 69% of BME staff had the likelihood of accessing Non-Mandatory training.
- In comparison for both White and the Unknown category these figures are 56 % and 52% respectively
- The data shows that there has been a drop from last years figure of White staff accessing mandatory training by (0.22)

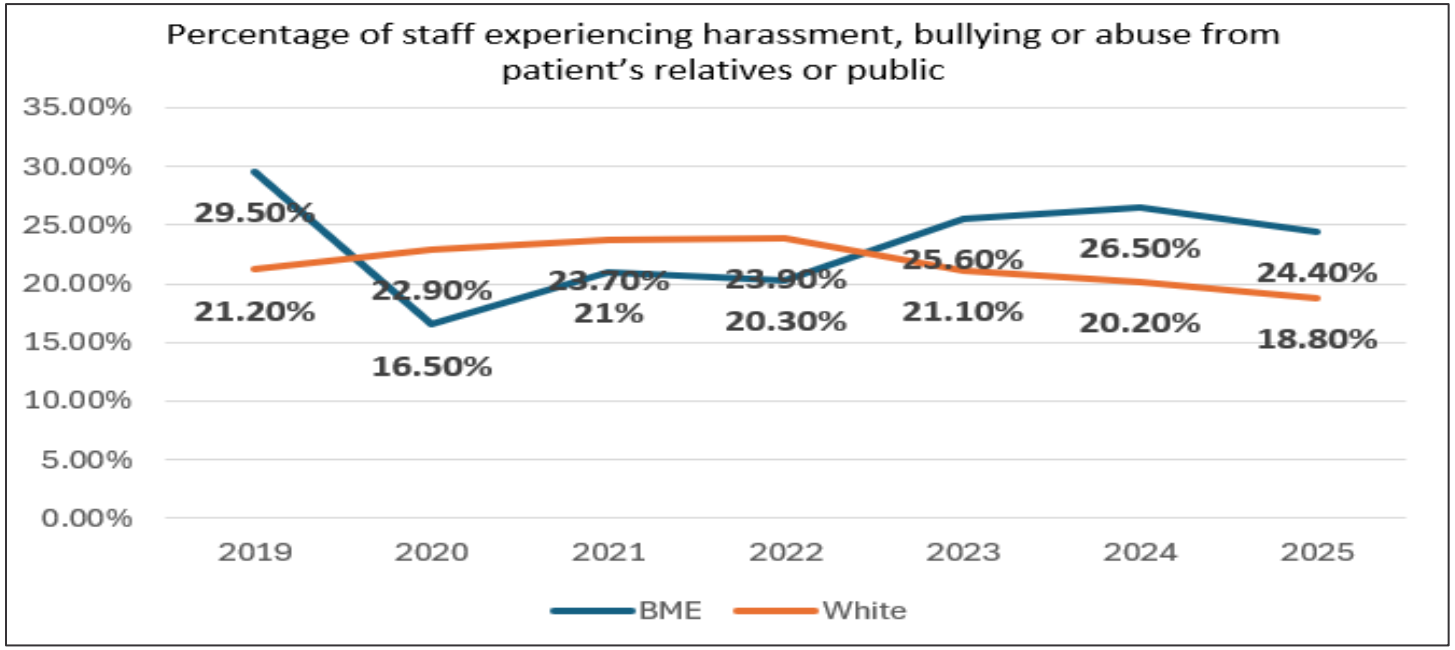
Action 1 in the action plan aims to support improvement with this indicator

Indicator 5 WRES Staff Survey Data 2025

Percentage of staff experiencing harassment, bullying or abuse from patient's relatives or public in the last 12 month

Gateshead Health NHS Foundation Trust

Staff Survey Indicators		2019	2020	2021	2022	2023	2024	2025
Percentage of staff experiencing harassment, bullying or abuse from patient's relatives or public in the last 12 months	**BME**	**29.5%**	**16.5%**	**21%**	**20.3%**	**25.6%**	**26.5%**	**24.4%**
	White	21.2%	22.9%	23.7%	23.9%	21.1%	20.2%	18.8%



The figures over the last 7 years show:

- For BME staff after the dip from **29.5% in** 2019 to **16.5**% in 2020. This figure had increased by 4.5% from 2020 to 2021 with a miniscule drop (**0.7%)** in 2022, but continued to rise for the next 2 years and dropped by **2.1%** last year**.**
- The figure for White staff also show an increase from 2020 **(22.9%)** and have hovered around this mark before showing a consistent drop in 2024/2025 with a **1.4% decrease.**
- The percentage decrease from **to 2024/2025** for BME staff is very small **(2.1%),** it is a worry that across both groups, the percentage rates of staff experiencing harassment over the last 3 years are consistently within the 18% - 20+% mark
- While there is an increase in the knowledge and confidence in reporting processes, providing Managers with Zero Tolerance / Civility Saves lives might be a reason for the drop. However, the figures are worrying.

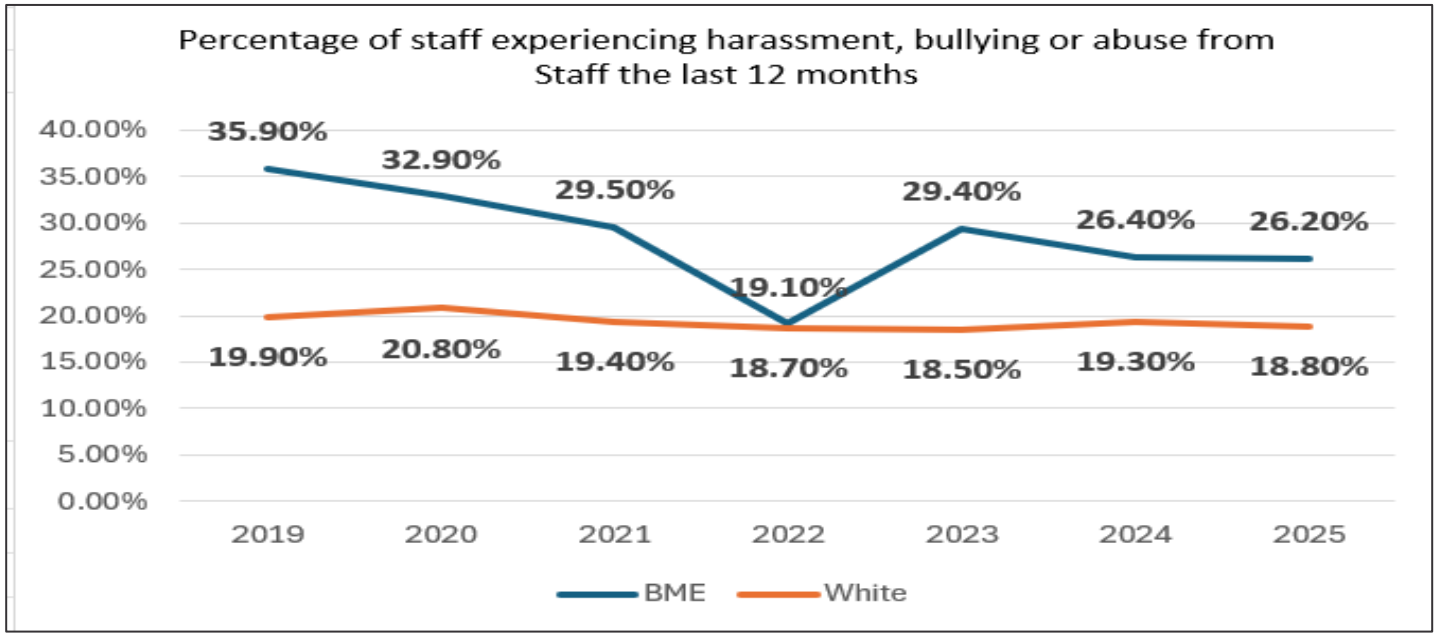
Action 2 in the action plan aims to support improvement with this indicator

Indicator 6 WRES Staff Survey Data 2025

Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months

Gateshead Health NHS Foundation Trust

		2019	2020	2021	2022	2023	2024	2025
Percentage of staff experiencing harassment, bullying or abuse from Staff the last 12 months	**BME**	**35.9%**	**32.9%**	**29.5%**	**19.1%**	**29.4%**	**26.4%**	**26.2%**
	White	19.9%	20.8%	19.4%	18.7%	18.5%	19.3%	18.8%



This indicator shows that in the last 4 years:

- BME staff experiences of harassment, bullying or abuse shows **a decrease** from **2023. This figure dropped by 0.2% in 2025.**
- For White staff experiences of harassment, bullying or abuse showed **an increase of 0.8%** in **2024** and has dropped by **0.5%**

These figures are comparable with the regional figures. For BME staff the trajectory could reflect the backdrop of the continuous backlash from the riots, polarisation in the ongoing immigration debate and increased tensions in respect of unrest across the middle east.

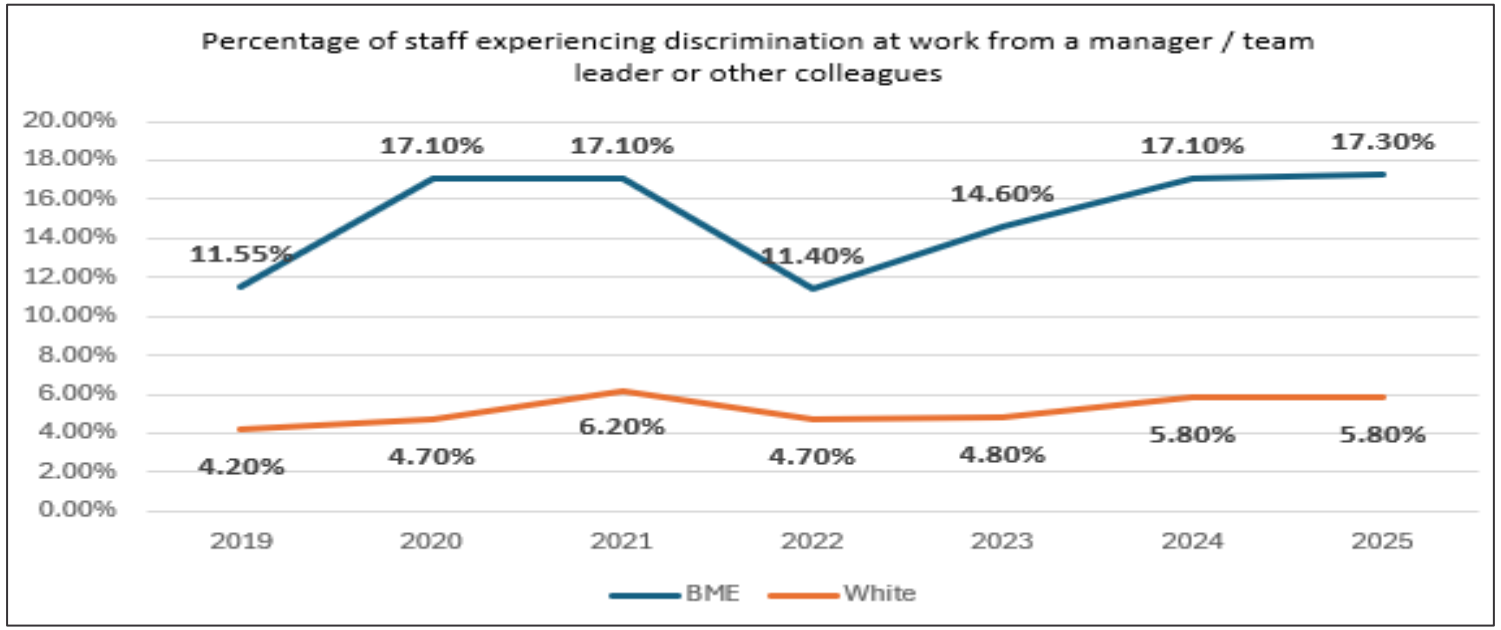
This discourse is reflected through conversations with staff who have family and friends in areas of ongoing conflict whether here or abroad . Tensions within the local communities and BME groups have increased since this unrest and may contribute to the trend of abuse against BME staff

Action 2 in the action plan aims to support improvement with this indicator

Indicator 7 WRES Staff Survey Data 2025

Percentage of staff experiencing discrimination at work from a manager / team leader or other colleagues

		2019	2020	2021	2022	2023	2024	2025
Percentage of staff experiencing discrimination at work from a manager / team leader or other colleagues	**BME**	**11.55%**	**17.1%**	**17.1%**	**11.4%**	**14.6%**	**17.1%**	**17.3%**
	White	4.2%	4.7%	6.2%	4.7%	4.8%	5.8%	5.8%



- In 2022 for both, **BME and White staff** experiences of harassment decreased (**5.7% / 1.5%** respectively). This figure however has now risen for both groups. For BME groups have increased year by year. The 2025 figure show an increase of **0.2% to 17.30%**
- The difference between the groups shows BME staff are around 3 times more likely to experience discrimination than their White colleagues.

It should be noted that the increased percentages could well be accounted for by increasing knowledge and confidence in reporting processes.

- Having undertaken the Z tolerance training, colleagues may feel more confident in reporting as identified in Indicator 5.
- Tensions within the local communities and BME groups have increased since this the last unrest and may contribute to the trend of abuse against BME staff as identified in Indicator 6.

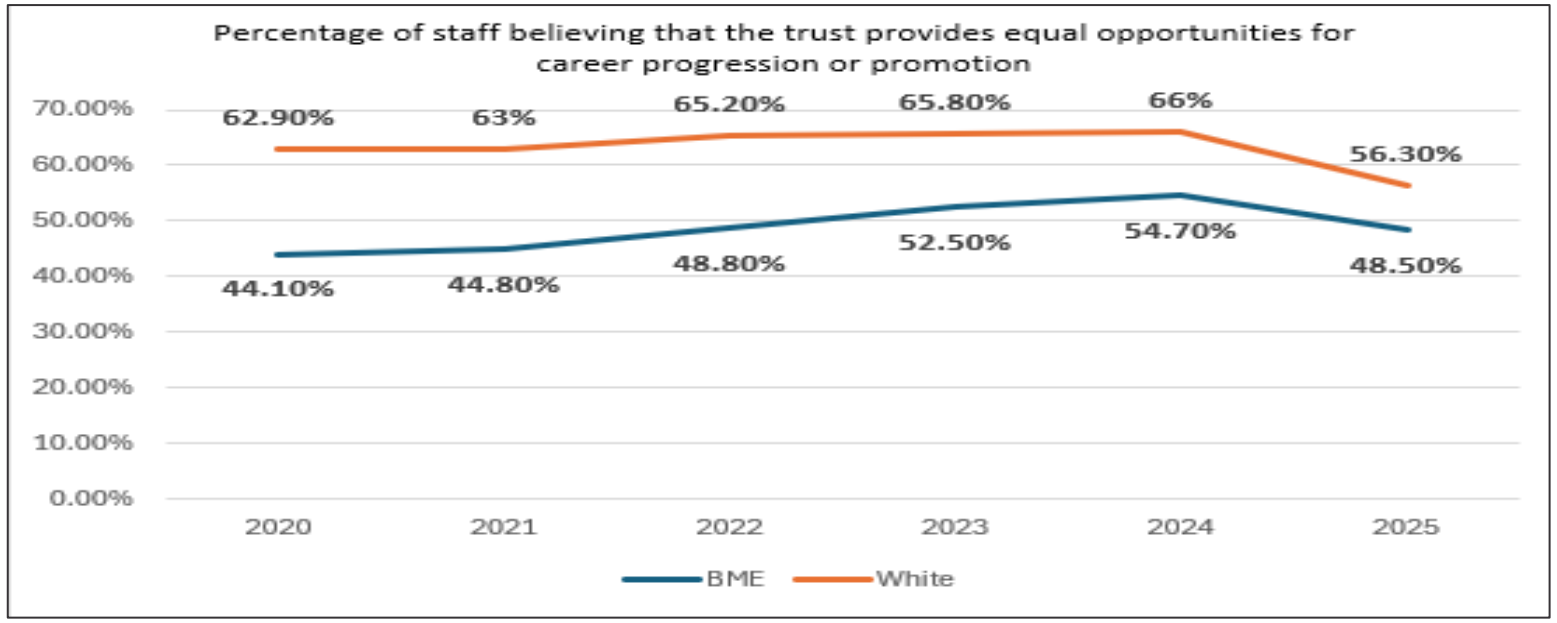
Action 2 in the action plan aims to support improvement with this indicator

Indicator 8 WRES Staff Survey Data 2024

Percentage of staff believing that the trust provides equal opportunities for career progression or promotion

Gateshead Health NHS Foundation Trust

		2020	2021	2022	2023	2024	2025
Percentage of staff believing that the trust provides equal opportunities for career progression or promotion	**BME**	**44.1%**	**44.8%**	**48.8%**	**52.5%**	**54.7%**	**48.5%**
	White	62.9%	63%	65.2%	65.8%	66%	56.3%

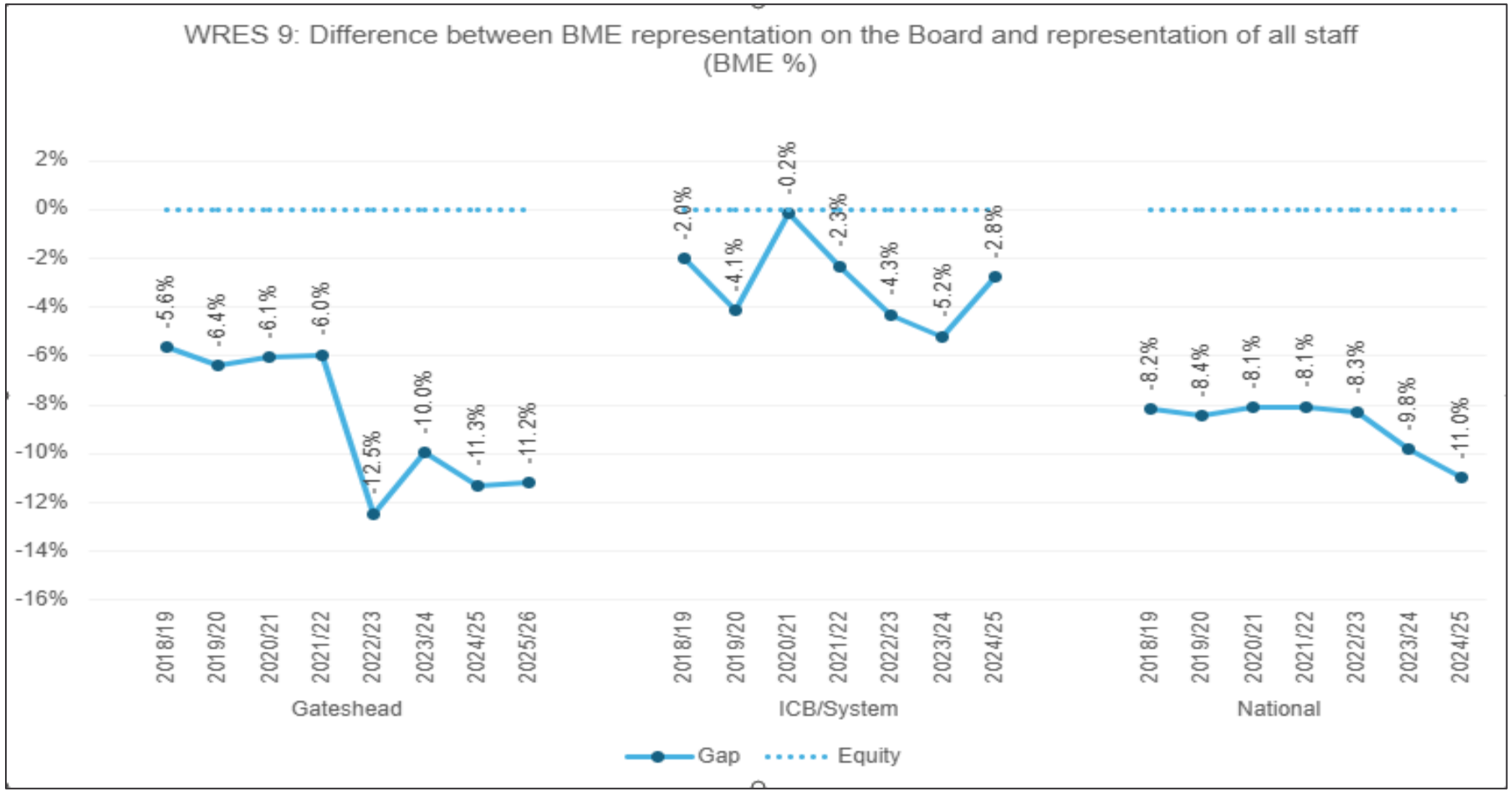


- Confidence in equal career progression **fell sharply in 2025** for both groups.
- BME staff fell from **54.7% to 48.5%**; White staff from **66.0% to 56.3%**.
- A **7.8 percentage-point gap** remains.
- Although the gap narrowed, this was mainly because White staff scores fell faster—not because BME staff improved.
- Perceptions worsened across the workforce, with BME staff still less likely to believe opportunities are equal.

Action 1 and 3 in the action plan aims to support improvement with this indicator

WRES Indicator 9
BME Board membership

Gateshead Health NHS Foundation Trust



Overall Board membership shows that as of March 2025, the difference between BME representation on the Board and the workforce was -11%. BME members were underrepresented by 1 as member of the Board.

Action 1 and 3 in the action plan aims to support improvement with this indicator

Gateshead Health NHS Foundation Trust

WRES action plan

No	Action	WRES Indicator
1	**To reduce inequalities in recruitment, career progression, leadership development and access to opportunities.** 1. Strengthen Recruitment and Selection Policy so all recruitment at Band 8a and above and wherever possible at all levels, there is consideration for diversity of the applicants and reflect this within the panel representation i.e. interview panel members GEM backgrounds. 2. Establish a targeted talent and succession programme for clinical global ethnic majority staff at bands 5 / 6 to increase confidence in applying for senior roles. 3. Actively promote the CPD and development offer via staff networks to increase awareness of development opportunities beyond mandatory learning to enhance skills and in-turn, employability prospects.	Indicators 1, 2, 4, 8, 9
2	**To reduce experiences of bullying, harassment, discrimination and incivility.** 1. Arrange specific, targeted civility awareness sessions and FTSU sessions with all staff networks, to raise awareness and support confidence in raising concerns, incorporating changes to the grievance policy and let them know about triangulation meetings. 2. Triangulate staff survey data where there are high levels of incivility reported through the staff survey, and high levels of protected characteristics to deliver targeted civility awareness sessions and offer managers support. 3. Training for investigators on racism and racial harassment 4. Training for commissioning managers on recognising bias, making decisions cases proceed to formal processes etc.	Indicators 7, 6, 5
3	**To strengthen leadership accountability and ensure EDI outcomes are embedded within organisational governance arrangements.** 1. Introduce / strengthen EDI objectives into Executive and senior leader appraisal arrangements, need to be aligned to the priorities and actions agreed within this paper. 2. Develop a Non-Executive Director development programme to increase diversity 3. Align a member of the executive team to the staff networks acting as an ally and a key contact outside of the Executive Director of People and OD 4. Raise awareness of the governance arrangements around EDI with staff networks to assure them issues are tacked and discussed appropriately	Indicators 1, 2, 8, 9

5. FIT FOR THE FUTURE

a - Green Plan

Presented by the Medical Director

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 5a

Report Title:	Greener NHS Programme and Green Plan Delivery Annual Report 2025/26			
Name of Meeting:	Trust Board of Directors			
Date of Meeting:	29th September 2026			
Author:	Sarah Medhurst, Sustainability and Waste Manager, QE Facilities Ltd			
Executive Sponsor:	Jane Taylor, Director of Corporate Services			
Report presented by:	Dr Carmen Howey, Medical Director and Board Lead for the Green Plan			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To provide assurance on delivery of the Trust Green Plan 2025–2028 during 2025/26; highlight progress, material gaps and risks; and seek Board endorsement of strengthened accountability, governance and Board development arrangements.			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	New annual report. Delivery has been overseen through the Greener NHS Group and Net Zero Delivery Sub-group.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• Delivery is mixed: strong progress in waste, fleet transition, water reduction and medical gases is offset by limited progress in clinical models of care, digital sustainability, adaptation and biodiversity. • The developing partnership with Northumbria Healthcare strengthens specialist capacity through shared expertise, resources, training and an Energy and Carbon Manager. • Board oversight should be strengthened through a 2026/27 development session, six-monthly Board reporting and a quarterly, action-led Net Zero Delivery Group. • Capital availability, electrical capacity, incomplete carbon data and limited sustainability resource remain material constraints; these should be			

Gateshead Health NHS Foundation Trust

	reflected in planning, prioritisation and risk management.	
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	• note the current delivery position and accept partial assurance on delivery of the Trust Green Plan; • endorse the proposed direction of travel to replace the existing governance arrangements with a single quarterly Greener Gateshead Delivery Group, supported by a measurable delivery action plan and named leads; • support formal consultation on the proposed governance arrangements, action plan and action ownership before final approval; • support regular Board development sessions focusing on specific areas of the action plan; • recognise the Northumbria partnership as a key enabler, while confirming that the Trust retains ownership of its Green Plan and QEF is responsible for delivering and assuring actions within its agreed service-provider remit; and • require six-monthly assurance reporting to the Trust Executive Management Team.	
Trust strategic priorities that the report relates to:	☒	Excellent patient care
	☒	Great place to work
	☒	Working together for healthier communities
	☒	Fit for the future
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	• We will be a clinically-led organisation focused on delivering safe, high-quality care and improving health outcomes for our patients • We will continually improve our services creating a restorative culture where learning, innovation and research can flourish • We will grow and develop our people with a focus on celebrating achievements and creating a culture of high performance and innovation • We will collaborate with system partners with an emphasis on maximising efficient use of collective resources across health and care services • We will focus on productive utilisation of our estate to facilitate care in the right setting and providing our services in an environmentally sustainable way	

Gateshead Health NHS Foundation Trust

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

Gateshead Health NHS Foundation Trust

Greener NHS Programme and Green Plan Delivery Annual Report 2025/26

1. Executive Summary

The Green Plan 2025–2028 provides the framework through which Gateshead Health NHS Foundation Trust and QE Facilities Ltd contribute to the NHS net zero commitment, improve environmental sustainability and build resilience to climate-related risks. This first annual report concludes that the organisation can take partial assurance from delivery during the first 12 months of the Green Plan.

There is clear evidence of progress in several operational areas. The clinical waste split reached 74:23:3 against the 60:20:20 ambition; total waste reduced by 65 tonnes; water consumption reduced by 14.83%; zero-emission vehicles reached 22% of the main Spire House fleet, with an ambition to reach 42% over the next 12–18 months; and nitrous oxide and Entonox use reduced by 16% and 23% respectively. NHS England funding of £133,000 also supported additional electric vehicle charging infrastructure.

Assurance is constrained by inconsistent attendance and ownership across the Green Plan workstreams, incomplete carbon and operational data, limited clinical, Digital and EPRR engagement, and dependence on external funding for major decarbonisation projects. Energy consumption increased marginally by 0.05%, staff single-occupancy car travel increased from 63% to 67%, recycling remained at 29%, and no measurable progress was reported for biodiversity.

The emerging partnership with Northumbria Healthcare NHS Foundation Trust provides a significant opportunity to increase capability through shared technical expertise, resources, training, engagement materials and the planned shared Energy and Carbon Manager from October 2026. This is an enabling partnership: Gateshead Health and QEF remain responsible for their own statutory duties, priorities, investment decisions, Green Plan outcomes and assurance.

The principal recommendation is to revise the governance arrangements for Green Plan leadership and operational delivery. This will provide a clearer and more consistent framework for coordinating delivery, monitoring progress, addressing barriers and escalating matters requiring executive support. The revised arrangements will be reported through the Trust Executive Management Team and QEF Executive Management Team, supported by regular Board development sessions focusing on specific areas of the action plan.

2. Introduction and background

This report summarises performance during the last 12 months since the publication of the Trust Green Plan 2025-2028 against the ten focus areas and associated metrics in the plan. It provides the Board with an assessment of delivery, the principal constraints and the changes required to strengthen accountability and assurance.

The NHS has committed to reaching net zero carbon emissions by 2040 for emissions it directly controls, with an ambition to reach an 80% reduction by 2028–2032. For emissions influenced through the wider NHS supply chain, the target is net zero by 2045.

Gateshead Health NHS Foundation Trust is required to maintain a Board-approved Green Plan setting out how it will contribute to these national commitments while improving environmental performance, reducing avoidable cost and supporting healthier communities. Delivery extends beyond energy and waste and includes estates and facilities, procurement, medicines, travel and transport, food and nutrition, digital transformation, clinical services, workforce engagement and adaptation to climate-related risks.

The next phase requires sustainability to be embedded within mainstream operational, clinical and financial decision-making.

3. Overall delivery position

Focus area	2025/26 position	Priority for 2026/27
Workforce system and leadership	Amber – Board lead appointed; workforce engagement and training remain limited.	Board development; relaunch champions as Net Zero Heroes; Review leadership and operational delivery arrangements to strengthen workforce engagement and delivery.
Sustainable models of care	Red – no clinical lead, formal training or accreditation in place.	Appoint clinical lead and begin a targeted Green ED pathway, subject to clinical capacity.
Digital	Red – no confirmed digital emissions baseline or paper-reduction data.	Establish a baseline, measures and benefits linked to clinical transformation.
Travel and transport	Amber – fleet transition progressing, but staff single-occupancy car use increased.	Deliver travel strategy, fleet and charging plan, and interventions to reduce single-occupancy travel.
Estates and facilities	Amber/Red – water improved, but energy use did not reduce and major projects lack funding.	Use shared Energy and Carbon Manager capacity to strengthen data, prioritise schemes and develop investable cases.
Waste and circular economy	Green/Amber – waste split and total reduction improved; recycling remained static.	Implement food and glass recycling, formal reuse and further waste prevention.

Gateshead Health NHS Foundation Trust

Focus area	2025/26 position	Priority for 2026/27
Medicines	Green/Amber – material reductions in nitrous oxide and Entonox; manifold project remains incomplete.	Complete manifold decommissioning and sustain reductions, including occupational exposure controls.
Supply chain and procurement	Amber – requirements are embedded in contracts, but performance data are incomplete.	Establish Scope 3 baseline and strengthen contract KPI monitoring, reuse and demand reduction.
Food and nutrition	Amber – electronic ordering rollout continues; food-waste baseline established.	Complete rollout and establish reliable local measurement as wider food-waste collections expand.
Adaptation and greening the estate	Red – adaptation plan incomplete and no biodiversity baseline.	EPRR ownership and coordination of the adaptation plan and QEF to establish a biodiversity baseline.

4. Governance Arrangements and Delivery Proposal

4.1 Current arrangements and case for change

The Net Zero Delivery Sub-group was established in September 2025 to oversee delivery of the Trust Green Plan. The existing governance model consists of monthly Net Zero Delivery Sub-group meetings alongside a separate biannual Greener NHS Group.

Although participation was initially positive, attendance and reporting became inconsistent during 2026. Across the four meetings held between February and July, several designated Green Plan leads did not attend or provide sufficient progress updates. The separation of the two groups has also created some duplication without consistently providing the clear action ownership, performance information and escalation required to demonstrate delivery.

The principal recommendation is therefore to revise the governance arrangements for Green Plan leadership and operational delivery. The proposed model will replace the two existing groups with one integrated structure, supported by a single measurable action plan.

This will:

- reduce duplication and simplify reporting;
- establish a named lead for each area of the Green Plan;
- provide a consistent basis for measuring and reporting progress;
- focus meeting time on performance, barriers, dependencies and decisions;
- strengthen escalation to executive and Board level; and
- support more detailed Board development in priority areas.

The proposed model has been informed by the Trust's partnership with Northumbria Healthcare NHS Foundation Trust and the sustainability governance arrangements operating across the Alliance. Broad alignment with this approach will enable Gateshead Health to benefit from established practice, shared expertise and more consistent reporting, while retaining local ownership of and responsibility for its Green Plan.

4.2 Greener Gateshead Delivery Action Plan

A Greener Gateshead Delivery Action Plan has been developed to translate the commitments within the Trust Green Plan 2025–2028 into a focused and measurable programme of delivery. The action plan consolidates the existing Green Plan commitments under seven areas:

- Corporate Approach
- Our Buildings and Estate
- Waste and Reuse
- Journeys and Clean Air
- People and Engagement
- Supply Chain
- Sustainable Healthcare

The action plan supports the Trust Green Plan; it does not replace it or transfer ownership to QEF. The Trust will remain the owner of the Green Plan and each focus area will require a named lead with sufficient authority to drive delivery, coordinate contributors and report progress.

QEF will support the Trust as its service provider and will lead or contribute to actions falling within its operational remit, including relevant Estates, Facilities, waste and sustainability activities. Reporting arrangements will clearly distinguish between the Trust's ownership of the Green Plan and QEF's responsibilities for supporting or delivering specified actions.

4.3 Proposed delivery and governance model

It is proposed that the monthly Net Zero Delivery Sub-group and the biannual Greener NHS Group are replaced by a single Greener Gateshead Delivery Group. The new group will meet quarterly from January 2027 and will use the Greener Gateshead Delivery Action Plan as the principal mechanism for overseeing delivery.

It is recommended that the current Chair of the Greener NHS Group chairs the new group, maintaining executive leadership and continuity of oversight.

Each of the seven focus areas will operate as a delivery workstream. Existing groups and governance arrangements will be used wherever appropriate, with a separate subgroup established only where necessary to coordinate delivery effectively.

Ahead of each quarterly meeting, the relevant leads will update their allocated actions. Reporting will cover:

- progress against agreed actions and milestones;
- performance against relevant measures and targets;
- achievements and improvements delivered;
- risks, barriers and dependencies;
- decisions or organisational support required; and
- matters requiring escalation.

Meetings will focus on areas where delivery is behind plan, cross-organisational support is required or a decision cannot be made at workstream level. This will move the governance process away from general updates and towards active performance management, decision-making and escalation.

4.4 Consultation, approval and implementation

The proposed action plan and governance arrangements will be formally consulted upon through the existing Trust and QEF governance frameworks.

Proposed focus-area leads and action owners will be invited to the next Net Zero Delivery Sub-group meeting to review the relevant actions, consider the proposed ownership and identify the contributors, resources and dependencies required for delivery. This will ensure that responsibilities are discussed and agreed with the relevant leads rather than allocated through email consultation alone.

Following consultation:

1. The revised action plan, proposed leads and governance arrangements will be considered through the appropriate Trust governance route.
2. Actions falling within QEF's remit will be considered through the QEF Quality and Governance Group.
3. Any unresolved ownership, resource or delivery issues will be escalated before final approval.
4. The action plan will be presented to the Trust and QEF Boards by December 2026, in accordance with their respective responsibilities.
5. The approved action plan and revised governance arrangements will be launched in January 2027.

4.5 Reporting, assurance and Board development

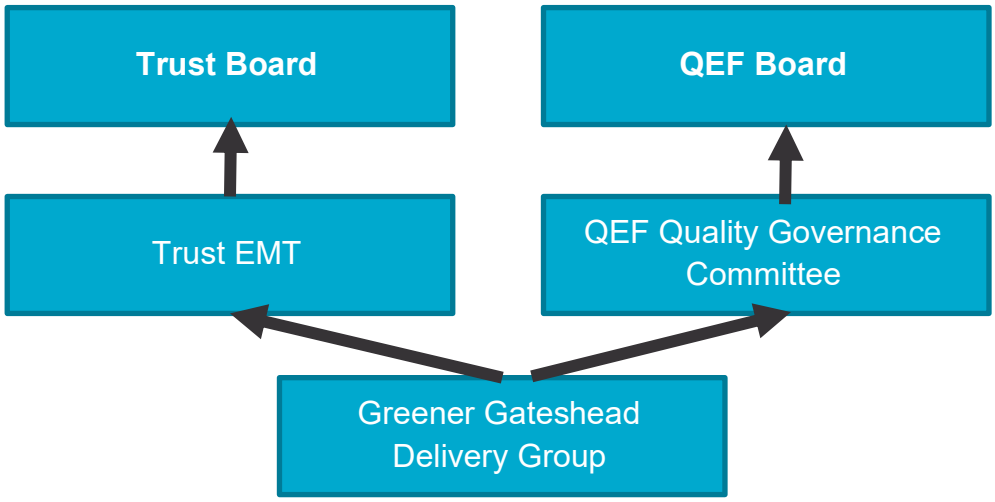
The Greener Gateshead Delivery Group will provide six-monthly assurance reports to the Trust Executive Management Team and the QEF Quality and Governance Committee. Material risks, significant barriers or decisions requiring executive intervention will be escalated between scheduled reporting periods where necessary.

The reporting cycle will include:

- an in-year assurance presentation covering progress, performance, principal risks and decisions required;

- an annual sustainability report based on the previous financial year's performance data; and
- six-monthly Board development sessions examining a specific area of the action plan in greater depth.

The Board development sessions will strengthen organisational understanding of the individual Green Plan areas and allow focused consideration of the strategic direction, investment, resources and support required to maintain delivery.



5. Carbon Reduction Plan

A Carbon Reduction Plan is required to support compliance with relevant procurement requirements and participation in qualifying contracts and frameworks. The absence of a completed plan has previously been identified as a strategic and commercial risk, principally due to gaps in emissions data and limited dedicated resource and supporting systems.

The Alliance Net Zero Data Officer is supporting both the Trust and QE Facilities to establish the 2019/20 emissions baseline and compile data for 2024/25 and 2025/26. An initial Carbon Reduction Plan is expected by the end of October 2026. However, some datasets remain incomplete or cannot yet be fully validated. The initial plan will therefore clearly identify any data limitations, assumptions and areas requiring further development. The baseline may need to be revised as more complete and reliable information becomes available.

During 2027/28, work will continue to obtain data for the intervening years from 2020/21 to 2023/24. This will provide a more complete assessment of trajectory or emissions, and enable progress against the 2019/20 baseline to be evaluated more reliably.

Sustaining an effective Carbon Reduction Plan will require consistent and timely data returns from relevant Trust and QEF functions, supported by clear ownership, appropriate resource and suitable carbon-management software. These arrangements will be

necessary to strengthen data assurance, support annual reporting and demonstrate measurable progress against the relevant organisations carbon-reduction commitments.

6. Partnership with Northumbria Healthcare

The developing partnership with Northumbria Healthcare and its facilities management company creates access to a larger specialist sustainability function and an established governance model. Current and planned benefits include shared technical advice, common training and engagement resources, support for the Net Zero Heroes network, development of Board training, and shared energy and carbon management capacity.

A shared Energy and Carbon Manager is expected to commence in October 2026, working across Northumbria and Gateshead. This should improve energy oversight, data quality, project development and delivery of the estate heat decarbonisation actions. Northumbria support may also accelerate work on biodiversity, green space, clinical sustainability and staff engagement.

The partnership should be governed through an agreed work programme, clear allocation of capacity, deliverables and reporting. It should supplement, rather than replace, accountable leadership within Gateshead. The Trust and QEF must retain ownership of their Green Plan, risk decisions, resources and assurance.

7. Performance by Green Plan focus area

7.1 Workforce system and leadership

Dr Carmen Howey is the Board-level lead and sustainability updates have been routed through the Greener NHS Group and Finance and Performance Committee. However, no Board members have completed formal Carbon Literacy training and the number of Green Champions remained at eight. The proposed alternative is a tailored Board development sessions in 2026/27, followed by a relaunch of the staff network as Net Zero Heroes using shared Northumbria resources.

The Alliance Net Zero Data Officer appointed in April 2026 is developing a more complete organisational carbon footprint and historic baseline. This is important because the currently reported NHS Carbon Footprint figures are incomplete and do not yet support reliable assessment against the stated 7% annual reduction ambition.

7.2 Sustainable models of care

Progress in embedding sustainability within clinical service delivery remains limited. No clinical lead has been appointed to coordinate this area, no sustainable quality improvement training has been reported, and no clinical service has yet achieved a recognised green accreditation. As a result, there is currently no consistent mechanism for identifying, testing and sharing changes that could reduce the environmental impact of care while maintaining or improving quality, patient experience and operational efficiency.

Through the partnership with Northumbria Healthcare NHS Foundation Trust, initial contacts and learning opportunities have been identified from a Gold-accredited Green Emergency Department programme. This provides access to an established approach and practical examples that could help Gateshead Health begin developing its own programme.

A targeted pathway towards Bronze Green ED accreditation could provide a realistic and measurable starting point. This would allow the Trust to test the approach within one clinical area before considering wider adoption across other services. Progress will, however, require a named clinical lead, dedicated clinical time and support to undertake sustainable quality improvement training, establish a baseline, agree priority actions and coordinate evidence for accreditation.

7.3 Digital

No baseline for emissions from Digital and IT services has been established and no paper-consumption update was available. Digital change can increase direct energy and equipment impacts while also reducing travel, waste and inefficient pathways. Digital sustainability should therefore be integrated with clinical transformation and included in the Alliance carbon-baselining work, with clear measures and accountable ownership.

7.4 Travel and transport

Zero-emission vehicles increased to 22% of the main fleet at Spire House, with an ambition to reach 42% over the next 12–18 months. NHS England funding of £133,000 supported a 40 kW rapid charger and six dual charging points. Further transition is constrained by electrical capacity and reliance on external funding; an additional charging-infrastructure bid was unsuccessful.

The fleet has a significant operational footprint across England and Scotland. NHS England identified Gateshead's reported diesel volume as the highest among submitted Trust returns; the Transport team validated the figure and attributed it to the scale of contracted activity. Emissions data should continue to be reconciled to fleet activity and used to prioritise replacement decisions.

Staff commuting remains a concern. Single-occupancy car use increased from 63% in the 2025 survey to 67% in 2026, while bus use reduced from 13% to 10.5%. Work with the North East Combined Authority, Mobilityways and Go North East has already informed timetable improvements. The next phase should include a Sustainable Travel Strategy, local travel plans, parking-policy review and consideration of electric pool cars where a business case can demonstrate benefit.

7.5 Estates and facilities

Energy consumption in 2025/26 was 39.15 million kWh, a 0.05% increase from the stated 2023/24 baseline of 39.13 million kWh and therefore not on trajectory against the 7% annual reduction ambition. Water consumption reduced from 133,730 m³ to 113,886 m³, a 14.83% improvement. Reported LED coverage reached 80% at Queen Elizabeth Hospital, 40% at Bensham Hospital and 100% at the Community Diagnostic Centre. No additional sub-metering was installed, and renewable generation data were not available because solar panels were not active and heat-pump generation was not reported.

The main estate decarbonisation option identified is connection to the Gateshead District Heat Network. The current indicative capital requirement is approximately £26 million and no suitable external funding route has been identified. This, together with electrical-capacity constraints, requires a prioritised, evidence-led investment plan and transparent treatment through capital and risk governance.

7.6 Waste and circular economy

Performance improved materially. By June 2026 the healthcare waste split was 74% offensive, 23% clinical and 3% high-temperature incineration, exceeding the 60:20:20 ambition. Total waste reduced from 1,321 tonnes to 1,256 tonnes, a reduction of 65 tonnes. The Trust was shortlisted for an Award for Excellence in Waste Management for Best Reduction in Clinical Waste.

Non-healthcare recycling remained unchanged at 29%. Priorities are introduction of food and glass recycling under Simpler Recycling requirements, a formal reuse scheme with storage, and use of NHS reupholstery services where viable. The potential extension of the UK Emissions Trading Scheme to Energy from Waste has been delayed, but the report estimates a future cost exposure of approximately £100,000 per year unless waste is reduced substantially.

7.7 Medicines

Nitrous oxide use reduced from 183,600 litres to 153,000 litres, with reported emissions reducing from 89.8 to 74.84 tonnes CO2e. Entonox use reduced from 2,231,588 litres to 1,700,484 litres, with reported emissions reducing from 554 to 422.2 tonnes CO2e. These equate to volume reductions of approximately 16% and 23% respectively. Progress to decommission nitrous oxide manifolds has been slower than planned and should be completed to secure further reductions and support control of occupational exposure. Desflurane represented 1.02% of volatile anaesthetic gas use, the first reported use since 2022/23, and should be reviewed clinically.

7.8 Supply chain and procurement

Supply chain emissions are expected to be the largest component of the NHS Carbon Footprint Plus. Procurement requirements reflect relevant net zero policy expectations and teams are working with clinical services to consider reusable alternatives. However, no updated supplier participation data were available and contract sustainability KPIs require stronger monitoring. The Alliance Net Zero Data Officer is working to establish the Scope 3 baseline and historic trend. In parallel, priority should be given to demand reduction, reuse and targeted product substitution where quality, safety and whole-life value are demonstrated.

7.9 Food and nutrition

The electronic patient meal-ordering system has been trialled and is planned for wider rollout across the Queen Elizabeth Hospital site by the end of 2026/27. The first full-year catering food-waste baseline is 17.3 tonnes. Wider collection under Simpler Recycling will make contractor data less specific to Catering, so the department will need a practical method to retain local performance measurement while a joint baseline is established.

7.10 Adaptation and greening the estate

The Climate Adaptation Plan remains in draft and no biodiversity baseline has been established. Delivery has been affected by uncertainty over ownership and limited engagement. EPRR should be confirmed as the accountable operational function for adaptation, working with Estates, clinical services and Sustainability. Support from the regional adaptation lead and Northumbria's sustainability team should be used to accelerate delivery. Recent periods of high temperature reinforce the need to assess impacts on patients, staff, infrastructure and continuity of care.

8 Principal risks and constraints

- Capital and affordability: major estate decarbonisation and charging infrastructure cannot currently be delivered at the required pace without prioritised internal investment or external funding.
- Infrastructure: electrical capacity may constrain fleet electrification and wider decarbonisation.
- Leadership and capacity: limited protected time and variable attendance weaken delivery across clinical, Digital, EPRR and other enabling functions.
- Data quality: incomplete baselines and missing operational data limit reliable measurement of trajectory and benefits.
- Workforce and behaviour: Board and staff development, clinical engagement, active travel and waste prevention require sustained organisational participation.
- Future cost exposure: failure to reduce energy, fleet and residual waste may increase operating costs and reduce resilience to future policy or market changes.

9 Priorities for 2026/27

- Introduce the Greener Gateshead Action plan with the 7 sub-group reports updated before each quarterly Net Zero Delivery Group meeting, presenting highlights, risks and barriers.
- Deliver a board development session covering the NHS net zero commitment, climate-related health and operational risks, CQC Well-led expectations and leadership responsibilities.
- Agree the Northumbria partnership work programme, including shared capacity, deliverables, reporting and review arrangements.
- Complete the organisational carbon baseline and improve data.
- Complete the Climate Adaptation Plan and establish a biodiversity baseline.
- Develop the Sustainable Travel Strategy and the prioritised estate and fleet infrastructure investment plan.
- Embed net zero considerations into business cases, capital, clinical change, digital investment, procurement and annual planning.

10 Recommendations

The Board is asked to:

- note the current delivery position and accept partial assurance on delivery of the Trust Green Plan;
- endorse the proposed direction of travel to replace the existing governance arrangements with a single quarterly Greener Gateshead Delivery Group, supported by a measurable delivery action plan and named leads;
- support formal consultation on the proposed governance arrangements, action plan and action ownership before final approval;
- support regular Board development sessions focusing on specific areas of the action plan;
- recognise the Northumbria partnership as a key enabler, while confirming that the Trust retains ownership of its Green Plan and QEF is responsible for delivering and assuring actions within its agreed service-provider remit; and
- require six-monthly assurance reporting to the Trust Executive Management Team.

b - Governance Reports

i) Organisational Risk Register

Presented by the Chief Nurse

Gateshead Health NHS Foundation Trust

Board of Directors Agenda Item: 5bi

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

Gateshead Health NHS Foundation Trust

• *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	reductions or closures recorded noted between 17th July and the 17th September. • 18 risks in total on the Organisational risk register, this remains consistent with the previous reporting period. • Summary of movements over 12-month period is shown within the attached report. • Compliance with reviews in period has remained positive, and consistent with the previous reporting period at 94% for risks and 95% for associated actions.
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board are asked to: • Review the risks on the report and discuss and seek further information as appropriate. • Acknowledge movements over 12-month period listed in the attached report. • Note compliance with risk and action reviews remains consistently positive in line with the previous reporting period. • Be sighted on changes to September's Top composite risks • Take assurance over the ongoing management of organisational and Strategic risk.
Trust strategic priorities that the report relates to:	☒ Excellent patient care ☒ Great place to work ☒ Working together for healthier communities ☒ Fit for the future
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	1. We will be a clinically-led organisation focused on delivering safe, high-quality care and improving health outcomes for our patients 2. We will ensure our patients experience the best possible compassionate care and make every contact count 3. We will continually improve our services creating a restorative culture where learning, innovation and research can flourish

Gateshead Health NHS Foundation Trust

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

Gateshead Health NHS Foundation Trust

Organisational Risk Register

1. Executive Summary

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

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

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

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

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

2. Organisational Risk Register

Current risk profile

The Executive Risk Management Group met in August and September 2026, and formally reviewed the organisational risks, agreeing there were no changes in period.
There have been 0 escalations, 0 reductions, and 0 closures.
The total number of ORR risks remains stable at 18, reflecting consistency with the previous reporting period.

3. Top Composite Organisational Risks

The board is asked to acknowledge a shift in focus for one of its key composite risks. While the digital and estates risks remain mostly unchanged, the previous financial sustainability risk has been reframed.
The updated risk now focuses on the challenges of delivering the broader sustainability elements required by the national oversight framework.

These 3 composite risks are as follows:

1. **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

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

3. **Sustainability** - Risk to delivery of all key metrics included in the National Oversight Framework impacting on our strategic aims of Excellent Patient Care, Great Place to Work, Working Together for Healthier Communities and Fit for the Future.

4. Compliance with Risk reviews

Compliance rates for reviews during this period remained consistent with the previous two-month dataset, holding steady at 94% for risks and 95% for associated actions.

5. Recommendations

The Board of Directors are asked to:

- Review the organisational risks and discuss and seek further information relating to risks as appropriate.
- Note the updated Top composite Organisational risks for September 2026.
- Take assurance over the development and review of the Organisational Risk Register as per risk governance framework.

Organisational Risk Report- September 2026.

Total Risks (Current/Managed)

18

People 3

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

Quality 5

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

Finance 8

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

Regulation 2

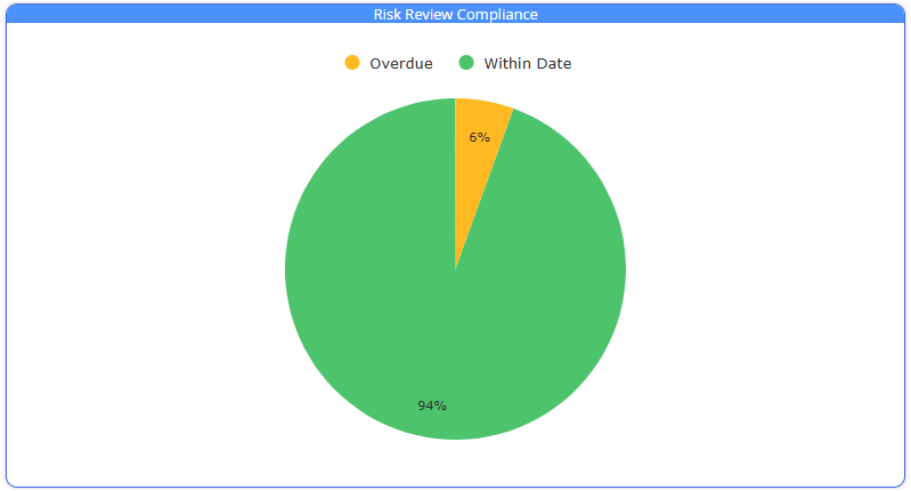
Risk Sub Type	Division	Risk ID	Risk Title	Current Rating
Compliance	QE Facilities	4839	Risk of Non-Compliance with Statutory Fire Safety Legislation	20
Compliance	Digital	4907	Information Governance & Records Lifecycle Compliance	12

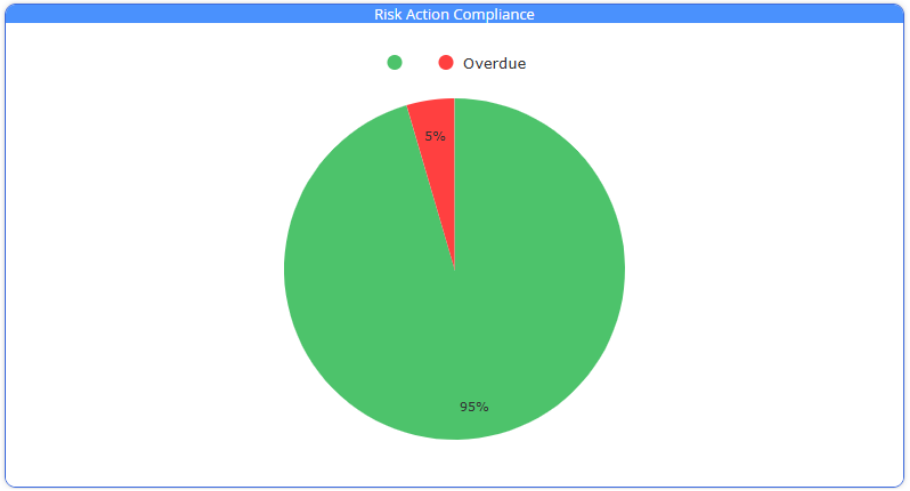
All Organisational Risks- Movements in Scores over 12 Months. October 2025- September 2026

Changes to Current Score over 12 Months

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

Risk review and action review compliance- September 2026





Top Composite Organisational Risks- September 2026

1. **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.
2. **Estates** - Risk to sustainability of core estates infrastructure and the ability to invest in clinical advances and the working environment for our staff
3. **Sustainability** - Risk to delivery of all key metrics included in the National Oversight Framework impacting on our strategic aims of Excellent Patient Care, Great Place to Work, Working Together for Healthier Communities and Fit for the Future.

ii) Board Assurance Framework

Presented by the Company Secretary

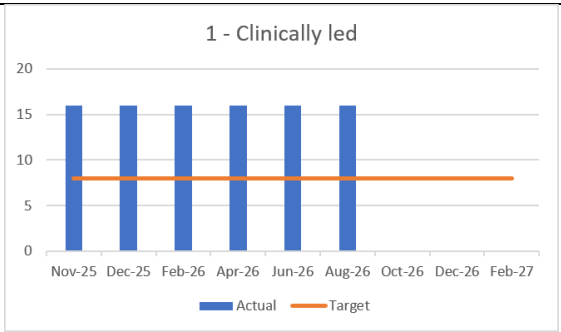
NHS Gateshead Health NHS Foundation Trust

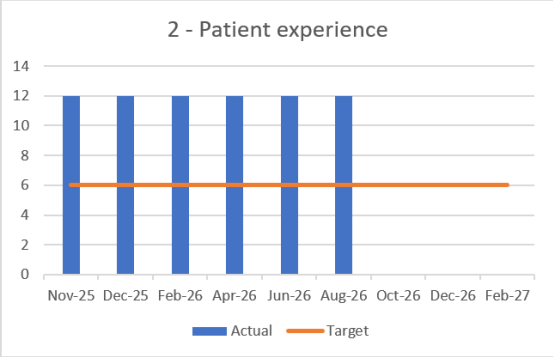
Report Cover Sheet Agenda Item: 5bii

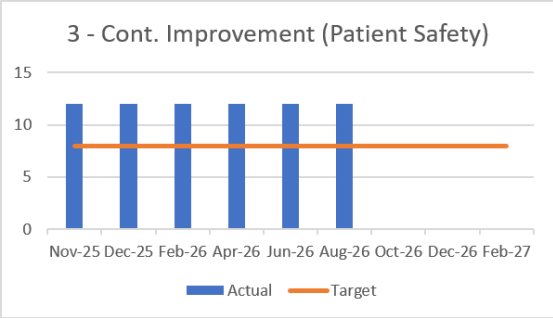
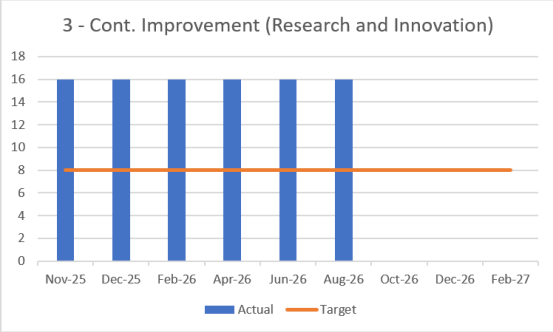
Report Title:	**Board Assurance Framework**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29 September 2026			
Author:	Jennifer Boyle, Company Secretary Executive Directors			
Sponsor:	Executive Directors			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To review the Board Assurance Framework (BAF), triangulating its content against the items discussed on the agenda.			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	BAF extracts have been presented to each of the Board committees, with a summary of the discussions outlined in this accompanying report.			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	• The BAF has been updated through the Board committees. • At committee meetings in recent months a level of concern has been expressed regarding the lack of movement in summary risk scores and it was agreed that the Executive Directors would take an action to review the BAF and its strategic delivery out-with the meeting. Discussions are ongoing at the Executive level regarding the most effective way of progressing with this action. • To support the discussions the Company Secretary has commenced a review of other BAFs to identify whether there is an alternative format which may support the committees and Board in their use of the BAF as an effective tool for assurance. • In the meantime there is evidence of a reduction in current risk scores for some of the summary risks – namely those relating to Culture, Neighbourhoods and Estates, with			

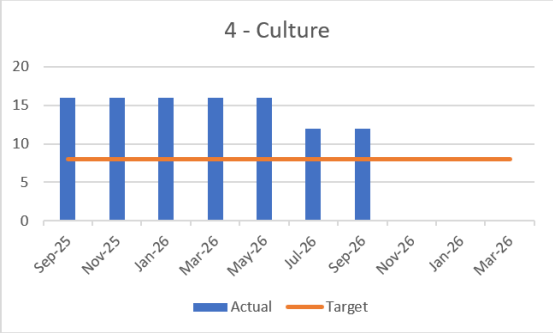
<table>
<tr><td></td><td>Neighbourhoods and Estates now scoring below the target level. In addition, risk score reduction proposals were included in the BAF at August's Quality Governance Committee in relation to Clinically Led and Continuous Improvement. Due to time constraints the BAF discussion was deferred to the next meeting, where the risk score proposals will be considered.
• The BAF key is as follows:
<table><tr><th>Key</th><th>Description</th></tr><tr><td></td><td>Not yet started</td></tr><tr><td></td><td>Started and on track no risks to delivery</td></tr><tr><td></td><td>Plan in place with some risks to delivery</td></tr><tr><td></td><td>Off track, risks to delivery and or no plan/timescales and or objective not achievable</td></tr><tr><td></td><td>Complete</td></tr></table></td></tr>
<tr><td>Recommended actions for this meeting:
Outline what the meeting is expected to do with this paper</td><td>To review the BAF for completeness, accuracy and triangulation against the assurances and risks discussed as part of the Board meeting, being assured that works continues to populate the controls, assurances and associated gaps.</td></tr>
<tr><td>Trust strategic priorities that the report relates to:</td><td><table><tr><td>☒</td><td>Excellent patient care</td></tr><tr><td>☒</td><td>Great place to work</td></tr><tr><td>☒</td><td>Working together for healthier communities</td></tr><tr><td>☒</td><td>Fit for the future</td></tr></table></td></tr>
<tr><td>Trust strategic objectives that the report relates to (2025 to 2030 strategy):</td><td>All – as outlined on the BAF itself.</td></tr>
<tr><td>Links to CQC Key Lines of Enquiry (KLOE):</td><td><table><tr><td>Caring ☒</td><td>Responsive ☒</td><td>Well-led ☒</td><td>Effective ☒</td><td>Safe ☒</td></tr></table></td></tr>
<tr><td colspan="2">Risks / implications from this report (positive or negative):</td></tr>
<tr><td>Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):</td><td>Risks identified on the BAF</td></tr>
<tr><td>Has a Quality and Equality Impact Assessment (QEIA) been completed?</td><td><table><tr><td>Yes ☐</td><td>No ☐</td><td>Not applicable ☒</td></tr></table></td></tr>
</table>

Board Assurance Framework – Summary from Board Committee Meetings to September 2026

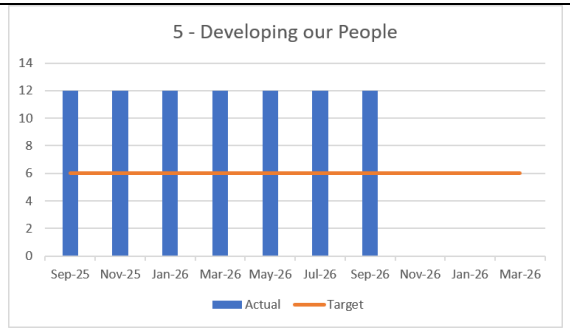
Strategic Objective	Summary risk	Risk scores	Overview
1) We will be a clinically-led organisation focused on delivering safe, high-quality care and improving health outcomes for our patients	There is a risk that decisions relating to the provision of care are made which are not reflective of the clinical voice. This may be due to the new model of clinical leadership not being fully embedded and therefore impacting upon the ability to inform strategic decision-making. This would result in a detrimental impact on patient care, safety and outcomes and disharmony amongst clinical leaders.		In November 2025 the Quality Governance Committee reviewed the BAF and reflected that more work was required to populate the controls and assurances. No change was proposed to the current score of 16. In December 2025 the Quality Governance Committee considered the BAF and noted that further controls, assurances and actions had been added following the previous meeting. The Committee noted the action to enhance clinical oversight of the Equality and Quality Impact Assessment (EQIA) process. No change was proposed to the current score of 16. In February 2026 given the time pressures of the meeting the BAF was not reviewed in the same level of detail as usual. It was agreed it would be elevated higher on the agenda with protected time for discussion at the next meeting in April 2026. In April 2026 the Committee delegated decision-making on the BAF content to the Chair and Interim Chief Nurse and Company Secretary who met in May 2026 to review the BAF on behalf of the Committee. As a result of this discussion, it was agreed that a full reflective review of the BAF would be undertaken by the Executive Directors. In June 2026 the Committee acknowledged the updates made to the BAF, noted the intent to review the BAF across all committees and agreed to retain the current score of 12. In August 2026 the BAF was deferred due to time pressures within the meeting and the need to prioritise the business-critical items. Note that there was a proposal to reduce this

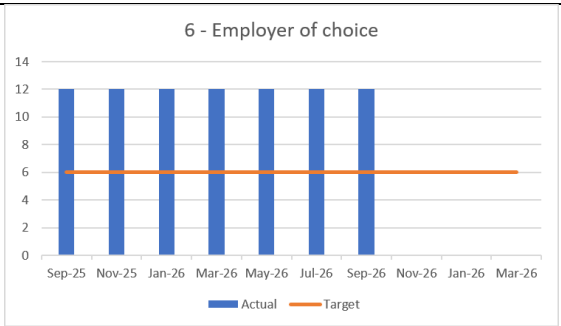
Strategic Objective	Summary risk	Risk scores	Overview
			current score to 12, which will be considered by the Committee at its next meeting.
2) We will ensure our patients experience the best possible compassionate care and make every contact count	There is a risk that patients do not have the best possible experience due to a number of potential contributory factors. This would lead to patient dissatisfaction, poor reputation and poor staff morale.		In November 2025 the Quality Governance Committee reviewed the BAF and reflected that more work was required to populate the controls and assurances. No change was proposed to the current score of 12. In December 2025 the Quality Governance Committee considered the BAF and noted that further controls, assurances and actions had been added following the previous meeting. The Committee noted the action to enhance clinical oversight of the Equality and Quality Impact Assessment (EQIA) process. No change was proposed to the current score of 12. In February 2026 given the time pressures of the meeting the BAF was not reviewed in the same level of detail as usual. It was agreed it would be elevated higher on the agenda with protected time for discussion at the next meeting in April 2026. In April 2026 the Committee delegated decision-making on the BAF content to the Chair and Interim Chief Nurse and Company Secretary who met in May 2026 to review the BAF on behalf of the Committee. As a result of this discussion, it was agreed that a full reflective review of the BAF would be undertaken by the Executive Directors. In June 2026 the Committee acknowledged the updates made to the BAF, noted the intent to review the BAF across all committees and agreed to retain the current score of 12. In August 2026 the BAF was deferred due to time pressures within the meeting and the need to prioritise the business-critical items.

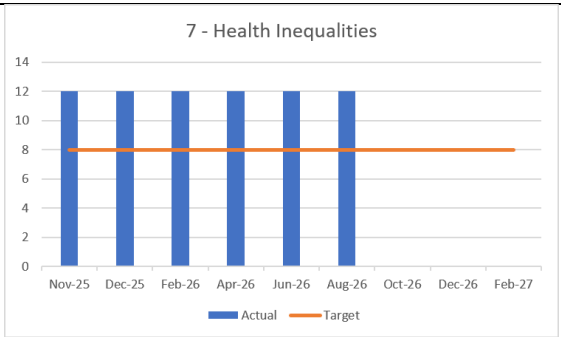
Strategic Objective	Summary risk	Risk scores	Overview
3) We will continually improve our services creating a restorative culture where learning, innovation and research can flourish	There is a risk that we do not achieve continuous improvement in the quality and safety of our services. This could be caused by poor organisational culture and a poor adoption / embedding of learning, research and development. This would impact on patient safety and our credibility and reputation as an innovative and quality-driven organisation.	 	In November 2025 the Quality Governance Committee reviewed the BAF and reflected that more work was required to populate the controls and assurances. No change was proposed to the current scores of 12 for the patient safety element of the risk and 16 for the research and innovation element of the risk. In December 2025 the Quality Governance Committee considered the BAF and noted that further controls, assurances and actions had been added following the previous meeting. No change was proposed to current risk scores of 12 for the patient safety element of the risk and 16 for the research and innovation element of the risk. In February 2026 given the time pressures of the meeting the BAF was not reviewed in the same level of detail as usual. It was agreed it would be elevated higher on the agenda with protected time for discussion at the next meeting in April 2026. In April 2026 the Committee delegated decision-making on the BAF content to the Chair and Interim Chief Nurse and Company Secretary who met in May 2026 to review the BAF on behalf of the Committee. As a result of this discussion, it was agreed that a full reflective review of the BAF would be undertaken by the Executive Directors. In June 2026 the Committee acknowledged the updates made to the BAF, noted the intent to review the BAF across all committees and agreed to retain the current scores. In August 2026 the BAF was deferred due to time pressures within the meeting and the need to prioritise the business-critical items. Note that there was a proposal to reduce the current score for the risk relating to the embedding of research

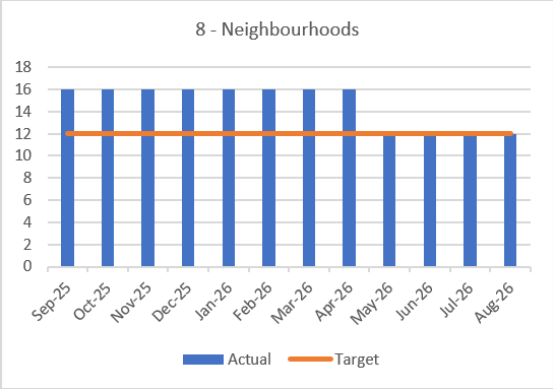
Strategic Objective	Summary risk	Risk scores	Overview
			and development to 12, which will be considered by the Committee at its next meeting.
4) We will care for our people, creating a fair, inclusive and respectful environment where everyone can thrive in their role	There is a risk that the Trust's culture does not reflect the organisational values. This may be caused by poor behaviours which are not appropriately addressed and a lack of confidence that issues raised will be listened to and acted on. This could lead to low morale, high sickness absence, an inability to attract and retain staff and poorer patient outcomes.		At the September 2025 meeting the People and OD Committee members concurred with the current score of 16, which was reflective of some of the issues which had been raised as part of the agenda items. It was noted that further information could be added to the BAF for completeness following the discussions. At the November 2025 meeting the discussed the change to the incivility and disrespectful behaviours risk on the Organisational Risk Register (ORR), which had been reframed and de-escalated from the ORR. A discussion was held regarding the impact of this on the summary risk score of 16. Upon reflection it was agreed to retain the current score at 16, which reflected that the summary risk includes broader considerations around inclusivity. At the January 2026 meeting the Committee reflected on the significant amount of work undertaken in relation to the 10 Point Plan for resident doctors, sickness absence and violence and aggression. A number of updates were made to controls and assurances to reflect this. The Committee referred to the emerging staff survey results and the need to develop action plans following the full analysis. It was noted that whilst a risk relating to raising concerns had been de-escalated the Organisational Risk Register, there may be a need to reflect on this and re-articulate the risk at the next Executive Risk Management Group. The Committee agreed to retain the current score of 16.

Strategic Objective	Summary risk	Risk scores	Overview
			At the meeting in March 2026 the Committee reflected the gaps around the apprenticeship levy usage (noting a report would be presented at the next meeting) as well as the need to reflect the introduction of the STAR Shoutout Board. The Committee agreed to retain the current risk score of 12. At the meeting in May 2026 the Committee undertook a broader reflection on the BAF and whether this was driving improvements in controls and assurances given the lack of movement in the scores. The discussion covered the level of depth of the BAF and whether it might be pertinent to focus on fewer but more specific areas in order to drive reduction in risk scores. It also touched on the level 2 and 3 assurances and whether there were more assurances to capture on the document. It was agreed that the Executive Team would review the BAF concept outwith the meeting in order to ensure that it was being used as a tool to support the reduction in strategic risks. At the meeting in July 2026 the Committee reflected on the work that had been undertaken to reduce sickness absence, strengthen triangulation, engage in good communication with staff networks and the evidence of impact in the calibre of candidates applying for consultant and Board roles. On this basis the Committee supported the recommendation from the Executive Director of People and OD to reduce the risk score to 12. It was noted that scores for some of the linked ORR were higher than 12, but looking specifically at the summary risk wording the Committee was assured that it remained appropriate to reduce this risk. The Committee felt that the Lord Mann review should be removed as a Level 3 assurance – the assurance will derive from the Trust's action plan and self-assessment.

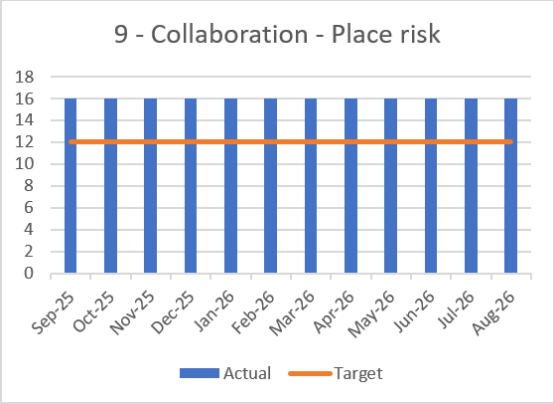
Strategic Objective	Summary risk	Risk scores	Overview
			At the meeting in September 2026 the Committee reflected on the Equality, Diversity and Inclusion (EDI) report presented. The proposals were well received and the Committee agreed a prudent approach of recognising EDI assurance as a current gap until the impact of the proposals can be measured. The current risk score was retained at 12.
5) We will grow and develop our people with a focus on celebrating achievements and creating a culture of high performance and innovation	There is a risk that there is a failure to deliver equity in access to staff experience and career development opportunities. This may be caused by inequalities, financial constraints and other operational pressures to deliver performance. This could lead to a lack of capable and diverse talent pipelines and a failure to build sustainable leadership capacity at all levels and into the place, alliance and system.		At the September 2025 meeting the People and OD Committee members concurred with the current score of 12. At the meeting in November 2025 the POD Committee members agreed to retain the score of 12. At the meeting in January 2026 the Committee sought further assurance in relation to the apprenticeship levy position. The Committee agreed to retain the current risk score of 12. At the meeting in March 2026 the Committee reflected the gaps around the apprenticeship levy usage (noting a report would be presented at the next meeting) as well as the need to reflect the introduction of the STAR Shoutout Board. The Committee agreed to retain the current risk score of 12. In May 2026 the Committee engaged in a broader discussion on the concept and usage of the BAF – see the overview under 4) for more detail. In July 2026 the Committee noted that the risk regarding Health Care Assistants (HCAs) had been added as a linked ORR risk on the BAF, whilst also recognising the progress made in the approval of the HCA apprenticeship programme. Committee members felt that further assurance was required around equality, diversity and inclusion and queried whether the true risks / gaps were fully reflected on the BAF. It was agreed that

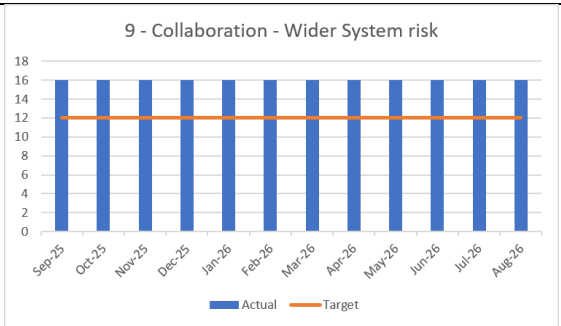
Strategic Objective	Summary risk	Risk scores	Overview
			this would be an area of focus for the next meeting. On this basis it was agreed to retain the score of 12. In September 2026 the Committee reviewed the BAF content and agreed to retain the current risk score of 12.
6) We will be an employer and training provider of choice within the local community recognising our role as an anchor institution	There is a risk that the Trust is not seen as an employer or training provider of choice within the local community. This may be due to limited ability and reduced capacity to work with system partners. This may result in an inability to attract and retain talent from diverse backgrounds that reflect our community and could have a negative impact on patient outcomes.		At the September 2025 meeting the People and OD Committee members concurred with the current score of 12 and noted that further level 3 assurance could be added to reflect the Annual Dean's Quality Monitoring report which had been considered as part of the papers. At the meeting in November 2025 a number of updates were made to this BAF extract, including reflecting the work undertaken in relation to the Resident Doctors' 10 Point Plan. It was agreed to retain the score of 12. At the meeting in January 2026 the Committee noted the commitment to go beyond the requirements of the 10 Point Plan and deliver improvements for wider cohorts of colleagues. Additional assurances were noted regarding the Guardian of Safe Working exception report and GMC (General Medical Council) survey. It was agreed to retain the current score of 12. At the meeting in March 2026 the Committee noted the gap in control relating to HCA Band 2 to 3 progression. It was also noted that whilst the reporting of payroll errors for resident doctors had been noted as a gap in assurance this was based on national reports rather than local circumstances. The Committee reflected that it was therefore not an issue at Gateshead and not a gap that needed to be address on the BAF. The important role of the Trust as an anchor institute for local employment was noted as a control. It was agreed to retain the current score of 12.

Strategic Objective	Summary risk	Risk scores	Overview
			In May 2026 the Committee engaged in a broader discussion on the concept and usage of the BAF – see the overview under 4) for more detail. In July 2026 the Committee acknowledged the progress made in relation to the HCA apprenticeship, which is equally applicable for this BAF extract. At present it was agreed to retain the score of 12. In September 2026 the Committee identified a gap in control relating to the temporary vacancy of the Guardian of Safe Working position, but also recorded the positive assurance provided by the September 2026 Annual Dean's Quality Meeting report. The Committee agreed to retain the current score of 12.
7) We will work in collaboration with our partners to improve the health of our population and reduce health inequalities	There is a risk that the Trust does not effectively collaborate with partners to maximise impact on health improvement in a way which reduces health inequalities for our Gateshead population. This may be caused by a lack of enabling access to data and resource due to historical and organisational barriers, cultural resistance, capacity and ability or appetite to make difficult decisions. This results in poor patient outcomes and an inability to deliver		In November 2025 the Quality Governance Committee reviewed the BAF and reflected that more work was required to populate the controls and assurances. No change was proposed to the current score of 12. In December 2025 the Quality Governance Committee considered the BAF and noted that further controls, assurances and actions had been added following the previous meeting. No change was proposed to the current score of 12. In February 2026 given the time pressures of the meeting the BAF was not reviewed in the same level of detail as usual. It was agreed it would be elevated higher on the agenda with protected time for discussion at the next meeting in April 2026. In April 2026 the Committee delegated decision-making on the BAF content to the Chair and Interim Chief Nurse and Company Secretary who met in May 2026 to review the BAF on behalf of the Committee. As a result of this discussion, it was agreed that

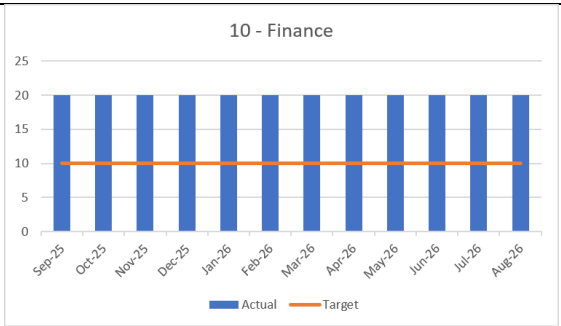
Strategic Objective	Summary risk	Risk scores	Overview
	against the NHS 10 Year Plan sickness to prevention shifts		a full reflective review of the BAF would be undertaken by the Executive Directors. In June 2026 the Committee acknowledged the updates made to the BAF, noted the intent to review the BAF across all committees and agreed to retain the current score of 12. In August 2026 the BAF was deferred due to time pressures within the meeting and the need to prioritise the business-critical items.
8) We will develop our neighbourhoods in line with the NHS 10 year plan	There is a risk that the ability to deliver care and prevention at neighbourhood and place level is not fully maximised. This may be caused by a lack of internal strategic resource to engage at this level or a lack of internal understanding of the neighbourhood concept resulting in a failure to co-create Neighbourhood health services. This results in poor patient outcomes and an inability to deliver against the NHS 10 Year Plan hospital to community shift		At the September 2025 meeting Finance and Performance Committee members noted the current score of 16, reflecting on the recent Board development session which set out the strategic landscape for neighbourhood working. No changes to the score of 16 were proposed. At the October 2025 meeting F&P members noted the importance of gaining traction on the neighbourhood agenda to fully deliver in this area. It was agreed to retain the score of 16. At the November 2025 meeting F&P members reflected that the neighbourhood framework and commissioning arrangements had not yet been published. It was noted that this is impacting upon the ability to make progress and driving the risk (the ambition and commitment of the Trust in relation to neighbourhoods is clear). No changes to the score of 16 were proposed. Since the meeting work has been undertaken by the Medical Director, Medical Director of Strategic Relations and Company Secretary to further populate this BAF area.

Strategic Objective	Summary risk	Risk scores	Overview
			At the December 2025 meeting the BAF was reviewed and no changes proposed to the score. At the January 2026 meeting the Committee discussed the Community Diagnostic Centre business case and noted that in time this would further support the provision of neighbourhood health. The Committee concluded that whilst this should be reflected on the BAF it was too early to reduce the score, and therefore the current score of 16 was retained. In February 2026 the Committee held a shortened meeting and therefore the BAF was not discussed in detail, but the Committee assured that a detailed review would take place in March 2026. At the March 2026 meeting the Committee approved the proposed changes and the actions recommended for closure (relating to the governance of neighbourhood at place). It was agreed to retain the current score of 16. At the April 2026 meeting the Committee noted that discussions were underway on the possible configuration of neighbourhoods with some potential streamlining of service models. As this is in the early stages it was agreed to retain the current score of 16. In May 2026 the Committee reduce the likelihood to 3, reducing the overall current risk score to 12 – achieving the target level. This is reflective of the progress made in achieving agreement at place level on neighbourhood models and its inclusion in the capital plan. It was noted that there may be a possibility the risk score could increase in the coming months as local leadership changes occur and ICB roles are clarified. In June 2026 the Committee identified that several ORR risks had been updated since the production of the BAF report and would be updated for the next iteration. The Committee

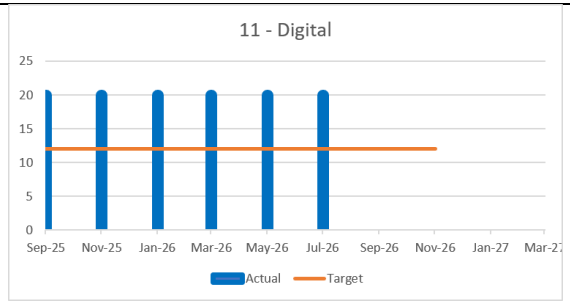
Strategic Objective	Summary risk	Risk scores	Overview
			reflected on the summary score of 12, noting that this had been reduced last month to reflect the maturing relationships. No further additions to the BAF or reductions to the risk score were agreed at this time. In July 2026 the Committee noted that discussions are taking place with the Divisional Directors of Operations around pathways of care therefore will be reviewed in more detail at the next meeting. The current score of 12 was maintained. In August 2026 the Committee acknowledged the publication of the ICB neighbour strategy. An action was identified regarding defining the role of the Trust in relation to neighbourhood delivery and developing a plan for this. The Committee agreed that the outcome of this would impact upon the risk score, which remained at 12 at present.
9) We will collaborate with system partners with an emphasis on maximising the efficient use of collective resources across health and care services	There is a risk that we are unable to utilise our collective resources across health and care services in a way that delivers value for money and the best outcomes for patients. This may be caused by a lack of effective engagement and collaboration within the Great North Healthcare Alliance, Place arrangements and wider partnerships. Contributing factors may include unclear governance arrangements, lack of clarity on leadership, differing		In September 2025 Finance and Performance Committee members reflected that meeting discussions had identified several areas where Alliance and partnership working would be critical to maximising the efficient use of collective resources. It was noted that the BAF could be populated further to more accurately reflect the controls and assurance in place around both the Alliance and wider partnership working. In relation to the Alliance there was a discussion about the need to be clear on the memorandum of understanding and how this can drive improvement. A review of the governance of the Alliance is underway and the BAF has been updated to reflect this action. It was agreed to maintain the current score of 16.

Strategic Objective	Summary risk	Risk scores	Overview
	organisational priorities and operational complexity in aligning resources and decision-making. This may result in missed opportunities to optimise service delivery, reduced ability to attract future funding and potential reputational impact if collaborative ambitions are not realised		At the October 2025 meeting F&P members agreed to retain the current score of 16. At the November 2025 meeting F&P members reflected the impact of the change in ICB commissioning arrangements and the need to assess the impact on service funding. It was agreed to maintain the current score of 16 for both risks. Since the meeting work has been undertaken by the Medical Director, Medical Director of Strategic Relations and Company Secretary to further populate this BAF area. At the December 2025 meeting the BAF was reviewed and no changes proposed to the score. At the January 2026 meeting it was noted that the CEO, Medical Director of Strategic Relations and Director of Strategy and Partnerships are meeting with the CEO of Gateshead Council to discuss place-based leadership arrangements. In time this could support a reduction in the score, but at present the Committee felt the current scores of 16 for the risks should be retained. In February 2026 the Committee held a shortened meeting and therefore the BAF was not discussed in detail, but the Committee assured that a detailed review would take place in March 2026. At the March 2026 meeting the Committee approved the proposed changes and the actions recommended for closure (relating to the Alliance Strategic Intent and place-based governance structures). It was agreed to retain the current score of 16. At the April 2026 meeting the Committee was assured that agreements had been made in respect of firming up the model

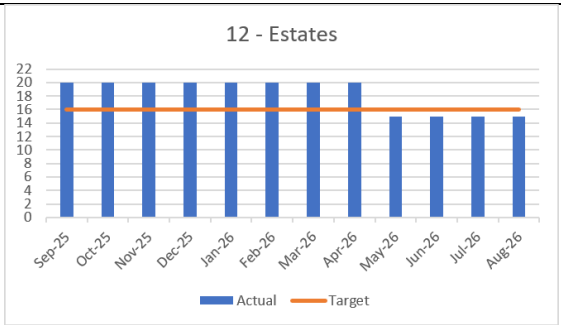
Strategic Objective	Summary risk	Risk scores	Overview
			for place-based governance. A discussion was held as to whether this was sufficient to enable the Committee to consider a reduction to the current risk score. On balance it was felt that further clarity was required in relation to strategic commissioning at place and neighbourhood level and the risk score of 16 was therefore retained. At the May 2026 meeting the Committee felt assured that effective collaboration is happening but agreed to retain the current score of 16 at present and keep this under review. At the June 2026 meeting the Committee reflected on collaborative work with Northumbria Healthcare on the Green Plan and the launch of the Alliance Clinical Framework Group which both support positive collaboration. It was agreed to retain the score of 16 at present. At the July 2026 meeting the Committee reflected that further work needs to take place around pathways of care in relation to collaborative working and as such agreed to retain both risks at a score of 16. At the August 2026 meeting the Committee reflected the commonality between the strategic objective linked to this BAF area and the strategic objective linked to the previous BAF area (neighbourhoods). It was felt that there may be a need for refinement of actions around collective deliver. It was agreed to retain the current risk scores of 16.

Strategic Objective	Summary risk	Risk scores	Overview
10) We will ensure effective and efficient use of our resources identifying opportunities to improve productivity and ensure best use of public money	There is a risk that the Trust does not improve its financial sustainability and therefore fails to utilise public money to best effect. This may be caused by limited access to, or inconsistent understanding of, data, trends, forecasts, and improvement methodologies or lack of improvement culture / financial governance & accountability. This would result in reduced responsiveness to patient needs, an inability to meet financial targets and a loss of reputation and organisational autonomy.		In September 2025 Finance and Performance Committee members noted the assurances provided regarding achieving the financial plan for month 5. It was noted that additional controls and assurances could be added to the BAF for completeness. Discussions were held regarding what the Committee would expect to see to enable the current score to be reduced. The potential for reducing the likelihood to 3 (and therefore the overall score to 15) were debated, although no changes were agreed at that time. The Committee reflected that it would be beneficial for Executive Risk Management Group to review the underlying financial risks on the Organisational Risk Register and make a recommendation as to whether their risk scores should be lowered. This would then support the Committee in making decisions regarding the summary risk score. It was agreed to maintain the current score of 20. At the October 2025 meeting F&P members agreed to retain the current score of 20. It was noted that the planning information had been published earlier than usual, but the detailed documents to support this were still awaited. At the November 2025 meeting it was agreed to maintain the current score of 20. At the December 2025 meeting the BAF was reviewed and no changes proposed to the score. At the time of the January 2026 meeting work was still being progressed to develop the next iteration of the medium term plan. At this point it was not clear whether the Board-approved plan would be compliant with the requirements set and

Strategic Objective	Summary risk	Risk scores	Overview
			therefore there were no proposed changes to the current risk score of 20. Members also reflected that whilst the in-year position was delivering against plan there remained a challenging underlying position. In February 2026 the Committee held a shortened meeting and therefore the BAF was not discussed in detail, but the Committee assured that a detailed review would take place in March 2026. At the March 2026 meeting the Committee approved the proposed changes and the actions recommended for closure (recruitment to the finance team and the development of divisional CRP plans). It was agreed to retain the current score of 20 to reflect the continued challenges in respect of the underlying deficit. In April 26 the Committee acknowledged the progress made and the improvement in the underlying position. Given however that the underlying deficit remained significant the Committee agreed to retain the score of 20. In May 2026 the Committee reflected on the performance against plan and the additional financial controls being introduced to support the management of the risk. In light of this the Committee agreed to retain the score of 20. In June 2026 the Committee identified additional assurances in the form of the recovery plan and the Board Assurance Statement which could be added to the BAF. It was agreed to retain the score of 20. In July 2026 the Committee it was noted that there is no improvement to the plan but improvements have been reported

Strategic Objective	Summary risk	Risk scores	Overview
			in relation to controls – it was agreed that the risk score will remain the same. In August 2026 the Committee acknowledged the improvement in controls and agreed to review the score in September to determine whether sufficient progress had been made to warrant a reduction.
11) We will be a data informed, digitally enabled organisation using technology to transform the way we plan and deliver care	There is a risk that the Trust does not utilise digital technology effectively. This may be caused by a lack of a clear digital strategy, a lack of effective business continuity a lack of resource (e.g. financial, skilled people) and a lack of appropriate clinical input into decision-making. This may result in a lack of ability to utilise digital technology to support cultural transformation, productivity, efficiency, clinical safety and patient experience.		In November 2025 the Digital Committee noted that updates which had been made to the BAF regarding the confirmation of the SIRO role, the launch of the new strategy with its digital chapter and the remaining gaps in assurance relating to the Digital Records Programme. Sub-objectives may be needed to achieve the 5-year strategic goal. It was noted that the summary risk had linkages to People and OD and that whilst the Digital Committee would lead on this, there may be a need to obtain some input from the People and OD Committee from time to time. It was agreed to retain the current risk score of 20. In January 2026 the Committee discussed whether the implementation of the digital strategy would impact on the current risk score. It was agreed to retain the current score of 20 for now, pending evidence of impact of strategic delivery. A gap in control was added in relation to Clinical Safety Officer capacity and wider digital team skills. An additional gap was noted in relation to digital transformation assurance flowing to the Committee. In March 2026 the Committee recognised the progress made in a number of areas which supported the closure of gaps in controls and assurance relating to the Committee structure, the

Strategic Objective	Summary risk	Risk scores	Overview
			Digital Delivery Plan and the agreement of the future direction of travel for digital records. Progress was also noted in respect of the plans in place to train 20 CSOs and introduce new KPI reporting into the Committee (which should assist in closing remaining gaps in assurance relating to SIRO and Information Governance KPIs). It was agreed that a further review of the BAF content ahead of the next meeting would be helpful. The Committee agreed to retain the current score of 20. In May 2026 the Committee acknowledged the addition of controls and assurances on the BAF, providing a good evolving picture. It was felt that the key issue in delivering the objective (which would benefit from being disaggregated into smaller component objectives to support overall delivery) is the ability to develop an achievable and costed plan. This would be critical for the delivery of each step towards overall objective achievement. The Committee identified the lack of costed plans to be an issue in respect of the Digital Records Programme and the data plan, alongside resourcing pressures. On this basis it was agreed to retain the current score of 20. In July 2026 the Committee acknowledged that whilst progress has been made in the last six months this hasn't been sufficient to be able to reduce the risk score. The importance of reach a position in order to make a strategic decision over the Electronic Patient Record programme was noted. It was agreed to retain the current score of 20.

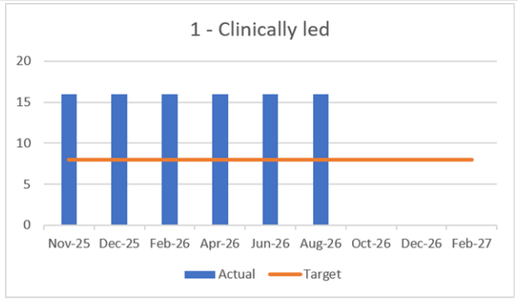
Strategic Objective	Summary risk	Risk scores	Overview
12) We will focus on productive utilisation of our estate to facilitate care in the right setting and providing our services in an environmentally sustainable way	There is a risk that the Group will be unable to develop its estate in line with changing clinical requirements and may experience failure of critical infrastructure, as a result of insufficient capital investment, This could result in compromised patient safety, disruption to business continuity, reduced staff morale, non-compliance with statutory obligations, and failure to deliver on environmental sustainability commitments.		In September 2025 the Finance and Performance Committee discussed that the lack of an agreed estates strategy impacts on the ability to forward plan for 2026/27. It was recognised that there will be limited capital for 2026/27 and there would be a need to develop a realistic plan. The Committee felt the target risk score of 16 may not be ambitious enough and further reflection on this was required. It was agreed to maintain the current score of 20. At the October 2025 meeting F&P members agreed to retain the current score of 20. At the November 2025 meeting F&P members agreed to retain the current score of 20. At the December 2025 meeting the BAF was reviewed and no changes proposed to the score. At the January 2026 meeting members noted that the BAF should be updated to reflect the fire safety risk identified and the work undertaken in relation to the capital programme. No changes were proposed to the current score. In February 2026 the Committee held a shortened meeting and therefore the BAF was not discussed in detail, but the Committee assured that a detailed review would take place in March 2026. At the March 2026 meeting there were no specific updates to note, but the Committee agreed to retain the current score of 20.

Strategic Objective	Summary risk	Risk scores	Overview
			At the April 2026 meeting the Committee agreed to retain the score of 20. It was noted that improvements to the estate would have a longer term impact of driving up efficiencies and therefore interlinks with the finance risk on the BAF. At the May 2026 meeting the Committee agreed to retain the score of 20 but noted the assurances relating to the maternity safety and infrastructure redevelopment programme. *CORRECTION – it was identified that the BAF summary report for May was incorrect. As recorded in the minutes the Committee agreed to reduce the score to 15 based on the progress made in developing the estates plan. This change has now been reflected retrospectively on the BAF.* At the June 2026 it was noted the environmental sustainability report had been received by the Committee for assurance. No change was proposed to the current score. The current score of 15 is below the target score of 16, reflecting positive progress. In July 2026 the Committee noted that the Premises Assurance Model (PAM) will come back to the Committee in August 2026. No change to risk score was proposed by the Committee, maintaining the current score of 15. In August 2026 the Committee felt that the BAF should referenced the power outages and the after-action review scheduled to take place. It was agreed to maintain the current score of 15.

EXCELLENT PATIENT CARE

Strategic objective:	1) We will be a clinically-led organisation focused on delivering safe, high-quality care and improving health outcomes for our patients
Executive Owner:	Chief Nurse & Medical Director
Board Committee Oversight:	Quality Governance Committee
Date of Last Review:	Aug-26
Summary risk	

There is a risk that decisions relating to the provision of care are made which are not reflective of the clinical voice. This may be due to the new model of clinical leadership not being fully embedded and therefore impacting upon the ability to inform strategic decision-making. This would result in a detrimental impact on patient care, safety and outcomes and disharmony amongst clinical leaders.



CURRENT RISK SCORE			**TARGET RISK SCORE**		
Likelihood	Impact	Score	Likelihood	Impact	Score
4 **Proposed - 3**	**4**	**16** **Proposed - 12**	**2**	**4**	**8**

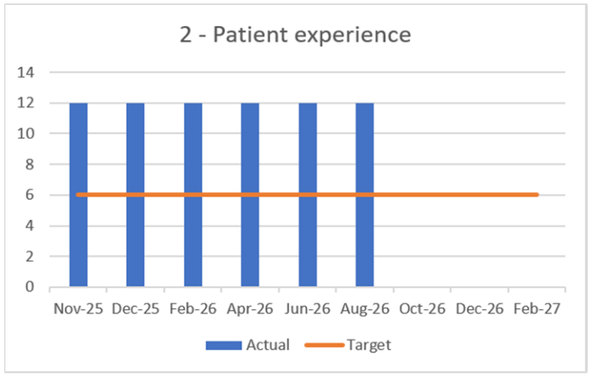
Links to risks on the ORR:	4920 - Risk that the trust is unable to deliver its cost reduction programme to the required quantum, quality and timescale without adverse impact on quality, safety and workforce (16) Composite risk - Sustainability - Risk to delivery of all key metrics included in the National Oversight Framework impacting on our strategic aims of Excellent Patient Care, Great Place to Work, Working Together for Healthier Communities and Fit for the Future. Composite risk - 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 Composite risk - Estates - Risk to sustainability of core infrastructure and to invest in clinical advances and the working environment for our staff 4752 - Delays to breast pathways due to reduced service capacity (16)

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
A Trust-wide definition of 'clinically led' is agreed, approved at Board and embedded into governance structures.	No formally agreed organisational definition of clinically led. Action - Develop and approve a standardised definition and embed within governance structures and job descriptions.	CEO	Jan-26	April 26 - revisions have been made to the governance structure with new ToR in place for Executive Committee, Clinical Strategy Group, Operational Oversight Group and the new divisional performance meeting. This provides greater clarity on clinical leadership and decision-making in the Trust. **Action agreed as closed.**	

Highlight clinical leaders and influencers working within GH.		Limited visibility of clinical opinion leaders and those contributing to external bodies. Action- Develop and maintain a register of clinical opinion leaders including external roles (NHSE, NICE, GIRFT, Royal Colleges).	MD/CN	~~01/03/2026~~ May 2026	April 26 - in the process of creating a register of clinical leaders / influencers to be drawn from to inform clinical decision-making / clinical strategy work. Proposal to extend timescale for completion to May 2026. July 26 - new Strategy, Planning and Partnerships Group developed in the governance structure which will bring intelligence from attendance at external meetings together. **Recommendation to close.**	
Minimum required clinical representation established for all decision-making forums						
Effective triumvirate leadership model with defined roles, responsibilities and delegated authority in place.						
Leadership capability: leadership development pathway for clinical leaders.		Leadership capability varies across triumvirates. Actions- Launch Leading Forward programme; scope wrap-around coaching and mentoring.	MD/CN	Dec-25	23/11/2025 - Program launched. Action recommended for closure. Action agreed as closed.	
A clinically led EQIA process requiring divisional sign-off before CN/MD approval.		EQIA clinical oversight inconsistent and not evidenced. Action -Review EQIA process; implement divisional clinical sign-off; establish EQIA assurance reporting to QGC.	MD/CN	~~01/03/2026~~ June 2026 September 2026	April 26 - EQIA process has been reviewed. A new screening tool has been developed and a dedicated weekly meeting will occur to review EQIAs associated with clinical change (CN and MD are core members). Policy to flow through formal review and approval process. Proposed revised date June 2026 July 26 - policy drafted and under consultation. Proposed revised date of Sept	
Strengthen NMAHP engagement and participation in key decision-making forums.		No NMAHP forum currently influencing decision making and workforce planning. Action- Re-establish NMAHP Professional Forum; embed structured reporting into ~~GHLG~~ Safecare - Confirm numbers of NM&AHP staff working at enhanced, advanced and consultant level to ensure all have appropriate governance, supervision and forums for support and development	CN	~~01/03/2026~~ June 2026	23/11/25 NM&AHP forum being re-established from Jan 26 with TOR and reporting governance line Report commissioned by CN in relation to levels of advanced practice, location and banding. Feeding into GHLD & execs. April 26 - Nursing Midwifery and AHP Professional Forum developed and launching in May. Included in revised meeting structure. July 26 - numbers confirmed for NM&AHP workforce through career mapping work. Action proposed for closure NMAHP Forum has now met. **Action proposed for closure**	

Leading Forward Programme in place		No bespoke leadership programme in place for senior nursing staff. Action - delivery of Dare to Lead Programme planned for senior nursing, midwifery and AHP staff. This will complement Leading Forward	CN	Jun-26	July 26 - commissioned two cohorts. First cohort delivery and second scheduled. **Action recommended for closure**	
Dare to Lead programme in place						
Strategy, Planning and Partnership Group terms of reference approved and group being established - intelligence from key external meetings to be shared for triangulation						
NMAHP Professional Forum now in place						
Revised terms of reference in place for Executive Committee, Clinical Strategy Group and Operational Oversight Group						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
Chief Nurse and Medical Director have operational oversight and sign-off of all EQIAs		EQIAs assurance reporting to be established to QGC - to outline provide assurance on process and decision making.	MD / CN	~~01/02/2026~~ August 2026	April 26 - EQIA statistics and overview to be included in Chief Nurse report to QGC from Quarter 1 onwards. This will include an overview of the EQIAs reviewed and the conclusion reached. Proposed revised date of August 2026 July 26 - June Chief Nurse reported incorporated an update. **Action recommended for closure**	
Evidence of triumvirate decision-making within divisional governance reporting		Incorporate attendance matrix to all Tier 2 meetings. This can then be monitored and audited. Plan to review Tier 2 effectiveness and include a review of attendance and quoracy (as per the Tier 1 reviews)	COO/ MD/ CN	~~01/03/2026~~ March 2027	Proposal to realign the reviews of effectiveness to the year end - March 2027	
Attendance monitoring of clinical representatives at governance groups		Establish a standardised reporting framework for all senior professional forums (Medical, Nursing/Midwifery/AHP), ensuring that key themes, risks, decisions and escalation points are formally captured and submitted to GHLG Safecare	CN	~~01/03/2026~~ June 2026	April 26 - Nursing Midwifery and AHP Professional Forum developed and launching in May. Included in revised meeting structure. This will link to Clinical Strategy Group with a dotted line to Executive Committee. Clinical Strategy Group has also been reviewed and new structure about to launch with reporting line to Executive Committee. **Proposed revised date of June 2026**	

Senior professional forums (Medical Forum, Nursing/Midwifery/AHP Forum) providing direct operational feedback into governance structure		Conduct an annual effectiveness review to provide assurance to board that all appropriate reports are feeding appropriately through the governance structure	CN / MD / Company secretary	~~01/03/2026~~ June 2026	April 26 - Board development session planned to be delivered by CQC - this will inform the next steps and determine the scale and timeframes for the review. **Proposed update to be provided in June 2026** July 26 - committee effectiveness reviews completed and flowing to Board for assurance. **Action recommended for closure**	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)		Identified areas for strengthening from the Aubrey self-assessment. Action - develop a plan to address identified areas	CN	Apr-26	April 26 - action plan developed and shared with Board for assurance in March. Actions will flow through Board committees. **Action agreed as closed.**	
OOG & CSG 3A reporting to Executive Committee						
Maternity IOR report presented to the Board by the Associate Director of Midwifery/SCBU						
Monthly Executive Risk Management Group oversight of divisional and corporate clinical risks						
Quality Governance Committee oversight of PSII actions, EQIAs, clinical standards and divisional governance outputs						
POD Committee oversight of leadership development, workforce sustainability and succession planning						
Self-assessment undertaken against Aubrey report and submitted to the ICB						
Review of effectiveness completed for Board committees						
Chief Nurse report includes EQIA						
Aubrey action plan developed and reviewed at Board						
Assurance (Level 3 – external)						
JAG reaccreditation confirmed						
CQC Nuclear Medicine inspection report						

EXCELLENT PATIENT CARE								
Strategic objective:	2) We will ensure our patients experience the best possible compassionate care and make every contact count							
Executive Owner:	Chief Nurse, Medical Director and Chief Operating Officer							
Board Committee Oversight:	Quality Governance Committee							
Date of Last Review:	Aug-26							
Summary risk								
There is a risk that patients do not have the best possible experience due to a number of potential contributory factors. This would lead to patient dissatisfaction, poor reputation and poor staff morale.		**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		4	**3**	**12**	**2**	**3**	**6**
Links to risks on the ORR:	Composite risk - Sustainability - Risk to delivery of all key metrics included in the National Oversight Framework impacting on our strategic aims of Excellent Patient Care, Great Place to Work, Working Together for Healthier Communities and Fit for the Future. Composite risk - 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 Composite risk - Estates - Risk to sustainability of core infrastructure and to invest in clinical advances and the working environment for our staff 4854 - Trustwide healthcare assistant vacancy position (12) 4752 - Delays to breast pathways due to reduced service capacity (16)							

Controls		**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
PSIRF policy and plan in place (note it is out of date - see associated action)		EQIA clinical oversight inconsistent and not evidenced. Action -Review EQIA process; implement divisional clinical sign-off; establish EQIA assurance reporting to QGC.	MD/CN	~~01/03/2026~~ August 2026	April 26 - EQIA statistics and overview to be included in Chief Nurse report to QGC from Quarter 1 onwards. This will include an overview of the EQIAs reviewed and the conclusion reached. Proposed revised date of August 2026 July 26 - June Chief Nurse reported incorporated an update. **Action recommended for closure**	

Quality priorities in place with 2 specific priorities focussed on patient experience (timeliness of complaints and strengthening voluntary workforce) and 2 on patient safety (eliminating unnecessary waits and implementing the Maternity 3 Year Delivery Plan)	Learning Disability, Mental Health and Autism Group in development	Chief Nurse	~~01/03/2026~~ June 2026	April 26 - to commence from May 2026. The group will agree and deliver a mental health, autism and LD strategy. MH reporting into Safecare has already been strengthened. Proposed new date of June 2026 July 26 - group now established. **Action recommended for closure**	
Falls workstream in place with a focus on improving patient safety and experience	Quality Improvement Plan in development which will align with the CQC Fundamental Standards	Chief Nurse	Mar-26	April 26 - CN has reviewed current approach and recommends moving to quality priorities, PSIRF workstream and clinical assurance processes rather than a separate Quality Improvement Plan. Action therefore agreed as closed given change in approach.	
New learning forum in place - Safety Huddle	Limited triangulation of patient experience data. Action to review the terms of reference of the Patient Experience Group to further support triangulation and enable reporting to SafeCare	Chief Nurse	~~01/03/2026~~ ~~June 2026~~ September 2026	April 26 - ILOM introduced and Executive Oversight Meeting about to launch. Reviewing potential opportunities for investment in Inphase audit module to support triangulation. Proposed date change to June 2026 July 26 - work ongoing to strengthen patient experience group. **Proposed new date of September 2026**	
Patient experience team and PALS team in place	A need to revise the terms of reference of SafeCare Steering Group to ensure there is appropriate time allocated for a focus on patient stories and patient feedback	Chief Nurse	~~01/03/2026~~ ~~June 2026~~ September 2026	April 26 - terms of reference reviewed. Further work underway to ensure appropriate flow of patient stories through the governance structure to inform Board patient story agenda item. Proposed date change to June 2026 July 26 - revised action - patient stories will be received at Patient Experience Group and then onwards to Board. **Proposed new date of September 2026**	
Cancer Lead Nurse in post	PSIRF plan out of date Action 1 - update the plan and developed workstreams Action 2 - closer alignment quality priorities for 2027/28 onwards against the PSIRF plan	CN	Action 1 - ~~01/09/2026~~ Sept 2026 Action 2 - June 2027	April 26 - group being convened to review and agree new PSIRF plan and associated workstreams for 2026 - 2028. July 26 - proposed new date for action 1 - September 26. Plan has been drafted	
Process in place for tracking quality priorities					
Volunteer service in place					
EQIA process					
MVP in place					
Learning Disability, Mental Health and Autism Group in place					
Maternity Safety Champion in place					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**

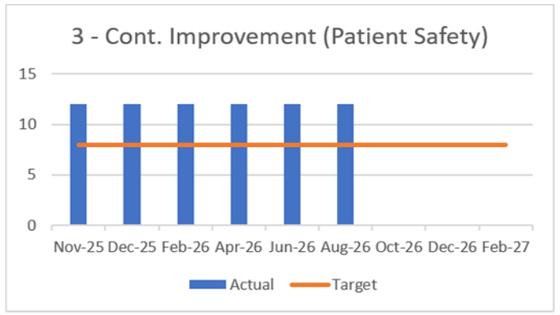
Oversight of key metrics through the Patient Experience Group	[redacted]	Surgical Site Infections - consolidated action plan developed and a formal report to be presented to the Quality Governance Committee	Chief Nurse	Oct-25	Dec 25 - Committee closed the related action on the action log and concluded that report has been updated and shared. Ongoing monitoring of actions and movement to business as usual with monitoring via division Safecare with escalation to Safecare and QGC. **Action agreed for closure**	
Oversight of key metrics through the Safecare Steering Group	[redacted]	Learning Disability, Mental Health and Autism Group meeting but 3A assurance reporting not flowing into GHLG (note this will now report to Safecare)	Chief Nurse	01/06/2026	April 26 - to commence from May 2026. The group will agree and deliver a mental health, autism and LD strategy. MH reporting into Safecare has already been strengthened. Proposed new date of June 2026 - agreed. July 26 - first meeting held and 3A report scheduled for August Safecare. **Action recommended for closure**.	
Quality priorities tracked	[redacted]	SafeCare currently doesn't hear directly about the experiences of patients. This will be addressed through addition of an enhanced report / agenda item which will include a patient story to the Group	Chief Nurse	01/03/2026 ~~June 2026~~ September 2026	April 26 - terms of reference reviewed. Further work underway to ensure appropriate flow of patient stories through the governance structure to inform Board patient story agenda item. Proposed date change to June 2026 July 26 - revised action - patient stories will be received at Patient Experience Group and then onwards to Board. **Proposed new date of September 2026**	
Mental health report to Safecare	[redacted]	Feedback from Board walkabouts no longer being formally documented and therefore no reported to Board. Action - review process and reporting	Chief Nurse	01/03/2026 July 2026	April 2026 - Revised Board walkabout process in place with the aim for the Board to engage with both staff and patients. New reporting form under development to capture feedback in real time. This will then link to the CEO report at Board. Proposed new date July 2026 July 26 - new online form established to capture feedback which will be included in the CEO report from September 2026. **Action recommended for closure.**	
Learning Disability, Mental Health and Autism Group to Safecare reporting established (Aug 26)						
New Safety Huddle meeting every two months to share learning across the organisation						

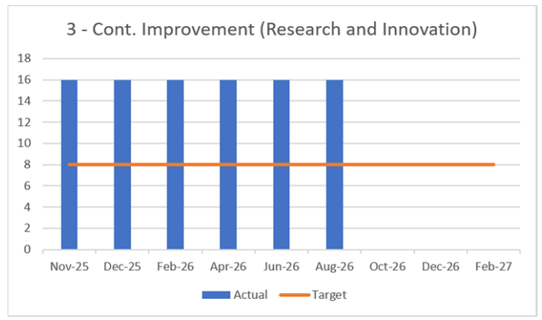
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Patient experience metrics reported to Quality Governance Committee					
Mental health report to Quality Governance Committee					
Patient experience metrics reported to the Board as part of the performance report					
Safecare Steering Group reports to Executive Committee through the 3A report with opportunity to escalate any significant patient experience issues					
PLACE visits conducted weekly with representation from volunteers and Governors					
15 Step programme in place					
New Maternity Safety Board report captures feedback from Maternity and Neonatal Voices Partnership					
Quality priorities and progress against these formally reported to the Quality Governance Committee, SafeCare Steering Group					
Quality priorities and their progress formally reported to ICB and the local authority					
Volunteer representatives formally attend the Patient Experience Group					
Falls workstream reports into SafeCare					
Cancer Group reports to Executive Committee					
Walkabout Wednesdays in place provide protected time for the Board to visit services and speak with patients and colleagues					
SSI action plan reviewed by Quality Governance Committee					
Patient stories featured at Board					
Assurance (Level 3 – external)					
Cancer Patient Experience Survey - 9.2 out of 10					
CQC Maternity patient survey - top performing trust					
Adult Inpatient Survey - 12th of out 61 organisations					
Children's Bladder and Bowel Service awarded Gold Standard for Autism					
Nursing Times Award nomination for breast care nurses and children's books innovation					

National Cancer Patient Experience Survey results released in July 2026 - GHFT ranked highly with positive results	[redacted]					
National Inpatient CQC Survey - positive results	[redacted]					

EXCELLENT PATIENT CARE	
Strategic objective:	3) We will continually improve our services creating a restorative culture where learning, innovation and research can flourish
Executive Owner:	Medical Director
Board Committee Oversight:	Quality Governance Committee
Date of Last Review:	Aug-26
Summary risk	

There is a risk that we do not achieve continuous improvement in the quality and safety of our services. This could be caused by poor organisational culture and a poor adoption / embedding of learning, research and development. This would impact on patient safety and our credibility and reputation as an innovative and quality-driven organisation.





	CURRENT RISK SCORE			TARGET RISK SCORE		
	Likelihood	Impact	Score	Likelihood	Impact	Score
Patient safety risk:	3	4	12	2	4	8
Risk of not embedding R&D and innovation	4 Proposed - 3	4	16 Proposed - 12	2	4	8

Links to risks on the ORR:	
	4920 - Risk that the trust is unable to deliver its cost reduction programme to the required quantum, quality and timescale without adverse impact on quality, safety and workforce (16) Composite risk - Estates - Risk to sustainability of core infrastructure and to invest in clinical advances and the working environment for our staff
	Composite risk - Sustainability - Risk to delivery of all key metrics included in the National Oversight Framework impacting on our strategic aims of Excellent Patient Care, Great Place to Work, Working Together for Healthier Communities and Fit for the Future. Composite risk - 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 4752 - Delays to breast pathways due to reduced service capacity (16)

Controls	**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
EQIA process in place for all policies and major service changes	EQIA clinical oversight inconsistent and not evidenced. Action -Review EQIA process; implement divisional clinical sign-off; establish EQIA assurance reporting to QGC.	MD/CN	~~01/03/2026~~ August 2026	April 26 - EQIA statistics and overview to be included in Chief Nurse report to QGC from Quarter 1 onwards. This will include an overview of the EQIAs reviewed and the conclusion reached. Proposed revised date of August 2026 July 26 - June Chief Nurse reported incorporated an update. **Action recommended for closure**	

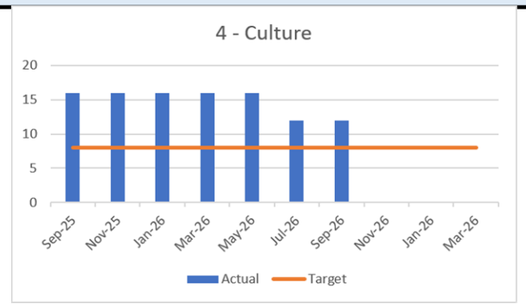
Innovation Manager is a dedicated post in the Trust					
New learning forum in place					
Research and innovation team in place					
Clinical audit programme in place					
Clinical audit processes revised to include new escalation process and increased resource					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
Audit and Effectiveness Group reports to Safecare Steering Group	ToR of Research and Innovation Group to be reviewed and to report to Strategy and Partnerships Group in governance refresh. To be supported through Internal Audit of Research and Innovation governance.	MD	01/09/2026	ToR of R&I Group drafted and shared with MD April 2026.	
Research and Development tier 3 meeting reporting to CSG					
ILOM meeting in place to identify and share learning					
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Clinical audit reporting to Quality Governance Committee on outcomes, learnings and improvements					
Clinical audit reporting to Group Audit Committee on the processes and controls for the development and delivery of the clinical audit plan					
Safecare Steering Group reports to Quality Governance Committee through the 3A report with opportunity to escalate any significant issues relating to this remit					
Learning from Deaths reporting to QGC evidencing continuous improvement in timeliness of review					
Research and Innovation annual report presented to QGC in August 2026					
Assurance (Level 3 – external)					
Children's Bladder and Bowel Service awarded Gold Standard for Autism					
RRDN visit 01/04/2026					

GREAT PLACE TO WORK

Strategic objective:	4) We will care for our people, creating a fair, inclusive and respectful environment where everyone can thrive in their role
Executive Owner:	Executive Director of People & OD
Board Committee Oversight:	People and OD Committee
Date of Last Review:	Sep-26
Summary risk	

There is a risk that the Trust's culture does not reflect the organisational values.

This may be caused by poor behaviours which are not appropriately addressed and a lack of confidence that issues raised will be listened to and acted on. This could lead to low morale, high sickness absence, an inability to attract and retain staff and poorer patient outcomes.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
3	4	12	2	4	8

Links to risks on the ORR:

3132 - Exposure to incidents of violence and aggression (12)

COMPOSITE RISK - Sustainability – Risk to delivery of all key metrics included in the National Oversight Framework impacting on strategic aims of excellent patient care, great place to work, fit for the future and working together for healthy communities

Composite risk - 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

4797 - Incivility and behaviours in the workplace (12)

4854 - Trustwide healthcare assistant vacancy position (12)

Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Health and wellbeing offer in place	FTSU Guardian temporarily absent - recruitment of an interim Guardian underway	Executive Director of POD	Sep-25	Complete - Interim appointed	
Zero tolerance campaign continues to be delivered	Instances of poor behaviours - incivility, discrimination, harassment still taking place. Continue to promote culture of speaking out, hold people to account and take appropriate action	Executive Director of POD	Ongoing	Ongoing action - mark as complete, but retain on the BAF	
FTSU Champions in place	Triangulation of lessons learned from POD with the Trust Learning panel	Head of People Advisory	Feb-26	Triangulation meeting now including relevant info from Inphase.	
Absence taskforce in place	Continued instances of Violence and Aggression towards staff. Action to ensure that training targeted at the right cohort of staff	Executive Director of POD	Mar-26	March 26 - identified by the Committee as an emerging concern given sustained level of incidents. Work ongoing to enhance support and visibility of actions and controls. Future update to come to PODC. Agreed to close	

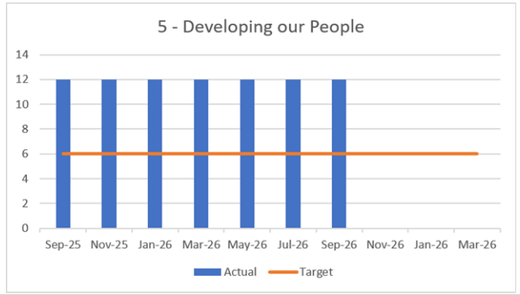
New prevention of violence at work policy developed		To develop an action plan to address the emerging findings of the staff survey, including a specific focus on supporting colleagues with protected characteristics	Executive Director of POD	Mar-26	March 26 - update report provided to the Committee outlining an analysis of the free text comments and the next steps in relation to key areas of focus. Committee agreed that a further assurance report be presented in six months time. April 26 - based on above action recommended for closure (with the six month report noted below as an action for assurance) Sept 26 - six month report presented - action recommended for closure	
Staff networks in place						
EQIA process in place for all policies and major service changes						
FTSU Guardian in place						
Annual staff survey and quarterly staff survey takes place						
EDI Policy being updated						
Engagement with the staff network chairs						
Sexual Safety Policy in place						
Bullying and Harassment policy in place						
Culture Insight and triangulation meeting in place						
People policies in place re: absence and leave provisions						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
Staff Experience and EDI Group to seek assurance over culture at Tier 3 level - new group triangulating information on culture		Some gaps in assurance around the triangulation of data and themes specifically with staff experience and EDI, which the merged Tier 3 Group seeks to address.	Executive Director of POD	Oct-25	New group met with engaged membership and TOR agreed. Agreed to close	
POD team meetings to review metrics and indicators		Some gaps identified on assurance of staff survey actions being taken by the business units to demonstrate changes made. Corrective action to refresh the approach for next year, aligned to the medium term planning framework. Going to Staff Experience and Inclusion group in December	Head of Staff Experience	01/01/2026	Staff survey discussions at POD Steering Group with each division to present plans and actions. Action agreed as closed.	
POD Steering group well embedded with engaged membership. Reviews metrics and decision making enabled		Multi-year plan needed to support addressing the gender pay gap report findings. Plan to be developed and presented to the Committee in 6 months time.	Executive Director of POD	Sep-26	Sept 26 - priorities and success measures included in the EDI paper presented to the Committee with a proposed overview of future reporting to Committee. Action recommended for closure.	
Staff survey action plans in place		Committee requires strategic overview of employee relations activity. Agreed that a report will be considered and an update provided at a future Committee meeting	Executive Director of POD	Sep-26	Q1 report on the agenda for July 2026 and on COB. Complete and action closed.	

Positive reduction noted in long term sickness absence data.		Ongoing assurance required over implementation of staff survey action plan. Committee agreed to receive a further update in six months time	Executive Director of POD	Sep-26	Sept 26 - Committee received an update report on the staff survey action plan as agreed. Action recommended for closure.	
Violence and aggression 3A report presented to the POD Steering Group		Plan presented to September's Committee re: EDI, recognising the need for further assurance - new EDI assurance approach required	Executive Director of POD	Mar-27	Sept 26 - 4 strategic priorities agreed and proposals well received. Action to remain open until Committee can see progress in delivery through the revised assurance reporting	
Regular Review of Lesson Learnt take place						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Assurance reports to POD Committee re: staff survey outcomes and action plans						
POD Committee receives deep dive assurance reports on sickness absence						
POD Committee receives assurance reports on the actions as a result of recent cultural reviews						
Sick absence report provides assurance over progress (including regional position for context) and confirmed closure of the absence task force						
Progress reported to Committee re: the progress with the 10 Point Plan for resident doctors						
Trust and QEF gender pay gap reports received						
GMC Survey Action Plan reported to the POD Committee - full assurance provided						
EDI reporting to POD Committee including progress against the EDI strategy						
Trust and QEF gender pay gap reports published						
Employee relations report now on the POD Committee cycle of business						
Group Ethnicity Pay gap report received						
Assurance (Level 3 – external)						
Occupational Health SEQOSH accredited						
Sexual Safety monthly return commenced						

GREAT PLACE TO WORK

Strategic objective:	5) We will grow and develop our people with a focus on celebrating achievements and creating a culture of high performance and innovation
Executive Owner:	Executive Director of People & OD
Board Committee Oversight:	People and OD Committee
Date of Last Review:	Sep-26
Summary risk	

There is a risk that there is a failure to deliver equity in access to staff experience and career development opportunities. This may be caused by inequalities, financial constraints and other operational pressures to deliver performance. This could lead to a lack of capable and diverse talent pipelines and a failure to build sustainable leadership capacity at all levels and into the place, alliance and system.

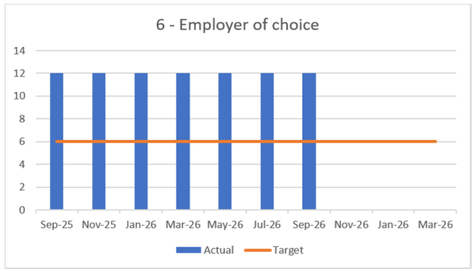


CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
3	**4**	**12**	**2**	**3**	**6**

Links to risks on the ORR:	4713 - Risk of not delivering our sustainable CRP on a recurring basis (16) 4854 - Trustwide healthcare assistant vacancy position (12) 4525 - Risk of Lack of a strategic workforce planning (9) COMPOSITE RISK - Sustainability – Risk to delivery of all key metrics included in the National Oversight Framework impacting on strategic aims of excellent patient care, great place to work, fit for the future and working together for healthy communities 4797 - Incivility and behaviours in the workplace (12)

Controls		Gap in controls and corrective action	Owner	Timescale	Update	Action status
New leadership and management programme - Leading Forward - launched		Level 7 apprenticeship funding changes will create a gap in leadership development opportunities with a more proactive and strategic and proactive approach needed.	Head of Staff Experience	Jan-26	March 26 - more detailed paper to be presented to the May 2026 Committee on the actions taken re: apprenticeships. Action complete	
People plan in place as part of annual planning		Lack of 10 year workforce plan to support the NHS 10 yr plan - delayed. Once received will need reviewed and implemented in a planed and achievable way.	Executive Director of POD	Driven by national publication	April 2026 - NHS 10 Year Workforce Plan publication still awaited	
Medical staffing function strengthened		Clinical Placement capacity remains a challenge for students, trainees and apprentices. To be reviewed via the E&T group and any proposals scoped and shared.	Head of Staff Experience	Mar-26		
Controls in place to prevent unintentional workforce growth						
Reinvigoration of Star Awards to celebrate success						
Monthly You're a Star award presented by the Chair						
STAR Shoutout Board launched on the intranet						
Recruitment process ensures appropriate focus on minimising bias						
Mid-year planning submission completed						

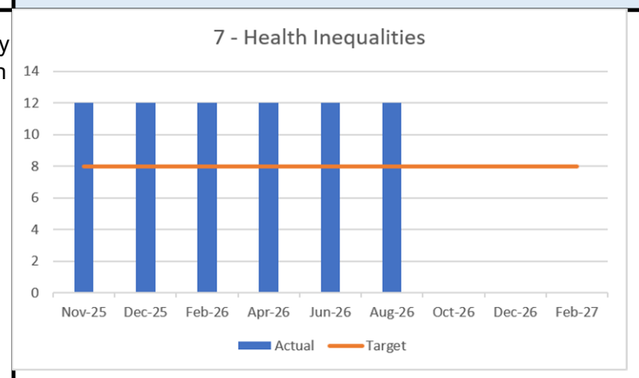
Healthcare Assistant apprenticeship programme approved by Board and launched					
Strategic partnership and MOU in place with Derwentside College to create career opportunities for local people while addressing workforce needs					
Education and Training group established containing Professional Leads, corporate reps and operational colleagues					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
POD team meetings to review metrics and indicators	Apprenticeship levy underutilisation risk due to funding changes; need for a clear plan to maximise use and align with workforce strategy.	Head of Staff Experience	Jan-26	Jan 26 - There is a need for further analysis on the apprenticeship levy position and the likely impact March 26 - more detailed paper to be presented to the May 2026 Committee on the actions taken re: the Apprenticeship Levy. The paper to include a focus on HCA recruitment / development June 26 - HCA apprenticeship programme approved and launched. Agreed as closed.	
POD Steering Group and supporting groups in place					
Q1 EDI dashboard					
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
POD Committee receives assurance updates on key workforce and employment metrics through the People Metrics report					
HCA apprenticeship programme papers to POD Committee to provide assurance					
Nurse Staffing Report presented to every POD Committee meeting					
WRES and WDES Metrics and Reports reviewed at POD Committee and Board					
Assurance (Level 3 – external)					
ADQM Outcome Report					
CPD submission shared with NHS England					

GREAT PLACE TO WORK								
Strategic objective:	6) We will be an employer and training provider of choice within the local community recognising our role as an anchor institution							
Executive Owner:	Executive Director of People & OD							
Board Committee Oversight:	People and OD Committee							
Date of Last Review:	Sep-26							
Summary risk								
There is a risk that the Trust is not seen as an employer or training provider of choice within the local community. This may be due to limited ability and reduced capacity to work with system partners. This may result in an inability to attract and retain talent from diverse backgrounds that reflect our community and could have a negative impact on patient outcomes.		**CURRENT RISK SCORE**			**TARGET RISK SCORE**			
		Likelihood	Impact	Score	Likelihood	Impact	Score	
		4	**3**	**12**	**2**	**3**	**6**	
Links to risks on the ORR:	4525 - Risk of Lack of a strategic workforce planning (9) 4713 - Risk of not delivering our sustainable CRP on a recurring basis (16) 2341 - There is a risk to ongoing business continuity of service provision due to ageing trust estate (16) COMPOSITE RISK - Sustainability – Risk to delivery of all key metrics included in the National Oversight Framework impacting on strategic aims of excellent patient care, great place to work, fit for the future and working together for healthy communities 4854 - Trustwide healthcare assistant vacancy position (12)							

Controls		Gap in controls and corrective action	Owner	Timescale	Update	Action status
New leadership and management programme - Leading Forward - launching imminently		Ongoing need to improve communication and clarity around consultation vs. engagement in change process	Deputy Director of POD	Nov-26	Complete - updated consultation template, using for all consultations	
People plan in place as part of annual planning		Sexual safety/harassment training not mandatory. Discussion with the RDPL to develop awareness session in the Resident Doctor induction.	Head of Staff Experience	Feb-26	May 26 - session developed for induction and shared with Medical Education, awaiting confirmation from Medical Education as to if this has been incorporated into the resident doctor induction. June 26 - now incorporated into induction. To close - no further action required beyond June update.	

Medical staffing function strengthened		Resident doctors are still required to complete some local training at induction, despite national agreements to accept prior training. Blood Transfusion training is under review.	~~Head of Staff Experience~~ Associate Director of Medical Staffing	Mar-26	May 26 - discussions ongoing within the medical directorate regarding blood transfusion for resident doctors. This is not logged within ESR and not a core competency. June 26 - The proposal is reducing the Blood transfusion session in induction on the basis that doctors must demonstrate completion of the eLf blood transfusion modules within the appropriate timescale (3 Years), To support this we are proposing that we accept the LET record of compliance as sufficient. (We receive a monthly record from the LET of Mandatory Training Compliance), For any doctor for whom we cannot confirm their compliance, or for whom we recognise the need for additional training, we direct them to the eLfH module. If there is still an issue, we would arrange a one to one session with the transfusion practitioners. We are just waiting confirmation from the HTC chair on this as an option. Its supported by MD and DME. August 26 – Original proposal accepted by HTC Chair and implemented for August 2026 Induction and action completed. However, following this the Trust has received confirmation from the LET that Blood Transfusion has been removed completely from their Statuary and Mandatory training and is no longer mandatory from the LET perspective, therefore additional actions required to ensure clinical risk and training compliance is monitored and actioned as necessary. Will be picked up as BAU. **Agreed for closure**	
Festive meal vouchers to be used as a thank you initiative		Limiting numbers of places being made available for T Level students, schools outreach and work experience students due to capacity. To be reviewed on an ongoing basis to assess impact	Head of Staff Experience	Nov-27	August 26 - placement numbers for T Level, and work experience agreed to remain as at 25/26 levels, not increasing ask given operational pressures. School Outreach agreed via E&T to only engage with schools within the Gateshead region. impact monitored via E&T - agreed for closure	
Actions plans in place for any areas of the 10 Point Plan for Resident Junior Doctors that are not yet currently met.		Continued challenges in HCA vacancy rate. An apprenticeship development programme is being scoped to provide opportunities to fill the vacancies and support career development. Update report due at May Committee	Executive Director of People and OD	May-26	June 26 - HCA apprenticeship programme approved and launched. Task and Finish group looking at further recruitment approaches. Agreed to close	
Appointment of the Senior Lead for Resident Doctor Experience and appointment of the Resident Doctor Peer Lead for resident doctor experience.		Guardian of Safe Working role current vacant - work is in progress to address this	Executive Director of People and OD	Nov-26	Sept 26 - update to be provided at the next Committee on progress made	
Trust takes a leading role as an Anchor Institution with regards to employment in the local area and apprenticeships						
HCA Apprenticeship Programme in place						
Strategic partnership in place with Derwentside College to create career opportunities for local people while addressing workforce needs						
E&T team outreach work in Gateshead schools						
Increased OD support for organisational change, including documentation and frameworks for managers						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
POD team meetings to review metrics and indicators		Delay in launching Learning Disability pledge	EDI Manager	Dec-26		

POD Steering Group and supporting groups in place						
Experience and Inclusion group established with broad engaged membership						
Initial self-assessment against 10 Point Plan for Resident Junior Doctors highlighted the Trust meets (or partially) meets the majority of points in the plan.						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
POD Committee receives quarterly assurance from the Guardian of Safe Working						
Reporting of the Resident Doctor 10 Point Plan to POD Committee						
Committee assured plans are in place to go beyond the requirements of the 10 Point Plan for resident doctors to apply the principles to for other cohorts of colleagues						
Committee receives Guardian of Safe Working Exception report						
Assurance (Level 3 – external)						
ADQM report provides external assurance - Sept 26						
GMC survey results reviewed by POD Committee for assurance						

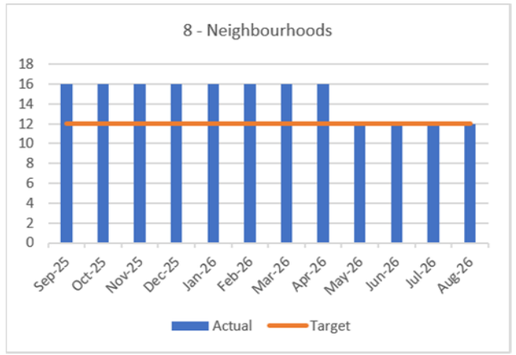
EXCELLENT PATIENT CARE	
Strategic objective:	7) We will work in collaboration with our partners to improve the health of our population and reduce health inequalities
Executive Owner:	Medical Director
Board Committee Oversight:	Quality Governance Committee
Date of Last Review:	Aug-26
Summary risk	
There is a risk that the Trust does not effectively collaborate with partners to maximise impact on health improvement in a way which reduces health inequalities for our Gateshead population. This may be caused by a lack of enabling access to data and resource due to historical and organisational barriers, cultural resistance, capacity and ability or appetite to make difficult decisions. This results in poor patient outcomes and an inability to deliver against the NHS 10 Year Plan sickness to prevention shifts	
Links to risks on the ORR:	4920 - Risk that the trust is unable to deliver its cost reduction programme to the required quantum, quality and timescale without adverse impact on quality, safety and workforce (16) 4913 - Interoperability & Single Patient View (Trust-wide) (16) Composite risk - 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 Composite risk - Sustainability - Risk to delivery of all key metrics included in the National Oversight Framework impacting on our strategic aims of Excellent Patient Care, Great Place to Work, Working Together for Healthier Communities and Fit for the Future.

CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
3	**4**	**12**	**2**	**4**	**8**

Controls		Gap in controls and corrective action	Owner	Timescale	Update	Action status
Health Inequalities Group in place		Lack of operational engagement in the Health Inequalities Group and Equitable Elective Recovery workstream - in terms of representation and data.	MD	Feb-26	March 26 - SLM and Information Team working with Public Health trainee from local authority work plan being developed with aim to reduce HI to reduce DNAs in T&O service. Action agreed as closed.	
Public Health engagement and involvement in health inequalities within the Trust		Health Inequalities Ambassadors not yet in place	MD	~~01/03/2026~~ ~~June 2026~~ September 2026	Work been undertaken to develop intranet page - to be launched in April and this will be key to engagement and the recruitment of the Ambassadors. Proposed new date June 26 July 26 - roles to be finalised in the August Health Inequalities meeting. **New proposed date of September for completion**	

Health inequalities workplan in place		Lack of visibility of health inequalities through Trust comms channels	MD	~~01/03/2026~~ May 2026	Work been undertaken to develop intranet page - to be launched in April and this will be key to engagement and the recruitment of the Ambassadors. Proposed new date May 26 July 26 - launched and now live. **Action recommendation for closure.**	
Board Development session held to commence discussions on strategic positioning re: health inequalities and neighbourhood health		Lack of embedding of health inequalities throughout the Trust - not captured as part of the decision-making process. Review of EQIA process and business case template to incorporate consideration of HI	MD & CN	~~01/03/2026~~ ~~May 2026~~ September 2026	HI now considered as part of EQIA - policy to be updated in April 26. Recommend update to date of May 26 July 26 - updated EQIA policy has been drafted and scheduled for PRG in August. **New revised date of September proposed for launch**	
Key priorities identified following a review by the Specialty Registrar in Public Health Medicine		Health inequalities group reporting line to be adjusted to new Strategy and Partnerships Group	MD	~~01/04/2026~~ June 2026 September 2026	April 26 - propose to update date June 26 to allow time for the Strategy and Partnerships Group to be launched July 26 - new Strategy, Planning and Partnerships Group will not be the formal reporting line for Health Inequalities. Review of governance structure currently underway. **New proposed date of September**	
Significant engagement at Place including the CEO chairing the Gateshead Place Committee		Work plans to support the Health and Wellbeing Strategy not yet developed	MD	May-26	July - note that this refers to the local authority strategy. This was launched prior to the local elections. Commitment to work with the local authority to deliver work plans once leadership embedded and established. **Action recommended for closure here as outwith organisational control**	
Engagement in the Community Promise at Alliance level		Place committee governance structure currently under review. Proposal to H&WB Board in March with immediate implementation to follow	MD	Apr-26	Agreed that CEO will be co-chair of Gateshead H&WB sub-group	
Practitioners recruited into the HIVE programme to address health inequalities in the lung cancer pathway		Head of Programme Lead for Health Inequalities at ICB post has been disestablished. New relationship to be established with ICB Director of Population Health	MD	Jun-26	July 26- Ben Anderson appointed as ICB Director of Population Health - relationships are being established. **Action completed and recommended for closure**	
HI now considered as part of EQIA considerations						
Health and Wellbeing Manager engaged in HI Group re impact of HI on staff						
New Health and Wellbeing Strategy in place						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**

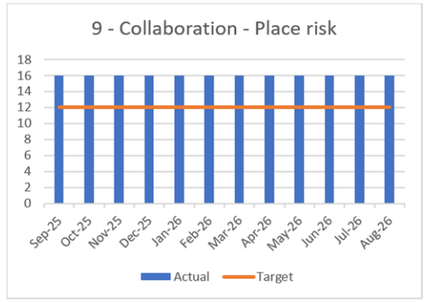
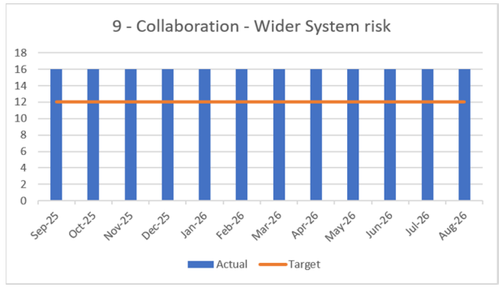
	[redacted]	Lack of dedicated reporting on Place and collaboration at Board committee level - to include health inequalities	MD	~~01/06/2026~~ September 2026	July - to be reviewed as part of gov structure work. **Revised timescale of September recommended**	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Assurance (Level 3 – external)						

WORKING TOGETHER FOR HEALTHIER COMMUNITIES								
Strategic objective:	8) We will develop our neighbourhoods in line with the NHS 10 year plan							
Executive Owner:	Medical Director							
Board Committee Oversight:	Finance and Performance Committee							
Date of Last Review:	Aug-26							
Summary risk								
There is a risk that the ability to deliver care and prevention at neighbourhood and place level is not fully maximised. This may be caused by a lack of internal strategic resource to engage at this level or a lack of internal understanding of the neighbourhood concept resulting in a failure to co-create Neighbourhood health services . This results in poor patient outcomes and an inability to deliver against the NHS 10 Year Plan hospital to community shift				**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
				Likelihood	Impact	Score	Likelihood	Impact	Score
				3	4	12	3	4	12
Links to risks on the ORR:	4920 - Risk that the trust is unable to deliver its cost reduction programme to the required quantum, quality and timescale without adverse impact on quality, safety and workforce (16) COMPOSITE RISK - Sustainability – Risk to delivery of all key metrics included in the National Oversight Framework impacting on strategic aims of excellent patient care, great place to work, fit for the future and working together for healthy communities								

Controls		**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Medical Director and Director of Strategy in place to provide senior leadership		Neighbourhood Health Planning Framework and Model Neighbourhood Framework not yet published nationally. Due to be published in November 2025 by NHS England - once published they will assist in developing the next steps	Medical Director	NHSE publication date	National guidance documents awaited. In the meantime contributing to the development of the Gateshead neighbourhood plan for the deadline of April 2026. Note date adjusted to *NHSE publication date* , as the timescale is not within our control April 26 - Neighbourhood health document now published and under review by the Director of Strategy and Partnerships	
Board Development session held to commence discussions on strategic positioning re: neighbourhood health		Governance not yet clear on neighbour and place-based structures at present. Action - active dialogue between Trust Executives, Local Authority and partner organisations to develop the governance and reporting	CEO / MD / Director Strategy and Partnerships	Mar-26	There is now clarity around future structures - transition plan to be determined. Action recommended for closure March - action agreed as closed	
Appropriate director level attendance at Gateshead Overview and Scrutiny and Health and Wellbeing Boards		National information regarding specifics of 'how' to deliver is not yet clear - awaiting NHSE framework for neighbourhoods. Note gap - not within our control, but important to note	N/a	N/a	N/a	

Trust Strategy and Clinical Strategy feature 3 shifts, 10 Year Plan prominently - i.e. alignment of clinical plans, including focus on neighbourhood	Succession plan required for leading neighbourhood work following planned retirement of Medical Director of Strategic Relations	CEO / MD / Director Strategy and Partnerships	~~01/03/2026~~ June 26	Note this is intrinsically linked to the H&WB Board structures and workplans which are in development. Recommend to adjust timescale to enable assessment to be made as the new structures are launched and embedded March - Committee approved revised timescale of June August - confirmed that CEO is taking overall strategic leadership at place of neighbourhood work, supported by the Director of Strategy and Partnerships. **Action agreed for closure.**	
Community Diagnostic Centre expansion provides greater scope for neighbourhood health provision	New place-based structures not yet implemented. Action - transition to the new structures in collaboration with place partners.	CEO / MD / Director Strategy and Partnerships	Jun-26	April 26 - discussions taking place regarding possible configuration of neighbourhoods at place level. May 26 - the Committee noted that there may be further changes given local leadership changes and ICB roles also remain unclear August 26 - ICB Director of Commissioning in place who is the lead ICB Director for Gateshead Place. Place-based structures now established. **Action agreed for closure**	
Neighbourhood Health Framework published by NHSE					
CEO and local authority CEO to co-chair the Health and Wellbeing Board Integrated Neighbourhood Sub-Group					
Place-based structures confirmed					
ICB strategy on neighbourhoods now in place					
Governance structure now established at place-level					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
Neighbourhood work to flow through new Strategy and Partnerships Group	Workplans in their infancy against draft health and wellbeing strategy for Gateshead.	Medical Director / Director of Strategy	Apr-26	Prioritisation work has taken place - frailty and respiratory. Women's health and child and adolescent work to also remain priorities. Note that these are shared priorities for Gateshead	
	Currently neighbourhood work does not flow through the governance structure and there is a need to define this and ensure it is clear from Tier 3 through to Board committee assurance. To address through the governance structure review led by the CEO	CEO / MD / Director Strategy and Partnerships	Mar-26	Agreement that this will flow through the Strategy and Partnerships Group. Action recommended for closure March 26 - Committee approved closure of action.	
	Local strategy on neighbourhood not yet in place. To review the newly-published ICB neighbourhood strategy, identify the Trust's role in delivery and develop a plan based on this. Consider this as a topic for Board development	CEO / MD / Director Strategy and Partnerships	Dec-26		
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Board approval of Community Diagnostic Centre business case					
Neighbourhood model referenced in the capital plan approved at Board					

	[redacted]					
Assurance (Level 3 – external)						

WORKING TOGETHER FOR HEALTHIER COMMUNITIES								
Strategic objective:	9) We will collaborate with system partners with an emphasis on maximising the efficient use of collective resources across health and care services							
Executive Owner:	Group Director of Finance							
Board Committee Oversight:	Finance and Performance Committee							
Date of Last Review:	Aug-26							
Summary risk								
There is a risk that we are unable to utilise our collective resources across health and care services in a way that delivers value for money and the best outcomes for patients. This may be caused by a lack of effective engagement and collaboration within the Great North Healthcare Alliance, Place arrangements and wider partnerships. Contributing factors may include unclear governance arrangements, lack of clarity on leadership, differing organisational priorities and operational complexity in aligning resources and decision-making. This may result in missed opportunities to optimise service delivery, reduced ability to attract future funding and potential reputational impact if collaborative ambitions are not realised	 		**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
	Place aspect of risk:	**4**	**4**	**16**	**3**	**4**	**12**
	Wider system aspect of risk:	**4**	**4**	**16**	**3**	**4**	**12**
Links to risks on the ORR:	4920 - Risk that the trust is unable to deliver its cost reduction programme to the required quantum, quality and timescale without adverse impact on quality, safety and workforce (16) 4752 - delays to breast pathways due to reduced service capacity (16) 4885- inability to deliver contracting services (16) COMPOSITE RISK - Sustainability – Risk to delivery of all key metrics included in the National Oversight Framework impacting on strategic aims of excellent patient care, great place to work, fit for the future and working together for healthy communities						

Controls		**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Appropriate director level attendance at Gateshead Overview and Scrutiny and Health and Wellbeing Boards		Work is underway to align constitutions around Chair provisions	Company Secretary	Jan-26	Sept 25 - collaborative working with NUTH and NHCT supported with legal advice. Feb 26 - GHFT element of the review complete but awaiting completion by all Alliance partners before taking through Trust governance. June 26 - position remains unchanged July 26 - recommendation to pause this pending potential further constitutional changes from the Health Bill. Assurance provided that the proposed chair updates do not present a risk if implementation is delayed. Action recommended for closure.	

Collaborative approach to capital in place with Alliance and Provider Collaborative partners	[redacted]	Work is underway via the Alliance Formation Team to review and revise the terms of reference for the Committee in Common and Joint Committee. This will be presented to Board for approval in December 2025	Company Secretary	~~01/12/2025~~ Jan 26	December Alliance meetings cancelled and therefore to be reconsidered in January 2026. Timescale amended accordingly. Feb 26 - this was approved at the Alliance meetings in Feb 26 and will flow through to the next Board as part of the Alliance Strategic Intent document. Action recommended for closure as work completed. March 26 - action agreed as closed	
CEO, Medical Director of Strategic Relations and Director of Strategy and Partnerships meeting with the CEO of Gateshead Council to discuss place-based leadership arrangements	[redacted]	Governance not yet clear on neighbour and place-based structures at present. Action - active dialogue between Trust Executives, Local Authority and partner organisations to develop the governance and reporting	CEO and Medical Director	Mar-26	There is now clarity around future structures - transition plan to be determined. Action recommended for closure March - action agreed as closed	
Direct engagement with GPs and PCNs through PCN Lead meetings	[redacted]	Place committee governance structure currently under review. Proposal to H&WB Board in March with immediate implementation to follow	MD	Apr-26	April 26 - place-based governance structures now in place via the Health and Wellbeing Board. Action agreed as closed	
Systems approach taken to winter planning	[redacted]					
Strong representation at the Alliance for GHFT - Committee in Common, Joint Committee, Alliance Formation Team	[redacted]					
Weekly meetings of Alliance CEOs	[redacted]					
Shared Chair in place from 1/10/25	[redacted]					
Governor events held across the Alliance	[redacted]					
Alliance risk management framework in place	[redacted]					
Governor engagement across the Alliance through Lead Governors	[redacted]					
Jointly funded Quality Assurance Manager role in place with NUTH to support larger scale collaborative research and commercial opportunities	[redacted]					
Regular Executive Director meetings across Alliance on specific pieces of work e.g. financial plan development	[redacted]					
Collaboration with other providers and Provider Collab re MMC	[redacted]					
Collaborative approach to capital in place with Alliance and Provider Collaborative partners	[redacted]					
Chief Digital Officer in place across the Alliance	[redacted]					
Engagement in the Alliance Construction Programme with market engagement undertaken	[redacted]					
Second Alliance Governor event held 24 October	[redacted]					
East Coast MD events taken place to consider medical clinical priorities across the Alliance	[redacted]					
Alliance Clinical Framework Reference Group in development	[redacted]					
Collaborative working re: the medium term financial plan across the Alliance	[redacted]					
Governance structure now established at place-level	[redacted]					
CEO and local authority CEO to co-chair the Health and Wellbeing Board Integrated Neighbourhood Sub-Group	[redacted]					
Collaborative work with Northumbria on the Green Plan	[redacted]					
Collaborative work being undertaken by Company Secretaries on the Health Bill and Governor implications	[redacted]					

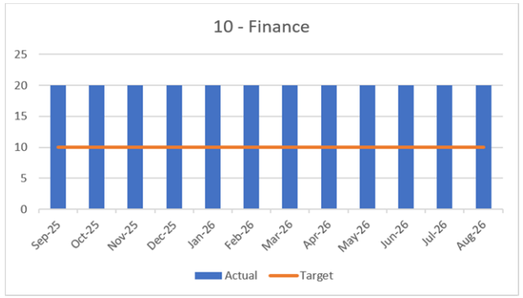
Alliance Clinical Framework Reference Group now in place and meetings have commenced					
Alliance Strategic Intent developed to set future direction - approved at Board					
Assurance (Level 1: Operational Oversight)	**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
Regular updates to internal leadership forums on place, Alliance and system working - e.g. via Gateshead Health Leadership Forum & Executive Committee	Currently neighbourhood work does not flow through the governance structure and there is a need to define this and ensure it is clear from Tier 3 through to Board committee assurance. To address through the governance structure review led by the CEO	CEO / MD / Co Sec	Mar-26	Agreement that this will flow through the Strategy and Partnerships Group. Action recommended for closure March 26 - Committee approved closure of action.	
Neighbourhood work to flow through new Strategy and Partnerships Group	Alliance Strategic Intent document not yet formally reviewed by the Board - to be presented at the March Board meeting	CEO / MD / Co Sec	Mar-26	On agenda for the Board in March - action recommended for closure March 26 - Committee approved closure of action.	
Assurance (Level 2: Reports / metrics seen by Board / committee etc)					
Alliance updates shared at Board					
Committee in Common and Joint Committee minutes and 3A reports presented at Trust Board					
Board approval of Community Diagnostic Centre business case					
MMC reporting to Board - decision-making, risk sharing, finance					
Alliance Strategic Intent document developed and reviewed by the Alliance Steering Group - approved at March Board					
Board workshop on 19 August re: implications of the Health Bill on Governors					
Paper presented to the Alliance Steering Group on the collaborative work to prepare for the implications of the Health Bill on Governors, engagement and accountability					
Assurance (Level 3 – external)					

FIT FOR THE FUTURE

Strategic objective:	10) We will ensure effective and efficient use of our resources identifying opportunities to improve productivity and ensure best use of public money
Executive Owner:	Group Director of Finance / Chief Operating Officer
Board Committee Oversight:	Finance and Performance Committee
Date of Last Review:	Aug-26
Summary risk	

There is a risk that the Trust does not improve its financial sustainability and therefore fails to utilise public money to best effect. This may be caused by limited access to, or inconsistent understanding of, data, trends, forecasts, and improvement methodologies or lack of improvement culture / financial governance & accountability.

This would result in reduced responsiveness to patient needs, an inability to meet financial targets and a loss of reputation and organisational autonomy.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
4	5	20	2	5	10

Links to risks on the ORR:

4920 - Risk that the trust is unable to deliver its cost reduction programme to the required quantum, quality and timescale without adverse impact on quality, safety and workforce (16)

4921 - Risk that the trust is unable to deliver the approved in year financial plan (16)
4922 -The trust does not deliver improved underlying sustainability (16)
4923 - Unable to maintain sufficient cash liquidity (16)
4924 - Risk that the scale, timing or cost of capital investment, including backlog and major schemes, generates unaffordable revenue consequences (12)
4925 - Risk that the trust is overfunded relative to activity delivered, resulting in phased reduction in funding over future periods (16)
4704 - Risk of failure to review appropriate clinical information due to multiple sources of data stored across a variety of digital systems (16)
COMPOSITE RISK - Sustainability – Risk to delivery of all key metrics included in the National Oversight Framework impacting on strategic aims of excellent patient care, great place to work, fit for the future and working together for healthy communities

COMPOSITE RISK - Estates - Risk to sustainability of core infrastructure and to invest in clinical advances and the working environment for our staff
2341 - There is a risk to ongoing business continuity of service provision due to the ageing Trust estate (16)

4854 - Trustwide Healthcare vacancy position (12)

4752 - Delays to breast pathways due to reduced service capacity (16)

4885 - inability to deliver contracting services (16)

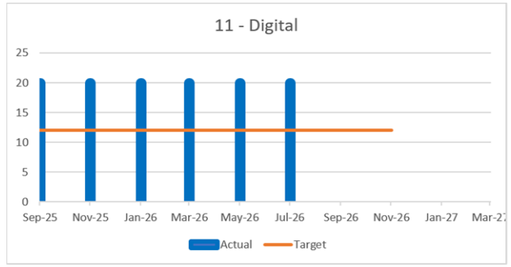
Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Annual plan developed and in place	Medium term financial plan in development with Alliance partners as part of the Joint Committee working	DoF	Dec-25	Regular Alliance DoF meetings in place - frequency increased in planning round Feb 26 - plan submitted - action recommended for closure March 26 - Committee approved closure	
Agreed budgets in place for each division and corporate area	High level of vacancies within the finance team - this is being addressed through the implementation of a new operating model.	DoF	Mar-26	Recruitment underway alongside a supporting development plan for the whole team. March 26 - Committee approved closure of the action following successful recruitment to the team	

Corporate Governance Manual updated and ratified at the March 2026 Board		Target operating models for all corporate functions not yet signed off - to be presented through CRP Steering Group	DoF	Oct-25	Dedicated GHLG meetings held during Jan 26 to develop CRP 10% plans for each corporate and operational division. Work is ongoing to develop 25-27 plan, but this related to 25-26 and therefore action recommended for closure March 26 - Committee approved closure	
Securing Our Sustainable Future work programme developed						
Post recruited to lead the Sustainable Future work						
Financial accountability framework in place						
Internal planning framework in place with clear roles and responsibilities and agreed timetable (in absence of detailed guidance from NHSE) - planning to proceed with clearly defined internal assumptions to ensure no internal delay						
Internal audit plan agreed for 26-27						
There is a risk that the Trust does not improve its financial sustainability and therefore fails to utilise public money to best effect. This may be caused by limited access to, or inconsistent understanding of, data, trends, forecasts, and improvement me						
Additional capital secured to be spent by 31 March 2026 - governance process in place to oversee delivery						
Governance for 26-27 CRP agreed at Executive Committee - enhanced controls in place						
Divisional CRP plans in development						
Key vacancies filled within finance team						
Medium term financial plan in place						
Additional controls put in place to tighten grip on spend, including discretionary spend						
Model Hospital Data and corporate benchmarking used to support productivity and efficiency plans						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
Key Indicators report circulated to leadership team on a weekly data to provide timely insight into performance		Performance reporting to be realigned to the new strategic priorities and objectives to maximise productivity and efficiency	DoF / COO	Mar-26	Year end timescale set to reflect capacity constraints and prioritisation of planning and statutory obligations	
CRP Steering Group in place to seek assurance over plans and their delivery		Detail of higher risk CRP schemes to be presented to F&P / Board	DoF	~~01/03/2026~~ June 2026	Note also included within draft Board development plan with an indicative date of June 2026 for presentation April 26 - proposal to update the timescale to June to align with Board development June 2026 - Board development session held on CRP schemes with a focus on risk. Action recommended for closure. Action agreed as closed.	
Peer benchmarking e.g. corporate services benchmarking across Alliance reported to Tier 2 groups		Assurance paper to be developed for F&P following Board Development session to provide detail on the immediate actions and controls and the expected financial impact of the controls	DoF	Jun-26	July - paper on risk stratification presented to F&P. Regular updates to be provided as part of the cycle of business. Action recommended for closure. Action agreed as closed.	

Cash monitoring and scenario modelling in place with options appraisal to manage risk - reported to FFPAG	[redacted]					
Strategic planning group meets weekly with agreed terms of reference/ purpose to seek assurance that planning is on track						
Assurance (Level 2: Reports / metrics seen by Board / committee etc)						
Monthly finance and CRP reporting to Finance and Performance Committee and Board which report on the underlying financial position						
Quarterly reporting to the Council of Governors on finance and wider performance, including updates on the Sustainable Future work						
Reporting to Board on financial, operational, quality and people performance against plan						
QEF financial performance reported to F&P Committee						
Update on CRP delivered to the Council of Governors workshops during the year						
Improved reporting to F&P Committee re: cash modelling and scenario forecasting						
Initial submission of the medium term plan approved by Board in December 25						
Workshops held with the Board and Council of Governors in respect of the medium term plan						
Board approved additional capital funding 25/26 and spending schemes - with delegated authority agreed to support delivery in timescales						
Board approved final submission of a compliant medium term financial plan - Feb 26						
Achievement of financial plan for 25/26 reported to F&P Committee (subject to audit)						
Board Assurance Statement to NHSE signed off						
Recovery plan reviewed at F&P Committee						
Assurance (Level 3 – external)						
NHS Oversight Framework ratings and league tables now published & provide benchmarking information						
Clean external audit opinion for 24/25						
NHSE and ICB financial deep dive - assurance provided over efficiency plans and leadership						

FIT FOR THE FUTURE	
Strategic objective:	11) We will be a data informed, digitally enabled organisation using technology to transform the way we plan and deliver care
Executive Owner:	Chief Digital Officer and Group Director of Finance
Board Committee Oversight:	Digital Committee
Date of Last Review:	Jul-26
Summary risk	

There is a risk that the Trust does not utilise digital technology effectively. This may be caused by a lack of a clear digital strategy, a lack of effective business continuity a lack of resource (e.g. financial, skilled people) and a lack of appropriate clinical input into decision-making. This may result in a lack of ability to utilise digital technology to support cultural transformation, productivity, efficiency, clinical safety and patient experience.



CURRENT RISK SCORE			TARGET RISK SCORE		
Likelihood	Impact	Score	Likelihood	Impact	Score
5	4	20	3	4	12

Links to risks on the ORR:

~~4402 - Inability to support legislation and best practice associated with records management (16)~~
~~4704 - Risk of failure to review appropriate clinical information due to multiple sources of data stored across a variety of digital systems (16)~~
~~4405 - Risk that data is not accessed appropriately, leading to misuse or inappropriate disclosure (8)~~
Risks closed and replaced by 2 new digital risks as outlined below:

4907 - Information Governance & Records Lifecycle Compliance (12)

4913 - Interoperability & Single Patient View (Trust-wide) (16)

Composite risk - 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

COMPOSITE RISK - Sustainability – Risk to delivery of all key metrics included in the National Oversight Framework impacting on strategic aims of excellent patient care, great place to work, fit for the future and working together for healthy communities

4920 - Risk that the trust is unable to deliver its cost reduction programme to the required quantum, quality and timescale without adverse impact on quality, safety and workforce (16)

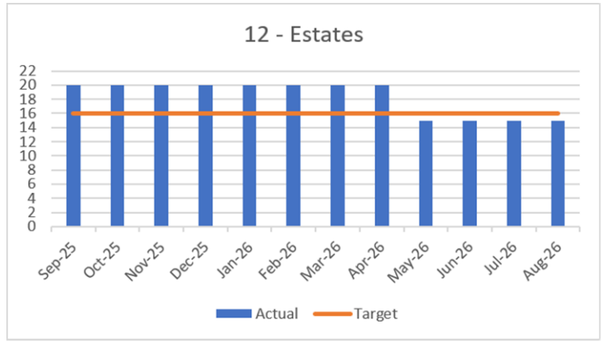
4924 - Risk that the scale, timing or cost of capital investment, including backlog and major schemes, generates unaffordable revenue consequences (12)

4554 - Cyber threats and vulnerabilities (10)

Controls	Gap in controls and corrective action	Owner	Timescale	Update	Action status
Chief Digital Officer in place across the Alliance	Digital Committee membership, scope and terms of reference to be revisited in light of recent new appointments (including a new Chair of the Committee)	Chief Digital Officer / Chair of the Committee	Oct-25	Discussions to be held in advance of the next Digital Committee meeting in Jan 26 March 26 - terms of referenced reviewed and approved at the Jan meeting. Action recommended for closure. March 26 - action agreed as closed.	
Associate Director of Digital appointment made	Digital chapter to be developed to provide a clear digital strategy as part of the Trust's new 5 year strategy - for sign off at September Board	Chief Digital Officer	Sep-25	Strategy signed off at the Board in September with a chapter on digital to align to the priority and therefore action recommended for closure. Action agreed as closed in Nov 25.	
Digital Committee in place with supporting groups at Tier 2 and Tier 3	IRM / SIRO meeting has not taken place for a period of time - resulting in a gap in reporting and assurance. In addition, the SIRO requires role-specific training	Chief Digital Officer	Jan-26	SIRO training arranged for Dec 25 and the IRM / SIRO meeting will be recommenced shortly after this time March 26 - confirmed SIRO training has been delivered and action agreed as closed	

SIRO role confirmed as the Group Director of Finance		Costed model for digital strategy delivery not in place - to be developed as part of the detail sitting behind the digital chapter of the new corporate strategy	Chief Digital Officer	Mar-26	Currently being developed with the aim to be in place for the start of the new financial year March 26 - Committee agreed to leave this action open and revisit at the next meeting May 26 - continues to be no costed plan for the Digital Records Programme. Funding is the key issue - a need to identify the collective actions needed to build an achievable and costed plan for the digital plan delivery July 26 - the Committee noted that there is a potential of being in a position to make a decision on the digital records programme by October as part of the capital reprioritisation process	
New 5 year corporate strategy launched with the digital chapter included		Direction of travel for the digital records programme not yet agreed	Chief Digital Officer	Mar-26	A costed case for consideration is being developed in line with the costed model for the digital strategy delivery March 26 - update included on March Committee agenda. March 26 - Committee agreed to close this action as a direction of travel has been agreed. Progress to be tracked as a delivery project	
PACS upgrade successfully completed to provide enhanced level of stability for the system		There is a gap in control in relation to Clinical Safety Officer capacity within the organisation to support the digital work, alongside a wider a broader skills gap within the digital team. Actions underway to address this	Chief Digital Officer	Mar-26	March 26 - Committee confirmed progress has been made with plans in place to train 20 CSOs, which is in line with the aspiration of having in place 20 CSOs. Agreed to keep the action open until the capacity is realised (i.e. the training is complete).	
Digital strategic plan in place						
Digital Committee terms of reference reviewed and revised to ensure appropriate governance in place						
SIRO training delivered						
Direction of travel for digital records programme agreed and approved						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**

		Following discussion at the June Digital Committee further work is needed to develop a recommended position on the Digital Records Programme and provide assurance over resource allocation and prioritisation	Chief Digital Officer	Sep-25	Nov 25 - Committee concluded that gaps remain re: the digital records programme March 26 - Committee agreed to close this action as a direction of travel has been agreed. Progress to be tracked as a delivery project	
		To enhance assurance reporting to the Digital Committee to ensure that the patient care impact on developments, risks and proposals is clearly articulated in papers to the Committee	Chief Digital Officer	~~31/03/2026~~ May 2026	March 26 - The Committee agreed that an update on enhanced assurance reporting to be provided at the next meeting.	
		As outlined above, assurance over IRM / SIRO areas not being received as the meeting has not taken place for some time. A plan to restart this is in place.	Chief Digital Officer	Jan-26	SIRO training arranged for Dec 25 and the IRM / SIRO meeting will be recommenced shortly after this time March 26 - Committee agreed that there would be a cross-check between the new KPI report and key metrics for SIRO and IG to check for completeness and identify any omissions July 26 - SIRO report now presented formally at Digital Committee. Action agreed as closed.	
		The Committee is not currently sighted on digital transformation assurance. To identify ways in which assurance flows can be strengthened	Chief Digital Officer	31/03/2026		
Assurance (Level 2: Reports / metrics seen by Board / committee etc)		Gap in assurance in relation to the existence of an achievable and costed plan to support delivery of the overall digital objective	Chief Digital Officer	Jul-26		
Digital service KPIs reviewed at every Digital Committee						
Following the audit the Digital Co now receives clinical safety activity reporting to provide greater oversight and assurance in this area						
Regular assurance updates to Committee on the digital records programme delivery now that direction of travel is agreed						
SIRO report to Digital Committee						
Assurance (Level 3 – external)						
Internal Audit: Cyber Assurance Framework (CAF) Aligned Data Security Protection Toolkit (DSTP) Independent Assessment - outcome High / Low assessment rating.						
Internal Audit: Clinical Safety System Changes - Reasonable Assurance rating, Badgernet - Reasonable Assurance						

FIT FOR THE FUTURE								
Strategic objective:	12) We will focus on productive utilisation of our estate to facilitate care in the right setting and providing our services in an environmentally sustainable way							
Executive Owner:	QEF Managing Director and Group Director of Finance							
Board Committee Oversight:	Finance and Performance Committee							
Date of Last Review:	Aug-26							
Summary risk								
There is a risk that the Group will be unable to develop its estate in line with changing clinical requirements and may experience failure of critical infrastructure, as a result of insufficient capital investment, This could result in compromised patient safety, disruption to business continuity, reduced staff morale, non-compliance with statutory obligations, and failure to deliver on environmental sustainability commitments.		**CURRENT RISK SCORE**			**TARGET RISK SCORE**		
		Likelihood	Impact	Score	Likelihood	Impact	Score
		3	**5**	**15**	**4**	**4**	**16**
Links to risks on the ORR:	2341 - There is a risk to ongoing business continuity of service provision due to ageing trust estate (16) 4921 - Risk that the trust is unable to deliver the approved in year financial plan (16) 4922 -The trust does not deliver improved underlying sustainability (16) 4923 - Unable to maintain sufficient cash liquidity (16) 4924 - Risk that the scale, timing or cost of capital investment, including backlog and major schemes, generates unaffordable revenue consequences (12)						
	4920 - Risk that the trust is unable to deliver its cost reduction programme to the required quantum, quality and timescale without adverse impact on quality, safety and workforce (16) 4839 - Risk of non-compliance with statutory fire safety legislation (20) COMPOSITE RISK - Sustainability – Risk to delivery of all key metrics included in the National Oversight Framework impacting on strategic aims of excellent patient care, great place to work, fit for the future and working together for healthy communities COMPOSITE RISK - Estates - Risk to sustainability of core infrastructure and to invest in clinical advances and the working environment for our staff 2984 - There is a risk to our ability to continue to run maternity services from the designated building due to a catastrophic failure of the steam supply, resulting in enactment of a business continuity plan (20)						

Controls		**Gap in controls and corrective action**	**Owner**	**Timescale**	**Update**	**Action status**
Capital plan in place for 25/26		Outline capital plan in place for 26-27 but not yet fully approved	QEF MD	Jan-26	Jan 26 - action recommended for closure. Approved capital plan has been in place for this financial year	

Governance structure includes strengthened focus on capital and estates through 1 single Capital Oversight Group at Tier 3 and the accommodation group		Estates strategy not yet in place - impacts on ability to develop the outline capital plan	QEF MD	Jun-26	Jan 26 - due date updated as per Board workshop discussions May 26 - estates plan approved at May Board - action closed.	
Corporate Governance Manual updated and ratified at the March 2026 Board		Fire safety survey to be conducted to inform risk assessment	QEF MD	Timescale to be agreed	Jan 26 - Board supported the need for the survey at its workshop in December 25 Feb 26 - elements of the survey commissioned for completion before 31 March 2026 with the additional funding secured	
Green Plan approved at Board Sept 25		Electrical distribution assessment to be undertaken to inform site risk assessment	QEF MD	Timescale to be agreed	Jan 26 - Board supported the need for the assessment at its workshop in December 25	
Collaborative approach to capital in place with Alliance and Provider Collaborative partners						
Engagement in the Alliance Construction Programme with market engagement undertaken						
Capital plan in place						
Additional capital secured to be spent by 31 March 2026 - governance process in place to oversee delivery						
Estates plan in place and approved at Board (May 26)						
Estates matters now included within the scope of the Committee - as per updated terms of reference						
Maternity estate capital scheme developed and approved						
Greener NHS Group established						
Assurance (Level 1: Operational Oversight)		**Gaps in assurance and corrective action (all levels)**	**Owner**	**Timescale**	**Update**	**Action status**
Capital Oversight Group meets monthly to review capital plans, spend and reprioritisation		Power outage occurred in August on the QE site - after-action review scheduled. Assurance required from this to identify any learnings and improvements	QEF MD / CEO	Sep-26		
Capital Oversight Group reports to the Operational Oversight Group via 3A reporting						

Assurance (Level 2: Reports / metrics seen by Board / committee etc)	[redacted]					
Capital reporting and monitoring to F&P Committee and Board of Directors via finance reports						
Board development session held on the estates position- Dec 25						
Board approved additional capital funding 25/26 and spending schemes - with delegated authority agreed to support delivery in timescales						
Board approved additional capital funding 25/26 and spending schemes - with delegated authority agreed to support delivery in timescales						
Board approved plan for maternity estate in place						
ERIC report to F&P						
PAM report to F&P - reviewed in July and to be re-presented in August						
Reports to Board and F&P on maternity estate scheme						
Environmental sustainability report to F&P - June 2026						
Assurance (Level 3 – external)						

c - Finance Report

Presented by the Director of Finance

NHS Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 5c

Report Title:	**Consolidated Finance Report**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29th September 2026			
Author:	Ms Jane Fay, Deputy Director of Finance			
Executive Sponsor:	Ms Kris Mackenzie, Group Director of Finance			
Report presented by:	Ms Kris Mackenzie, Group Director of Finance			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	The purpose of this paper is to provide assurance against financial corporate objectives and address financial risks			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	N/A			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	The Trust has an approved 2026-27 planned deficit of **£3.338m** before adjustments for donated asset depreciation, and deficit support funding. As of August 2026, the Trust has reported an actual deficit of **£2.291m** after adjustments for donated asset depreciation and excluding deficit support funding. This is an adverse variance of **£1.064m** for reasons detailed in the body of this report. The 2026-27 capital plan totals **£34.435m** including £23.023m PDC funded schemes and £11.412m internally funded schemes. Spend up to the end of August 2026 is **£2.261m**, and an under-spend of **£10.953m** for the year-to-date. Cash balances as at 31st August 2026 total **£32.581m** and **£29.369m** above planned values for the reasons detailed in the body of this report.			

Gateshead Health NHS Foundation Trust

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

Gateshead Health NHS Foundation Trust

1.0 Introduction

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

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

2.0 Key Financial Performance Indicators

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

Finance KPIs	Month 05 - Aug-26 Budget £ '000	Actual £ '000	Variance £ '000	RAG	YTD Budget £ '000	Actual £ '000	Variance £ '000	RAG
I&E (Surplus) / Deficit (adjusted perf.)	243	(321)	(563)		1,227	2,291	1,064	
Operating Income	-36,967	-36,688	279		-185,600	-183,321	2,278	
Pay Expenditure	24,637	24,387	(250)		124,133	122,572	(1,562)	
Non Pay Expenditure	11,740	11,619	(121)		59,723	60,698	974	
Non Operating Income	-8	-114	(106)		-68	-530	(462)	
Non Operating Expenditure	629	507	(122)		3,203	3,036	(167)	
Remove capital donations / grant I&E Impact	-32	-33	(1)		-159	-163	(4)	
Balancing adj to NHSE Plan	-82	0	82		-82	0	82	
Bank Expenditure	640	654	14		3,145	3,930	785	
Agency Expenditure	64	117	48		339	801	462	
CRP Delivery	2,295	953	(1,342)		10,999	3,722	(7,277)	
Capital Expenditure	2,626	741	(1,885)		13,214	2,261	(10,953)	
Cash position	-56	6,271	6,327		3,212	32,579	29,367	
Liquidity (days)	21	11	(9.9)		21	10	(10.7)	
Better Payment Practice Code (BPPC)								
NHS	95.0%	62.8%	-32.2%		95.0%	43.9%	-51.1%	
Non NHS	95.0%	99.3%	4.3%		95.0%	98.7%	3.7%	
Aged Debt								
Receivables over 90 days NHS	10.0%	30.4%	20.4%		10.0%	33.8%	23.8%	
Receivables over 90 days non NHS	10.0%	44.1%	34.1%		10.0%	46.2%	36.2%	

Table 1: Finance KPIs

2.2 The Trust reported a surplus of **£0.321m** for August, which is a favourable variance of **£0.563m** against the planned position. Year to date, the Trust has reported a deficit of **£2.291m**, which is **£1.064m** adverse variance from plan. This position is excluding Deficit Support Funding (DSF) of which £0.738m cash was received for Q1. The main driver behind the adverse position is unmet CRP which is being partially mitigated by pay underspends driven by high vacancy levels.

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

Gateshead Health NHS Foundation Trust

3.0 Cost Reduction Programme

3.1 Performance against the year to date target is £3.722m against a target of £10.999m resulting in a year to date under achievement of £7.277m.

Division	Target as at Aug 26 £000	Achieved as at Aug 26 £000	(Under)/ Over Achieved as at Aug 26 £000	26-27 Annual Target £000	26-27 Forecast £000	26-27 (Under)/Over Forecast £000	Recurring Forecast Underlying Impact £000
Chief Executive	66	0	(66)	166	214	48	218
Chief Operating Officer	105	34	(71)	265	236	(29)	316
Clinical Support & Screening Services	3,470	345	(3,125)	8,729	4,496	(4,233)	6,747
Community Diagnostic Centre	115	0	(115)	290	0	(290)	0
Digital	458	0	(458)	1,152	922	(230)	1,180
Estates & Facilities	109	0	(109)	274	0	(274)	0
Finance	46	75	29	116	181	65	181
Information & Performance	75	0	(75)	189	190	1	250
Medical Director	48	65	16	121	237	116	131
Medicine & Community	3,038	1,065	(1,972)	7,641	2,936	(4,705)	3,271
Nursing & Midwifery	93	-20	(113)	233	34	(199)	49
POD	97	63	(34)	244	264	20	272
Surgery	2,853	126	(2,728)	7,178	1,892	(5,286)	2,441
Central Unallocated Target	425	1,969	1,544	1,075	5,219	4,144	63
Total	**10,999**	**3,721**	**(7,277)**	**27,672**	**16,820**	**(10,852)**	**15,119**

Table 2 Cost Reduction Performance

3.2 The annual achievement is forecast at £16.820m, which is an under-achievement of £10.852m against the annual target and is being mitigated by a number of cost containment controls.

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

4.0 Underlying Trust Financial Position

4.1 The Trust medium term financial plan set a target underlying 2026-27 exit deficit of **£34.910m**, on the assumption £15.119m of the 2026-27 cost improvement target is achieved on a recurring basis and no new recurring pressures arise in the year.

4.2 To date the Trust is forecasting delivery of £15.119m recurring cost reduction schemes and £0.846m new recurring pressure arising from the AfC and medical and dental pay award, forecasting an exit-underlying deficit of **£36.962m**.

5.0 Capital

5.1 The approved 2026-27 capital plan as summarised in Table 15 totals **£31.486m**, with a further £2.949m of new public dividend capital (PDC) schemes awarded to date.

Gateshead Health NHS Foundation Trust

5.2 The Trust has reported capital expenditure totalling **£2.261m** against a year-to-date plan of £13.214m. Expenditure is mainly against the PDC funded maternity scheme totalling £1.352m, theatre ventilation totalling £0.327m and gamma camera totalling £0.168m.

Capital Scheme	2026/2027 Annual Plan £000's	2026/2027 In-Year PDC Awards £000's	2026/2027 In-Year Scheme Approvals £000's	2026/2027 Updated Annual Plan £000's	2026/2027 YTD Plan £000's	2026/2027 YTD Actual £000's	2026/2027 YTD Variance £000's	2026/2027 Likely Forecast £000's	2026/2027 Likely Forecast Variance £000's
Gamma Camera	2,358			2,358	1,475	168	(1,307)	2,358	0
Theatre Ventilation	529			529	440	327	(113)	626	97
Agile Lift	24			24	24	45	21	66	42
Bensham Boiler	0			0	0	14	14	14	14
IPS/UPS SCBU	257			257	215	0	(215)	257	0
Estates - Fire Safety	1,000			1,000	415	26	(389)	1,013	13
Estates - Primary Electrical Infrastructure	2,500			2,500	1,040	0	(1,040)	700	(1,800)
Estates - General M&E	1,300			1,300	540	1	(539)	1,300	0
Estates - General Reactive	250			250	100	16	(84)	435	185
Medical Equipment Replacement	520			520	0	0	0	726	206
Business Critical Equipment Replacement	60			60	60	0	(60)	0	(60)
Digital	100			100	0	(1)	(1)	100	0
IFRS16 Lease Renewal	1,311			1,311	545	117	(428)	1,450	139
Clinical EPR	1,203			1,203	0	0	0	180	(1,023)
Medicines Manufacturing Unit	0			0	0	0		350	350
25-26 Carry Forward Scheme	0			0	0	(15)	(15)	(557)	(557)
Sub-total Internally Funded	**11,412**	**0**	**0**	**11,412**	**4,854**	**699**	**(4,155)**	**9,018**	**(2,394)**
2026-27 Maternity	12,000			12,000	5,000	1,352	(3,648)	7,800	(4,200)
2026-27 Estates Safety Fund	1,074	159		1,233	445	0	(445)	1,233	0
2026-26 Community Diagnostic Centre Phase 2	2,500			2,500	1,040	210	(830)	2,500	0
2026-26 Community Diagnostic Centre Phase 2	4,500			4,500	1,875	0	(1,875)	4,500	0
Screening Programme - Self Sampling	0	377		377	0	0	0	377	0
Screening Programme - HPV Relocation	0	1,483		1,483	0	0	0	1,483	0
Screening Programme - FIT at 80	0	173		173	0	0	0	173	0
ECC - Retinal camera for SDEC	0	7		7	0	0	0	7	0
Community Hub	0	750		750	0	0	0	750	0
Sub-total PDC Funded	**20,074**	**2,949**	**0**	**23,023**	**8,360**	**1,562**	**(6,798)**	**18,823**	**(4,200)**
Total Capital 2026-27	**31,486**	**2,949**	**0**	**34,435**	**13,214**	**2,261**	**(10,953)**	**27,841**	**(6,594)**
Funded By:									
CDEL Depreciation	11,412	0		11,412	4,854	699	(4,155)	9,018	(2,394)
Public Dividend Capital	20,074	2,949		23,023	8,360	1,562	(6,798)	18,823	(4,200)
Charitable Funds	0	0		0	0	0	0	0	0
Total Funding	**31,486**	**2,949**		**34,435**	**13,214**	**2,261**	**(10,953)**	**27,841**	**(6,594)**

Table 4: Capital Programme Spend

5.3 Due to late notification of capital funding from NHSE, the Trust is forecasting likely slippage against the annual capital plan, which is expected to be mitigated by an updated capital plan for approval by Trust Board in October.

6.0 Cash Balances

6.1 Group cash at the 31st August 2026 totalled **£32.579m**, **£29.367m** more than planned. The key drivers behind this favourable variance are due to trade and other payables being £16.607m higher than planned, £4.155m slippage against internally

Gateshead Health NHS Foundation Trust

funded capital plan and trade and other receivables also being £1.069m lower than plan.

6.2 The cash balance is the equivalent to an estimated 29.31 days operating costs (July: 23.23 days).

6.3 In the current month our cash balance again appears to be a much stronger position than anticipated, however, the underlying liquidity position of the organisation remains a significant risk. Modelling suggests that we will need revenue support funding in March 2027 and to access this we will need to make a decision by the end of quarter 3 in order to access the funding.

6.4 Performance against the Better Payment Practice Code has improved in month in terms of value, with 98.3% of invoices paid within 30 days against the target 95% (July 2026: 95.7%); alongside an increase in total numbers of invoices paid at 96.5% (July 2026: 95.1%); (target 95%).

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

7.0 Conclusion

7.1 The Trust has reported an adjusted in month deficit of **£0.321m** a favourable variance to plan of **£0.563m**.

7.2 For the year-to-date, the Trust reported an adjusted deficit of **£2.291m** against a plan of £1.227m resulting in an adverse variance of £1.064m. This excludes Deficit Support Funding of £0.738m, received for Q1.

7.3 The Trust has reported total capital spend of **£2.261m** against a plan of £13.214m resulting in an underspend of **£10.953m**. The current forecast is modelling a likely underspend of £6.594m requiring a refreshed capital plan to be approved by Trust Board in October.

7.4 The Trust has reported achievement of **£3.722m** against the year to date 2026-27 cost reduction plan, with **£16.820m** forecast against annual target of £27.672m; resulting in an indicative shortfall of **£10.852m** that will need to be bridged to achieve the target deficit.

7.5 Group cash at 31st August 2026 totalled **£32.579m**, **£29.367m** more than planned, mainly driven by trade and other payables, which are higher than planned by **£16.607m**, £4.155m slippage against the internally funded element of the capital programme and trade and other receivables also being £1.069m lower than plan.

Kris Mackenzie
Group Director of Finance

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Appendix A – Statement of Comprehensive Income (SOCI)

Statement of Comprehensive Income	Month 05 - Aug-26 Budget £ '000	Actual £ '000	Variance £ '000	YTD Budget £ '000	Actual £ '000	Variance £ '000
Operating Income from Patient Care activities						
Income From NHS Care Contracts	-33,485	-33,815	(330)	-168,567	-170,199	(1,632)
Income From Local Authority Care Contracts	-35	-35	(0)	-173	-174	(1)
Private Patient Revenue	-66	-49	17	-329	-289	40
Injury Cost Recovery	-42	-79	(37)	-208	-272	(63)
Other non-NHS clinical revenue	-14	-14	1	-72	-53	19
Total Operating Income From Patient Care activities	-33,642	-33,991	**(350)**	-169,350	-170,987	**(1,637)**
Other Operating Income						
Education and Training Income	-1,096	-1,030	66	-5,481	-5,030	451
R&D Income	-113	-96	17	-566	-485	81
Funding outside of System Envelope	0	0	0	0	0	0
Other Income	-2,040	-1,571	470	-10,202	-6,819	3,383
Donations & Grants Received	0	0	0	0	0	0
Cost Improvement Programme - Income	0	0	0	0	0	0
Total Other Operating Income	-3,250	-2,697	**553**	-16,249	-12,334	**3,915**
Total Operating Income	-36,891	-36,688	**203**	-185,600	-183,321	**2,278**
Operating Expenses						
Employee Expenses - Substantive	23,876	23,521	(355)	120,177	117,367	(2,810)
Employee Expenses - Bank	640	654	14	3,145	3,930	785
Employee Expenses - Agency	69	117	48	339	801	462
Employee Expenses - Other	94	95	1	472	474	1
Cost Improvement Programme - Pay	0	0	0	0	0	0
Total Employee Expenses	**24,680**	**24,387**	**(292)**	**124,133**	**122,572**	**(1,562)**
Purchase of Healthcare - NHS bodies	813	968	155	4,063	4,902	839
Purchase of Healthcare - Non NHS bodies	163	270	107	816	1,188	372
Purchase of Social Care	0	0	0	0	0	0
NED's	28	15	(13)	141	67	(74)
Supplies & Services - Clinical	3,227	3,464	238	17,339	18,300	960
Supplies & Services - General	233	264	31	1,166	1,250	84
Drugs	2,071	2,098	27	10,355	10,668	313
Research & Development expenses	4	-0	(4)	20	-0	(20)
Education & Training expenses	111	111	0	822	576	(246)
Consultancy costs	-7	3	10	-36	63	99
Establishment expenses	274	392	118	1,342	2,031	689
Premises	1,499	1,374	(126)	7,497	7,748	251
Transport	161	134	(28)	807	708	(100)
Clinical Negligence	670	690	20	3,352	3,200	(152)
Operating Leases	212	-74	(286)	1,062	342	(720)
Other Operating expenses	900	422	(477)	4,540	2,872	(1,667)
Movement in credit loss allowance	-50	171	221	-250	175	425
Cost Improvement Programme - Non Pay	0	0	0	0	0	0
Reserves	0	0	0	0	0	0
Operating Expenses included in EBITDA	**10,310**	**10,302**	**(8)**	**53,037**	**54,090**	**1,053**
Depreciation & Amortisation - Purchased / Constructed	1,297	1,036	(261)	5,160	5,190	30
Depreciation & Amortisation - Donated / Granted	21	33	12	159	163	4
Depreciation & Amortisation - Finance Leases	339	249	(90)	1,367	1,254	(113)
Impairment & Revaluation	0	0	0	0	0	0
Operating Expenses excluded from EBITDA	**1,657**	**1,317**	**(340)**	**6,686**	**6,608**	**(79)**
Total Operating Expenses	**36,647**	**36,007**	**(640)**	**183,857**	**183,270**	**(587)**
(Profit)/Loss from Operations	**(244)**	**(681)**	**(437)**	**(1,743)**	**(51)**	**1,691**
Non-Operating Income						
Finance Income	-14	-114	(100)	-68	-530	(462)
Gains on Disposal of Assets	0	0	0	0	0	0
Total Non-Operating Income	-14	-114	-100	-68	-530	**(462)**
Non-Operating Expenses						
Finance Expense	12	85	73	245	427	183
Gains / (Losses) on Disposal of Assets	0	0	0	0	0	0
PDC dividend expense	467	262	(204)	2,333	2,129	(204)
Total Finance Costs (for non-financial activities)	**479**	**348**	**(131)**	**2,578**	**2,557**	**(22)**
Other Non-Operating Expenses						
Misc. Other Non-Operating expenses	0	0	0	0	0	0
Total Non-Operating Expenses	**479**	**348**	**(131)**	**2,578**	**2,557**	**(22)**
(Surplus) / Deficit Before Tax	**221**	**(448)**	**(669)**	**767**	**1,975**	**1,208**
Corporation Tax	125	160	35	625	479	(146)
(Surplus) / Deficit After Tax	**346**	**(288)**	**(634)**	**1,392**	**2,454**	**1,062**
Balancing Adjustment to NHSE Plan	(82)		82	(6)		6
(Surplus) / Deficit After Tax from Continuing Operations	**264**	**(288)**	**(552)**	**1,386**	**2,454**	**1,068**
Remove impact of impairments	0	0	0	0	0	0
Remove capital donations / grants I&E impact	-21	-33	(12)	-159	-163	(4)
Adjusted Financial Performance (Surplus) / Deficit (exc DSF)	**243**	**(321)**	**(563)**	**1,227**	**2,291**	**1,064**
Deficit Support Funding	(246)		(563)	(1,231)	-738	493
Adjusted Financial Performance (Surplus) / Deficit (inc DSF)	**(3)**	**(321)**	**(1,127)**	**(4)**	**1,553**	**1,557**

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Appendix B Statement of Financial Position

Statement of Comprehensive Income	Month 05 - Aug-26 Budget £ '000	Actual £ '000	Variance £ '000	YTD Budget £ '000	Actual £ '000	Variance £ '000
Operating Income from Patient Care activities						
Income From NHS Care Contracts	-33,485	-33,815	(330)	-168,567	-170,199	(1,632)
Income From Local Authority Care Contracts	-35	-35	(0)	-173	-174	(1)
Private Patient Revenue	-66	-49	17	-329	-289	40
Injury Cost Recovery	-42	-79	(37)	-208	-272	(63)
Other non-NHS clinical revenue	-14	-14	1	-72	-53	19
Total Operating Income From Patient Care activities	-33,642	-33,991	**(350)**	-169,350	-170,987	**(1,637)**
Other Operating Income						
Education and Training Income	-1,096	-1,030	66	-5,481	-5,030	451
R&D Income	-113	-96	17	-566	-485	81
Funding outside of System Envelope	0	0	0	0	0	0
Other Income	-2,040	-1,571	470	-10,202	-6,819	3,383
Donations & Grants Received	0	0	0	0	0	0
Cost Improvement Programme - Income	0	0	0	0	0	0
Total Other Operating Income	-3,250	-2,697	**553**	-16,249	-12,334	**3,915**
Total Operating Income	-36,891	-36,688	**203**	-185,600	-183,321	**2,278**
Operating Expenses						
Employee Expenses - Substantive	23,876	23,521	(355)	120,177	117,367	(2,810)
Employee Expenses - Bank	640	654	14	3,145	3,930	785
Employee Expenses - Agency	69	117	48	339	801	462
Employee Expenses - Other	94	95	1	472	474	1
Cost Improvement Programme - Pay	0	0	0	0	0	0
Total Employee Expenses	**24,680**	**24,387**	**(292)**	**124,133**	**122,572**	**(1,562)**
Purchase of Healthcare - NHS bodies	813	968	155	4,063	4,902	839
Purchase of Healthcare - Non NHS bodies	163	270	107	816	1,188	372
Purchase of Social Care	0	0	0	0	0	0
NED's	28	15	(13)	141	67	(74)
Supplies & Services - Clinical	3,227	3,464	238	17,339	18,300	960
Supplies & Services - General	233	264	31	1,166	1,250	84
Drugs	2,071	2,098	27	10,355	10,668	313
Research & Development expenses	4	-0	(4)	20	-0	(20)
Education & Training expenses	111	111	0	822	576	(246)
Consultancy costs	-7	3	10	-36	63	99
Establishment expenses	274	392	118	1,342	2,031	689
Premises	1,499	1,374	(126)	7,497	7,748	251
Transport	161	134	(28)	807	708	(100)
Clinical Negligence	670	690	20	3,352	3,200	(152)
Operating Leases	212	-74	(286)	1,062	342	(720)
Other Operating expenses	900	422	(477)	4,540	2,872	(1,667)
Movement in credit loss allowance	-50	171	221	-250	175	425
Cost Improvement Programme - Non Pay	0	0	0	0	0	0
Reserves	0	0	0	0	0	0
Operating Expenses included in EBITDA	**10,310**	**10,302**	**(8)**	**53,037**	**54,090**	**1,053**
Depreciation & Amortisation - Purchased / Constructed	1,297	1,036	(261)	5,160	5,190	30
Depreciation & Amortisation - Donated / Granted	21	33	12	159	163	4
Depreciation & Amortisation - Finance Leases	339	249	(90)	1,367	1,254	(113)
Impairment & Revaluation	0	0	0	0	0	0
Operating Expenses excluded from EBITDA	**1,657**	**1,317**	**(340)**	**6,686**	**6,608**	**(79)**
Total Operating Expenses	**36,647**	**36,007**	**(640)**	**183,857**	**183,270**	**(587)**
(Profit)/Loss from Operations	**(244)**	**(681)**	**(437)**	**(1,743)**	**(51)**	**1,691**
Non-Operating Income						
Finance Income	-14	-114	(100)	-68	-530	(462)
Gains on Disposal of Assets	0	0	0	0	0	0
Total Non-Operating Income	-14	-114	-100	-68	-530	**(462)**
Non-Operating Expenses						
Finance Expense	12	85	73	245	427	183
Gains / (Losses) on Disposal of Assets	0	0	0	0	0	0
PDC dividend expense	467	262	(204)	2,333	2,129	(204)
Total Finance Costs (for non-financial activities)	**479**	**348**	**(131)**	**2,578**	**2,557**	**(22)**
Other Non-Operating Expenses						
Misc. Other Non-Operating expenses	0	0	0	0	0	0
Total Non-Operating Expenses	**479**	**348**	**(131)**	**2,578**	**2,557**	**(22)**
(Surplus) / Deficit Before Tax	**221**	**(448)**	**(669)**	**767**	**1,975**	**1,208**
Corporation Tax	125	160	35	625	479	(146)
(Surplus) / Deficit After Tax	**346**	**(288)**	**(634)**	**1,392**	**2,454**	**1,062**
Balancing Adjustment to NHSE Plan	(82)		82	(6)		6
(Surplus) / Deficit After Tax from Continuing Operations	**264**	**(288)**	**(552)**	**1,386**	**2,454**	**1,068**
Remove impact of impairments	0	0	0	0	0	0
Remove capital donations / grants I&E impact	-21	-33	(12)	-159	-163	(4)
Adjusted Financial Performance (Surplus) / Deficit (exc DSF)	**243**	**(321)**	**(563)**	**1,227**	**2,291**	**1,064**
Deficit Support Funding	(246)		(563)	(1,231)	-738	493
Adjusted Financial Performance (Surplus) / Deficit (inc DSF)	**(3)**	**(321)**	**(1,127)**	**(4)**	**1,553**	**1,557**

d - Strategic Objectives and Constitutional Standards Report

Presented by the Director of Finance

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 5d

Report Title:	Strategic Objectives & Constitutional Standards			
Name of Meeting:	Board of Directors			
Date of Meeting:	Tuesday 29th September 2026			
Author:	Deborah Renwick: Associate Director of Planning & Performance			
Executive Sponsor:	Kris Mackenzie: Director of Finance			
Report presented by:	Kris Mackenzie: Director of Finance			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☒	**Assurance:** ☐	**Information:** ☐
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☐ *No gaps in assurance*	**Partially assured** ☒ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	Executive Committee Finance and Performance Committee			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity, and inclusion*	**Excellent patient care** **Quality Improvement Plan:** Performance remains at 88% in August, below planned levels of key delivery areas and actions on track. Areas requiring improvement or remain challenging are Trustwide appraisal rates, Staff retention, local induction checklist compliance, Implementation of falls PSIRP workstream plan and Reduction of harm from falls of 5%. **PSIRP**: The falls harm rate has increased slightly in August to 4.1 which remains above the target, the falls steering group continue to meet and progress the current action plan. In support of identification and prevention of Venous Thromboembolisms (VTE) 95.9% of all patients admitted in August were risk assessed (in accordance with NICE guidance criteria), continuing to exceed the national standard of 95%. **QA**: The Trust reported one case of C. difficile in August and the in-month rate per 100k bed days decreased to 7.6.			

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	Performance against learning disability and autism training increased in month to exceed the target of 85% at 85.5%. Learning disabilities training has been replaced with The Oliver McGowan Mandatory Training on Learning Disability and Autism Part 1 eLearning as of the 1st of January 2026. Mental Health Act Policy training has increased to 94%, above the target of 90%. Delivery challenges remain evident in releasing ward staff and allocating time to train coupled with rotational issues and availability of Allied Health Professionals. Additional training dates continue to be released. The headline metrics underpinning and related to the development of the Estates strategy are detailed below: • In August, there was 1 new risk, a total of nineteen estate risks with a combined critical infrastructure risk score of 217. • Three patient safety incidents linked to estate issues were reported in August, no common themes were identified. • PLACE inspection visits in August took place in Ward 21, Majors/UTC/SDEC A&E and fracture. **Great place to work** • The Group vacancy rate reduced from 7.5% in July 2026 to 6.8% in August 2026, reflecting an improvement in the overall workforce position against budget. This reduction was driven primarily by a 38 WTE increase in trainee grade medical staff. Within the registered nursing workforce, the overall position remains relatively stable, with a vacancy rate of 3.1%. However, this masks some workforce movement within the staff group, with Band 5 Registered Nursing WTE decreasing by 7.2 WTE, partially offset by a 1.25 WTE increase in Band 7 nursing staff. Vacancies within Support to Nursing Staff have shown a longer-term improvement from the peak vacancy rate of 19.4% in August 2025, with a generally downward trend over the past four months. However, this progress reversed slightly in August, with the vacancy rate increasing from 12.4% in July to 13.2% in August 2026. Domestic Services continues to be an area of significant workforce pressure, with 24 WTE vacancies and a vacancy rate of 14.0%, remaining one of the highest vacancy rates across the organisation. • The annual staff survey results had a 42% completion rate, and an overall engagement score of 6.5, but a decline of 0.64 in the July People Pulse. There are various factors leading to this decline but areas with the largest in year change are career development and

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	learning, advocacy and organisational confidence, and feeling valued. The results have been cascaded throughout in January/February, and the Board and senior leaders have agreed two key areas of focus; working harder to show that patient care is our top priority and prioritising engagement. Divisions reported on local progress via People and OD Steering Group in June 2026, outlining clear action plans to improve staff experience locally. Executive committee have approved a 'you said we did' narrative which will inform the promotional campaign in the lead up to the 2026 survey, so staff are clear on what tangible actions have taken place, a clear communications plan has been prepared. • While Trust turnover remains at target, turnover continues to be influenced by QEF, which remains affected by the March 2026 TUPE transfers. Outside of QEF, the largest contributors to turnover by volume continue to be the Trust's largest workforce areas within Medicine & Community, CSS and Surgical Services. At service level, turnover remains elevated within Clinical Support Therapy Services (16.2%), Community Services (12.7%) and Surgical SLM 3 (14.4%), reflecting ongoing turnover pressures within sizeable workforce groups. The most notable large workforce areas above target are Community Midwifery (24.8%), Occupational Therapy (14.7%), Community Contracting (20.9%), Domestic Services (17.5%) and New Lab Biochemistry (15.2%). • Sickness absence deteriorated during August, with the rolling 12-month rate increasing to 5.59% and in-month sickness rising sharply from 5.2% to 5.7%. The increase is notable given the time of year and warrants monitoring as the organisation enters the autumn and winter period. The greatest impact continues to come from the Trust's largest workforce areas, particularly Medicine & Community (2,239 FTE days lost), Surgical Services (1,818 FTE days lost) and CSS (1,658 FTE days lost). Community Services (11.4%), Surgical SLM 1 (7.7%) and Clinical Support Pathology (6.0%) remain key areas of pressure, with Pathology recording 743 FTE days lost during August. Anxiety, stress and depression continue to be the largest cause of sickness absence across the organisation. • Agency spend remains under target at 0.5% and has been consistently under target in the past 12 months. Agency spend continues in hard to fill roles in Elderly Care, Surgery, Cardiac Diagnostics and QEF

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Pathology Transport. Agency is also being used for gaps in Healthcare Support Worker staffing due to high vacancy rates.

Fit for the future

Improve the quality-of-care delivery and accessibility for patients by meeting locally agreed stretch targets.

- Performance against the 4-hr standard in ED decreased slightly in August with performance reported at 79.9%.
- Reducing time in department remained stable with 104 patients, 1.9% of Type 1 patients spending more than 12 hours in ED in August. This is below the national tolerance of <2% and the planned target of 4%.
- There were four reportable 12-hr delays for admission.
- The Trust remains a top performer in Ambulance Handover times, in August an average hand-over time of 14 mins 30 seconds against the national standard of <15mins. In August four handovers exceeded 45 minutes with none of those over 60 minutes.

Improvement activities continue to support further recovery going into 2026/27.

- In August average NEL length of stay decreased to 6.82 days, although remaining higher than planned levels, social care discharges continue to have an impact.
- 87.3% of patients were discharged on their discharge ready date.
- A daily average of 46 patients no longer meet the criteria to reside, actions to improve this will be incorporated into the discharge program work.
- There were 425 beds open in August, 5 beds less than planned.

At the time of writing the unconfirmed August RTT waiting list is 241 patients above plan.

- Key Waiting list pressures remain in all services.

Unconfirmed August RTT performance is 75.4% with eight 52+ week waiters in Urology at the end of the month.

The Elective Recovery Programme combines multiple approaches to ensure waiting times, and the volume of waiters are reduced, themes for recovery include demand management, targeted validation, and capacity realignment.

The Trust's cancer position has been affected by the increase in referrals for urgent suspected cancer in Breast, if this tumour

	site fails the target, it has a significant impact on the Trust overall performance. The unvalidated 28 Day Faster Diagnosis performance in August had decreased to 42%, significantly below the expected national position of 80% throughout 2026/27. 31 day performance for July was 97.1%, above the 96% standard. 62 day performance was 50.7% in July. Challenges in the breast tumour site and those pathways which are shared with other providers are ongoing. Diagnostics: The operating plan for 2026/27 now includes all DM01 waiters. The Waiting List at the end of August had fallen to 6069, this is 513 above plan. DM01 performance stands at 90%, above the plan of 88.2% but remains below the constitutional standard of 99%. **Evidence of reduction in cost base & an increase in patient care related income by the end of March 2027 to achieve the financial plan for 2026/27.** **Plan:** The Trust planned deficit for 2026-27 financial year is breakeven, and breakeven at month 4. Actual performance was £1.553m deficit which is an adverse variance of £1.553m. This is largely driven by unmet planned CRP, and unidentified gap being consistent with plan submission offset in part by higher than planned vacancies, internal mitigations and delayed spending against internal strategic initiatives. Risks remain around overspending against delegated budgets and identification and delivery of CRP on both a recurrent and non-recurrent basis. This risk is being further quantified through both internal financial accounting framework escalation, and the introduction of the Provider Assurance Model requirement for NHSE. **Cost Reduction Plan:** The Trust planned year-to-date CRP target in August was £10.999m and actual performance of £3.722m. Focus remains on identifying recurrent savings schemes to support future financial sustainability. Cash was £32.581m on 31st August 2026 which is above the £5m target set within the trust plan. However, the headroom between current cash balance and future run rate commitments, particularly capital expenditure, should CRP plans not be cash releasing in 2026-27 is challenging and forecasts suggest cash shortage towards the end of Q3. **Working together for healthier communities.** Gynaecology outpatient median waiting times increased to 32.9 weeks. Service plans to support recovery are in development to

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	improve waiting times. Paediatric autism assessments and diagnosis waiting times have decreased to a median wait of 64 weeks. Work continues to increase external income as part of business efficiency plans. QEF generated income is down in August from the previous 12 months.				
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The recommendations to the Committee are to receive this report, discuss the potential implications and note the improvement or challenge in key areas				
Trust strategic priorities that the report relates to:	☒	Excellent patient care			
	☒	Great place to work			
	☒	Working together for healthier communities			
	☒	Fit for the future			
Trust strategic objectives that the report relates to (2025 to 2030 strategy):	All strategic objectives				
Links to CQC Key Lines of Enquiry (KLOE):	Caring ☒	Responsive ☒	Well-led ☒	Effective ☒	Safe ☒
Risks / implications from this report (positive or negative):					
Links to risks (identify significant risks – new risks, or those already recognised on our risk management system with risk reference number):	Areas requiring attention: **Excellent patient care:** • Quality Improvement Plans • Estates risks • Harm falls rates • C-difficile rates **Great place to work:** • Staff engagement • vacancy rates • sickness absence rates. **Fit for the future:** • All cancer standards now at risk • RTT WL size, performance, and long waiters • UEC, 4 hour and long waits performance • Criteria to reside and non-elective LOS				

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	• Maintaining financial sustainability, reducing expenditure, and achieving CRP. **Working together for healthier communities:** • Waiting times for Gynaecology and Paediatric Autism patients • Smoking status recording		
Has an Equality and Quality Impact Assessment (EQIA) been completed?	**Yes** ☐	**No** ☐	**Not applicable** ☒

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Constitutional Standards 2026/27

Reporting Period: August 2026

Constitutional standards 2026/27	Constitutional Standards metrics Assurance Heatmap

NHS Gateshead Health NHS Foundation Trust

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

Constitutional Standards 2026/27

Metrics

NHS Gateshead Health NHS Foundation Trust

Metric	Target	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Ass/Var
Achievement of the A&E 4 hour standard **	>82%	82.2%	82.3%	77.4%	73.7%	77.6%	73.0%	69.1%	75.1%	75.1%	77.0%	74.3%	77.7%	80.1%	79.9%	
12 hour trolley waits (DTA to left department)	0	1	0	2	21	6	2	12	1	1	0	3	5	3	4	
% of ED attendances > 12 hours in department (Type 1) ** *Reset April 2025 to align with 2025/26 operational guidance definitions* *Standard reset April 2026 to align with 2026/27 plan*	<4%	0.25%	0.23%	1.19%	5.68%	1.61%	3.85%	9.59%	3.43%	5.13%	4.83%	5.10%	1.91%	1.84%	1.93%	
Ambulance handover delays 30-60 minutes	0	5	1	8	21	7	23	72	15	27	23	31	26	12	24	
Ambulance handover delays over 45 minutes **	0	0	0	0	8	1	15	37	6	15	16	14	5	9	4	
Achievement of the RTT 18 week standard **	>92%	68.6%	67.4%	68.3%	67.9%	69.5%	70.1%	71.4%	71.6%	77.5%	76.4%	78.4%	78.2%	77.2%	75.5%	H F
Achievement of the 52 week RTT standard **	0%	35	55	52	41	33	25	20	26	17	9	8	2	5	8	L F
Achievement of the 6 week diagnostic standard (DM01) **	>95%	74.8%	71.1%	81.6%	86.3%	96.6%	95.8%	94.6%	96.2%	95.2%	92.9%	92.2%	92.7%	92.1%	90.0%	H
Achievement of the Cancer 28 day standard ** *Reset April 2025 to align with operational guidance standard*	>80%	76.0%	75.6%	64.9%	74.7%	80.3%	72.2%	39.4%	55.2%	60.8%	42.8%	45.0%	47.3%	42.1%	42.0%	L
Achievement of the Cancer 31 day standard **	>96%	100.0%	97.9%	96.7%	100.0%	97.2%	92.2%	91.5%	99.0%	97.4%	97.9%	100.0%	96.7%	97.1%	96.6%	
Achievement of the Cancer 62 day standard ** *Reset April 2026 to align with 2026/27 operational guidance standard*	>80%	75.3%	70.8%	71.1%	72.7%	69.3%	60.1%	52.0%	63.0%	65.7%	65.7%	65.2%	60.1%	50.7%	57.4%	

Validated data unavailable at time of report

Constitutional Standards 2026/27

Metrics (SPC)

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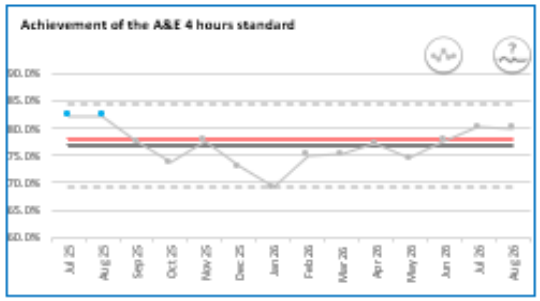

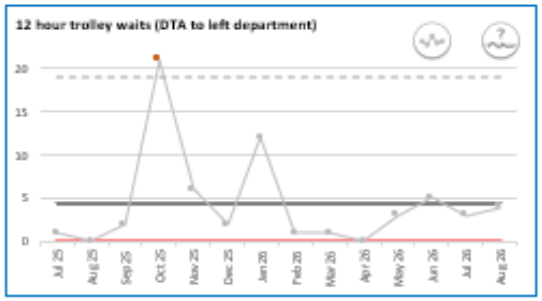

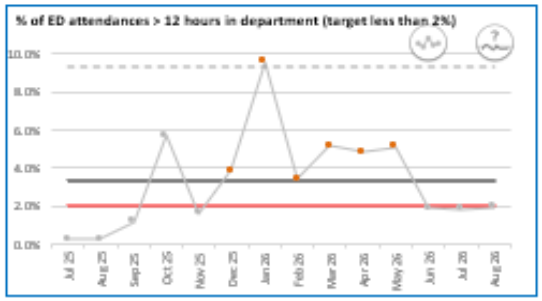

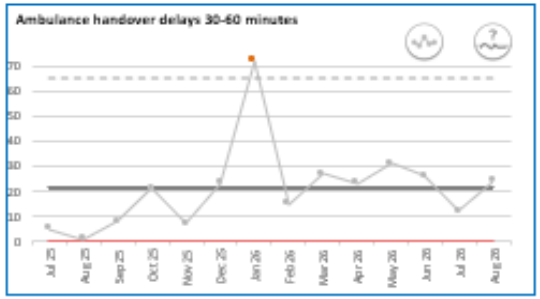

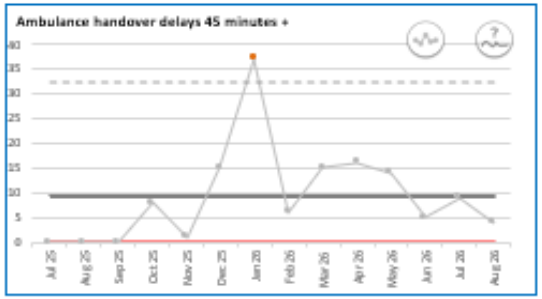

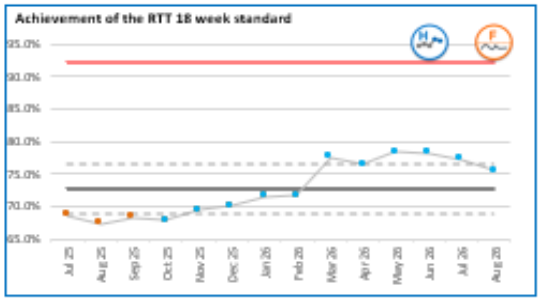

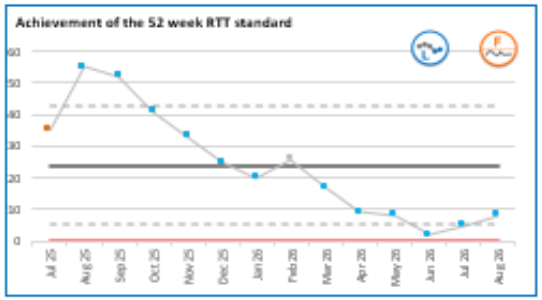

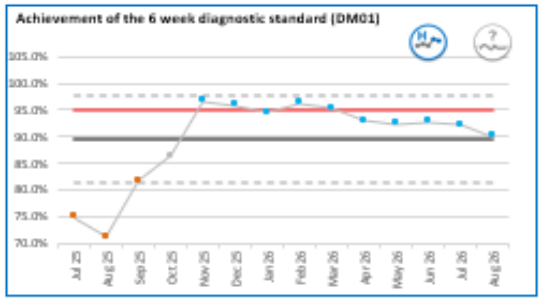

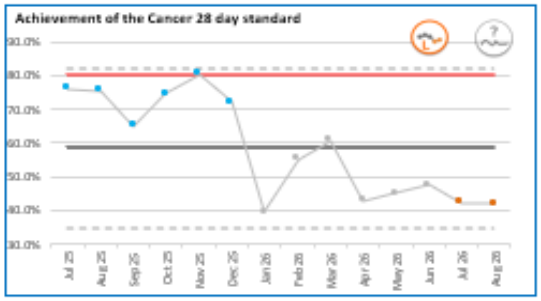

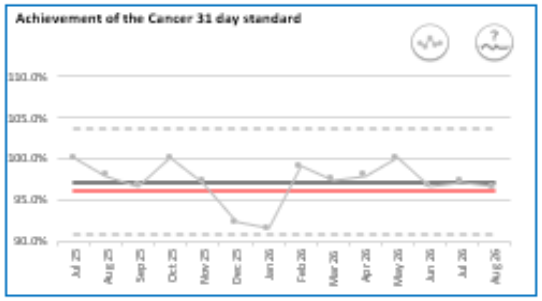

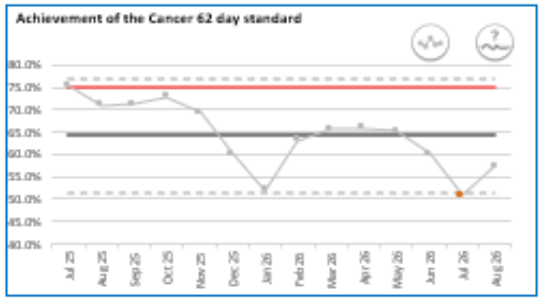

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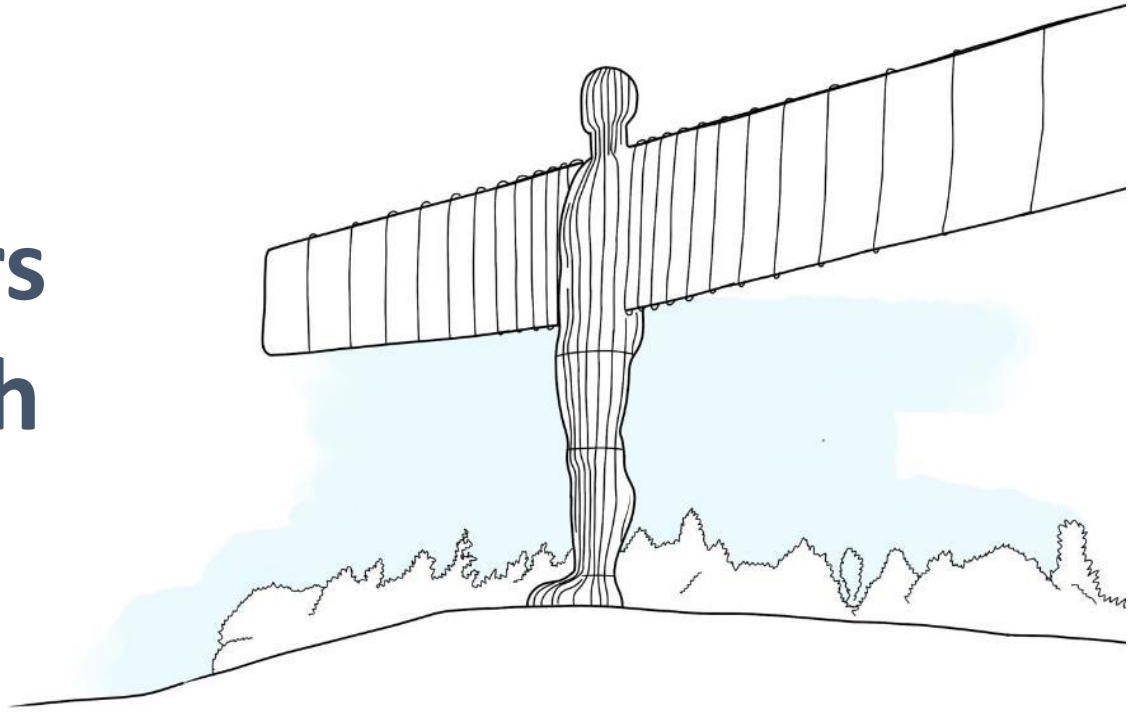
Strategic Objectives 2026/27

Leading Indicators and Breakthrough Objectives



Including Constitutional standards monitoring metrics

Reporting Period: August 2026

Strategic Objectives 2026/27 | **What are we aiming for**

NHS Gateshead Health NHS Foundation Trust

Our patients Our people Our partners

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

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

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

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

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

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

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

Our Strategic aims:

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

Our strategic intent:

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

Strategic Objectives 2026/27

Executive Summary

NHS Gateshead Health NHS Foundation Trust

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

Strategic Objectives 2026/27

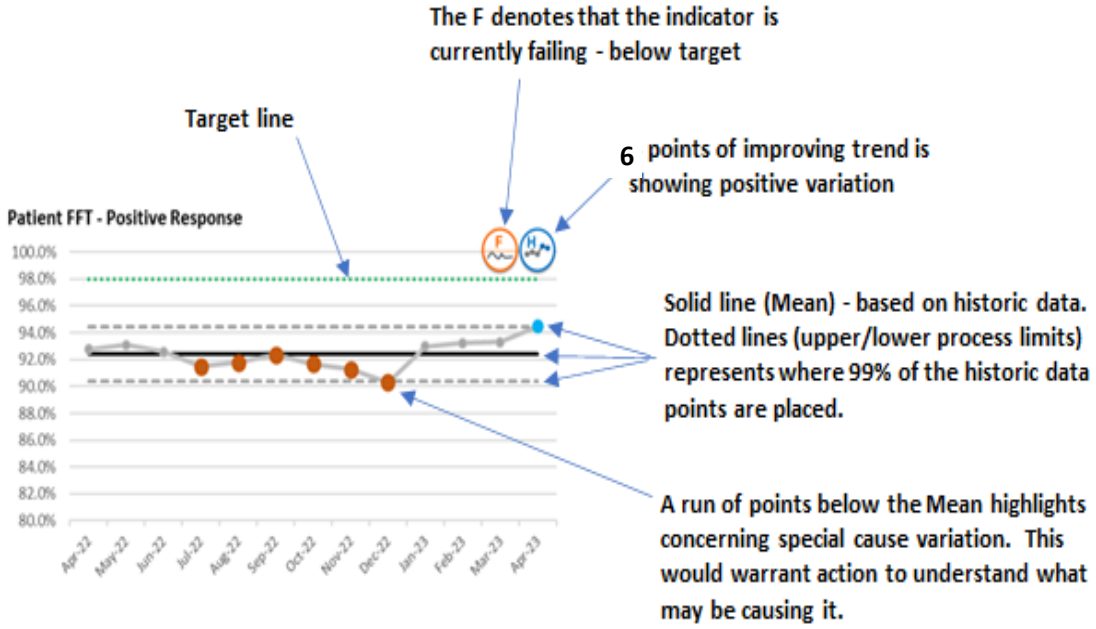
How to interpret the SPC icons and charts

Gateshead Health NHS Foundation Trust

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

What are Statistical Process Control (SPC) charts

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



SPC Rules

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

Icon Colours Explained

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

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

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

NHS Gateshead Health NHS Foundation Trust

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

NHS Gateshead Health NHS Foundation Trust

Strategic Objectives 2026/27

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

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

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

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

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

Metric	Target	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Ass/Var	Trend
LEADING INDICATORS																	
Ockenden Recommendations % compliance with Total Recommendations	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Maternity Incentive Schemes % compliance with Total Recommendations	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
Reduction in patient safety incidents linked to estate issues	<=4	2	2	5	8	6	5	7	5	4	6	3	6	4	3		
Compliance with the quality improvement plan indicated by the % of actions on track	100%	76%	84%	84%	84%	84%	84%	84%	84%	84%	84%	84%	88%	88%	88%		
BREAKTHROUGH OBJECTIVES																	
Reduction in severity of risk score linked to estates	TBA	266	234	246	240	256	244	263	267	205	206	206	197	205	217		
Harm falls rate per 1000 bed days (5% reduction)	3.2	4.61	4.78	4.12	3.75	4.31	5.18	3.49	4.56	4.43	3.10	4.24	4.43	3.93	4.10		
C.Diff Healthcare associated rate per 100,000 occupied bed days	<=3.20	28.9	0.0	46.1	42.8	22.2	14.0	20.4	70.4	34.9	50.4	28.8	30.2	22.5	7.6		
90% of staff to complete Mental Health Act training.	90%	88.0%	86.0%	91.0%	89.0%	87.0%	82.0%	86.0%	87.0%	91.0%	94.4%	88.0%	91.0%	94.0%	94.0%		
Venous thromboembolism (VTE) risk assessment	95%	99.1%	99.0%	99.3%	98.9%	99.0%	99.2%	99.3%	99.0%	99.2%	99.2%	99.0%	98.5%	96.3%	95.9%		
85% of staff to complete Learning disability and autism training	85%	79.39%	80.86%	81.76%	83.00%	83.72%	84.48%	86.17%	86.95%	87.24%	82.46%	80.51%	82.30%	84.62%	85.50%		

Strategic Objectives 2026/27

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

NHS Gateshead Health NHS Foundation Trust

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

Measures requiring focus this month

	Measure	Summary
1	Ockenden recommendations % compliance with total recommendations	Compliance 100%, Ongoing work to maintain full compliance including updates to website & personalised care plans in collaboration with our own Maternity & Neonatal Voices Partnership (MNVP) & the Local Maternity & Neonatal System (LMNS). Required audits embedded into ongoing audit plan. No further updates required by LMNS to evidence full compliance with this report.
	Maternity incentive schemes % compliance with total recommendations	The Trust is reporting compliance at 100%. Reported & confirmed by NHS Resolution that Gateshead Maternity Service satisfied the standards for full compliance.
2	Compliance with the quality improvement plan indicated by the % of actions on track.	Latest reported data relates to August 2026 with 88% of the Improvement Plan actions delivered, this is below planned levels. Action Plans are in place with the relevant action owners for actions that are reporting risk of non achievement. Non compliant areas: Trustwide appraisal rates, Staff retention, local induction checklist compliance. Actions not yet completed: Quality Strategy : >75% staff to receive the flu vaccination - This action was not achieved. Develop a Quality Oversight Report for Allied Health Professionals in line with Trust strategic aims and ambitions, the Trust AHP 3yr strategy, the national AHP strategy and the NHS long-term workforce plan. Due to organisation change process this work has not yet been enacted. Work to bring all AHP staff together is still ongoing and until this is complete we wont have access to the right data to develop this report. This Action will be reviewed as part of the 2025/26 QIP planning work. Future actions/developments: Reduction in harm caused by falls. The trusts Falls prevention group now meets monthly, Work ongoing work to reduce falls across the organisation, as well as nationally and across the region. A national Enhanced Care program has now been established to support with how we engage with patients to reduce falls. The documentation audit is currently paused while the quality team and clinical effectiveness team do some scoping work reviewing the current questions and linking with the CQC KHLOEs.
	85% of staff to complete GHFT Level 1 learning disability and autism training from April 2024. Develop plans for Level 1 Face to face interactive training as part of mandatory training offer.	Compliance with learning disability is 0.5% above the compliance level. Compliance has increased by 0.88% from last month. Learning disabilities training has been replaced with The Oliver McGowan Mandatory Training on Learning Disability and Autism Part 1 eLearning as of the 1st January 2026. Compliance from the learning disability has been transferred over to the new e-learning. Oliver McGowan Tier 1 and Tier 2 training is also taking place and is monitored via NHS England externally on a monthly basis.
	Improve Mental Health Act Policy Training Compliance to 90% for all *registered* staff via training and audit.	The number of mental health staff trained is currently at 94% which remains the same as August. Compliance for qualified staff remains at 95%. Compliance for HCAs & support workers has increased and is currently at 93%. Cragside are 100% compliant with training, Sunniside are 79% compliant, an increase from July. The CPN team, Younger Persons Memory Service, Memory Hub remain at 100% compliance with training. The Mental Health Liaison team remains at 89% compliance. The OT's are at 92% compliance. Bespoke training for OT staff is arranged for all new staff members rotating into the team. MHA awareness training has been provided for 50 acute staff. Updates on training compliance are emailed out to all MH ward/ team managers on a monthly basis.
	Improve our IPC C.Difficile infection rates per 100 000 occupied bed days.	Rates per 100 000 bed days have decreased to 7.6, one case was reported in August 2026, a total of nineteen to date in 26/27. A 10 point c-diff reduction plan is in place, with a drive to 'back to basics' for clinical areas particularly around hand hygiene, AMP and learning. A review into antimicrobial prescribing is ongoing. Community prevalence continues to be higher then normal levels, reflecting national and local elevated levels of C.Diff.
	Venous thromboembolism (VTE) risk assessment	Healthcare associated venous thromboembolism (VTE), commonly known as blood clots, is a significant international patient safety issue. The first step in preventing death and disability from VTE is to identify those at risk so that preventative treatments (prophylaxis) can be given. This data collection quantifies the numbers of hospital admissions (aged 16 and over at the time of admission) who are being risk assessed for VTE to identify those who should be given appropriate prophylaxis based on guidance from the National Institute for Health and Care Excellence (NICE). The Trust continuously performs well against the standard of 95% with August performance reported at 95.9%.
	Harm related falls will reduce by 5%.	57 harm falls were reported in August 2026, 54 of these were low harm and three severe harm. The falls steering group continue to meet and progress the current action plan. There was a discussion around the way the data is collated, which may be out of line with national reporting. A paper with a suggested change is being produced by the group to highlight the proposed changes, and will assist in determining new targets for falls prevention.
3	Reduction in risks and severity of scores linked to estate issues	August position, 19 Risks with combined critical infrastructure risk score of 217. 1 new risk in period, Ref- 4948 cath lab equipment [score 12], no other risks amended or closed.
	Reduction in patient safety incidents linked to estate issues	Three patient safety incidents related to estates issues in August 2026. No common themes were identified. Figures exclude incidents related to pressure damage and incidents reported as Harm not related to Gateshead on Inphase.
	Scoring in domains in areas of PLACE inspection composite score > 95%	Visits to Ward 21, Majors/UTC/SDEC, A&E and Fracture took place in August, The review of the Urgent Treatment Centre identified no matters requiring escalation to the Board. A number of areas were highlighted for ongoing monitoring and improvement, including the replacement of patient-room clocks with dementia-friendly alternatives, updating the nurse-in-charge board and signage to reflect current information and terminology, and providing a wider range of chair sizes to meet patients' varying needs. It was also suggested that a visual patient journey could be displayed to improve understanding of the patient pathway. Positive assurance was noted through the daily room-cleaning schedule and the availability of hand-sanitiser dispensers throughout the area. Treatment rooms were spacious and bright, although further visual enhancements could improve the environment.
	Reduction in value of backlog maintenance score as reported via the ERIC return	A clinically prioritised plan to review and deliver the backlog maintenance programme. The challenges are limitations on capital available to support the plan & CDEL allocation. Rationalisation of our existing aging estate is required. The capital programme has been confirmed and an update will be available when capital projects are completed.

Strategic Objectives 2026/27

We will be a great organisation with a highly engaged workforce

NHS Gateshead Health NHS Foundation Trust

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

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

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

Metric	Target	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Ass/Var	Trend
LEADING INDICATORS																	
Maintain the vacancy rate	<=2.5%	6.6%	6.3%	5.6%	6.7%	7.2%	7.3%	7.5%	7.5%	7.2%	6.8%	6.9%	7.3%	7.5%	6.8%		
Improve the staff engagement score	>=7.3	5.63						5.88			5.97			5.86			
BREAKTHROUGH OBJECTIVES																	
Achievement of the internal turnover standard	<=12%	12.0%	11.7%	12.1%	12.6%	12.4%	12.1%	12.0%	12.0%	12.2%	12.1%	12.4%	12.1%	11.8%	12.0%		
Achievement of the internal sickness absence standard	4.90%	5.58%	5.58%	5.57%	5.52%	5.50%	5.45%	5.41%	5.43%	5.46%	5.48%	5.50%	5.48%	5.51%	5.59%		
Reduction in temporary staffing spend of pay bill evidenced month on month	<=2.3%	0.5%	0.5%	0.3%	0.5%	0.4%	0.4%	0.7%	0.5%	0.6%	0.8%	0.9%	0.6%	0.6%	0.5%		

Measures requiring focus this month

Measure	Summary
Maintain the vacancy rate at <=2.5%	The Group vacancy rate reduced from 7.5% in July 2026 to 6.8% in August 2026, reflecting an improvement in the overall workforce position against budget. This reduction was driven primarily by a 38 WTE increase in trainee grade medical staff. Within the registered nursing workforce, the overall position remains relatively stable, with a vacancy rate of 3.1%. However, this masks some workforce movement within the staff group, with Band 5 Registered Nursing WTE decreasing by 7.2 WTE, partially offset by a 1.25 WTE increase in Band 7 nursing staff. Vacancies within Support to Nursing Staff have shown a longer-term improvement from the peak vacancy rate of 19.4% in August 2025, with a generally downward trend over the past four months. However, this progress reversed slightly in August, with the vacancy rate increasing from 12.4% in July to 13.2% in August 2026. Domestic Services continues to be an area of significant workforce pressure, with 24 WTE vacancies and a vacancy rate of 14.0%, remaining one of the highest vacancy rates across the organisation.
Improve the staff engagement score to 7.3	The annual staff survey results had a 42% completion rate, and an overall engagement score of 6.5, but a decline of 0.64 in the July People Pulse. There are various factors leading to this decline but areas with the largest in year change are career development and learning, advocacy and organisational confidence, and feeling valued. The results have been cascaded throughout in January/February, and the Board and senior leaders have agreed two key areas of focus; working harder to show that patient care is our top priority and prioritising engagement. Divisions reported on local progress via People and OD Steering Group in June 2026, outlining clear action plans to improve staff experience locally. Executive committee have approved a 'you said we did' narrative which will inform the promotional campaign in the lead up to the 2026 survey so staff are clear on what tangible actions have taken place, a clear communicaitions plan has been prepared.
Achievement of the internal turnover standard of 9.7%	While Trust turnover remains at target, turnover continues to be influenced by QEF, which remains affected by the March 2026 TUPE transfers. Outside of QEF, the largest contributors to turnover by volume continue to be the Trust's largest workforce areas within Medicine & Community, CSS and Surgical Services. At service level, turnover remains elevated within Clinical Support Therapy Services (16.2%), Community Services (12.7%) and Surgical SLM 3 (14.4%), reflecting ongoing turnover pressures within sizeable workforce groups. The most notable large workforce areas above target are Community Midwifery (24.8%), Occupational Therapy (14.7%), Community Contracting (20.9%), Domestic Services (17.5%) and New Lab Biochemistry (15.2%).
Achievement of the internal sickness absence standard of 4.9%	Sickness absence deteriorated during August, with the rolling 12-month rate increasing to 5.59% and in-month sickness rising sharply from 5.2% to 5.7%. The increase is notable given the time of year and warrants monitoring as the organisation enters the autumn and winter period. The greatest impact continues to come from the Trust's largest workforce areas, particularly Medicine & Community (2,239 FTE days lost), Surgical Services (1,818 FTE days lost) and CSS (1,658 FTE days lost). Community Services (11.4%), Surgical SLM 1 (7.7%) and Clinical Support Pathology (6.0%) remain key areas of pressure, with Pathology recording 743 FTE days lost during August. Anxiety, stress and depression continues to be the largest cause of sickness absence across the organisation.
Reduction in temporary staffing spend evidenced month on month reduction and no higher than 2.3 % of pay bill.	Agency spend remains under target at 0.5% and has been consistently under target in the past 12 months. Agency spend continues in hard to fill roles in Elderly Care, Surgery, Cardiac Diagnostics and QEF Pathology Transport. Agency is also being used for gaps in Healthcare Support Worker staffing due to high vacancy rates.

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

NHS Gateshead Health NHS Foundation Trust

Improve the quality of care delivery and accessibility for patients

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

Metric	Target	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Ass/Var	Trend
LEADING INDICATORS																	
Average Length of Stay Non-Elective ** *Reset April 2025 to align with operational guidance definitions*	<=4	7.66	7.66	7.75	8.13	7.51	7.59	8.14	7.92	8.25	8.45	7.61	7.24	7.90	6.82		
Achievement of the 4 hours trajectory ** *Standard reset April 2026 to align with 2026/27 plan*	>82%	82.2%	82.3%	77.4%	73.7%	77.6%	73.0%	69.1%	75.1%	75.1%	77.0%	74.3%	77.7%	80.1%	79.9%		
Achievement of the 52 week RTT standard **	0	35	55	52	41	33	25	20	26	17	9	8	2	5	10		
Achievement of financial Plan - Variance (£k)	Figure in brackets favourable	0.337	-0.027	-0.174	-0.185	-0.032	-0.007	-0.207	-0.041	-0.057	0.570	1.4	2.557	1.873	1,553		
Finance - Forecast Out-turn Deficit (Plan)	tbc	8,381	8,381	8,381	8,381	8,381	8,381	8,381	8,381	5,048	0	0	0	0	0		
BREAKTHROUGH OBJECTIVES																	
Achievement of the trajectory to reduce >12 hour total time in Emergency Department (Type 1) ** *Standard reset April 2026 to align with 2026/27 plan*	0	16	13	67	337	98	240	567	182	308	262	299	112	105	104		
	4.0%	0.3%	0.23%	1.19%	5.68%	1.61%	3.85%	9.59%	3.43%	5.13%	4.83%	5.10%	1.91%	1.84%	1.93%		
Reduce the number of patients with no Criteria to Reside **	<10	49	45	43	45	42	48	48	54	54	51	40	45	46	46		
Achievement of the trajectory to achieve RTA to Bed within 1 hour **	60.0%	19.1%	16.9%	10.3%	8.3%	13.5%	9.4%	5.9%	10.3%	8.7%	9.4%	6.5%	11.2%	16.2%	16.1%		
Reduce % of Follow up Outpatient without procedures *Reset April 2025 to align with 2025/26 operational guidance definitions*	<=67%	66.4%	66.7%	65.0%	65.1%	65.2%	65.7%	64.4%	63.8%	64.0%	67.1%	66.3%	65.6%	67.4%	68.6%		
CRP Delivery Variance	Figure in brackets favourable	0	0	0	0	0	0	0	0	0	1556	2846	4143	5933	7277		
No less than £5m cash as per forecast at year end	>=£5m	£24m	£31m	£22m	£24m	£18m	£19.3m	£19.9m	£31m	£30m	£30m	£28m	£24m	£26m	£32.6m		

Validated data unavailable at time of report

** improvement workstream in place

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

NHS Gateshead Health NHS Foundation Trust

Improve the quality of care delivery and accessibility for patients

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

Measures requiring focus this month

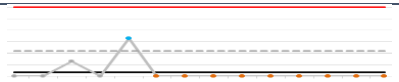
Measure		Summary
1	**Average Length of Stay Non-Elective <4 days**	Length of decreased significantly during August. Alongside ongoing improvement work, flow remained good and EAU had capacity which allowed further patients to be reviewed and discharged in a timely manner.
	Achievement of the 4 hours trajectory	ED 4-hour performance deteriorated slightly to 79.8%, but remains in a positive position when compared with regional colleagues. A plan to introduce Rapid Access and Treatment more consistently should take effect in October which is anticipated to have a positive impact.
	Achievement of the trajectory to reduce >12 hour total time in Emergency Department	12-hour waits remain high but steady. This reflects high bed occupancy persisting into August
	Achievement of the trajectory to achieve 60% RTA to Bed within 1 hour	Performance remains steady
	Reduce the number of patients with no Criteria to Reside	The number of patients without criteria to reside has remained static, and levels remain well above the target of <10, indicating continuing discharge flow challenges including procurement of beds and package of cares for P2/3 patients.
	Achievement of the 52 week RTT standard and delivery of the waiting list trajectory	The number of patients waiting over 52 weeks for treatment has increased to 10 in August all in Urology. The Urology position remains challenging and we continue to work through a series of actions to mitigate the current position, including consideration of the continuation of insourcing, mutual aid, additionality from current workforce and wider work within the alliance.
	Increase in New Outpatient activity	We continue to scope alternative ways of working to ensure we achieve the standard through the elective care transformation group with the aim to achieve the required standard consistently
2	**Evidence achievement of the financial plan**	The Trust planned deficit for 2026-27 financial year is breakeven, and breakeven at month 4. Actual performance was £1.553m deficit which is an adverse variance of £1.553m. This is largely driven by unmet planned CRP, and unidentified gap being consistent with plan submission offset in part by higher than planned vacancies, internal mitigations and delayed spending against internal strategic initiatives. Risks remain around overspending against delegated budgets and identification and delivery of CRP on both a recurrent and non-recurrent basis. This risk is being further quantified through both internal financial accounting framework escalation, and the introduction of the Provider Assurance Model requirement for NHSE. The Trust planned year-to-date CRP target at August was £10.999m and actual performance of £3.722m. Focus remains on identifying recurrent savings schemes to support future financial sustainability. Cash was £32.581m at 31st August 2026 which is above the £5m target set within the trust plan. However, the headroom between current cash balance and future run rate commitments, particularly capital expenditure, should CRP plans not be cash releasing in 2026-27 is challenging and forecasts suggest cash shortage towards the end of Q3.
3	**Review & revise the green plan & align with the group structure**	Plans to embed the Green plan governance structure and align with group governance. 10 workstreams will provide update reports aligned to our sustainability objectives. Work plan priorities include: waste, active travel, fleet, procurement, estates & facilities, workforce/communications, sustainable care, medicine, digital transformation and adaptation. Plans include a survey of understanding across the Board/EMT and Senior Leadership Group members.

Strategic Objectives 2026/27

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

NHS Gateshead Health NHS Foundation Trust

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

Metric	Target	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Ass/Var	Trend
BREAKTHROUGH OBJECTIVES																	
Increase in the number of digital devices repurposed to the local community	>300	0	0	66	0	164	0	0	0	0	0	0	0	0	0	L, F	
Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients *Reset September 2025 to align with National definitions*	>=98%	95.5%	93.7%	91.0%	90.9%	89.2%	89.8%	90.5%	90.3%	90.3%	90.6%	90.0%	91.1%	90.5%	90.5%	F	
Reduction in the wait for gynaecology outpatients to no more than 26 weeks	<=26	33.0	32.0	32.0	32.0	29.9	29.0	29.0	28.9	27.0	27.0	27.3	29.6	31.9	32.9	H, F	
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30	<=30	42	69	38	27	62	58	32	61	40	89	59	56	65	64	?	

Measures requiring focus this month

Measure	Summary
Evidence a reduction in the number of 'fragile' and 'vulnerable' services as a direct outcome of Alliance working	This will be reviewed quarterly as part of the Provider Collaborative Sustainability review. Outputs and products from this work will be reviewed to inform the annual planning process and is contained in the Project Plan for 2025/26 to support planning for 2026/27.
Evidence in an improvement in health inequalities in the key focus areas linked to the determinants of Health for Gateshead	Key determinants of Health for Gateshead are to be defined through the Health Inequalities Group workstream. Evidence/measures and controls will be implemented as part of the focused work to progress in 2026/27.
Increase in the number of digital devices repurposed to the local community	Digital exclusion is where members of the population have inadequate access and capacity to use digital technologies that are essential to participate in society. The risk to this target is that the quantity of devices being made available for recycling and repurposed is dependant on Trust usage and need. This is therefore entirely variable throughout the course of the year. In 24/25 318 devices reached end of life, the Trust will continue to recycle equipment as swiftly and efficiently as possible with 324 devices being recycled in 2025/26.
Smoking status to be recorded in the clinical record at the immediate time of admission in 98% of all inpatients	August compliance 90.5%, these figures now take into account patients that are admitted and discharged on the same day following review of national guidance. Previously only patients with an overnight stay were included in this calculation. The numbers have reduced given the challenges of collecting the smoking status for patients admitted and discharged same day - many of these patient have only been an inpatient for possibly as low as an hour or two. GHNFT has the highest performing smoking status recorded on admission in the NENC ICB region, this has been consistent for >12 months. Ongoing actions to improve compliance are - Training of all staff on Nervecentre. Regular focused Tobacco dependency training on wards both ad hoc and planned. Communication Strategy. The Tobacco Dependency Treatment Service is providing an equitable service for all patients with 7 day a week coverage although sickness absence is a temporary challenge to this. Weekend working for the QUIT team was due to be introduced to ensure smoking status collection on weekends, however due to low staffing levels this has not yet been implemented.
Reduction in the wait for gynaecology outpatients to no more than 26 weeks	The median wait for 1st OP appointment in Gynaecology increased to 32.9 weeks in August due to pressures in antenatal capacity where we have prioritised resources, as well as redirecting resource to urgent rapid access clinics to address demand. We continue to focus on reducing waits through the elective care transformation group with key workstreams on increasing PIFU, A&G, Reducing DNA's and clinic template review to increase new patient capacity. New single point of access model now live following a successful pilot to focus on demand and ensuring patients are seen at the right place by the right team.
Reduction in the waiting times for paediatric autism pathway referrals from over 52 weeks to <30 weeks	Current median wait has reduced to 64 weeks, with the average time for 1st Outpatient appointment also decreasing. Overall waiting list size has increased slightly due to a reduction in capacity- sickness/ leavers within the service and a workshop took place in June and again in August to review the operational delivery model. Continues to be monitored weekly through Access & Performance meetings.

Strategic Objectives 2026/27

We will develop and expand our services within and beyond Gateshead

NHS Gateshead Health NHS Foundation Trust

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

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

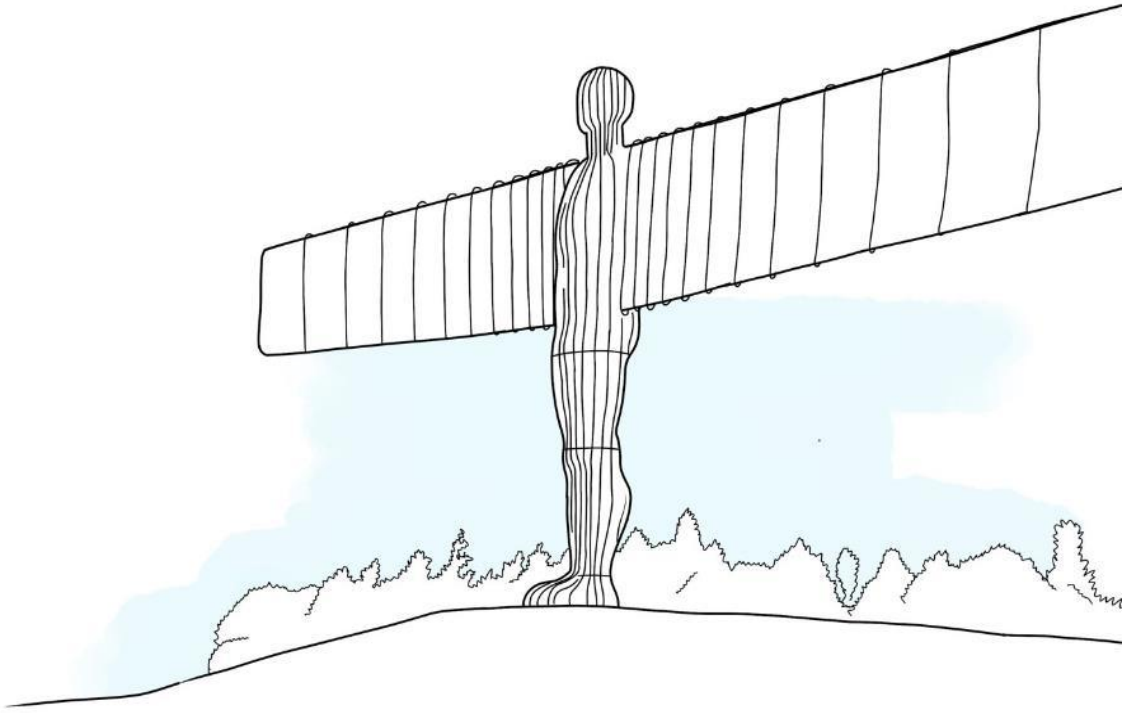
Metric	Target	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Ass/Var	Trend
LEADING INDICATORS																	
0.5% increase in QEF externally generated turnover from previous financial year	>=0.5%	24.0%	28.6%	22.9%	20.0%	19.0%	11.1%	11.0%	9.2%	13.3%	18.8%	12.3%	-4.9%	-4.1%	-2.2%		

Measures requiring focus this month

Measure	Summary
0.5% increase in QEF externally generated turnover	Impact in August of IT Procurement framework income being down by £167k YTD compared with 2025-26. This is expected to be timing. Work is currently ongoing within QEF to target increases in external income as part of Business Efficiency plans within the service, this is across VAT Consultancy, Logistics services and Pharmacy in the first instance. Pharmacy is up compared to prior year with high revenue YTD in External Homecare due to a number of new contracts with Northumbria and North Cumbria.

NHS
Gateshead Health
NHS Foundation Trust

Plan and Benchmarking 2026/27



Reporting Period: August 2026

Contractual & Planning Standards						M5 2026/26 Year to Date				
Activity	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Plan	Activity		Variance	% Variance
POD										
Daycase	101.2%	89.3%	110.0%	99.3%	93.7%	16,073	15,836		- 237	98.5%
Elective Overnight	101.7%	95.5%	100.4%	98.1%	106.9%	1,242	1,245		3	100.2%
Total Inpatients	101.2%	89.8%	109.2%	99.2%	94.5%	17,315	17,081		- 234	98.6%
Outpatient New Consultant Led	98.5%	93.4%	113.9%	94.3%	86.8%	21,737	21,235		- 502	97.7%
Outpatient Follow Up Consultant Led	106.2%	103.4%	122.9%	105.1%	96.8%	27,420	29,322		1,902	106.9%
Total new Outpatient attendances	95.0%	90.3%	110.5%	94.8%	86.6%	33,744	32,264		- 1,480	95.6%
Total follow up Outpatient attendances	102.2%	95.5%	117.1%	100.2%	93.5%	78,117	79,387		1,270	101.6%
OP Follow Up with procedures Consultant Led	82.0%	105.7%	104.5%	106.8%	117.6%	685	706		21	103.1%
Non Elective	1,851	1,925	1,967	1,964	1,843	9,551	9,550		- 1	100.0%
Emergency (UEC attendances)	10,046	10,619	10,729	10,518	10,055	50,596	51,967		1,371	102.7%

2026/27 High Level Plan & Contractual Standards

Planning Domain	Planning Metric	2026/27 Target	2026/27 Plan Mar 27	M1	M2	M3	M4	M5	M5 Position
				Variance against plan					
Finance	Surplus/Deficit Position	Breakeven	Breakeven	-£570,000	-£1,400,000	-£2,557,000	-£2,004,000	-£1,716,000	●
	CIP as % of allocation/ operating expenses	6%	£ 27,667,000	-£1,556,000	-£2,846,000	-£4,143,000	-£5,933,000	-£7,277,000	●
				Variance against plan					
Reducing the time people wait for elective care	Percentage of RTT Waiting List < 18 weeks	82%	82%	2.40%	3.40%	2.10%	0.1%	-2.4%	●
	Patients waiting > 52 weeks for treatment	Zero	Zero	9	8	2	5	8	●
	Total Waiting List*	Reduce	11,028	-61	111	-188	110	245	●
	28 Day Faster Diagnosis Standard	80%	80%	-37.2%	-35.0%	-32.7%	-37.9%	-38.0%	●
	31 day treatment standard	94%	96.30%	1.8%	3.7%	0.40%	1.10%	0.00%	●
	62 day first definitive treatment standard	80%	75.2%	-7.9%	-8.7%	-13.8%	-23.7%	-17.9%	●
	DM01 Diagnostic Waits > 6 weeks	Reduce	9.90%	-5.7%	-4.9%	-5.1%	-4.2%	-1.7%	●
	DM01 Diagnostic Waiting List*	Reduce	5,560	542	695	672	864	513	●
				Variance against plan					
Improving UEC waiting times	4-Hr A&E performance	82%	82%	-4.7%	-7.4%	-9.10%	-1.10%	-2.40%	●
	4-Hr Paediatric performance *	95%	95%	0.20%	1.20%	1.10%	2.20%	3.50%	●
	% 12-hr time in department breaches	4%	4%	0.80%	1.10%	-2.10%	-2.20%	-2.10%	●
	12- hr DTA Breaches	Zero	4%	0	3	5	3	4	●
	Average Hand over times*	<00:15:00	<00:15:00	00:00:20	00:00:24	00:00:28	00:00:40	00:00:30	●
	Handover delay +45 mins*	0	0	16	14	5	9	4	●
	Handover delays +60 mins*	Zero		5	3	2	3	0	●
				Variance against plan					
Improving community services waiting times	Rapid Response < 2 hrs*	80%	80%	-1.8%	-6.49%	-7.72%	-5.15%	-7.81%	●
	Community RTT < 18 weeks	78%	84%	1.1%	-1.7%	-2.30%	-2.00%	0.30%	●
	Community RTT C&YP		74.70%	11.9%	8.3%	10.70%	7.60%	-1.00%	●
	Community RTT Adults		87.90%	-3.00%	-5.20%	-6.80%	-5.40%	0.40%	●
	Community > 52 week waiters	Zero	Zero	139	176	193	129	7	●

Unconfirmed data

NHS England Performance Dashboard/Trust Ranking

	RTT < 18 weeks Rank of 107	RTT > 52 weeks Rank of 117	Cancer FDS Rank of 117	Cancer 31 Day Rank of 117	Cancer 62 Day Rank of 117	Diagnostics DM01 Rank of 117	A&E 4-hr Rank of 117	A&E 12-hr Rank of 117
	Jul-26	Jul-26	Jul-26	Jul-26	Jul-26	Jul-26	Aug-26	Aug-26
Gateshead Health NHS FT	77.2% 4	0.0% 10	42.1% 117	97.1% 33	50.7% 116	7.9% 24	79.9% 19	2.0% 8
Northumbria Healthcare NHS FT	83.9% 1	0.00% 1	86.4% 14	93.6% 71	83.6% 13	0.4% 2	91.80% 1	0.10% 1
Newcastle Upon Tyne Hospitals NHS FT	73.9% 8	0.8% 45	85.3% 19	74.7% 117	66.8% 90	19.8% 67	77.0% 46	2.0% 9
North Cumbria Integrated Care NHS FT	66.1% 47	1.1% 55	78.3% 78	93.1% 77	70.9% 67	16.6% 51	64.5% 108	8.5% 47
South Tyneside & Sunderland NHS FT	75.8% 6	0.0% 4	82.7% 38	99.0% 7	73.4% 52	29.2% 64	78.9% 29	0.9% 4
North Tees & Hartlepool NHS FT	71.2% 17	0.7% 41	78.2% 81	87.7% 105	59.9% 106	7.7% 23	82.8% 8	1.7% 6
County Durham & Darlington NHS FT	no data no rank	2.2% 97	71.9% 107	89.4% 100	74.8% 44	18.6% 58	77.9% 35	10.9% 64
South Tees Hospitals NHS FT	65.8% 53	1.3% 65	79.2% 71	84.2% 112	67.1% 88	15.4% 47	79.1% 26	3.1% 14

6. ITEMS FOR INFORMATION / MEETING GOVERNANCE

a - Register of Official Seal

Presented by the Company Secretary

Gateshead Health NHS Foundation Trust

Report Cover Sheet Agenda Item: 6a

Report Title:	**Register of Official Seal**			
Name of Meeting:	Board of Directors			
Date of Meeting:	29th September 2026			
Author:	Diane Waites, Corporate Services Assistant			
Executive Sponsor:	Sean Fenwick, Chief Executive			
Report presented by:	Jennifer Boyle, Company Secretary			
Purpose of Report *Briefly describe why this report is being presented at this meeting*	**Decision:** ☐	**Discussion:** ☐	**Assurance:** ☒	**Information:** ☐
	To received details of the use of the Trust's official seal between 1 September 2025 and 31 August 2026			
Proposed level of assurance *– to be completed by paper sponsor:*	**Fully assured** ☒ *No gaps in assurance*	**Partially assured** ☐ *Some gaps identified*	**Not assured** ☐ *Significant assurance gaps*	**Not applicable** ☐
Paper previously considered by: *State where this paper (or a version of it) has been considered prior to this point if applicable*	n/a			
Key issues: *Briefly outline what the top 3-5 key points are from the paper in bullet point format* *Consider key implications e.g.* • *Finance* • *Patient outcomes / experience* • *Quality and safety* • *People and organisational development* • *Governance and legal* • *Equality, diversity and inclusion*	In accordance with the Board's Standing Orders paragraph 25.5, the Board must receive an annual report documenting when the official Trust seal has been used throughout the year. This report is presented to the Board each September in accordance with the cycle of business and formally documents the use of the official seal in accordance with Standing Order paragraph 25.5.			
Recommended actions for this meeting: *Outline what the meeting is expected to do with this paper*	The Board is asked to formally note the use of the official seal during this current year (September 2025-2026).			

Gateshead Health NHS Foundation Trust

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

Gateshead Health NHS Foundation Trust

Gateshead Health NHS Foundation Trust

Register of Official Seal

1 September 2025 – 31 August 2026

Seal No	Date	Description	Signed	Witness
323	31.03.2026	Transfer of whole of registered title – Shearer House, Hillfield Street, Gateshead NE8 1QE	Gerry Morrow Sean Fenwick	Kris Mackenzie

b - Cycle of Business 2026/27

Presented by the Company Secretary

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

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

c - Questions from Governors in Attendance

d - Any Other Business

e - Date and Time of Next Meeting - 9:30am on Wednesday 25 November 2026

Meeting Closure and Exclusion of the Press and Public